

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Misty Willow Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, distributed, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. The facility failed to ensure food was properly stored, labeled, and dated in the walk-in refrigerator, walk-in freezer, and dry goods pantry. The facility failed to ensure dietary staff used facial hair restraints while in the kitchen properly while food was actively being prepared. These failures placed all residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings Include: Observation of the walk-in refrigerator on 12/02/2025 at 8:47 AM revealed:1. One open box on bottom shelf exposing raw, in-shell eggs on trays undated2. One open box on 4th shelf down of bulk raw bacon in an open plastic bag exposed to air, no open date on box3. One bag on 2nd shelf down of sliced potatoes was open and top loosely folded over not secured, no dates on bag Observation of the walk-in freezer on 12/02/2025 at 8:55 AM revealed:1. One open box on middle shelf of individually quick-frozen raw chicken in open bag and not dated2. One open box on middle shelf of bulk corn dogs, interior bag opened, and items exposed to air, not dated Observation of dry goods storage on 12/02/2025 at 9:00AM revealed:1. One open bag on middle shelf of basmati rice, rice exposed to air, not dated2. One open bag on middle shelf of grits, top loosely rolled down and not secured, dated opened 12/23. Floors under shelving have debris and particles spilled from open bags and dirty4. One pan covered in foil on bottom shelf with tear containing unknown contents dated 4/16/255. One bag of cornmeal on bottom shelf open and top loosely rolled down unsecured and undated6. One bag of sugar on bottom shelf open and top loosely rolled down unsecured and undated Observation on 12/02/2025 at 11:28 AM of kitchen stove with uncovered food items cooking and steam table area revealed the DM draining oil from a deep fryer not wearing a beard net. In an interview on 12/0/2025 at 9:15 AM, DA E stated that whoever returned food items to the refrigerator, freezer, or pantry was responsible for making sure it (the food item) was closed and dated properly. DA E stated that the DM was responsible for the kitchen staff and ensured proper procedures were followed. In an interview on 12/02/2025 at 11:30 AM, the DM stated he had a beard net on earlier when he started changing the oil in the fryer and stepped away to handle another task. He forgot to replace the beard net when he returned to the active cooking area of the kitchen. The DM stated that he would start keeping a closer watch on how food items were put away after packaging was opened, that he checked more often for proper labeling on opened packaging, and that items were stored so that they were protected from possible contamination. The DM stated the risk of improperly stored items was potential for residents to become ill, item could be contaminated by pests, attracting pests/mice, premature spoilage of items, and no way to know when items were opened to comply with facility policy of use within 3 days of opening. The DM stated he would order food safe storage bags to seal open items into that should be delivered by Friday, 12/5/25, he would ensure all opened food items were securely wrapped in plastic wrap until bags received, and would in-service kitchen staff on proper food labeling and storage. In an interview on 12/04/2025 at 3:04 PM, the Administrator stated that improperly stored food items could be a risk for cross contamination from other items that would impact residents. The Administrator (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 676251	If continuation sheet Page 1 of 12

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated that items not labeled when received and when opened would have posed a risk of items being safe to consume based on knowing correct expiration date and correct consume by dated based on item specifications as some will need to be used sooner than others. The Administrator stated that labelling items was also important to follow a first in first out use theory to avoid waste. In an interview on 12/04/2025 at 3:36 PM, the DON stated there was a risk to residents from improper food storage of items becoming contaminated and potential for residents to become sick. Record review of Food Storage Policy/Procedure revised 8/2007 revealed the following:Policy: It is the policy of this facility that food storage areas shall be maintained in a clean, safe, and sanitary manner.Procedures:1. Food storage areas shall be clean at all times. