STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676251	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Misty Willow Healthcare and Rehabilitation Center	12921 Misty Willow Dr 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 closed record (CR #1) of 4 residents reviewed for resident rights. The facility failed to follow their fall protocols and ensured CR #1 received a nursing assessment. This failure could affect the residents who require assistance with their ADLs from facility staff by placing them at risk for social isolation, loss of dignity, and self-worth. The findings included: Record review of CR #1's face sheet dated 05/21/2025 reflected CR #1 was a [AGE] year-old female who admitted to the facility on [DATE] and discharged on 02/16/2025. CR #1's diagnosis of unspecified fall, hemiplegia and hemiparesis (neurological conditions causing motor impairment on one side of the body due to brain injury) following cerebral infarction (stroke: issue death (necrosis) in the brain caused by blocked blood flow) affecting left non-dominant side, nontraumatic intracerebral hemorrhage in hemisphere (fetal stroke), cognitive communication deficit (an impairment in communication-verbal or non-verbal-resulting from underlying cognitive issues rather than primary language or speech deficits), muscle weakness, muscle wasting and atrophy, other lack of coordination, morbid (severe) obesity due to excess calories. Record review of CR #1's discharge Minimum Data Set (MDS) dated [DATE] reflected CR #1 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating CR #1 had a cognitively intact mental status and required helper assistants with sitting to laying, laying to sitting on side of bed, sitting to standing, and char it to bed transfer Helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity with an active stroke diagnosis. Record review of CR #1's undated Care Plan reflected she was at risk for falls r/t weakness, hemiplegia and hemiplegia and hemiparesis following cerebral infarction affecting left side date initiated and created 09/04/2024. Record review of complaint received 02/18/2026 reflected CR #1 had an assistant fall on 02/13/2026, where resident's leg slipped from under her and became stuck underneath the bed will staff attempted to transfer her from her wheelchair to her bed. On 02/16/2026 that resident was sent to the hospital and diagnosed with a left femur fracture. The facility reported that the resident had not vocalized pain nor did not note swelling as the reason for not sending the resident out to the hospital immediately after the fall. On 02/16/2026 at time of transfer to the hospital, the facility made the family aware of the fall. As of 02/18/2026, the resident was awaiting surgery to correct the fracture. Record review of CR #1's February medication administration record (MAR) for monitoring and assess level of pain using the 0 - 10 scale: 0=no pain, 1-3=mild pain, 4- 6= moderate pain, 7-10=severe pain every shift - order date 08/29/2024 reflected on 02/14/2026 resident had a 4 pain level, on 02/15/2026 resident had a 0 pain level, and on 02/16/2026 resident had a 10 pain level. During an interview on 02/19/2026 at 05:40 p.m. CR #1 stated she could not recall the exact day or time, but it was on 02/14/2026 after dinner that she had a fall while being assisted from her wheelchair to the bed by certified nursing assistant (CNA) A and CNA B. She stated that the CNAs tried getting her out of her wheelchair and into the bed, (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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Misty Willow Healthcare and Rehabilitation Center	12921 Misty Willow Dr 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her leg slipped forward and she heard a crack sound, and the CNAs lowered her to the floor. She stated she was sitting on the floor crying while the CNAs struggled to get her up into bed. She stated once in bed, she struggled to sleep that evening tossing and turned into discomfort with a pain level of 9 of 10, 10 being the worst. She stated she also was sad and replayed the fall repeatedly in her mind all evening. She stated on 02/15/2026 at breakfast, she received Tylenol for the fall and a preexisting pain. She stated once she received the pain medication, she was able to sleep better. She stated on 02/16/2026 she told her CNA she needed more Tylenol and then ADON came to assess her, and the facility called 911 and sent her to the hospital. She stated at the hospital she learned she had a fracture break to her left leg and on 02/17/2027 she had surgery to the area. During an interview on 02/19/2026 at 09:47 a.m. DON stated she learned on 02/16/2026 that on 02/15/2026 CNA A and CNA B were transferring the resident from her wheelchair to the bed CR #1 had an assisted fall and the resident's leg had slipped forward. She stated that the CNAs lowered the resident to the floor and contacted licensed vocational nurse (LVN) A. She stated LVN A came to assess the resident finding no injuries or pain. She stated thereafter the CNAs assisted the resident back to the bed with no further issues or complaints from the resident as a result of the fall. She stated on 02/16/2026 ADON Awas informed that CR #1 was having pain. She stated ADON A assessed CR #1 and found that the resident had pain in her left extremity (leg) with edema (swelling) at the top of her left leg. She stated the resident voiced to the ADON had the pain resulting