STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676236	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Champions Healthcare at Willowbrook	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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident has the right to be free from abuse, neglect, misappropriation of property, and exploitation for 2 of 5 (Resident #44 and Resident #35) residents reviewed for abuse.The facility failed to protect Resident #44 from being slapped in the chest by Resident #35, in the hallway near the dining room, on 04/13/2026The failure placed residents at risk of injuries and psychosocial harm. Findings included:Record review of Resident #35's undated face sheet revealed a [AGE] year-old female who admitted into the facility on [DATE] with a recent admitted date of 04/15/2026. She had diagnoses of dementia, intellectual disabilities, convulsions, panic disorder, psychotic disorder, restlessness and agitation, and personal history of mental and behavioral disorders.Record review of Resident #35's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 06 out of 15 indicated severe cognitive impairment to reflect significant difficulty with short term memory, recall, and orientation. Resident #35 could not reliably participate in complex decision-making without support. Resident #35 was able to participate in care planning and did not have impairment on upper or lower extremities.Record review of Resident #35's Care Plan revised on 04/13/2026 revealed the focus of behavioral problems r/t personal history of other mental and behavioral disorders. On 04/12/2026, Resident #35 hit another resident by the dining room door with interventions to monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, person involved, and situations. Document behavior and potential causes. Transfer to Hospital for evaluation and treat for behavior.Record review of Resident #35's active physician's orders dated 03/26/2026 revealed an order for DULoxetine HCl Capsule Delayed Release Particles 20 MG Give 1 capsule by mouth one time a day for depression and Donepezil HCl Oral Tablet 10 MG (Donepezil Hydrochloride) Give 2 tablet by mouth at bedtime related to PRIMARY INSOMNIA, dated 03/27/2026 risperiDONE Oral Tablet 1 MG (Risperidone) Give 1tablet by mouth every morning and at bedtime related to PANIC DISORDER [EPISODIC PAROXYSMAL ANXIETY].Record review of Resident #44's undated face sheet revealed a [AGE] year-old female who admitted into the facility on [DATE]. She had diagnoses of dementia, mixed anxiety and depressed mood, and unspecified psychosis due to a substance or known physiological condition.Record review of Resident #44's Quarterly MDS assessment dated [DATE] revealed a BIMS of 06 out of 15 indicated severe cognitive impairment to reflect significant difficulty with short term memory, recall, and orientation. Resident #44 could not reliably participate in complex decision-making without support. Resident #44 was able to participate in care planning and did not have impairment on upper or lower extremities. The Quarterly MDS Assessment included Resident #44 had behaviors of rejecting care which pertained to taking medications, bloodwork, ADL assistance, and care planning goals four to six days out of the week.Record review of Resident #44's Care Plan revised on 04/12/2026 revealed the focus of potential for a psychological well-being problem r/t ADJUSTMENT DISORDER, hoards items in room (snacks, facility supplies, and other), family discord, altercation with another resident. Interventions listed included documents related to resident's feelings relative to altercation with another resident.Record review of Resident #44's active (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	physician's orders dated 10/02/2025 revealed an order for FLUoxetine HCl Oral Tablet 20 MG (Fluoxetine HCl) Give 1 tablet by mouth at bedtime related to ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD -HOARDING DISORDER.Record review of the Provider Investigation Report dated 04/12/2026 revealed on 04/12/2026 at 5:20pm, Resident #35 was passing by the dining room and Resident #44 was sitting by the door in the dining room with her walker next to her. Resident #35 became verbally aggressive towards Resident #44. Resident #35 slapped Resident #44 in the chest, witnessed by CNA P. Both residents were separated and placed in each room. Resident #44 was assessed and an x-ray was ordered due to redness on the chest. Resident #35 was placed on one-to-one supervision while waiting to be sent to the hospital for a psychological evaluation. The results of the x-ray were completed on 04/12/2026 and showed no abnormalities to the chest area. Resident #35 returned to the facility on [DATE] and was placed on one-to-one supervision with facility staff until 04/21/2026 when she transferred to another facility.During an interview on 04/23/2026 at 10:02am with CNA P, she stated that she witnessed the incident and heard the altercation as it happened. She stated before the incident, she did not witness Resident #35 being agitated before the incident, but Resident #44 is always mad about something. She stated Resident #35 was aggressive and yelled often if something was not done timely or the way she wanted it to be. She stated Resident #44 was in pain after the incident and constantly pointed at her chest, which she informed the nurse. CNA P stated the protocol for residents to report to the nurse for the resident to assessed, immediately. She stated the police were not called to her knowledge. She stated Resident #44's coping skills were activities with the other residents, having conversations with her family and would listen to music to stay engaged and calm. CNA P stated that she was not in-serviced after the resident-to-resident altercation and her last in-service related to the incident was November 2025.During an interview on 04/23/2026 at 10:30am with Resident #44, she stated that she was scared after the incident, and she asked the staff to call the ambulance and the police, but they refused. She stated for five minutes it felt as if she collapsed and couldn't breathe after being hit so badly. She stated that after the incident she could not sleep for two to three days and stated she needed help, someone to talk to about how she was feeling at that time. Resident #44 stated that she did not know Resident #35 before the incident and never had a conversation with her. She also stated since the incident, she had not seen a therapist and the staff had not checked on her to see how she was doing. Resident #44 denied pain during the interview and stated she still felt scared to leave the room or even to get out of bed, afraid the same incident would happen again.RN B was attempted to be contacted by telephone on 04/23/2026 at 10:46am and again at 12:32pm. Voicemails were left during both attempts, and no return call was received, as