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 3 of 3 meals observed (lunches on 12/02/2025, 12/03/2025, and 12/04/2025) and reviewed for proper textures. The facility failed to ensure that mechanical soft foods were served at the proper texture on 12/02/2025, 12/03/2025, and 12/05/2025. This failure could affect all residents on mechanical soft texture diets by placing them at risk for choking and weight loss. Findings Included: Observation of meal service on 12/02/2025 at 12:20 PM revealed [NAME] F plating a mechanical soft meal of chicken enchiladas, Spanish rice, and refried beans. [NAME] F quickly hand-chopped the enchilada in the pan with the serving spatula before plating. The chicken in the enchiladas was originally sliced. There was no check to ensure the chicken or tortilla pieces were adequate in size for a mechanical soft diet. Observation of lunch test trays of regular texture and mechanical soft texture on 12/03/2025 at 12:10 PM revealed boneless pork chop with gravy, sliced carrot coins, mashed potatoes and a bread roll with a slice of cake for dessert. The mechanical soft plate had the pork chop finely minced with gravy on top, however no mechanical alterations to the carrots, bread roll, or cake. Observation of mechanical soft meal tray on 12/04/2025 at 1:14 PM on 100 hall revealed a plate that appeared untouched consisting of red beans and rice with pork, halved brussels sprouts, and a bread roll. The red beans and rice with pork was the same texture and particle size as the regular texture plate, brussels sprouts were halved, and bread roll was served whole. During interview on 12/02/2025 at 12:20 PM, [NAME] F stated that the chicken enchiladas were premade and received frozen; once baked the tortillas were soft enough from the sauce. [NAME] F stated that his hand chopping of the enchilada was adequate to meet mechanical soft because the residents could chew it to make it smaller if they wanted. During interview on 12/02/2025 at 2:05 PM, the DM stated he did not observe the mechanical soft plates as he was assisting with making the deli sandwiches some residents had requested as an alternate meal. The DM stated that he was unaware that [NAME] F was not uniformly chopping the chicken enchiladas for the mechanical soft plates and would address the different textures of each order type with all kitchen staff. The DM stated there were currently 16 residents who had orders for mechanical soft diets however that number could vary each day depending on who was in the facility for each meal. During interview on 12/04/2025 at 2:33PM, the DM stated that a mechanical soft serving of food should have flavor, taste good, be appetizing in appearance, and should be chopped or ground fine but still have texture and be identifiable compared to other plates when placed side by side. The DM, when shown a photograph of brussels sprouts cut in half on a 12/04/2025 lunch plate, stated he had made the substitution for fried okra as he knew the residents on a mechanical soft diet could not chew the fried vegetables. The DM, when showed the photograph of the carrot slices from the 12/03/2025 lunch plate, stated he thought the carrots were fine as they were a soft texture and did not think about the size as they easily cut with a fork. The DM stated that after seeing the photographs the risks to residents on mechanical soft diet orders were not being able to chew or swallow the items and may cause the resident to choke. During interview on 12/04/2025 at 3:04 PM, the Administrator stated that concerns with a mechanical soft diet would first be discussed with a clinical staff member to verify if the plate was appropriate. The Administrator stated as he did not have a clinical background, he may become concerned if he saw mechanical soft on a meal ticket and observed the same sized food items as on a regular texture serving. The Administrator stated that there could be a risk to residents of a swallow issue, and a risk of choking. The Administrator, when shown a photograph of brussels sprouts cut in half on a lunch plate on 12/04/3035, stated he would question what was observed and ask the kitchen team, dietician, or clinical team for clarification on size and for help understanding what the texture size should have been. During interview on 12/04/2025 at 3:36 PM, the DON stated that a mechanical soft diet should be a soft texture that was (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chopped or very small, fine pieces of food that were easy to chew and swallow. When shown photograph of brussels sprouts cut in half and served with a mechanical soft lunch tray on 12/04/2025, the DON stated the vegetable was too large for a mechanical soft item and needed to be smaller pieces. The DON stated that the photograph shown of cooked carrot slices served at lunch on 12/03/2025 were also too large in size. The DON stated the risk of serving food items that were ordered to be mechanical soft in too large of pieces was residents choking or aspirating on the food items. Record review of Therapeutic Diets Policy/Procedures, revised 10/2007 and reviewed 05/2021, revealed:Policy:It is the policy of this facility that therapeutic diets shall be prescribed by the attending physician.Procedures:1. A therapeutic diet must be prescribed by the resident's attending physician.2. Prescribed therapeutic diets are reviewed regularly along with other orders.3. Routine therapeutic menus are planned by the corporate office or dietary manager and approved by the registered dietician; however, unusual or complex therapeutic diets are planned in writing by the registered dietician. 