

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/09/2025
NAME OF PROVIDER OR SUPPLIER  Champions Healthcare at Willowbrook		STREET ADDRESS, CITY, STATE, ZIP CODE  13500 Breton Ridge Houston, TX 77070	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>(continued on next page)</p>

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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 of 10 (Resident #5) residents reviewed for dining services in 1 of 1 dining room. The facility failed to promote Resident #5's dignity on 10/28/2025 while dining when staff did not serve the resident her lunch tray at the same time as other residents at the same table. This failure could affect all residents who eat in the dining room, by contributing to poor self-esteem, and unmet needs. Findings included: Review of Resident #5's Face Sheet dated 10/28/2025 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5's diagnoses included heart failure, type 2 diabetes mellitus with unspecified complications (high blood sugar), hypertension (high blood pressure), cerebral infraction (stroke), convulsions (sudden and uncontrolled electrical disturbance in the brain that causes changes in behavior, movements, feelings, and consciousness), lack of coordination, anxiety (feeling of uneasiness or worry), and depression (mood disorder that causes persistent feeling of sadness). Record review of Resident #5's Quarterly MDS dated [DATE] revealed Resident #5 had a BIMS of 12 which indicated moderate impairment. The MDS also revealed that the residents were independent with eating. Record review of Resident #5's care plan dated 6/28/2025 revealed [Resident #5] had unplanned/unexpected weight gain related to overeating. The goal reflected [Resident #5] would not develop complications from weight gain such as skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, and impaired mobility. Interventions were to monitor/record eating habits, and patterns to assist in determining cause of overeating. Monitor/record/report to MD PRN situations leading to increased food consumption, reasons for weight gain, and significant weight changes. Weigh as ordered. Observation of dining services on 10/28/2025 at 11:45am revealed that Resident #5's tablemate got her meal tray. Resident #5 was still waiting for her meal tray; staff were passing trays to other tables. During an interview on 10/28/2025 at 12:03pm it was revealed that Resident #5 had to wait most of the time to get her meal tray. Resident #5 said that staff put her meal tray on the cart with the hall trays on 10/28/2025. She said she would like her meal tray when her tablemate got her tray. She said she did not feel good when she had to wait to get her food. Observation of dining services on 10/28/2025 at 12:09 pm revealed Resident #5 received her meal tray. Resident #5's tablemate had already finished her lunch by the time Resident #5 got her meal tray. During an interview on 10/29/2025 at 2:23 pm with the DM revealed he had been trained on resident rights. He said the policy for passing meal trays was staff were to serve one table at a time before moving to the next table. He said the nursing staff were to give the kitchen staff a list of residents eating in the dining room. He said a resident may feel upset because everyone was eating except them. He said nurses were supposed to monitor to ensure residents were getting their meal tray with their tablemates. He said the nurses monitored by checking the meal trays to ensure all residents had a tray at that table. He said that Resident #5 did not get her meal tray with her tablemate due to staff not putting Resident #5 on the list of dining room residents. During an interview with the ADM on 10/28/2025 at 3:04pm it was revealed that the facility did not have a meal tray policy. During an interview on 10/29/2025 at 1:28pm with CNA C revealed she had been trained on resident rights. She said the policy for meal tray pass in the dining room was to serve all residents at the same table at the same time. She said that the DM would get a list of residents every week who ate in the dining room. She said if a resident decided to eat in the dining room at the last minute the resident would have to wait to get their meal tray until the hall trays came out. She said staff do not tell the DM that a resident wanted to eat in the dining room. She said the nursing staff were responsible for making sure all residents at the same table had their food before moving on. She said that the nurses monitored to ensure all residents had their meal tray. She said the nurses monitored through observations. She said if a resident did not get their meal tray with their tablemate the resident may feel left out. She said that Resident #5 was not on the list to eat in the dining room, so she had to wait until her hall tray s came out to get her food. During an interview on 10/29/2025 at 2:44pm with the DON she and staff have been trained on resident rights. She said there was not a policy for meal trays being passed in the dining room. She said if staff knew that a resident was coming to the dining room staff should try to serve all residents at the same table at the same time. She said all the staff were responsible for ensuring all residents at a table had their meal tray before moving to the next table. She said if a resident did not get their meal tray with their</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, and record review the facility failed to prepare, store, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food and nutrition services. 