from a fall that occurred a couple days prior. She stated that ADON called the resident's physician and the resident was provided with pain medication and an x-rays and then was transferred to the hospital's emergency room (ER). She stated that the Family contacted the facility on Monday to understand how the fall had occurred resulting in the resident's pain. During an interview on 02/19/2026 at 3:13 p.m. DON stated that it had been the facility's protocol that all falls were to be reported to her. She stated on 02/16/2026, she was notified of CR #1's fall that had taken place on 02/15/2026. She stated on that same day she interviewed CR #1, learning the fall occurred a few days prior, but the resident could not recall the exact date or time and only provided a description of the staff that assisted her. She stated that she began an investigation and learned that CNA A and CNA B had been on shift and worked the hall CR #1 was on. She stated that LVN A had not contacted her about the resident's fall. She stated she interviewed CNA A and CNA B who both stated that the resident's fall was reported to LVN A. She stated that LVN A stated that she had not been made aware that CR #1's fall. She stated therefore CR #1's family had not received the fall informed on the resident until 02/16/2026. She stated that CNA A, CNA B, and LVN A were terminated. She stated that LVN A had a previous write-up/disciplinary action for failure to notify the DON of a resident's change of condition. She stated on 02/16/2026 the facility's nursing staff received an in-service training on abuse, neglect and exploitation (ANE) and reporting falls to the DON. During an interview on 02/20/2026 at 12:12 p.m. CNA A started she would not provide a statement. During an interview on 02/20/2026 at 12:13 p.m. CNA B started working at the facility on 02/13/2026 from 2:00 p.m. to 10:00 p.m. and stated on 02/13/2026 at about 06:30 p.m. CNA A asked her to assist with CR #1's wheelchair to bed transfer. She stated during the transfer, resident started to slip and they slowly lowered the resident onto the floor. She stated that CNA A went to alert the resident's nurse at the nurse's station who after 10 minutes had not come to assess resident. She stated that the resident began complaining about being cold on the floor. She stated that the resident had not verbalized any pain, had not been crying. She stated on 02/16/2026 when she came on shift at 2:00 p.m., ADON informed her the resident was sent out to the hospital with complaints of leg pain as result of the fall. She stated she was suspended pending an investigation. During an interview on 02/20/2026 at 12:26 p.m. LVN A stated she worked as needed (PRN) on Saturdays and Sundays from 7:00 a.m. to 7:00 p.m. only and had not worked on 02/13/2026. She stated on 02/15/2026 at 11:24 a.m. she was questioned via text by ADON about a fall that CR #1 had and requested that the resident receive a full body assessment. She stated on 02/15/2026 about 12 p.m., the resident would not allow her to be touched for an assessment and stated she was not in (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Misty Willow Healthcare and Rehabilitation Center	12921 Misty Willow Dr 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain. She stated on 02/16/2026 and was dismissed/fired for failure to report a fall. During an interview on 02/20/2026 at 01:24 p.m. ADON stated that on 02/16/2026 she interviewed CR #1's who stated she had a fall a few days ago and the staff picked her up and placed her back into the bed and on that day, the resident stated her leg was hurting. She stated that the DON performed a skin and pain assessment on the resident and found that the resident's leg was warm to touch and swollen. The ADON stated that residents' days were off and the fall took place on 02/15/2026. During an interview on 02/20/2026 at 11:43 a.m. Resident #2 stated that she was CR #1's roommate prior to the resident discharging to the ER. She stated that she was not in the room when the resident fell. She stated she could not recall the exact date of time but knew it was sometime over the weekend of 2/13/2026 - 02/15/2026. She stated that the resident was sitting in her bed crying in a curled-up position. She stated she asked the resident what was wrong and was told she had a nasty fall a few hours ago and was in pain. She stated the resident lay in the bed whining and whimpering all day. She stated that evening when she received her PRN pain medication, CR #1 asked for some too and received something. She stated that then a few days later the resident was in her bed curled up crying again and said she had a fall, but stated that the story was different then what CR #1 first shared, but that she could not recall what the details of either story were, she only remember what CR #1 had told her over the weekend and then what she told the DON on 02/16/2026 were two different stories. She stated after the DON spoke to CR #1 on 02/16/2026 about her fall, she asked the DON what was wrong with CR #1. She stated that the DON told her that CR #1 had a fall on 02/15/2026. She stated that Resident had not fallen on 02/15/2026, because Resident had told her a few days prior about fall when she was crying. During an interview on 03/06/2026 at 01:09 p.m. DON stated that on 02/16/2026 sometime during the late part of the morning meeting, ADON B asked her to step into the hall and notified her that CR #1 had complained of