4. A tray identification system is established to ensure that each resident receives his/her diet as ordered.5. The dietician and dietary manager record in the resident's medical record significant information relating to the resident's response to his/her therapeutic diet. 6. Mechanically altered diets will be considered therapeutic diets.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 3 (Residents #45, #73, and #89) of 8 residents reviewed for refrigerators in the rooms. The facility failed to monitor temperatures and did not put thermometers in Residents #45, #73, and #89's refrigerators. These failures could affect residents by placing them at risk for food-borne illnesses. Finding included: Resident #89Record review of Resident # 89's face sheet, dated 12/02/25, revealed she was a [AGE] year-old female with an original admission date of 01/28/22 and readmitted to the facility on [DATE]. Her primary diagnosis was cerebral infraction due to embolism of the middle cerebral artery (this is a stroke caused by a blood clot in the brain). Record review of Resident #89's care plan initiated on 01/27/24 revealed Resident #89 had occasional nausea and vomiting. The goal was to have minimal or no nausea and vomit. Interventions included Avoid foods that cause intestinal hyperactivity, caffeine, carbonated beverages, chocolate, or acidic items like orange juice. Observation and interview with Resident #89 on 12/2/25 at 10:12 AM and 12:49 PM revealed she had two small refrigerators. No temperature log was attached to the two refrigerators, and there were no thermometers inside both refrigerators. Resident #89 said she had been at the facility for 5 years. She said that she had just gotten two small refrigerators a couple of months ago. She said that she was not aware that she needed a thermometer inside to monitor the temperatures. She said she could tell by touching the items by the coolness of the item that both refrigerators were working well. She said she did not recall anyone checking the temperatures in the two refrigerators. She said she could see why it was important to monitor the temperature for food safety. She said that she had not consumed anything that had spoiled in her refrigerators. Resident#45 Record review of Resident # 45's face sheet, dated 12/02/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of hypertensive heart disease with heart failure and right-side paralysis and weakness following stroke. Record review of Resident#45's care plan initiated on 03/18/24 revealed Resident #45 had occasional nausea and vomiting. The goal was to have minimal or no nausea and vomit. The interventions were to educate residents/family/caregivers about the relationship of nausea and vomiting to food, medicine, treatment regimen, disease process and psychosocial factors. To teach resident/family/caregivers to identify and avoid causative factors. Resident #73Record review of Resident # 73's face sheet, dated 12/02/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of nontraumatic intracerebral hemorrhage in hemisphere subcortical (this is a stroke caused by blood vessel rupture), diabetes mellitus II (uncontrolled blood sugars), and communication difficulty. Record review of Resident #73's care plan initiated 09/13/24 revealed a focus of diabetes mellitus II; the goal was to have no complications related to diabetes through the review date. The interventions included discussing mealtimes, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, and compliance with nutritional regimen. Observation and interview with Resident #45 and #93 on 12/02/25 at 12:23 PM revealed two personal refrigerators for Resident #45 and #73. No temperature log was attached to the two refrigerators, and there were no thermometers inside both refrigerators. Resident #45 said that she did not recall anyone checking her fridge temperature, but she also had not eaten any food that would make her sick from her refrigerators. Resident #73 said that she bought her own snacks and had the fridge cleaned out if anything was bad from there. In an interview with CNA D on 12/3/25 at 12:50 PM, she said she had been at the facility for four and a half months. She said that she was not sure who (continued