it was related from the DON, she was on leave.During an interview on 04/23/2026 at 11:51am with the SW, she stated that she was not on-site when the incident occurred, as it was the weekend. She stated that when she returned to work, Resident #35 was sent out for a psychological evaluation, and she began the referral process to transfer Resident #35 to another facility. The SW stated that Resident #44 enjoys speaking to other residents and she enjoyed sitting at the nurse's station. The SW stated that she did not follow up with further evaluation for Resident #44 after the incident because Resident #44 seemed to have bounced back after the altercation and there was no change in her demeanor, based on her observation she was always smiling and a bubbly personality. She stated that she has spoken to Resident #44 in the hallway and did not notice any different behaviors and was doing her daily routine of being seated in her wheelchair at the nurses station. She stated that if Resident #44 needed someone to speak to, it would have been her, and she would have also referred to Resident #44 to counseling and companionship. She stated that Resident #44 was referred to see a psychiatrist previously but has always refused services. She stated the protocol for a resident-to-resident altercation was to ensure each resident's safety and separated.During an interview on 04/23/2026 at 1:19pm with the LVN O, she stated she did not witness nor was present on the day of the resident-to-resident altercation. She stated that she began safe surveys on 04/13/2026 but Resident #44 was not included and did not (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	state why.Record review of Champions at Willowbrook Safe Survey's revealed, there were eight residents from the 100 and 200 hall completed safe surveys which included; is the staff friendly and nice, does the staff treat you with respect, and if someone were to mistreat you, who would you to inform? The resident's response displayed the staff were nice, they love the way they are treated, and they didn't know who to inform if they were mistreated.During an interview on 04/23/2026 at 1:34pm with CNA L, she stated that she was assigned to sit with Resident #35 upon the return from the hospital and was placed on one-to-one supervision until she was approved to transfer nursing facilities. She stated that she was to stay near Resident #35 and should she become agitated, to use coping mechanisms to keep her calm, which was typically through verbal communication. CNA L stated after the incident and while Resident #35 was on one-to-one supervision, she didn't have another altercation with any resident. CNA L stated that she had not noticed any changes in Resident #44's behavior and that she was a clown, loved to joke and sing. CNA L stated if two residents were to have an altercation, she was to separate and report the incident, immediately.During an interview on 04/23/2026 at 2:02pm with the DON, she stated she was not present when the altercation occurred. The DON stated once she was notified, Resident #35 was to be sent out of the facility for a psychological evaluation and placed on one-to-one when she returned to the facility due to behavioral issues. She stated Resident #44 was to be assessed for any injury and to follow any additional orders from the physician. The DON stated that Resident #35 did not recall the incident and Resident #44 did not voice any concern how she felt after the incident. The DON stated she did not follow up with Resident #44 after the altercation because she appeared to be okay and back to her usual self, sitting next to the nurse's station and speaking to everyone. She stated that she last spoke to Resident #44 on 04/23/2026, and stated Resident #44 responded that she was doing okay. The DON stated Resident #35 can become agitated if things did not go as she wanted and Resident #44 has been verbally aggressive to other residents in the past. She stated her expectations of staff during a resident-to-resident altercation is to ensure safety and separate.During an interview on 04/23/2026 at 2:25pm with the Administrator, he stated that the expectations of his staff when a resident-to-resident altercation occur are to separate and create a safe environment for all residents. He stated Resident #35 was sent out due to being the aggressor and due to current medications prescribed. He stated when Resident #35 returned to the facility from the hospital, she was immediately placed on one-to-one supervision with an aide who was on light duty until she discharged to another facility, which was already being processed before she returned. He stated he did not follow up with Resident #44 after the incident to have an in-depth conversation regarding the incident and how she was feeling because he was checking on her daily and she reported being fine and feeling good.In interview on 04/23/2026 at 3:05pm with CNA M she stated Resident #44's daily routine is staying in her room during the morning hours which would include breakfast. She stated if Resident #44 missed lunch, she will be sitting in the dining room for dinner. She also stated Resident #44's nature is aggressive, rude at times and Resident #44 has not expressed fear towards any other residents at the facility. During an interview on 04/23/2026 at 2:45 with RN G, she stated she worked with Resident #44, and she would bully other residents and say things to get them agitated. She stated that she was not working on the day of the incident but stated Resident #35 and Resident #44 had spoken to each other before as they would argue over who could sit in what chair while in the dining room because Resident #44 had a preferred chair. She stated Resident #44 has not threatened any nurses or any other staff, she likes to notice and help other residents.In an observation on 04/23/2026 at 5:17pm revealed Resident #44 was sitting in the dining room eating dinner.Record review of in-service training report dated 04/12/2026 revealed for all departments which pertained to Abuse. Contents of training session included who the abuse coordinator was, when to report abuse, which is immediately, and the different types of abuse being physical, sexual, emotional, neglect, and abandonment.Record review of facility's Abuse: Prevention of and Prohibition Against revised on 04/2025 revealed.PolicyIt is the policy of this Facility that each resident has the right to be free from (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	abuse, neglect, misappropriation of resident property, exploitation and mistreatment. The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, exploitation, or use of technology that would infringe on the resident's right to personal privacy.Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Neglect is the failure of the Facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. ˆ Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress.ˆ Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress.Physical Abuse includes but is not limited to hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 1 of 5 residents (Resident #66) reviewed for ADL care.The facility failed to ensure LVN R assisted Resident #66 off the bedpan in a timely manner on 4/20/26, causing physical and emotional pain to the resident.This failure could place the residents at risk of decreased feelings of self-worth and pain.Findings included:Record review of Resident #66's face sheet dated 08/23/26 revealed a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnosis included injury of muscle, fascia and tendon of the posterior muscle group at thigh level, muscle weakness, and reduced mobility.Record review of Resident #66's 5-day MDS assessment dated [DATE] revealed a BIMS score of 14 out of 15 which indicated intact cognition. She had range of motion impairment of the lower extremity on one side. She was frequently incontinent of bowel and occasionally incontinent of urine.Record review of Resident #66's care plan revised on 4/15/26 revealed she had an ADL self-care performance deficit related to unspecified injury of muscle fascia and tendon, type 2 diabetes mellitus, COPD, and obesity due to excess calories. Interventions included: toilet use: requires staff participation to use toilet (4/21/26), bed mobility requires staff participation to reposition and turn in bed. She had chronic pain and interventions were to administer analgesia medication as per orders.Record review of Resident #66's skilled evaluation dated 4/20/26 revealed she used a bedpan for toileting.Record review of an undated statement by LVN R revealed, .I gave [Resident #66] her pain medication. Some time later, I noticed that her call light was on, so I responded. She told me that she needed help off the bedpan. She was talking to her friend in the room at the time and did not appear distressed so I asked her if she would be able to wait a few minutes for the CNA [CNA A] to finish showering another resident. She said that's sure, yes, that's fine, Then she continued talking to her friend, so I left the call light on and returned to my med cart to continue with administration of PRN pain medication. Shortly afterward [CNA A] passed me in the hallway and told me that she would be there in a few minutes. I went back into [Resident #66's] room and turned off the call light and reassured [Resident #66] that the CNA would be in shortly. After that, I met with the pharmacy at the nurses' station to receive medications. While I was at the nurses' station [Resident #66's] friend came to the nurses' station and asked me if someone could come help her off the bedpan. I went to the room and began to help her off the bedpan, and then CNA came in. At that time, [Resident #66] told me that she was upset about having to wait on the bedpan. [Resident #66] did not appear to be in any distress, but was very upset about having to wait.Record review of an undated statement by CNA A revealed, .On that night [4/20/26], I was giving a shower to one of my residents so I was in the shower room with her. When I finished I brought her to her room. While I was bringing her to her room, I noticed that nurse [LVN R] was in front of [Resident #66's] room and the call light was on. As I was passing by, I asked nurse [LVN R] if she could address the call light. I cleaned, clothed, and put my resident to bed. Then I was preparing to shower my next resident, but I was waiting for him to finish using the restroom. So during that time I left and entered [Resident #66's] room to check on her. [LVN R] entered shortly after me.As I was getting things ready to move her off the bedpan, [Resident #66] told us that she had been waiting for a long time for help off the bedpan and that she was upset with the nurse for asking her to wait.In an observation, interview, and record review on 4/21/26 at 12:21 p.m. Resident #66 said last night (4/20/26) she informed her nurse (LVN R) that she needed assistance getting off the bedpan, but the nurse left the room and informed the CNA. Resident #66 said her buttock was red from sitting on the bedpan for so long (last night). She said she had been left on the bedpan many times for 30 minutes to one hour and had a damaged bladder and would spasm for an hour to an hour and a half if left on too long. Resident #66 showed the Surveyor a picture on her mobile device with a time of 9:09 p.m. Review of the picture revealed a (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	bright red imprint around the sacral area (a triangular bone in the lower back formed from fused vertebrae and situated between the two hip bones of the pelvis). Resident #66 was tearful during the interview and said it affected her spiritually, emotionally, and physically.In an interview on 4/21/26 at 2:10 p.m. the Administrator said he received a grievance yesterday (4/20/26) from Resident #66's family member who was concerned because of a slow response to her call light. He said LVN R was suspended pending an investigation and staff were in-serviced. He said during the facility's investigation there were concerns about the action and there was a slow response to the call light. He said LVN R did not follow call light expectations, and it was a failure of call light response.In an interview on 4/21/26 at 2:45 p.m. the DON said all nursing staff could help with incontinent care. She said she expected LVN R to remove Resident #66 from the bedpan when she first answered the call light and there was no reason for her not to. She said Resident #66 put herself on the bedpan and could not provide a timeframe of when she got on or how long she was waiting for assistance. She said she spoke with Resident #66 this morning and was informed by the resident that being on the bedpan too long could cause her muscle spasms. She said Resident #66 showed her a picture of her sacral area and it appeared red. She said the redness was dependent on positioning, weight, and length of time on the bedpan. She said she did not remember if Resident #66 expressed pain to her and said the resident already had pain. She said the risk of staying on the bedpan too long could be extra pain and bruising, but Resident #66 only had a little redness. The DON said she felt it was a poor response to a call light and education was provided to the nursing staff on call light response time.In an interview on 4/21/26 at 3:40 p.m. Resident #66 said the DON informed her she was on the bedpan for 36 minutes (on 4/20/26). Resident #66 said she was on the bed pan closer to 50 minutes because she said she waited a bit before the call light was answered by staff.In an interview on 4/22/26 at 5:15 p.m. the Administrator said he reviewed the camera footage, and it was hard to tell how long Resident #66 waited for assistance. He said according to the resident it was an extended period