pain in her lower extremity after a post fall. She stated she went into CR #1's room to find that the resident had pain to lower extremity after post fall. DON stated MD was contacted ordered an x-ray and 2- tables Tylenol 650mg/Administered. DON stated due to the pain, CR #1 was transported 911 to the hospital for x-rays to be performed at a higher level of care center for immediate attention to the resident's pain. During an interview on 03/06/2026 at 01:26 p.m. ADM stated CR #1 had to have had her assisted fall on 02/14/2026. He stated it had been his expectation that he would have been notified immediately if a resident had a fall to know he needed to complete an incident report. He stated because CR #1 was able to explain the fall and there were two witnessing CNAs he had not completed an incident report. At the time of the assisted fall, it was reported that the resident had not verbalized any pain. He stated on 02/16/2026 the resident made her first complaint of pain, and the DON addressed the resident and sent CR #1 to the hospital immediately. During an interview on 03/06/2026 at 02:31 p.m. ADON B stated that she received a call from LVN A on 02/15/2026 that CR #1 had informed LVN A she had a fall. She stated that from what LVN A understood no fall had been reported to her. She stated she advice LVN A to perform a head-to-toe assessment and report back the findings. She stated that LVN A attempted to perform the assessment, but that CR #1 refused and stated that she had no pain. Record review of policy titled Resident Rights and Responsibilities, Notice of dated 11/2025 reflected: Policy: It is the policy of this facility to inform the resident both orally and in writing of his/her rights as a resident, as well as, the rules and regulations governing the resident's conduct and responsibilities during his/her stay in the facility.Procedure: 1. Prior to or upon admission, a representative of the admitting office will provide the resident with a written copy of resident rights and a copy of all rules and regulations governing the resident's conduct and responsibilities during his/her stay in the facility. The resident will also be provided with a State developed notice of Medicaid rights and obligations, if any.2. The resident will be required to sign a statement acknowledging that he/she was informed of his/her rights and responsibilities. (See Resident Rights Form)3. Should a resident be found incompetent by a court of law, the resident's representative shall act on behalf of the resident.4. The facility will inform the resident of his/her (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rights and responsibilities in a language that is both clear and understandable to the resident. Should the resident's knowledge of English be inadequate for understanding such rights and responsibilities, his/her rights and responsibilities will be explained in the language that is familiar to the resident.5. For foreign languages commonly encountered in our community the facility will provide the resident with written and oral translations of his/her rights and responsibilities through an interpreter. If the foreign language is not common to our community, the representative (sponsor) may sign that he/she has interpreted the statement of rights and responsibilities to the resident.6. Should the resident be hearing impaired and communicate by signing, the resident will be informed of his/her rights and responsibilities through an interpreter.7. To assure that our residents, staff, and visitors are continually informed and aware of resident rights, grievance procedures, and responsibilities, large print copies may be posted in a prominent area in the facility.8. Written copies of resident rights and responsibilities are available upon request and may be obtained from the social services department during normal office hours (8:00 a.m.- 5:00 p.m., Monday-Friday (except holidays)).9. The resident will be promptly informed, both orally and in writing, of a change in resident rights and when changes occur in facility rules that govern the resident's conduct or responsibilities.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices based on the resident's comprehensive assessment for 1 closed record (CR #1) and 3 of 3 residents reviewed for quality of care.The facility failed to seek medical guidance or report a fall that resulted in injury, including pain, swelling and a broken femur, to CR #1 for approximately 3-days.The facility nurse failed to assess CR #1 after a fall. On 03/06/2026 at 06:38 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 03/08/2026 12:46 p.m. the facility remained out of compliance at a scope of isolation and a severity of harm with potential for more than the minimal harm that was not an immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.These failures could place residents at risk or delay of appropriate medical treatment leading to pain, discomfort, and death.This was determined to be an IJ on 03/06/226 at 6:38 p.m. Administrator (ADM) and director of nursing (DON) were notified. The ADM was provided and signed the IJ template on 03/06/2026 at 06:42 p.m. Findings included: Record review of CR #1's face sheet dated 05/21/2025 reflected CR #1 was a [AGE] year-old female, admitted on [DATE] and discharged on 02/16/2026. CR #1's diagnoses included hypertension (high blood pressure, a chronic condition where blood force against artery walls is consistently too high), type 