on next page)		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was responsible for monitoring the temperature logs. She said maybe the housekeeping was responsible. She said it was important to monitor the refrigerator temperature because some residents had milk, and it could go bad and cause them to become sick. In an interview with Housekeeping Aide G on 12/04/25 at 11:58 AM, she said she was informed by her supervisor yesterday (12/03/25) to start monitoring the refrigerators daily. She said prior to yesterday she was not sure who was monitoring them. She said she had been instructed to make sure all refrigerators had thermometers, daily temperature log, food was labelled, and it could only be in the fridge for 3 days if it was from the facility, and to report to maintenance if the refrigerator was not getting cold. She said the risk of not checking temps or not having a thermometer was that the food could make the residents sick if it went bad. Interview with the Housekeeping Supervisor 12/04/25 at 10:30 AM revealed the nursing department had been responsible for monitoring the refrigerators but now as of yesterday 12/3/25, the housekeeping will monitor them. He said he did not know why they were not monitored or why they did not have thermometers. He said, moving forward, he got thermometers in each refrigerator and added a temperature log to each refrigerator. He said the risk of not being monitored was food illness. In an interview with the ADON on 12/04/25 at 11:33 AM, he said he thought the housekeeping department was keeping logs of temperatures for the refrigerators. He said the safe temperature was between 30 to 41 degrees. He said he did not know why the temperature logs were not done or why there were no thermometers in some of the refrigerators. He said they now have a solid plan with the housekeeping being responsible for making sure that all refrigerators have temperature logs and inside they have thermometers. The ADON said that he was not aware that Resident #89 had two refrigerators because they looked colorful and looked like storage containers. He said he will personally see to it that Residents #45 and #73 had thermometers and temp logs. He said the risk was not knowing what the temperature was inside the refrigerators. Interview with the Administrator on 12/04/25 at 04:10 PM revealed he was not aware that some refrigerators had no thermometers in them. He said when he was notified, he sent someone to go to the store and buy some. He said they did not have a concrete plan on who was monitoring but now moving forward they have assigned housekeeping to be responsible for making sure all refrigerators have thermometers and that the logs are completed daily. He said he has also instructed department head during the guardian angel rounds to check the temp logs to make sure it is done. He said the expectation was that daily refrigerators were checked by staff. He said it was a food safety concern and could have an impact on their health. Record Review of the Facility policy titled Resident Personal Food Storage revised 04/2025 revealed Food or beverage brought in from outside sources for storage in the facility pantries, refrigeration units or personal resident room refrigeration units will be monitored by designated staff for food safety) 4. All refrigeration units will have internal thermometers to monitor food storage temperatures. Units must maintain safe internal temperatures in accordance with State and Federal standards for safe food storage temperatures. Staff will monitor and document unit refrigerator temperatures .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that resident's environment remained as free of accident hazards as was possible, and each resident received adequate supervision and assistance devices to prevent accidents for 2 (Residents #21 and #47) of 15 residents reviewed for accidents. The facility failed to ensure Residents #21 and #47 had an environment free of accident and hazards by not providing a safe shower chair that had wobbly, loose, unsteady legs. This failure affected residents by placing them at risk of slipping and falling while taking a shower. Findings include: Record review of Resident #21's Face Sheet dated 12-4-2025 revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #21 had a primary diagnosis of acute on chronic systolic congestive heart failure (a condition where the ventricle struggles to pump effectively. It signifies a sudden worsening of long-standing heart weakness (systolic failure) where the heart can't pump enough blood, leading to fluid buildup) with secondary diagnoses of muscle weakness, lack of coordination, anxiety disorder, and chronic kidney disease. Record review of Resident #21's annual MDS assessment dated [DATE] signified a BIMS score of 14 revealing she was