of time. In an interview on 4/23/26 at 4:29 p.m. LVN R said around 7:40 p.m. (on 4/20/26) Resident #66 put her call light on for pain medication and said she was on the bedpan. LVN R asked Resident #66 if she could give her a few minutes. LVN R said she stepped out of the room and went back to the medication cart and left Resident #66's call light on. She said the CNA (CNA A) waved and asked her to turn the light off because she would be there in a minute. LVN R said she reassured Resident #66 that the CNA finished her showers and would assist her. During that time Resident #66 had no signs of distress. LVN R said once she stepped out of the resident's room, she saw the pharmacy with a delivery, and she signed for the medication. LVN R said then Resident #66's family member came out of the room and asked if someone could get Resident #66 off the bedpan because she needed to eat her meal. LVN R said she was disappointed in her CNA because she should have already been in there. LVN R said she removed Resident #66 from the bedpan and said it had been a while. LVN R said the resident was on the bedpan for approximately 30 minutes or less, it was long enough. She said her sacral area was red but could have appeared on the skin even if she had been on the bedpan for 5 minutes. She said the resident was not in tears or distress and did not request pain medication. She said the resident was previously medicated at 8:00 p.m.In an interview on 4/22/26 at 3:10 p.m. Resident #66 said the fact that the nurse told the aide who was already busy (with someone else), to assist her, made her feel awful. She said she could never treat a person like that, and it made her feel less than. She said she had 4 different spasms while on the bedpan. Record review of the facility's Nursing Services policy reviewed 8/2024 read in part, .Adl, Services to carry out. Policy: It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. Procedures: 1. If a resident is unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, toileting and personal oral hygiene will be provided by qualified staff.Record review of the facility's Call Light policy reviewed 8/2024 read in part, .It is the policy of this facility to provide the resident a means of communication (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	with nursing staff. Procedures: 1. Answer the light/bell within a reasonable time frame. 3. Respond to the request. If the item is not available or you are unable to assist, explain to the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for 1 of 2 (1st floor kitchen) kitchens reviewed for food service safety.The kitchen staff failed to check temperatures before meal service to ensure food were held at safe temperatures in the 1st floor kitchen (main kitchen).This deficient practice could place residents at risk for foodborne illness due to unsafe temperatures.Findings included:During an observation on 04/22/2026 at 12:11pm in the Main Kitchen on the 1st floor, revealed beef liver and onions with gravy, wheat dinner rolls, seasoned potatoes, chicken fingers, green peas, and mashed potatoes were the foods being prepped and plated. At 12:22pm the first plate was dished up and placed on the service rack for delivery to residents in the dining room, and temperature checks were not conducted beforehand.During an interview on 04/22/2026 at 12:40pm with the DM, he stated that he started the position two weeks ago and could only locate temperature logs for March 2026, which were completed. For April 2026, he stated that he had to locate them and once he did, the temperature checks were missing for 04/21/2026 lunch and dinner, 04/22/2026 breakfast and lunch. He stated the expectations for the temperature checks were to be completed once the food was out of the oven and once again while on the steam table, before serving. He stated there was no excuse why temperature checks were not completed on 04/21/2026 or 04/22/2026 and the cook was responsible for checking the temperatures before serving but could be completed by anyone in the kitchen. The DM stated the risk of not checking food temperatures before service was that food may be served at unsafe temperatures, allowing harmful bacteria to grow and increasing the potential for foodborne illness.During an interview on 04/22/2026 at 2:35pm with the Administrator, he stated that food temperatures should be checked according to the facility's food service policy, which he was not familiar with. He stated he was not aware that temperatures were not being checked but noted that the thermometer has been replaced in January 2026. He stated the expectation was for the DM to bring forward any concerns related to temperatures not being checked and in-service staff as needed. He stated the risk had the potential hazard of food not being fully cooked.During an interview on 04/23/2026 at 8:46am with the Cook, she stated the expectation for temperature checks was to be completed before putting the food on the line and while on the line before serving. She stated she forgot to write the temperature amount down on 04/22/2026, but the DM informed her it was to be completed every day for each meal that was to be served. She stated the risk of not checking food temperatures before service was uncooked food, cold food, salmonella, and the residents could get sick.Record review of the facility's Infection Control Policy/Procedure - Dietary Services revised 05/2007 revealed. POLICY:It is the policy of this facility to prevent contamination of food products and therefore preventfoodborne illness.DIRECTOR OF FOOD SERVICE RESPONSIBILITIESProvide safe food services for residents and employees Provide and document personnel education regarding personal hygiene and food handling sanitation.All meats, stuffings and poultry meat are to be heated throughout to a minimum temperature of 165 F; pork 180 F.Steam tables1) Must be able to maintain hot foods at temperatures of 140 F or above.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Champions Healthcare at Willowbrook	13500 Breton Ridge Houston, TX 77070