2 diabetes mellitus without complications (indicates a diagnosis of chronic high blood sugar where the condition has not yet caused damage to organs, nerves, or blood vessels), anemia (occurs when there is not enough hemoglobin, or there are not enough red blood cells), unspecified fall, hemiplegia and hemiparesis (neurological conditions causing motor impairment on one side of the body due to brain injury) following cerebral infarction (stroke: issue death (necrosis) in the brain caused by blocked blood flow) affecting left non-dominant side, nontraumatic intracerebral hemorrhage in hemisphere (fetal stroke), cognitive communication deficit (an impairment in communication-verbal or non-verbal-resulting from underlying cognitive issues rather than primary language or speech deficits), muscle weakness, muscle wasting and atrophy, other lack of coordination, morbid (severe) obesity due to excess calories. Record review of CR #1's discharge Minimum Data Set (MDS) dated [DATE] reflected CR #1 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating CR #1 was cognitively intact. The MDS indicated in section GG: functional abilities/mobile devices; wheelchair for mobility CR #1 required the following:Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed. Substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk and limbs and provides more than half the effort.Sit to lying: The ability to move from sitting onside of bed to lying flat on the bed. Substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds truck and limbs and provides more than half the effort.Laying to sitting on side of bed: Substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk and limbs and provides more than half the effort.Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair or on the side of the bed. Dependent - Helper does all of the effort. Resident did none of the effort to complete the activity. Or, the assistance of 2 or more helpers was required for the resident to complete the activity.Chair/Bed-to-chair transfer: The ability to transfer to and from a bed to a chair (wheelchair). Dependent - Helper does all of the effort. Resident did none of the effort to complete the activity. Or, the assistance of 2 or more helpers was required for the resident to complete the activity.Section - Active Diagnoses: Stroke Record review of CR #1's undated Care Plan reflected she had left sided hemiplegia/hemiparesis related to (r/t) hemorrhage, stroke date created and initiated: 09/13/2024, hypertension r/t stroke date initiated and created 09/13/2024, she may use mobility bar(s) to roll side to side or scoot up in the bed. Date initiated/created on: 09/19/2025, she was at risk for impaired cognitive function/dementia or (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	impaired thought processes date initiated/created 09/04/2024 and revised on 09/11/2024, she had assistance with daily living (ADL) self-care performance deficit r/t left hemiplegia, morbid obesity date initiated/created: 09/04/2024 and revision on 12/10/2025, she was at risk for falls r/t weakness, hemiplegia and hemiplegia and hemiparesis following cerebral infarction affecting left side date initiated and created 09/04/2024. Record review of CR #1's progress notes dated 02/13/26 at 08:58 a.m. reflected CR #1 was prescribed as needed (PRN) acetaminophen for general discomfort pain. Record review of CR #1's progress notes dated 02/13/26 at 04:14 a.m., reflected CR #1 received PRN acetaminophen for headache, pain scale 0. Record review of CR #1's incident report dated 02/15/2026 at 11:24 a.m., reflected CR #1 was alert in bed in a supine position alleging a fall a few days ago. The incident report reflected CR #1 was unable to give a specific day and indicated there were no witnesses. Record review of CR #1's progress notes dated 02/16/2026 at 10:30 a.m. reflected CR #1's skin was checked finding her skin warm and dry, skin color within normal limits (WNL) and turgor was normal. CR #1 refused to turn- unable to evaluate posterior. CR #1 transferred to hospital with acetaminophen administered. Record review of CR #1's progress notes dated 02/16/2026 at 12:07 a.m., reflected CR #1 received PRN acetaminophen for headache. Record review of CR #1's progress notes dated 02/16/2026 at 12:17 p.m., reflected CR #1 had a change of condition reporting new or worsening pain, pain scale 9. Record review of CR #1's progress notes, dated 02/16/26 at 02:09 p.m. reflected CR #1 had leg pain. Progress notes reflected CR #1's left leg was swollen and painful to touch with a pain level of 9 in the left leg. Medicated and assessed by assistant director of nursing (ADON), DON, and medical doctor (MD) made aware and ordered to send CR #1 out by way of (via) 911. Further review of CR #1's progress notes for 02/13/2026 to 01/16/2026 revealed no documentation related to a fall. Record review of facility's disciplinary actions dated 02/16/2026, reflected certified nursing assistant (CNA) A and CNA B were terminated for failure to report a fall to the charge nurse and licensed vocational nurse (LVN) A was terminated for failure to assess CR #1 after the fall and report the fall to DON. Record review of complaint received to Health and Human Services dated 02/18/2026 reflected CR #1 fell on [DATE], while the CR #1 was being transferred from her bed to the wheelchair and in the process the resident's leg was stuck under the bed. On 02/16/2026 that resident was sent out to higher