1) The facility failed to properly seal food product bags in the dry storage area to prevent exposure to air. 2) The facility failed to store food thickener items six inches off the floor and ensured it was not exposed to air. 3) The facility failed to maintain the proper temperature of the high heat sanitizing dish machine. The failures could have placed residents at risk for food contamination and foodborne illness. Findings included: Observation of the kitchen's dry food storage area on 10/28/2025 at 9:05 am revealed there was a bag of pasta noodles opened and exposed to air There was also a box of food thickener powder that was open, exposed to air, sitting on the floor by the shelf. Observation/Interview with DA A on 10/28/2025 at 9:45 am revealed that he had been washing dishes since 6:00am. He said the temperature on the dish machine was supposed to be 150 degrees Fahrenheit for washing, and 180 degrees Fahrenheit for the sanitizing cycle. Observation revealed that the wash cycle was at 130 degrees Fahrenheit according to the thermometer on the machine. The observation also revealed that the sanitizing cycle temperature was 152 degrees Fahrenheit according to the thermometer on the machine. Observation/Interview with the DM on 10/28/2025 at 11:42 am revealed that when the machine was cold staff needed to run the machine two or three times to get the machine up to the correct temperature. The DM ran the dish machine five times and said it was at temperature. The wash cycle was at 150 degrees Fahrenheit and the sanitized cycle was at 179 degrees Fahrenheit. When the surveyor informed them that the machine reflected the minimum for the sanitize cycle was 180 degrees Fahrenheit and the machine was not at the 180 degrees Fahrenheit the DM said he did not care how many times staff needed to run the machine, the staff needed to run the machine until the machine was at the correct temperature. Observation of DA B on 10/28/2025 at 1:13pm revealed DA B put the dishes in the dish rack and put the dishes in the dish machine. He did not run the machine. The temperature on the dish machine for wash cycle was 130 degrees Fahrenheit and for the sanitize cycle the temperature was 169 degrees Fahrenheit. During an interview with DA B on 10/28/2025 at 1:21pm it was revealed that the temperatures on the dish machine should be 160 degrees Fahrenheit for washing and 180 degrees Fahrenheit for sanitizing. He said he would consider the dishes he just did with the temperature of 130 degrees Fahrenheit and 169 degrees Fahrenheit to be clean. He said if the dish machine was not at the correct temperature the dishes might still have food on them and could get the residents sick. When asked about the dishes not being at the correct temperature he said that was an issue. He said he did not know why he did not check the temperature before he started the dishes, but he normally did. He said that when the temperature was not correct he would notify his manager, and they would shut the machine down and the facility would use paper products. During an interview with the RD on 10/28/2025 at 4:07pm it was revealed that her expectation for storing food was that items were to be 12 inches off the floor. She said she was not sure who was responsible for ensuring items were sealed and off the floor in the kitchen. She said the DM could be responsible or his assistant. She said if things in the kitchen were not sealed it could cause foodborne illness, mold, or contamination. She said the dietary manager was responsible for monitoring to ensure that everything was sealed and not stored on the floor. She said the DM was supposed to be doing weekly inspections. She said she did not know why items were not sealed, and off the floor because the facility only allowed her eight hours a month to oversee the facility kitchen. The RD also did not know what the temperatures of the dish machine should be. She said she thought the DM should have been getting a new dish machine. She said that if the high heat dish machine was not heating to the appropriate temperature the dishes were not getting sanitized. She said if the dishes were not getting sanitized it could cause a resident to get food poisoning, and cause contamination. She said she did not know why the staff were doing the dishes in the dish machine without it being at the correct temperatures. During an interview with the DM on 10/29/2025 at 11:15am it was revealed that the company for the dish machine came out that morning and checked the dish machine. He said that the technician had to turn the temperature up and now the machine was running at the correct temperatures. He also said that staff did not need to run the machine now before using. During an interview with DA A on 10/29/2025 at 10:29/2025 at 1:54pm it was revealed he had been trained on food storage and on the dish machine. He said that the policy for food storage was that food items could not be stored on the floor and anything that was open had to be labeled and dated. He said everyone in the kitchen was responsible for labeling and dating items in the kitchen. He said if items were not</p>		