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 8 residents (Resident #16) reviewed for pharmacy services.LVN E did not ensure the accurate administration of Novolog and Lantus insulins (a hormone to help regulate blood sugar levels of individuals who have diabetes) per manufacturer's instructions. LVN E did not prime the insulin pen (removing air bubbles from the needing) prior to administering to Resident #16 on 04/22/26.LVN E did not ensure the accurate administration of Novolog (a rapid acting insulin) and Lantus (a long acting insulin) per manufacturer's instructions. LVN E held the insulin pen injectors against Resident #16's skin for 2 seconds after injection, instead of the manufacturer's recommended time for each insulin, on 4/22/26. LVN E did not ensure Resident #16 rinsed with water and spit, per physician's orders, after the administration of the breathing treatment Budesonide (a steroid drug used to reduce inflammation) on 4/22/26. These deficient practices could affect residents who received medication and place them at risk of not receiving the appropriate amount of medication and could result in an adverse reaction or a decline in health. Record review of Resident #16's face sheet dated 04/23/26 revealed an [AGE] year-old admitted to the facility on [DATE] with diagnoses to include dementia (a decline in cognitive function), Diabetes (a chronic condition that occurs when the body cannot properly use blood sugars), COPD (chronic obstructive pulmonary disease) (a lung condition caused by damage to the airway), heart disease and anxiety.Record review of Resident #16's quarterly MDS resident assessment dated [DATE] revealed a BIMS score of 7 out of 15 indicating severe cognitive impairment. Resident #16 was taking hypoglycemic (drugs used to lower blood sugar levels in individuals with diabetes) (including insulin). Resident #16 received respiratory therapy.Record review of Resident #16's order summary report as of 04/22/26 revealed an order for Budesonide (inhalation suspension 0.5mg/2ml), 2ml inhale orally via nebulizer every 12 hours for COPD rinse mouth and spit out, order start date was 08/13/25; Lantus Solostar subcutaneous solution pen-injector 100units/ml (Insulin Glargine) inject 20 units subcutaneously every morning and at bedtime related to type 2 diabetes, order start date was 02/23/26; Novolog injection solution 100 units/ml (Insulin Aspart) inject as per sliding scale: if 151-200 = 2units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; >400 give 12 units and call MD, subcutaneously before meals and at bedtime for diabetes, order start date was 06/06/25.Record review of Resident #16's April 2026 MAR/TAR revealed Budesonide (inhalation suspension 0.5mg/2ml), 2ml inhale orally via nebulizer every 12 hours for COPD rinse mouth and spit out, was documented as administered on 04/22/26 at 8:00AM by LVN E. Lantus Solostar subcutaneous solution pen-injector 100units/ml (Insulin Glargine) inject 20 units subcutaneously every morning was documented as administered on 04/22/26 at 8:00 AM by LVN E. Novolog injection solution 100 units/ml (Insulin Aspart) inject as per sliding scale, 2 units for blood sugar of 174 was documented as administered on 04/22/26 at 7:00 AM by LVN E.Record review of Resident #16's undated care plan report revealed in part: Focus - has diabetes, potential for hypo/hyperglycemia r/t refusal of medication.Goal - will have no complications r/t diabetes through the review date.Interventions - .Diabetes medication as ordered by doctor.Focus - has COPD, has SOB while lying flat.Goal - will display optimal breathing pattern daily through review date.Interventions - .give aerosol or bronchodilators as ordered.Observation on 4/22/26 at 8:20 AM during medication pass for Resident #16's Novolog Insulin, revealed LVN E performed hand sanitization, put on clean gloves, removed the pen cap of the Novolog pen injector, wiped the tip of pen using alcohol swab, and attached the insulin pen needle. LVN E dialed 2 units of insulin, cleansed the site on Resident #16's left arm, injected the insulin and held the pen against the skin for 2 seconds before removing the insulin pen from the skin. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN E did not perform a safety test by priming the needle with 2 units of insulin after attaching the insulin pen. LVN A did not hold the pen to the resident's skin for 6 seconds to ensure administration of the full dose.Observation on 4/22/26 at 8:30 AM during medication pass for Resident #16's Lantus Insulin, revealed LVN E performed hand sanitization, put on clean gloves, removed the pen cap of the Novolog pen injector, wiped the tip of pen using alcohol swab, and attached the insulin pen needle. LVN E dialed 20 units of insulin, cleansed the site on Resident #16's left arm, injected the insulin and held the pen against the skin for 2 seconds before removing the insulin pen from the skin. LVN E did not perform a safety test by priming the needle with 2 units of insulin after attaching the insulin pen. LVN E did not hold the pen to the skin for 10 seconds to ensure administration of the full dose.Observation on 4/22/26 at 9:00AM during medication pass for Resident #16's breathing treatment, revealed the resident was awake, alert and in no respiratory distress. LVN E poured the Budesonide solution into the chamber of the nebulizer tubing, assisted Resident #16 to put on the mask over her nose and mouth then turned on the nebulizer to begin the treatment. After the treatment was completed, LVN E ensured Resident #16, was settled into the bed, ensured the bedside table and call light were in reach, walked out of the room and proceeded with medication pass for the next resident. LVN E did not ensure Resident #16 rinsed her mouth out with water and spit as per the physician's order.In an interview on 4/22/26 at 9:42 AM, Resident #16 stated that she knew she was supposed to rinse with water and spit after the breathing treatment but was never asked to. In an interview on 04/22/26 at 10:00 AM, regarding Resident #16's insulin administration, LVN E stated that he did prime the insulin pens with approximately 1 unit to expel air and did that before the needles were attached. When asked what the reason was for priming before attaching the needle, LVN E stated the needle and pen were primed and that the surveyor did not see that happen. When asked how long the needle and pen should be held against the skin after injecting insulin, LVN E stated for 10 seconds. When asked why the pen was held against the skin for 2 seconds, LVN E stated he missed that one. LVN E stated the risk of not getting all the ordered insulin would be hyperglycemia. In an interview on 04/22/26 at 10:15 AM, regarding Resident #16's breathing treatment, LVN E was asked what the purpose of rinsing with water was and spitting after the Budesonide treatment, and LVN E stated it was to make the resident feel better. LVN E stated he missed ensuring Resident #16 rinsed and spit, that he just forgot.In an interview on 04/22/26 at 2:30 PM, LVN B stated when administering insulin, she would attach the needle then prime the pen with 2 units because there could be air in the needle and to ensure all the ordered insulin was delivered to the resident. LVN B stated once the insulin was delivered, she would continue to hold the needle and pen at the skin and wait 5 to 10 seconds to ensure the resident received the full dose. LVN B stated the risk of not waiting 5 to 10 seconds would be the resident could continue to experience high blood sugar levels. LVN B stated when administering breathing treatment via nebulizer, the medication would be poured into the chamber, and the treatment would take 15 to 20 minutes to ensure all the solution was delivered