level care hospital, the resident was diagnosed with a left femur fracture. The facility staff reported the reason it took a few days to have the resident sent out was because the resident had not vocalized pain nor was any swelling noted. The family was not made away from the fall until 02/16/2026 at time of transfer to the hospital. As of 02/18/2026, the resident was awaiting surgery to correct the fracture. No copy of an incident report was provided or received as of 02/18/2026. Record review of CR #1's 02/2026 medication administration record (MAR) reflected resident was ordered Acetaminophen tablet 325 milligram (mg) to be given two-tablets by mouth every six-hours PRN for general discomfort pain as of order date 08/30/2024. For monitoring and assessed level of pain using the 0 - 10 scale: 0=no pain, 1-3=mild pain, 4- 6= moderate pain, 7-10=severe pain every shift - order date 08/29/2024. On 02/14/2026 at 08:58 a.m. CR #1 received medication and reported a 4-pain level. On 02/15/2026 CR #1 had a 0-pain level. On 02/16/2026 at 12:07 p.m. CR #1 received medication and reported a 10-pain level. Interview with CR #1 on 02/19/2026 at 05:40 p.m. CR #1 stated she fell but could not recall the exact day or time but thought it was after dinner on 02/14/2026. She stated CNA A and CNA B tried transferring her from the wheelchair into her bed. She stated her leg slipped forward, and she heard a crack sound, and the CNAs lowered her to the floor. She stated while on the floor the CNAs immediately tried to pick her up and put her onto the bed, but her leg got caught under the wheelchair and she told the CNAs to wait and back up the wheelchair first. She stated the CNAs had a hard time getting her up and her leg then got caught under the bed. She stated she heard one of the CNAs say, Obviously we're not strong enough she stated referring to the lack of strength the CNAs had to get the resident off the floor. She stated that the CNAs had not attempted to notify a nurse nor had a nurse come to assess her for pain or injuries. She stated that she was hollering and crying when the CNAs (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	attempted to get her off the floor due to pain from the fall. She stated the evening of 02/14/2026 she had a hard time sleeping and she tossed and turned from her discomfort. She stated she had not reported the discomfort to the evening staff even though her pain level was at 9 and she cried replaying the incident in her mind all evening. She stated during breakfast 02/15/2026 she received Tylenol because she told the nurse she had pain in her back and lower tailbone and then pain to the upper part of her left leg due to the fall. She stated once she received the pain medication, she was able to sleep and the following day 02/16/2026 she told her CNA she needed more Tylenol and then the ADON came to assess her and the facility called 911 and sent her to the hospital. She stated at the hospital she learned she had a fractured left leg and on 02/17/2027 she had surgery. She stated that she had a roommate, but she could not recall if Resident #1 was on her side of the room nearest the window when the fall occurred. During an interview on 02/19/2026 at 09:47 a.m., the DON stated she learned on 02/16/2026 that CR #1 fell on [DATE] when CNA A and CNA B were transferring the resident from her wheelchair to the bed. She stated she learned that the resident's leg slipped and her foot moved forward from under her and two CNAs lowered the resident to the floor and contacted LVN A to come assess CR #1. She stated LVN A came to assist the resident finding no injuries or pain and the resident voiced that she had no pain and was fine to transfer back to the bed. She stated thereafter the CNAs assisted the resident back to the bed with no further issues or complaints from the resident as a result of the fall. She stated on 02/16/2026, ADON A was informed that CR #1 was having pain and went to assess the resident. She stated ADON A found that the resident had pain in her left extremity (leg) with edema (swelling) and the resident pointed to the top of left leg. She stated that the resident voiced to ADON A had pain resulting from a fall that occurred a couple days ago. She stated ADON A called the resident's physician who agreed to provide the resident with pain medication, X-radiation (x-rays) and transfer the resident from the facility via 911 to obtain a higher level of care at a hospital emergency room (ER). She stated that the family contacted the facility on Monday to understand how the fall had occurred resulting in the CR #1's pain. During an interview on 02/19/2026 at 03:13 p.m., the DON stated that it was the facility's protocol to call the DON whenever there was a fall in the facility whether it was an assisted fall or not. She stated she was not notified that CR #1 fell on [DATE] during a staff assisted transfer. She stated on 02/16/2026, she interviewed CR #1 who stated she fell a couple of days ago but could not recall the exact date or time and provided descriptions of the staff that assisted her. She stated that she began an investigation and learned that CNA A and CNA B had been on shift and worked the hall CR #1 was on and that they were transferring CR #1 on 02/15/2026 when CR fell, resulting CR #1's leg fracture. She stated LVN A had not contacted her about CR #1's fall. She stated she interviewed CNA A and CNA B who both stated that the resident's fall was reported to LVN