cognitively intact. The functional ability section revealed Resident #21 needed assistance to shower where the helper does less than half of the effort by lifting, holding, supporting the trunk or limbs. The same level of assistance was needed to transfer in and out of the shower. A record review of Resident #21's care plan dated 10-12-2025 indicated she was at risk for falls related to muscle weakness and needs assistance with activities of daily living. In an observation and interview, on 12-2-2025 at 12:50 PM, Resident #21 was observed sitting in a wheelchair in her room. Resident #21 said when staff take her to shower, they sat her in a shower chair where the legs moved around and wobbled. Resident #21 said she told the staff that the chair was unsafe, and staff told her they would see what they could do. However, nothing had changed since she told them. Resident #21 said she felt unsafe sitting in the shower chair because it could make her fall. Record review of Resident #47's Face Sheet, dated 12-04-2025 revealed a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of cerebral aneurysm (a weak spot in a brain artery wall that bulges or balloons out, forming a small, blood-filled sac, similar to a tiny balloon or bubble on a weak part of a tire, which can leak or burst, causing a dangerous brain bleed), and secondary diagnoses of muscle weakness, epilepsy (a chronic neurological disorder causing recurrent, unprovoked seizures from abnormal brain electrical activity, also known as a seizure disorder), chronic diastolic congestive heart failure (when the heart muscle becomes stiff and thick, struggling to relax and fill properly with blood between beats, leading to symptoms like shortness of breath, fatigue, and swelling), and cerebrospinal fluid drainage device (a surgically implanted medical system used to divert excess cerebrospinal fluid from the brain or spinal cord to another part of the body, where it can be absorbed naturally). A record review of Resident #47's Quarterly MDS, dated [DATE], revealed Resident #47 had a BIMS score of 11 which indicated mild cognitive impairment. The functional ability section revealed Resident #47 needed assistance to shower where the helper does less than half of the effort by lifting, holding, supporting the trunk or limbs. The same level of assistance was needed to transfer in and out of the shower. A record review of Resident #47's Care Plan dated 7-28-2025, indicated Resident #47 had an activity of daily living deficit requiring showering assistance and was a fall risk. In an observation and interview, on 12-3-2025 at 2:20 PM, Resident #47 was sitting in her wheelchair at a resident council meeting. Resident #47 stated that the shower chair she had been put in was very flimsy because the legs wobbled. Resident #47 said she has told the CNA, who was showering her, about the chair being unsafe, but the CNA responded that she could not do anything about it. Resident #47 said the condition of the shower chair made her feel unsafe. In an observation on 12-2-2025 at 1:00 PM, it was discovered that the shower chair in the shower for the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	400-Hallway had wobbly legs and was unsafe for use. A video was taken of the shower chair. In an interview and observation, on 12-3-2025 at 3:00 PM, it was revealed that CNA A had worked at the facility for 7 months, worked the 2:00 PM-10:00 PM shift, and worked the 400 hallway. CNA A said she gave showers to residents in the 400-hallway area. CNA A was shown the shower room for the 400-hallway and the shower chair being used. CNA A said the potential problem with that shower chair was that it was not safe and could cause someone to fall. CNA A said the shower room used to have a shower bench, but it became unsafe to use, and the facility removed it. CNA A said she does not use the shower chair to shower residents. CNA A said she believed the facility had ordered a new shower bench, and staff were waiting for it to arrive. CNA A said staff were responsible for ensuring showers were safe. In an interview, on 12-3-2025 at 3:43 PM, it was revealed that LVN B had worked at the facility for 4 months, worked a 12-hour shift from 7:00 AM-7:00 PM, and worked the 400-hall. When LVN B saw the shower chair in the 400-hall shower room, she said it had wobbly legs and it was unsafe. LVN B said she was not aware of the faulty shower chair. LVN B said the concern for staff using this shower chair was that a resident could possibly get injured by falling. LVN B said the CNA's who showered residents were responsible for reporting faulty shower chairs to the maintenance department. The maintenance department was responsible for either repairing or replacing faulty chairs. LVN B said the facility had a software program called TELS within the PCC software, whereby