to the resident. LVN B stated if the medication was a steroid she would instruct the resident to rinse their mouth out with water and spit right after completion of the treatment to reduce the risk of developing thrush (an overgrowth of the microorganism which causes yeast infection in the mouth).In an interview on 4/22/26 at 4:55 PM, the DON stated as far as she knew the insulin pens did not need to be primed prior to administration. The DON stated the facility did not have a protocol for how long the pen should be left against the skin after administration of insulin using the pen, but it would be 5 to 10 seconds to ensure delivery of the insulin dose. The DON stated the risk to the residents would be the blood sugar levels could drop or elevate. The DON stated when giving breathing treatments she would expect the nurses to ensure the resident rinsed and spit after administration of a steroidal breathing treatment and that was protocol. The DON stated if rinsing and spitting were not done, the risk to the residents would be thrush.Record review of the facility policy for Insulin Administration revised on date May 2023, revealed in part: Purpose, to provide guidelines for safe administration of insulin to residents with diabetes.3. The type of insulin, dosage (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order.5. The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use.Record review of the facility policy for Medication Administration, revised on 05/2007 revealed in part: Policy: It is the policy of this facility that medications shall be administered as prescribed by the attending physician. Procedures:.2. Medications must be administered in accordance with the written orders of the attending physician.Record review of the facility policy for Physician Orders, revised 3/2023 revealed in part: .It is the policy of this facility to accurately transcribe and implement orders in addition to medication orders (treatment, procedures) only upon the written order of a person duly licensed and authorized.Record review of the Novolog (insulin aspart) injection FlexPen instructions for use, revised 02/2023 from the web page https://www.novolog.com, read in part: .B.screw the needle tightly onto your FlexPen.Giving the airshot before each injection-before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to select 2 units.G. Keep the needle pointing upwards, press the push-button all the way if. The dose selector returns to 0. A drop of insulin should appear at the needle tip.Selecting your dose - check and make sure that the dose selector is set at 0. H. Turn the dose selector to the number of units you need to inject.Giving the injection.I. insert the needle into your skin. Inject the dose by pressing the push-button all the way in until the 0 lines up with the pointer.J. Keep the needle in the skin for at least 6 seconds, and keep the push-button pressed all the way in until the needle has been pulled out from the skin. This will make sure that the full dose has been given.Record review of How to use your Lantus Solostar pen, A step by step guide to using your Lantus Solostar pen, dated 2022, from the web page https://www.lantus.com, read in part: .Step 2. Attach the needle.Step 3. Perform a Safety Test, dial a test dose of 2 units.press the injection button all the way in and check to see that insulin comes out of the needle.4. Select the dose, make sure the window shows 0 and then select the dose.Step. 5 Inject your dose.press the injection button all the way down. When the number in the dose window returns to 0 as you inject, slowly count to 10 before removing (Counting 10 will make you get your full insulin dose. Release the button and remove the needle from your skin.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature control, and only permit only authorized personnel to have access to the keys for 2 of 5 residents (Resident #42 and Resident #57) reviewed for storage of medications.The facility failed to keep Resident #42 and Resident #57's medications secured.The deficient practice could place residents at risk of not receiving the therapeutic benefit of medications, drug diversion, or ingestion of unprescribed medications to residents, staff, and visitors.Findings included:Record review of Resident #57's undated face sheet revealed a [AGE] year-old male who admitted into the facility on [DATE] and readmitted on [DATE]. He had diagnoses of chronic respiratory failure, pulmonary fibrosis (chronic lung disease), diabetes, dementia, and congestive heart failure.Record review of Resident #57's MDS assessment dated [DATE] revealed a BIMS score of 12 out 15 indicated mild impairment cognitive status with occasional difficulty in recall and orientation.Record review of Resident #57's Care Plan dated for 03/02/2026 did not reveal he could self-administer medication.Record review of Resident #57's eMAR dated 04/21/2026 revealed morning tablet medications for the date of 04/19/2026; Eliquis Oral Tablet 5MG and Furosemide Oral Tablet 40 MG. Resident #57 did not receive any PRN medications on this day.During an observation on 04/19/2026 at 9:51am, revealed an unidentifiable large white pill at the doorway of Resident #57.During an interview on 04/19/2026 at 9:54am with MA J she stated that she was assigned to administer medications for the 200 hall, which would have been for Resident #57. MA J stated the expectation for medication administration was to apply and follow the 10 rights. MA J stated that she was unsure where the pill could have come from or knew what the medication could have been because she had completed her medication pass. MA J stated the risk of medication being left on the floor is that a person could come by and pick it up.During an interview on 04/19/2026 at 9:58am with CNA P she stated the expectation for medication pass of the nurse and medication technicians was to follow the 10 rights when being administered. CNA P stated she did not administer any medication to Resident #57, and she did not identify the pill before now. CNA P stated the risk of the medication being left on the floor was that a person could come by, pick it up, and take it or the person who required the medication didn't receive their medicine and could be in pain or delay in treatment.During an interview on 04/19/2026 at 10:02am with Resident #57, he stated that he did receive all his medications that morning and did not recall taking a big white pill. Resident #57 stated that he had not gotten out of his bed and no one had come into his room.During an interview on 04/19/2026 at 9:59am with the DON, she stated the expectation for medication pass was for the Mas to follow the rights. She stated the medication should be swallowed and not left on bedside. The DON stated the risk of the medication being left on the floor was another resident could walk by and take it.Record review of Resident #42's undated face sheet revealed