A. She stated LVN A stated that she had not been made aware that CR #1 had a fall. She stated therefore CR #1's family was not informed of the resident's fall until 02/16/2026. She stated CNA A, CNA B, and LVN A were all terminated. She stated that LVN A had a previous write-up/disciplinary action for failure to notify the DON of a resident's change of condition. She stated on 02/16/2026 the facility's nursing staff received an in-service training on ANE and reporting falls to the DON. She stated she was not made aware CR #1 stated that her leg had gotten caught under the wheelchair and bed. During an interview on 02/20/2026 at 12:12 p.m. CNA A stated she would not provide a statement. During an interview on 02/20/2026 at 12:13 p.m. CNA B stated she started working at the facility on 02/13/2026 on a 2:00 p.m. to 10:00 p.m. shift. CNA B stated on 02/13/2026 at about 6:30 p.m., CNA A asked her to assist with CR #1's wheelchair to bed transfer. She stated she assisted CNA A getting CR #1 out of the wheelchair when the resident started slipping and they slowly lowered CR #1 onto the floor and CNA A went to alert the resident's nurse. She stated they waited for a nurse to come for about 10 minutes, but no one came and CR #1 complained of being cold on the floor. She stated they then got the resident off the floor and into the bed. She stated CR #1 had not verbalized any pain, swelling, nor had the resident cried, or grimaced with pain. She stated she had not seen the resident after that date/time. She stated on 02/16/2026 (continued on next page)

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	676251	A. Building B. Wing	03/09/2026

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Misty Willow Healthcare and Rehabilitation Center	12921 Misty Willow Dr 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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	when she went to work at 2:00 p.m., an ADON informed her the resident was sent out to the hospital with complaints of leg pain as result of the fall and that she would be suspended pending investigation. She stated she had received an ANE in-service training 2-weeks prior that also covered the facility's fall protocol. She stated that the fall protocol required all falls to be reported to the resident's nurse immediately. During an interview on 02/20/2026 at 12:26 p.m. LVN A stated she only worked as needed (PRN) on Saturdays and Sundays from 7:00 a.m. to 7:00 p.m., never any Fridays. LVN A stated on 02/15/2026 at 11:24 a.m. via text ADON A questioned her about CR #1's fall. She stated she told ADON she was not made aware CR #1 fell and ADON A requested she assess CR #1. She stated she attempted to perform a skin and pain assessment on CR #1 on 02/15/2026, about 12:00 p.m., but the CR #1 would not allow her to touch her, denied any pain, and the resident stated to leave her alone, and she stated that the resident had not asked for pain medication. She stated she cared for the CR #1 in the past who was a quiet and pleasant resident who mostly stayed in her room watching television. She stated she was asked to come into the facility on [DATE] and was dismissed/fired for failure to report a fall and contact the resident's physician and family. She stated CR #1 had not had a fall on her shift and had communicated that with ADON A and requested the fall protocol. She stated that ADON A told her that all falls were to be reported to the DON and to notify the resident's physician. She stated she had not had an alleged fall while working for the facility and could not recall when she had a fall in-service training and noted that she had an ANE in-service training on 02/16/2026 by ADON A noting forms of abuse were sexual, financial, emotional, and physical. During an interview on 02/20/2026 at 01:24 p.m. ADON A stated that on 02/16/2026 she interviewed CR #1 who stated she fell a few days ago and the staff picked her up and placed her back into the bed and on that day, the resident stated her leg was hurting. She stated that the DON performed a skin and pain assessment on the resident and found that the resident's leg was warm to touch and swollen. ADON stated CR #1's days were off (she was confused about the days) and the fall took place on 02/15/2026. During an interview on 02/20/2026 at 11:43 a.m. Resident #1 stated she was CR #1's roommate prior to the resident discharging to the ER. She stated that she was not in the room when the CR #1 fell. She stated she could not recall the exact date of time but knew it was sometime over the weekend of 2/13/2026 - 02/15/2026. She stated that the CR #1 was sitting in her bed crying in a curled-up position. She stated she asked CR #1 what was wrong and was told she had a nasty fall a few hours ago and was in pain. She stated the CR #1 laid in the bed whining and whimpering all day. She stated that evening when she received her PRN pain medication, CR #1 asked for some too and received something. She stated a few days later CR #1 was in her bed curled up crying again and said she had fell, but stated the story was different but could not recall details of either story. She stated after the DON spoke to CR #1 on 02/16/2026 about her fall, she asked the DON what was wrong with CR #1. She stated that the DON told her that CR #1 had a fall on 02/15/2026. She stated that Resident had not fallen on 02/15/2026, because Resident had told her a few days prior about fall when she was crying. During an interview on 