

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/28/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 5 residents (Resident #1) reviewed for reporting. The facility failed to report an allegation made by Resident #1 of sexual abuse on 7/27/26 to the State Survey Agency within the 2-hour timeframe. LVN A and CNA B failed to report an allegation of sexual abuse made by Resident #1 to the Administrator. This failure could place residents at risk of abuse. Findings included: Record review of Resident #1's Face Sheet dated 7/28/26 revealed an [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included muscle weakness, unsteadiness on feet, cognitive communication deficit, malignant neoplasm of prostate, and heart failure. Record review of Resident #1's 5-day MDS assessment dated [DATE] revealed a BIMS score of 14 out of 15 which indicated intact cognition. He had no behavioral symptoms and required substantial/maximal assistance of staff with toileting hygiene. Record review of Resident #1's care plan revised on 7/20/26 revealed he was at risk for impaired thought processes. Interventions included communication: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. Use simple, directive sentences. Provide with necessary cues- stop and return if agitated. Engage in simple, structured activities that avoid overly demanding tasks. Needs supervision/assistance with all decision making. Focus: Risk for decline in psychosocial wellbeing related to allegation of sexual abuse. Date Initiated: 07/27/2026. Interventions: Encourage resident to express feelings/concerns/thoughts in a safe space. Monitor for any change in mood/behavior and demeanor after allegation, offer counseling or provide psychological support services as ordered, Provide emotional support. Record review of CNA B's undated statement revealed in part, .I am writing to formally address the incident that occurred yesterday, July 27, 2026. During my rounds, I entered the resident's room to change him. After doing so, he requested that I apply cream to relieve itching. I applied the cream to both sides of his legs and the crease of his stomach before securing his diaper. I then proceeded to assist the next resident. I did not touch or access the resident's groin area at any point. Being approached with this accusation was deeply distressing. This is an insult to my character, as I hold my work to the highest professional and ethical standards. Record review of LVN A's statement dated 7/27/26 revealed in part, As CNA [CNA B] was providing incontinence care to resident, he asked her to apply cream to his (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: 676236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	groin area. She applied cream and then resident stated she was trying to masturbate him. [CNA B] left the room and immediately reported it to me. [CNA B] was visibly upset by the accusation. I went into the room he repeated the same thing to me. I assured him that was not her intentions. He stated he did not want her in his room anymore. I let him know she would not come back in his room. Record review of COTA's statement dated 7/27/26 revealed in part, I received the patient around 7:45 AM to start my occupational therapy treatment. Upon arrival, the patient appeared to be in distress. Thankful to see familiar therapist. The patient reported to me that there was an incident last night that occurred around roughly 4:00 AM with a CNA. The patient did provide me with a name [CNA B] and went on to describe the events that occurred. He reported that when the CNA came to change him, she only cleaned his front side and not the backside. Proceeded to apply cream to his thighs and make her way to his perineal area and rub him. The patient reports that he asked her multiple times to stop, and she responded with a hush gesture. He says he called his [family member] and family after it happened and still needs to be cleaned. Therapist stated that this would need to be reported. once concluded at toilet, completed handwashing at sink and positioned in wheelchair next to bedside in prep for breakfast. DON present at door once session concluding, hand off complete. Abuse coordinator (name). notified of session and statements made by [Resident #1]. Record review of DON's undated statement revealed in part, . Upon arriving at the facility at 0820, the DON was notified by the receptionist that the [family] of the resident in room [ROOM NUMBER] requested a return call regarding an incident that occurred during the PM shift involving his [family]. The DON and ADON immediately met with the resident to discuss the concern. The resident stated that at approximately 0455, CNA [CNA B] entered his room to provide incontinent care. The resident reported that after the CNA completed the incontinent care, he requested that cream be applied to his perineal area. The resident stated that the CNA then applied the cream to his perineal area. Following the application, the resident expressed concern regarding the manner in which the cream was applied and requested that the matter be reported and investigated. The resident was interviewed further, and his concerns were acknowledged. The DON and ADON assured the resident that the allegation would be reviewed in accordance with facility policy. The resident appeared calm during the interview and voiced understanding of the response provided. Record review of Resident #1's nursing note dated 7/27/26 at 11:07 a.m. written by the DON revealed in part, DON spoke with the resident's [family member] regarding the abuse allegation reported during the PM shift. The resident's [family member] stated that she is very satisfied with the facility and the care the resident is receiving. When informed that the allegation was required to be reported to the state, she appeared concerned and shook her head in disagreement. DON explained that reporting all allegations of abuse is a facility requirement and part of the established protocol to ensure resident safety and well-being. In an interview on 7/28/26 at 9:34 a.m. Resident #1 said staff treated him well except for one person. Resident said he needed a Spanish interpreter. Continued interview with Spanish interpreter revealed Resident #1 did not provide the staff name and when asked what the staff did, he would not say over the phone to the interpreter. In an attempted interview on 7/28/26 at 1:17 p.m. with CNA B, unable to leave voicemail and text message was sent with no return call. In an interview on 7/28/26 at 1:24 p.m. LVN A said yesterday (7/27/26) morning during the CNAs last round around 5 a.m. CNA B informed her that Resident #1's family member had cream that she (family member) placed around the resident's groin due to redness. CNA B informed her that Resident #1 asked if she could apply the cream but then the resident felt she tried to masturbate him (stimulate the genitals of someone to give them sexual pleasure). CNA B informed her she just applied the cream like the resident asked her to do. LVN A said she went into Resident #1's room and asked what was going on, is not this the cream (your family member applies)? (continued on next page)		