an [AGE] year-old female who admitted into the facility on [DATE]. She had diagnoses of dementia, psychotic disorder with hallucinations and delusions, anxiety disorder, cataract, and unspecified psychosis.Record review of Resident #42's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 06 out of 15 indicated moderate to severe cognitive impairment to reflect significant difficulty with short term memory, recall, and orientation. Resident #42 could not reliably participate in complex decision-making without support.Record review of Resident #42's Care Plan dated 12/04/2025 with a revised date as 01/05/2026 read the focus; at risk for impaired visual function r/t cataract right eye. The interventions reflected to arrange consultation with eye practitioner as required and monitor/document/report to MD the following s/sx of acute eye problems: Change in ability to perform ADLs, decline in mobility, sudden visual loss, pupils dilated, gray or milky, c/o halos around (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lights, double vision, tunnel vision, blurred or hazy vision. Resident #42's care plan did not reflect she could self-administer eye medication or interventions should she have irritation to her eyes.Record review of Resident #42's active physician's orders dated 04/21/2026 did not reveal any eye medications or eye drops. There was no order for self-administration or PRN orders.Record review of Resident #42's active eMAR dated 04/21/2026 did not reveal any eye medications or eye drops.During an interview and observation on 04/19/2026 at 10:17am with Resident #42 and in her room, revealed one eye-drop bottle on the vanity desk and another on the in-room sink. Resident #42 stated she kept the eye drops in her room because when she woke up her eyes burned every morning as if they were on fire. She then stated that the staff were aware of her having and administering her own eye drops.During an interview on 04/19/2026 at 3:01pm with the DON, she stated she had not been aware that Resident #42 was experiencing issues with her eyes and reported that Resident #42 did not have an active order for self-administered medications. She stated the facility's expectation was that medication be stored on the nurse's cart or in the medication storage room. She stated the risk was the resident potentially taking more medication than prescribed.Policy for Storage of Medications dated April 2007 revealed.Policy StatementThe facility shall store all drugs and biologicals in a safe, secure, and orderly manner.Policy Interpretation and Implementation1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers.2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner.8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.10. Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the residents medical records were accurate for 1 of 5 (CR #1) residents reviewed for medical records The facility failed to update CR #1's advance directive and care plan after receiving a completed DNR form from the physician and responsible party.This failure could cause a violation to the residents' right to self-determination.Findings included:Record review of Resident CR #1's undated face sheet revealed a [AGE] year-old male who admitted into the facility on [DATE]. His diagnoses included hypertension (high blood pressure), malignant neoplasm of the liver (liver cancer), dementia, and malnutrition.Record review of Resident CR #1's physician orders dated [DATE] revealed full code: use AED with CPR during sudden cardiac arrest.Record review of Resident CR #1's MDS assessment dated [DATE] revealed a BIMS score 06 out of 15 indicated moderate to severe cognitive impairment to reflect significant difficulty with short term memory, recall, and orientation. CR #1 could not reliably participate in complex decision-making without support.Record review of Resident CR #1's Care Plan dated [DATE] and revised on [DATE] revealed elected as full code status. The intervention included: provide advanced directive education and support in directive completion, review advance directives and preferences quarterly and PRN with resident/RP.Record review of Resident CR #1's Out of Hospital Do-Not-Resuscitate Order dated [DATE] revealed a signature from an immediate the family member of CR #1, two witness signatures, and the physician's signature.Record review of Resident CR #1's Nurse Note dated [DATE] at 13:05pm revealed at 7:30am [RN T] attempted to check residents blood sugar. Resident found lying in bed with normal skin color for his ethnicity, warm to touch. No vital signs obtained, no palpable pulse. Resident assessed to be unresponsive. Residents have an active Outˆofˆ Hospital DNR. DNR status was verified with original OOHˆDNR form and confirmed with another nurse. CPR was not initiated per DNR order.During an interview on [DATE] at 2:18pm with the SW, she stated she did keep a physical copy of all residents' out of hospital do not resuscitate orders, including CR #1. The SW stated that she did not upload the completed advance directive forms into the resident's medical records. She stated that once a resident or family completed a DNR or other advance directive form, she would submit the document to the ADON for review. The SW stated the ADON was responsible for uploading the form in the electronic medical record and ensuring the code status was updated accordingly. The SW stated she did recall being a witness for CR #1's DNR form and received the completed form from LVN F. The SW stated the failure to update the DNR, or other advanced directive would not honor the residents' wishes.During an interview on [DATE] at 3:05pm with RN T, she stated the day before CR #1 expired, she completed rounds with the doctor who signed the DNR that evening and provided the signed DNR or advance directive to the ADON. RN T stated the document was not completed at the hospital nor was the document completed prior to CR #1 being admitted into the facility, but the status change was within the week CR #1 expired, with family. RN T stated the failure to update and upload the DNR, or other advance directive would not honor the resident wishes.During an interview on [DATE] at 3:53pm with the ADON, she stated the provider signed the DNR or other advance directive order on [DATE], one day before CR #1 expired and it wasn't updated in the system at that time. The ADON stated she did not know why the status was not updated and for CR #1 regarding the DNR or other advance directive order. The ADON stated medical records or the SW were responsible for ensuring the documents were uploaded once they were completed. The ADON stated failure to update and upload the DNR, or another advanced directive could result in CPR being performed. During an interview on [DATE] at 4:38pm with the DON, she stated that when a resident was admitted into the facility from the hospital with a DNR, the facility's expectation was to verify all required signatures were present before updating the resident's code status in the medical record. The DON (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that until the DNR was fully signed and validated, the resident was entered as a full code in the system. The DON stated that if the advance directive was not updated and uploaded in a timely manner, the resident may remain listed as full code even though a DNR was completed. She stated that in an emergency, staff may initiate CPR or other resuscitative measures based on the outdated code status, which would not honor the residents or family expressed wishes. She stated that when the DNR or other advanced directive order is complete, it is expected to be updated immediately and uploaded into the electronic medical record for all staff to see by the staff member who has updated the order.