03/06/2026 at 01:26 p.m. ADM stated he was the facility's abuse coordinator (AC), and it was his expectation that facility staff report all allegations of ANE to him immediately. He stated the facility's investigation found that CR #1's fall occurred on 02/14/26 in the evening after dinner and because the CR #1 was cognitively intact and able to account for the event, and he did not initiate an incident report because of the recount. He stated he and the DON interviewed CR #1 on the morning of 02/16/2026 and CR #1 stated that her pain had begun that morning. He stated CR #1 not verbalized pain to any staff at the time CR #1 indicated she had fell. During an interview on 03/06/26 at 02:31 p.m. ADON A stated that on 02/15/2026, LVN A stated CR #1 told her she fell. ADON stated that LVN A did not feel that was accurate, because no staff had reported a fall to LVN A. ADON A stated she instructed LVN A to assess CR #1 and report the findings to the DON. During an interview on 03/06/2026 at 02:57 p.m. the MD stated the DON called on the morning of 02/16/2026 reporting that CR #1 fell on [DATE]. The MD stated she ordered CR #1 received x-rays, but due to CR #1's pain the DON requested CR #1 be (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	immediately sent out for higher level of care via 911 transport and MD agreed. MD stated sometime between 02/17/2026 and/or 2/18/2026 she and the DON spoke to three members of CR #1's family via telephone who had questions CR #1's fall and how CR #1 could have sustained a femur fracture. MD stated she informed the CR #1's family that CR #1's x-rays results showed CR #1 had deep mineralization the biological process of depositing calcium and phosphate minerals into the collagen matrix of bone, creating a rigid, strong, and dense structure) to the bones in and around the fracture area, noting, due to CR #1's age and condition made the bones brittle and susceptible to fractures. She stated individuals of younger age, who sustained that same fall would not necessarily experience bone fractures. She stated 1 of CR #1's family members noted that CR #1 usually when and if concerns arose, was her own advocate and if CR #1 was not able to handle the concerns would reach out to the family for assistance. MD stated from her understanding, CR #1 had not reached out other her family regarding the assisted fall. MD stated as a result of CR #1's fall, CR #1 could experience immediately, delayed, and/or progressive pain depending on the swelling of CR #1 tissue around her femur bone. During an interview on 03/06/2026 at 05:28 p.m. with ADM and DON, DON stated through the course of the facility's investigation of CR's fall the facility believed that on 02/15/26 after dinner, CNA A and CNA B assisted CR #1 from her wheelchair to bed when CR #1 communicated that she was slipping and the CNAs proceeded based on the fall process to lower CR #1 to the floor in a seated position. The DON stated once on the floor, 1-of the CNAs went to the nursing station to report the fall to a nurse. She stated that neither of the CNAs could identify which nurse CR's fall was reported to. The DON stated on 02/16/2026 ADON B reported to her that CR #1 had pain due to a fall. The DON stated ADON B assessed the CR #1 finding that CR #1 had pain and pointed to her the top area of her left leg. The DON stated that CR stated the pain resulted from a fall that occurred a few days prior when CNAs A and B attempted to transfer from her from the wheelchair to the bed. The DON stated that ADON C contacted MD who ordered x-rays. The DON stated that because of CR's pain, requested MD sent CR #1 to the ER for high level of care due and MD agreed. The DON stated that ADON C contacted the family and informed them of CR #1 anticipated transfer to the hospital. The DON stated later that same day she learned from the hospital liaison that CR #1 sustained a left hip fracture and was awaiting surgery. DON stated that same day, LVN A, CNA A and CNA B were suspended pending an investigation of CR #1's injury. The DON stated 02/17/26 the family telephoned questioning how CR #1 could have sustained a fracture to her hip by simply sitting on the floor and reported they were calling the state to report the incident. The DON stated she add MD to the call with CR #1's family and MD explained due to CR #1's diagnosis of osteoporosis, brittle bones, B-12 deficiency, and muscle weakness CR #1's bones were demineralized causing CR #1's bones to fracture easily. The DON stated on 02/17/26 the facility held a standard of care meeting with the facility's department heads to discuss how to increase awareness as falls and see where the facility could tighten up on delegating tasks, identify issues, and develop a plan resolve. The DON stated at present the process and review of falls was ongoing, and medical doctor was involved in the process. The DON stated on as of this date, the facility completed a complete audit of resident's care plans focusing transfer needs. The DON stated that therapy lead the audit and ensured that every resident had updated interventions on their care plans, but noted that all care plans were updated, none needing updates. She stated on 02/16/2026 and 02/17/2026 the facility staff received in-service training lead by the therapy department on proper body alignment, items needed for transfer, and understanding residents with high fall risk. She further stated that falls is a facility concern not a nursing