staff can let the maintenance department know of a problem that needs fixing. In an interview and observation on 12-3-2025 at 4:00 PM, the DON was shown the shower chair in the 400-hall shower room. The DON said the problem or concern with the shower chair was that it was unsafe and could potentially cause a resident to fall. The DON said she was taking the shower chair out of use now. The DON said the CNA's giving showers were responsible for reporting unsafe shower chairs to a nurse, and the nurse can either report the problem to management or put the information in the TELS system in PCC to let the maintenance staff know they need to either fix or replace the shower chair. The DON said her expectation was that only safe shower chairs were to be used at the facility. In an interview on 12-4-2025, at 11:20 AM, with the Administrator, it was revealed that the Administrator was responsible for ensuring that the shower chairs used at the facility were safe. The Administrator said the staff who were showering residents were responsible for letting the facility know that a shower chair was not safe to use. The Administrator said his expectation was that the facility would study shower chairs and consider changing the model of chair they were using. The Administrator said if a shower chair had unstable legs his concern was that it might not be safe for the residents. Review of the facility's Quality of Care ADL, Services to carry out policy, revised 01-2020, revealed, It is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his/her abilities.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interviews, and record review, the facility failed to ensure residents received parenteral fluids administered consistent with professional standards of practice and in accordance with physician orders for 1 of 1 (Resident #25) residents reviewed for peripheral intravenous care. The facility failed to ensure physician orders for Resident #25 were followed to change PICC (PICC line is a soft, flexible catheter inserted into a central vein used for prolonged antibiotic therapy) line dressing changes every 7 days as ordered. This failure could affect residents by placing them at risk of infection. Findings included: Record review of Resident #25's face sheet dated 12/02/25 indicated Resident #25 was a [AGE] year-old female with an initial admission on [DATE] and readmitted to the facility on [DATE] with a primary diagnosis of other acute osteomyelitis Right ankle and foot (this is an active bone infection in the ankle and foot). Record review of Resident #25's Quarterly MDS dated [DATE] indicated Resident #25 had a BIMS score of 00, indicating severe cognitive impairment. Record review of Resident #25s Physician order summary for December 2025 reflected PICC line care: Change PICCline dressing every 7 days if site is visible for assessment. Change dressing PRN if wet, soiled, saturated or loose. every night shifts every 7 day(s) - Order date-11/24/2025. Record review of Resident #25's care plan initiated on 11/12/25 indicated Resident #25 had osteomyelitis to my right ankle. The goal was to be free from complications related to infection through the review date. The interventions were to administer Ceftazidime and Vancomycin (types of antibiotics) intravenously for 37 days and to follow facility policy and procedures for line listing, summarizing and reporting infections. Observation on 12/02/25 at 4:46 PM, revealed Resident #25 was not interviewable. On her upper right arm was a PICC line with two ports dated 11/20/25. The PICC line dressing was intact, not loose and not saturated or soiled. In an interview with LVN C on 12/02/25 at 4:55 pm, she stated that she knew that all PICC line dressings were changed every 7 days. She said that she thought Resident #25's PICC dressing was dated 11/27/25 which meant it would be changed in a couple of days. She said she assessed the PICC line before medication administration earlier today to make sure there was no redness, swelling, pain, or any discoloration. She said that it was an honest mistake to have misread the date. She said that the risk of not changing IV dressing was infection. She said that she would consult with the DON so that it could be changed today. LVN C said that she knew how to change the IV dressing. Observation on 12/03/25 at 09:06 AM, revealed Resident#25's PICC dressing was changed and dated 12/02/25. An interview with the DON on 12/04/25 at 1:20 PM revealed that nurses were responsible for assessing PICC line dressings and completing dressing changes as ordered weekly. She said all PICC line dressing changes should be documented by the nurses. She said she did not know how the IV dressing change was missed. She said if the IV dressing did not get changed as ordered, then there was potential for an infection. Interview with the Administrator on 12/04/25 at 04:10 PM, he said the expectation was for nursing to work with Director of Nursing and have processes in place to prevent the risk of infection. Record review facility policy tilted PICC line dressing change revised on 07/13 reflected. The transparent dressing is changed every 7 days or sooner when it becomes loosened to the point of compromising sterility or presents a risk of accidental dislodgment of the catheter. An accumulation of moisture, fluid, blood, or exudate, can also be criteria for a dressing change.