STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676258	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial City Nursing and Rehabilitation Center	1341 Blalock Houston, TX 77055

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain grooming and personal hygiene for 3 out of 8 residents (Resident #22, Resident #17, and Resident #24) reviewed for ADLs.1. The facility failed to provide scheduled showers and/or bed baths on M/W/F to Resident #22 on 9/17/25, 9/19/25, 9/22/25, 9/26/25, 10/1/25, 10/3/25, 10/6/25, 10/8/25, 10/10/25, 10/13/25, and 10/15/25.2. The facility failed to provide scheduled showers and/or bed baths on M/W/F to Resident #17 on 9/17/25, 9/19/25, 9/22/25, 9/24/25, 9/26/25, 9/29/25, 10/1/25, 10/3/25, 10/6/25, 10/8/25, and 10/10/25.3. The facility failed to provide scheduled showers and/or bed baths on M/W/F to Resident #24 on 9/17/25, 9/19/25, 9/22/25, 9/24/25, 9/26/25, 10/1/25, 10/3/25, 10/6/25, 10/8/25, 10/10/25, 10/13/25, and 10/15/25.This failure could place residents at risk of skin breakdown, infection, and reduced feelings of self-worth.Findings included:1. Record review of Resident #22's undated face sheet revealed she was a [AGE] year-old female, who admitted on [DATE] with diagnoses of fracture of pubis (pelvis), iron deficiency anemia (not enough iron in the blood), and left upper limb radial nerve lesion (left upper arm, nerve problems).Record review of Resident #22's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, which indicated normal cognition. Per the MDS, the resident did not reject care (e.g., bloodwork, taking medications, ADL assistance) that was necessary to achieve the resident's goals for health and wellbeing. The resident had impairment on one side of her upper and lower extremity and was bed bound. The resident required substantial/maximal assistance (helper does more than half the effort) with showers/baths. Resident #22 was frequently incontinent of bowel and bladder.Record review of Resident #22's Care Plan dated 5/14/25 revealed a Focus: Resident had an ADL self-care performance deficit r/t fracture of unspecified pubis (Initiated: 5/14/25). The goal was to improve the level of function in ADLs through the review date (Target Date: 11/23/25). Interventions included: Bath/Showering- The resident required assistance by staff with bathing/showering 3 times per week and as needed. The Care Plan did not mention any refusals of showers/baths.Record review of Resident #22's Progress Notes from 9/18/25-10/13/25 revealed no notes about refusing a bath/shower.Record review of Resident #22's ADL - Bathing MWF Task, printed on 10/15/25 for the past 30 days revealed 1 bath/shower on 9/24/25 and 1 refusal on 9/29/25. She missed a bath on 9/17/25, 9/19/25, 9/22/25, 9/26/25, 10/1/25, 10/3/25, 10/6/25, 10/8/25, 10/10/25, 10/13/25, and 10/15/25.In an interview and observation on 10/14/25 at 9:43am, Resident #22 was sitting up in bed. She said that she had only had 4-5 baths since she got there in May. She said the staff did not even come in and offer her a bath and if she asked for one, they were rude to her. 2. Record review of Resident #17's undated face sheet revealed he was a 61year-old male admitted on [DATE] with diagnoses of heart failure (heart is not pumping effectively), COPD (lung diseases that cause airflow obstruction and breathing problems), need for assistance with personal care, cognitive communication deficit, functional quadriplegia (inability to move the limbs due to severe disability or frailty), afib (heart beat is irregular), polyosteoarthritis (inflammatory joint disease in multiple joints), chronic pain, bilateral cataracts (clouding over both eyes), and muscle wasting and atrophy.Record review of Resident #17's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15, which indicated the resident had moderately impaired cognition. Per the MDS, the resident did not reject care (e.g., bloodwork, taking medications, ADL assistance) that was necessary to achieve the resident's goals for health and wellbeing. The resident had impairment on both sides of his lower extremities and used a wheelchair for mobility. According to the assessment the resident was dependent (helper did all of the effort, resident did none of the effort to complete the activity) for showers/baths. Resident #17 was always incontinent of bowel and bladder. The resident had shortness of breath or trouble breathing with exertion (walking, bathing, transferring), when sitting at rest, and when lying flat, and was on oxygen.Record review of Resident #17's Care Plan dated 10/1/24 revealed the focus: The resident had an ADL self-care performance deficit r/t recent hospitalization for COPD exacerbation, generalized weakness, and afib (Initiated: 10/1/24, Revised: 10/8/24). The goal was to improve his level of function in ADLs through the review date (Target: 11/2/25). The interventions included: bathing/showering- The resident required assistance by staff with showering and as necessary.Record review of Resident #17's Progress Notes from 9/17/25-10/15/25 revealed 2 notes that he refused a bath/shower, on 10/13/25 and 10/15/25.Record review of Resident #17's ADL - Bathing MWF Task, printed on 10/15/25 for the past 30 days revealed No Data Found. The task did not note any refusals

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to adequately equip to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside for 1 (Residents #35) of 6 residents reviewed for call lights.-Residents #35 did not have her call light within reach while she was in bed.This failure could lead to residents not being able to request and receive prompt medical care and result in injury and harm.Record review of Resident #35's face sheet dated 10/16/2025, she was a [AGE] year-old female originally admitted on [DATE] with medical diagnoses including vascular dementia, bipolar disorder, generalized anxiety disorder, Alzheimer's Disease, hypertension, cognitive communication deficit and other abnormalities of gait and mobility.Record review of Resident #35's Quarterly MDS assessment dated [DATE], she had a BIMS score of 3 out of 15, indicating severe cognitive deficit related to memory and thinking. Resident #35 was coded for having a walker. Resident #35 required set-up/cleanup assistance with tasks such as toileting, oral hygiene and dressing, and mobility in bed.Record review of Resident #35's care plan dated 10/16/2025, she had an ADL self-care performance deficit r/t impaired mobility with resident requiring staff assistance for toileting, turning and re-positioning in bed as necessary. Resident #35 was at risk for falls r/t confusion, gait/balance problems with interventions including being sure the resident's call light was within reach and encouraging the resident to use it as needed, the resident needed prompt response to all requests for assistance. Observation and interview with Resident #35 on 10/14/2025 at 9:48am, revealed she was in bed and appeared well-groomed and in no distress. Resident #35 said staff took her call light out of her room a couple of days ago, and told her they removed it because she used it too much. The call light was observed on the floor in the middle of the room between two dressers, out of reach of the resident in bed. LVN M was called to the room, and she put on gloves and took the call light off the floor and gave it back to Resident #35 who wrapped it around her bedrail. LVN M said that she was the nurse for the hall on 10/14/2025 and had been at the facility for ten months. LVN M said everyone was responsible for putting call lights close to the residents. LVN M said Resident #35 was confused at baseline and did not use her call light, but the light should be near her. If residents did not have call lights nearby, then they could not call for help. LVM M said she would remind her aides to put call lights on beds. In an interview with the DON on 10/15/2025 at 3:33pm, she said that she did monthly in-services on call lights with staff. The DON said call lights should not be on the floor. If the lights were on the floor, residents would not be able to call for help and residents should always have access to staff. It was a safety concern so residents could tell staff what they needed. The DON said everyone was responsible for ensuring call lights were within residents' reach and to answer them. A call light policy was requested by email on 10/16/2025 at 9:36am with the DON who said the facility did not have a specific call light policy.