concern that was to be covered and monitored by all staff from all departments. On 02/19/2026 an investigation initiated and the state investigator provided an Immediate Jeopardy (IJ) Template notification that the regulatory services had determined that the condition at the facility constituted an immediate jeopardy to resident health and safety. The facility failed to seek medical guidance or report a fall that resulted in injury, including pain, swelling and a broken femur, to CR #1 for approximately 3-days. Based on the comprehensive assessment of a resident, the facility must (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ensure that residents receive treatment and care in accordance with professional standards of practice. The facility nurse failed to assess Resident #1 after an assisted fall. The following plan of removal was submitted by the facility and was accepted on 03/07/2026 at 02:01 p.m.IJ F684Plan-of-Removal03/07/2026Per the information outlined in the IJ template provided on March 6, 2026, at 6:38 p.m., the facility failed to assess Resident #1 following an assisted fall. The following actions were taken in response:The Medical Director was notified of the IJ on March 6, 2026, by the Executive Director and the Director of Nursing (DON).A necessary or needed (ad hoc) meeting was conducted on March 6, 2026, during which the Head-to-Toe Assessment and Fall Management System policies were reviewed by the Medical Director, DON, and Executive Director. No policy revisions were identified or implemented at that time.Fall Management System education was initiated on March 6, 2026, for nursing staff by the DON, ADON, RN Clinical Resources, and Cluster Nursing RN Leadership. Target completion date: 03/07/2026.On 03/06/26, Clinical RN Resources & Cluster Clinical DON(s), RN(s), conducted and completed facility wide audit for last 30 days Incidents/Accidents/Falls audit. No further findings similar to deficient practice were identified.DON, ADON(s), Clinical RN Resources will conduct and complete assessments for all residents including pain assessment by 03/07/26.All licensed nurses are required to complete education and competency check-offs for Head-to-Toe Assessments, including pain assessments. This process began on March 6, 2026, and is being facilitated by the DON, ADON, RN Clinical Resources, and Cluster Nursing RN Leadership. Target completion date: 03/07/2026.Education and competency validations will be completed in person with all nursing staff by 03/07/2026, prior to the start of their next scheduled shift. A member of the nursing management team will be present at the facility during each shift change to ensure completion. Staff will not be permitted to work on the floor until all training and competency requirements are met. This education will also be incorporated into new hire orientation and completed by PRN staff prior to working independently on the floor. These staff members will likewise not be permitted to work without completion of the required training and knowledge validation.An additional ad hoc meeting addressing the items identified in the IJ template will be held on March 7, 2026. Attendees will include the Medical Director, RN Clinical Resources, Administrator, Director of Nursing, ADON(s), and Cluster Clinical DONs (RNs). This meeting will include a review of the plan for removal and associated interventions.The DON, ADON, or RN Clinical Resources will review and verify completion of a comprehensive head-to-toe assessment, including skin and pain assessments, for all fall incident reports daily. Random Nursing staff post-fall knowledge checks will be conducted three times per week X 01 week, two times per week x 02 weeks, and once a week x 01 week or until substantial compliance has been achieved.Charge Nurse was terminated effective 02/16/26 and CR#1 was transferred to the hospital per Physician Order on 02/16/26. CR#1 has not returned to the facility.A summary of the IJ findings and corrective action plan will be reviewed by the QAPI Committee weekly for four weeks or until substantial compliance is established, and then monthly for 90 days to ensure substantial compliance. The investigator confirmed the plan of removal had been implemented sufficiently to remove the IJ by the following: During an observation on 03/06/2026 at 6:46 p.m. CNA C and CNA D were observed transferring Resident #3 from chair to bed by use of mechanical lift. Resident #3 had a lift pad between him and the wheelchair. CNAs were observed attaching the metal clams to secure the pad to the mechanical lift and used the lift to raise resident out of the chair and repositing the resident over his bed lowing him onto the bed. Once resident was lowered to the bed CNAs removed the pads clamp connectors from the mechanical lift and assisted resident by repositioning him higher into the bed. During an interview on 03/09/2026 at 9:01 a.m. CNA F indicated she would assisted Resident #4 from her bed into a wheelchair. CNA F placed a gait belt around Resident #4's waist, lowered her bed, and brought the resident's wheelchair in the bedside in the a wheel lock positioning. She assisted resident swing her legs off the bed placing them onto the floor. Staff stood in front of the resident. Resident# 4 placed her arms around CNA F's neck as the staff lifted and stood the resident with the gait belt around the waist. CNA F (continued on next page)

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