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 of 8 residents (Resident #52, # 17 and #98) reviewed for infection control. MA D failed to sanitize the automated blood pressure cuff used between Residents #52, #17 and #98 when checking blood pressures during medication pass.This deficient practice could affect residents needing blood pressure checks and place them at risk of cross contamination and infection. Record review of Resident #52's face sheet dated 4/23/26 revealed a [AGE] year-old admitted the facility on 10/30/24 and initially admitted on [DATE] with diagnoses to include dementia (a decline in cognitive function), hypertension (elevated blood pressure), stroke, heart failure, anemia, and chronic kidney disease.Record review of Resident #52's quarterly MDS resident assessment dated [DATE] revealed a BIMS score of 3 out of 15 indicating severe cognitive impairment. Record review of Resident #52's order summary report as of 04/23/26 revealed an order for Med Pass 90cc three times a day for supplement r/t malnutrition, start date 12/10/25.Record review of Resident #52's April 2026 MAR/TAR revealed Med Pass supplement was given daily at 8:00 AM, 12:00 PM and 4:00 PM.Record review of Resident #52's undated care plan revealed in part: .Focus - has hypertension, r/t CHF, Stroke.Interventions - Blood pressure taken as ordered.Record review of Resident #17's face sheet dated 4/23/26 revealed an [AGE] year-old admitted the facility on 04/10/26 with diagnoses to include dementia (a decline in cognitive function), hypertension (elevated blood pressure), Diabetes, skin cancer, and hypertensive chronic kidney disease.Record review of Resident #17's admission MDS resident assessment dated [DATE] revealed a BIMS score of 13 out of 15 indicating intact cognition. Record review of Resident #17's order summary report as of 04/23/26 revealed an order Amlodipine tablet 10mg by mouth once a day for hypertension, hold for SBP less than 110 and for heart rate less than 60 and Carvedilol tablet 3.25 mg by mouth twice a day for hypertension, hold for SBP less than 110 and for heart rate less than 60.Record review of Resident #17's April 2026 MAR/TAR revealed the Amlodipine and Carvedilol were due to be given daily at 8:00 AM.Record review of Resident #17's undated care plan revealed in part: .Focus - [Resident #17] is on antibiotics therapy r/t infection (urinary tract infection), date revised on 04/21/26.Interventions:.any antibiotic may cause diarrhea, nausea, vomiting.monitor every shift.Focus - has diabetes mellitus.interventions.monitor/document/report to MD PRN for s/sx of infection to any open areas.Record review of Resident #98's face sheet dated 4/23/26 revealed a [AGE] year-old admitted the facility on 04/20/26 with diagnoses to include hemiplegia (one sided paralysis or severe loss of strength on one side), Diabetes, and heart failure.Record review of Resident #98's nursing skilled evaluation progress note dated 04/22/26 at 10:45 PM, written by RN C, revealed: mental status - alert and oriented x 3, communicated verbally with clear speech.Record review of Resident #98's order summary report as of 04/23/26 revealed an order for Carvedilol tablet 25 mg by mouth twice a day for hypertension, hold for SBP less than 110 and for heart rate less than 60; Lasix 40mg oral tablet my mouth twice a day for CHF.Record review of Resident #98's April 2026 MAR/TAR revealed Carvedilol was given daily at 8:00 AM and at 4:00 PM. Further review revealed Lasix 40mg was given daily at 8:00 AM and 4:00 PM.Record review of Resident #98's undated care plan revealed in part: .Focus - [Resident #98] had ADL self care performance deficit r/t stroke and right side Hemiplegia.Interventions.Observation on 4/22/26 at 3:50 PM, revealed MA D used the automated blood pressure cuff to check Resident #52's vital signs. Resident #52's blood pressure reading was 150/68, pulse was 65. MA D administered med pass supplement to Resident #52. MA D returned the automated blood pressure cuff to the medication cart and performed hand sanitization. At 3:55PM, MA D used the same automated blood pressure cuff to check Resident #17's vital signs. Resident #17's blood pressure reading was 146/65, pulse 65. MA D administered the Carvedilol (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676236	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Champions Healthcare at Willowbrook	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.125mg to Resident #17, then returned the automated blood pressure cuff to the medication cart and performed hand sanitization. At 4:00 PM, MA D used the same blood pressure cuff to check Resident #98's vital signs. Resident #98's blood pressure reading was 142/77, pulse 48. MA D administered the Lasix 40 mg oral tablet and withheld the Carvedilol d/t pulse less than 60. MA D returned the automated blood pressure cuff to the medication cart and performed hand sanitization. MA D did not sanitize the blood pressure cuff between use on Residents #52, #17 and #98.In an observation and interview on 4/22/26 at 4:40 PM, MA D stated she did not sanitize the automated blood pressure cuff between resident use because she was thrown off by the fact some of the residents had re-located to different rooms. MA D stated the risk of not sanitizing blood pressure cuffs between residents was that germs could transfer to the next resident. MA D took disposable sanitizing cloths from the bottom drawer of the medication cart and wiped down the cuff and monitor.In an interview on 04/22/26 at 5:00 PM, the DON stated she expected the nursing staff to clean and sanitize the blood pressure cuff and monitor between each resident use for infection control.Record review of the facility's undated policy for Routine Cleaning and Disinfection revealed in part: Policy: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe and sanitary environment and to prevent the development and transmission of infections to the extent possible.4. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to:.k. blood pressure cuffs.