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 07/28/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN A said the resident told her no, no no, she (CNA B) tried to do this. the resident made an up and down motion. He said he did not want the aide in his room anymore. LVN A said the resident was upset and wanted to notify his family member right then at 5 a.m. LVN A said she discussed the incident with the CNA but did not notify the Administrator of the abuse allegation due to poor judgement. She said she should have called someone to notify them. She said she read and signed an in-service on reporting abuse and neglect today (7/28/26). She said CNA B completed her shift and ended work at 6 a.m. In an interview on 7/28/26 at 1:50 p.m. using Resident #1 family for Spanish interpreter Resident #1 said around 4:55 a.m. he was due for a brief change. The nurse came in, changed him, applied cream and said she would give him a massage. He said she placed the cream around his penis. She then pulled the foreskin (movable layer of skin that covers the head of the penis) down and placed lotion on in a sexual way. Resident #1 said the CNA was going up and down like a banana and he asked her what she was doing. He said he did not want her to do that and pushed her away. He said he had an erection and was frustrated, angry, and upset because he had limited mobility and no control over what was happening. When the CNA left the room, he put his call light on and 3 minutes later reported the assault to a staff member and said CNA B masturbated him. He said he was assured that CNA B would not return to his room. He said the staff member he reported the incident to clocked out and said it was not until he reported it again (that staff came to investigate). In an interview on 7/28/26 at 2:11 p.m. Resident #1's family member said on 7/27/26 at 8:27 a.m. he spoke with the DON who said she was not aware of the incident. He said the original person Resident #1 reported it to (LVN A) never reported the incident. He said at 8:46 a.m. the DON informed him that CNA B was suspended, and the nurse was disciplined for not alerting management of the incident. In an interview on 7/28/26 at 4:25 p.m. DON said she was made aware of Resident #1's allegation on Monday morning (7/27/26) around 8:10 a.m. when the receptionist told her to give Resident #1's family member a call. She said around the same time ADON and COTA were headed to notify her of the allegation. She said the ADON and Resident #1 informed her what happened, then she responded to Resident #1's family member phone call. She said Resident #1 informed her CNA B came in to provide incontinent care, started to put the brief on, but the resident told her to apply the cream. The resident said the aide went down one side (of the groin) with the cream, down the other side, and then went straight down the penis. The resident asked her to stop. DON said she told the resident the allegation was taken seriously and immediately started reporting it and asked staff to conduct a head-to-toe assessment and safe surveys. She started abuse/neglect in-services which included who to report abuse/neglect to. In an interview on 7/28/26 at 4:55 p.m. Administrator said he became aware of Resident #1's allegation at 7:57 a.m. yesterday (7/27/26), he said the DON immediately notified him when she found out. He said the moment he found out he immediately opened up an investigation and ensured the resident was safe and comfortable. He established statements, in-serviced staff, and started the self-report process. He said according to the resident the incident took place right before 5:00 a.m. and according to CNA B and LVN A it occurred right at or after 5:00 a.m. CNA B informed him at no point did she make contact with the resident's penis. He said the aide did finish her shift and when management found out at 8:00 a.m., the aide was suspended pending investigation. LVN A informed him that Resident #1 felt the CNA touched his private parts inappropriately. Administrator said there were write-ups for LVN A and CNA B regarding them not reporting the abuse right away. He said any allegation or suspicion of abuse should be reported immediately to the abuse coordinator by the person who observed or learned of the abuse. He said the facility previously serviced the staff on reporting abuse and neglect. A verbal in-service was conducted with LVN A over the phone on 7/27/26 and formal in-service was conducted today (continued on next page)		

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 07/28/2026
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(7/28/26). Record review of the Texas Unified Licensure Information Portal revealed the facility's self-report regarding Resident #1 's allegation of sexual abuse was received on 7/27/26 at 9:54 a.m. which was approximately 5 hours after Resident #1 reported the allegation. Record review of the facility's Reporting Alleged Violations of Abuse, Neglect, Exploitation or mistreatment policy revised 4/2025 revealed in part, .It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to, Facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, resident representatives, families, friends, or other individuals. If there is an allegation or suspicion of abuse, the facility will make a report to the appropriate agencies as designated by State and Federal laws.Sexual abuse is non-consensual sexual contact of any type with a resident. Procedure: 1. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will: a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but: Not later than two (2) hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury. 2. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to: a. The Administrator of the Facility b. The State Survey Agency.3. Ensure that, after receipt of a report of possible abuse, neglect, mistreatment, exploitation, or misappropriation of resident property, steps are immediately taken to protect the identified resident(s).		