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Misty Willow Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 observations, interviews, 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 one of five residents (Resident#71) reviewed for medication administration of insulin. LVN C failed to clean and disinfect Resident #71's skin before administering Insulin on his upper right arm on 12/02/25. This failure affected the residents by placing them at an increased and unnecessary risk of exposure to infections. Findings included: Record review of Resident #71's face sheet dated 12/02/25, revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included malignant neoplasm of prostate (this is Cancer of the prostate), cerebral infarction (stroke), and diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified (this is uncontrolled blood sugars diseases with nerve pain). Record review of Resident #71's Quarterly MDS dated [DATE] reflected a BIMS score of 10, indicating moderate cognitive impairment. MDS also revealed Resident #71 did not have any skin conditions related to diabetes. Record Review of Resident #71's active physician orders for December 2025 reflected- NovoLog Flex Pen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 151 - 200 = 2u; 201 - 250 = 4u; 251 - 300 = 6u; 301 - 350 = 8u; 351 - 400 = 10u; 401 - 450 = 12u 451 and up call md, subcutaneously two times a day for diabetes mellitus. Ordered 1/27/25. Record review of Resident #71's care plan revised on 09/06/21 indicated a focus of potential for pressure ulcerdevelopment related to the need for education on frequent repositioning. The goal was for Resident #71 to have intact skin, free of redness, blisters or discoloration by/through review date. The interventions included Monitor/document/report to Medical Doctor PRN changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size and stage. Observation on 12/02/25 at 4:45 PM with LVN C revealed she checked Resident #71's blood sugar. Blood sugar reading was 262. She said that she would administer 6 units of sliding scale Insulin Aspart. Resident #71 was lying in his bed facing the window on his left side with the upper right arm up. LVN asked Resident #71 where he wanted the injection, and he pointed to his upper right arm. LVN C pushed Resident #71's shirt sleeves up and without disinfecting the area she gave him 6 units of insulin. Interview with LVN C on 12/02/25 at 4:47 PM, when LVN C said that she missed disinfecting the area before giving Resident #71 his injection. She said that she did not know why she missed the step, could be because she was nervous being watched. She said the risk of not disinfecting the skin before insulin administration was a risk of exposing Resident #71 to infection. An interview with the DON on 12/04/25 at 1:20 PM, she said that she was not aware of the incident with the insulin. She said LVN C did not tell her. She said the expectation was that the skin would be disinfected by cleaning the area with an alcohol pad before insulin administration. She said that some of these mistakes should not happen because it was nursing practice to disinfect the skin before any injections. Record review facility policy titled Injection Insulin revision date 07/2017 revealed . 13. Cleanse injection site with alcohol Record review facility policy titled Administering Medications revised date 04/2020 reflected. Medication shall be administered in a safe and timely manner and as prescribed.2. The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and or have related functions. 14. Staff shall follow established facility infection control procedures (example given, hand washing, antiseptic technique, gloves, isolation precaution, etc.) when theses apply to the medication administration.		