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F 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Provide and implement an infection prevention and control program.  (continued on next page)

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 3 staff reviewed for infection control. 1. CNA E failed to perform hand hygiene when passing lunch trays on the 100 hall. 2. The DM did not conduct hand hygiene before giving Resident #5 her lunch tray, hugged another resident, and went to another resident. The DM then went from one resident to another doing a fist bump and shaking hands in between handing out resident trays and did not conduct handwashing or hand hygiene. 3. CNA F did not sanitize her hands between residents' trays and touched her clothes twice. These failures have the potential to affect all residents in the facility by exposing them to infection that could lead to the spread of viral or secondary infections and communicable diseases. Findings included: An observation on 10/28/25 at 12:15 pm revealed CNA F did not sanitize her hands after giving a resident their meal tray before giving another resident their meal tray. She also did not wash or sanitize her hands after touching her clothes before giving another resident their meal tray. She set up the resident's meal trays, opened their food touched items on their bedside tables. She did not sanitize or wash her hands at all while passing four residents their meal trays. Observation on 10/28/25 at 12:17 PM revealed CNA F was not conducting hand hygiene while passing lunch trays on hallway 100. She was observed coming out of a room and took Resident #1's tray to her room and did not conduct hand hygiene. Then she came out and picked up Resident #2's tray and took it into his room, assisted him with setting it up. She was observed not conducting hand hygiene and came out and took Resident #3's tray to his room. An interview on 10/28/25 at 12:31 PM with CNA F revealed she was trained to wash her hands before and after the meal tray pass. She stated she had forgotten to use hand gel between a couple of the residents. She stated she had received training on infection control and hand hygiene, and not doing hand hygiene between resident rooms could lead to cross contamination. An observation on 10/29/25 at 12:09 PM revealed the DM did not conduct hand hygiene before giving Resident #5 her lunch tray and then hugged another resident and went to another resident to help another resident with his food. The DM fist bumped one resident and shaking hands with a different resident and did not wash or sanitize his hands before passing other residents meal trays. An interview on 10/28/25 at 1:10 PM with CNA F revealed she had been working in the facility for one week. She stated she had been trained on infection control and hand hygiene during orientation, which included placing soiled linen in a bag before bringing it out of the resident's room, and always washing her hands. She further stated the policy for hand washing when providing resident care was to wash hands before the start care and wash hands when finished. She stated when passing meal trays to the residents' rooms, wash hands before and after passing trays, and wash hands between each resident. She stated if staff did not perform handwashing/hand hygiene properly, they could get infection/cross contamination and get sick. The aide stated they were always supposed to be on gloves and wash their hands when the staff remove and change gloves. She stated the DON, and nurses monitored to ensure staff were washing their hands. She stated she did not work yesterday and did not know why a staff member did not conduct hand hygiene between each resident when passing lunch trays. An interview on 10/29/25 at 1:28 PM with CNA E revealed she had worked in the facility for about 9 months. She stated she had been trained in infection control and hand hygiene in orientation, and about 2 months ago. She stated the training included enhanced barrier precautions, airborne, and droplet precautions. CNA E stated she was also enrolled in nursing school, where she was familiar with infection control precautions. She stated the facility policy on hand hygiene included conducting handwashing/hand hygiene every time you go into a resident room and every time you leave the resident room. She stated she should have used hand sanitizer between reach resident room when passing meal trays. She stated everybody should be washing their hands, and if staff did not conduct proper handwashing/hand hygiene, infection could spread diseases to the residents. She stated the DON monitored for hand washing and would enter the rooms to spot check on the staff members. CNA E stated she was picking up Resident #4's cup that had dropped, and then she started assisting him with eating. She stated she had left the room to get a straw and when she came back his cup had dropped, so she picked it up. CNA E stated she had walked around the bed and started to assist Resident #4 with eating. CNA E stated she should have changed her gloves and hand hygiene after she had come back into the room. CNA E stated the policy for meal tray passes was for the nurse to check that the meals matched what was on the meal</p>		