| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676230 | A. Building<br>B. Wing | 04/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Copperfield Healthcare and Rehabilitation | 7107 Queenston Blvd<br>Houston, TX 77095 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner in an environment that promotes maintenance or enhancement of his or her quality of life and recognizing each resident's individuality for 1 (Resident #1) of 4 residents reviewed resident rights. The facility failed to ensure CNA A treated Resident #1 with dignity and respect on [DATE] at 11:31 pm when discussing the need for incontinent care with the resident. This failure could place residents at risk for a diminished quality of life and a negative impact on the residents' psychosocial well-being. Findings included:Record review of Resident #1's face sheet revealed a 77- year- old man who was admitted to the facility on [DATE]. Admitting diagnoses were Parkinson's Disease (a progressive movement disorder of the nervous system), difficulty in walking, lack of coordination, muscle wasting and atrophy, and multiple myeloma without remission (type of blood cancer that originates in plasma cells, a type of white blood cell responsible for producing antibodies). Resident #1 received hospice services and was coded as a DNR (a medical directive instructing healthcare providers not to perform CPR if a patient's heart or breathing stops). Record review of Resident #1's MDS (resident assessment tool used to document a resident's clinical status, functional abilities, and care needs) completed [DATE] revealed a BIMS (cognitive assessment) score of 08 (moderate cognitive impairment). He required substantial and maximum assistance for toileting/hygiene and to shower and bathe himself. For toilet transfer, tub/shower transfer, sit to stand, and walk 10- 50 feet, Resident #1required supervision/maximal assistance. Record review of Resident #1's care plan initiated [DATE] revealed Resident #1 was dependent on staff for activities, cognitive stimulation, social interactions and he had the potential for problems with his psychosocial well-being related to hospice services and psychotic disorders. Care plan revealed a potential for ADL self-care performance and he was incontinent of bowel and bladder. Interventions highlighted checking for incontinence as required and allowed time to answer questions to verbalize feelings, perceptions, and fears. On [DATE] the care plan was updated to include that Resident #1 had the right to health, safety, and dignity as demonstrated by choice in implementation of the electronic device monitoring in his room. Record review of Resident #1's Request for Authorized Electronic Monitoring form 0066 dated [DATE] was signed by Resident #1's family member. In an interview on [DATE] at 11:28 a.m., Resident #1's FM stated on [DATE] around 11:30 p.m., she saw CNA A talking to Resident #1 after providing care to his roommate on video surveillance. FM stated that she would send the video footage to the surveyor for review. She stated that after this exchange, CNA A provided incontinent care to Resident #1. An observation on [DATE] at 2:31 p.m. of video footage inside of Resident #1's room on [DATE] at 11:31 p.m., CNA A asked Resident #1 if he needed to be changed. Resident #1 responded I will and CNA A stated You will? What that mean? You will or you do right now. When I'm leaving, I'm gone. Resident #1 responded, but it was low and inaudible through the footage. CNA A stated Well I'm asking, don't talk in riddles, I'm not well in riddles.either you need it now or you don't and the footage was cut off. In an interview on [DATE] at 12:06 p.m., Resident #1 said he could not remember the exchange between himself and<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676230 | A. Building<br>B. Wing | 04/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Copperfield Healthcare and Rehabilitation | 7107 Queenston Blvd<br>Houston, TX 77095 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | CNA A when she provided incontinent care on [DATE] at 11:30 p.m. He said he remembered seeing her around 4:30 a.m., and she made him feel this big (small, used his left hand to his left thumb and pointer finger parallel to each other). He stated that CNA A made him feel like she wanted nothing to do with him and he tried not to be that way with people. In an interview on [DATE] at 1:51 p.m., CNA A stated that she worked at the facility for 6 years before she was terminated. She said she normally worked the 10 p.m.- 6 a.m. shift and her first time working with Resident #1 was on [DATE]. She stated that she did not remember the exchange between her and Resident #1. She said she was probably playing and she sometimes just said things although she was not familiar with him. She said if she normally interacted with residents in an offensive way then she would have been reported more times prior to the incident and she had to be distracted or something. CNA A stated she was aware there was a camera in the room and she was suspended on [DATE]. She said she was asked to come in on [DATE] for an in-service and a statement about what happened. CNA A stated that she felt confused and deceived because she did not view the video footage and thought she was terminated because she told Resident #1 that he had shit on his hands as she was about to provide incontinent care. In an interview on [DATE] at 3:09 p.m., the DON stated that Resident #1's FM reported that CNA A was disrespectful and unprofessional with him (Resident #1) and she was adamant she did not want CNA A to work with him. The DON said CNA A was suspended while administration began their investigation. The DON said when CNA A was asked to come in and provide her statement, she was defensive and overtalked. The DON stated CNA A had members of her family call the facility to curse out administration, which ultimately led to her termination. The DON stated if CNA A would have just answered the questions to clear up things, she would have been given a 1-1 in-service on customer service but she continued to dig herself into a deeper hole. In an interview on [DATE] at 3:33 p.m., the ADM stated CNA A's response about talking in riddles to Resident #1 was inappropriate. The ADM stated she usually received compliments regarding CNA A but if you did not know her, the way she talked to people would make you go woah. She stated CNA A had received a write up on her customer service in the past but could not recall the date. The ADM stated that CNA A was terminated because of her attitude, her customer service, and because her daughter had called her (the ADM) on the phone and cursed her out. Record review of CNA's A Counseling/ Disciplinary Notice dated [DATE] revealed that she received a verbal warning due to arguing with a resident's family member. CNA A documented on the notice that she felt disrespected by the family member but the customer was always right. She was given a 1-1 in-service on customer service and professionalism. Record review of CNA A's termination form dated [DATE] revealed that her last day worked was on [DATE] and she was involuntarily terminated due to professionalism and customer service concerns noted after review of video footage. CNA A was termed over the phone on [DATE]. Record review of a Staff Development/In-service titled Abuse, Neglect, Exploitation on [DATE] was given to all staff. Record review of a Staff Development/In-service titled Professionalism/ Customer Service on [DATE] was given to all staff. Record review of a Staff Development/In-service titled Resident Rights on [DATE] was given to all staff. Record review of the facility's policy titled Resident Rights and Responsibilities revised [DATE] revealed: It is the policy of this facility to inform the residents both orally and in writing of their rights as a resident, as well as the rules and regulations governing the resident's conduct and responsibilities during their stay in the facility. Prior to or upon admission, a representative of the admitting office will provide the residents with a written copy of residents' rights. To ensure that our residents, staff, and visitors are continually informed and aware of resident rights, grievance procedures, and responsibilities, large print copies may be posted in a prominent area in the facility. |