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NAME OF PROVIDER OR SUPPLIER Misty Willow Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for one of five residents (Resident #92) reviewed for storage of medication. LVN B failed to ensure Pregabalin (control drug), Levetiracetam [seizure medication], Baclofen [pain medication] and multi vitamins were not stored at Resident #92's bedside table and failed to ensure it was secured in the medication cart or medication room when she was not at the bedside on 12/03/25. This failure could place residents at risk of medication misuse and accidental ingestion. The findings include: Record review of Resident #92's face sheet dated 12/03/25 revealed a [AGE] year-old female with an initial admission to the facility on [DATE] and was readmitted on [DATE] with a primary diagnosis of unspecified multiple sclerosis (this is an immune system disorder that causes the body to attack its own healthy cells). Her secondary diagnosis was paraplegia (in ability to voluntarily move the lower parts of the body), impulsiveness, high blood pressure, and gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individuals who have difficulty swallowing). Record review of Resident #92's MDS dated [DATE] indicated Resident #92 had a BIMS score of 00, indicating severe cognitive impairment. The MDS indicated he had a feeding tube and received 501 cc/day or more fluid and 51% or more of her calories through the g-tube. Record review of Resident #92's care plan initiated on 04/21/22 revealed a focus: I receive routine vitamins/supplements.Goal: I will be free from adverse drug reactions through the review date 02/19/26. Interventions: Discuss with residents and family about the number and type of medications a resident was taking and the potential for drug interactions and side effects from over-medication. Record review of Resident #92 MAR dated 12/03/25 reflected the following medications were due to be administered at 09:00 AM-Pregabalin Oral Capsule 50 MG [Control drug anticonvulsant used to treat nerve pain] Give 1 capsule via PEG-Tube one time a day related to MULTIPLE SCLEROSIS-Baclofen Oral Tablet 10 MG [medication to treat muscle spasm] Give 1 tablet via PEG-Tube two times a day related to MULTIPLE SCLEROSIS- Cholecalciferol Oral Tablet 25 MCG (1000 Unit) [Vitamin D]. Give 1 tablet via PEG-Tube two times a day for supplement- Levetiracetam Oral Solution 500 ML/5MG [Seizure medication] Give 10 ml via PEG-Tube two times a day related to MULTIPLE SCLEROSIS- Centrum Oral Liquid (Multiple Vitamins w/ Minerals) Give 15 ml via PEG-Tube one time a day for supplement multi Vite liquid During continuous medication observation on 12/03/25 from 08:25 AM to 08:40 AM with LVN B, she prepared the medications (Pregabalin, Baclofen, Cholecalciferol, Levetiracetam, and Centrum) in individual cups and took the medication and water to flush g-tube into Resident #92's room onto the bedside. As LVN B was flushing the residents' g-tube, LVN B said the g-tube had a slight blockage towards the end of the visible tube of the G-tube. She said that she needed to go and get something in the medication room to help dissolve the blockage. She walked away at 08:38 AM, leaving the medications at the bedside. LVB did not lock the medication into the medication cart nor take it with her to the medication room; she left the medication in Resident #92's room on her bedside table. No staff were in the room, and LVN B could not visually see the medications. The DON came to Resident #92's room and removed the medications at 08:41 AM. Interview with the DON on 12/03/25 at 08:41 AM she said that LVN B should not have left the medication at the bedside. She said it was the nurse's responsibility to make sure that the medication was secured. She said that it was a medication safety concern to leave medications unattended, and she would do a one-on-one in-service with her. She said the risk was unauthorized access to the medications. In an interview with LVN B on 12/03/25 at 4:02 PM, she said that it was (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Misty Willow Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an honest mistake. She was just trying to unblock the g-tube so that she would give the resident her medications. She said that the DON did a one-on-one training about medication safety with her after the incident today. She said the risk of leaving medication unattended was that anyone could have access to it. Interview with the DON on 12/04/25 at 1:20 PM, she said she had started in-servicing the current staff and was still working on oncoming staff which included all nurses and medication aides on medication safety. She revealed names on the in-service sheet that had already completed the in-service, including the one-on-one sheet that she had completed with LVN B on 12/03/25. Record review in-service titled Controlled Medications-Storage and Reconciliation led by DON on 09/12/25 revealed 30 staff including CNAs, Medication aides, nurses and LVN B had completed training. Review of the facility's policy, titled Storage of Medications, revised 04/2007, reflected in part, The facility stores all drugs and biologicals in a safe, secure, and orderly manner .The nursing staff shall be responsible for maintaining medication storage .		