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	04/28/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 13 residents (Resident #21) reviewed for abuse. The facility failed to ensure Resident #21 remained free from abuse when LVN A removed the resident's property (cell phone) as a way to restrict the resident's communication (preventing calls to 911).An IJ was identified on 04/25/2026. The IJ template was provided to the facility on [DATE] at 02:02 p.m. While the IJ was removed on 04/28/2026 at 10:43 a.m., the facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of an unsafe environment and unprotected from mistreatment. The findings included: Record review of Resident #21's face sheet dated 04/23/2026 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included systemic lupus erythematosus (a chronic, autoimmune disease where the immune system attacks healthy tissues, causing widespread inflammation and damage to organs), unspecified, epilepsy (chronic brain disorder characterized by recurrent, unprovoked seizures caused by electrical disturbances), anxiety disorder (mental health conditions characterized by excessive, persistent fear or worry that interferes with daily life), obesity (excess calories), pain in unspecified joint, stiffness of unspecified joint, muscle wasting and atrophy (reduced in size of boy tissues, muscles and organs), cognitive communication deficit (a communication impairment causing memory, or executive function deficits), and need for assistance with personal care. Record review of Resident #21's Comprehensive MDS, dated [DATE], reflected the resident had a BIMS score of 15 which indicated the resident had intact mental cognition. The resident had impairment on one side of her lower extremities and was dependent (helper does all of the effort and resident does none of the effort to complete the activity or the assistance of 2 or more helpers was required) for toileting, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. According to the assessment Resident #21 was always incontinent of bowel and bladder. Record review of Resident #21's care plan reflected the resident had an ADL, self-care performance deficit r/t CHF, lupus date intuited 01/21/2026 and revised 02/05/2026. Intervention: The resident requires assistance by staff with bathing/showering 3 x weekly & as needed. The resident requires assistance by staff to turn and reposition in bed as needed. The resident requires assistance by staff to dress. The resident requires assistance by staff to eat. The resident requires assistance by staff with personal hygiene and oral care. The resident requires assistance by staff for toileting. The resident requires assistance by staff to move between surfaces as needed. The resident discussed feelings about self-care deficit. Encourage the resident to participate to the fullest extent possible with each interaction. Encourage the resident to use bell to call for assistance. Monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Praise all efforts at self-care. Record review of Resident #21's progress notes dated 03/4/2026 at 04:28 a.m., reflected LVN A noted resident had called 911, 2-times tonight. While making (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: 676258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026

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ADON A received the resident at the nurse's station as resident was up having behavior and making 911 calls. Resident was then taken to her room at the resident's request and was placed to bed. ADON A, called Family A to inform him of the resident's behavior with no response. Record review of Resident #21's behavior monitoring assessment dated [DATE] reflected, resident had the following antidepressants behaviors noted: No behaviors noted. During an interview on 04/22/2026 at 10:52 a.m., Resident #21 stated she had a diagnosis of lupus, and the symptoms caused her chronic pain in her joints and back, that required frequent repositioning. She stated she relied on staff for that repositioning. She stated all too often, when she pressed the call light for assistance with repositioning, there would be a delay in staff responses and staff would be mad with her, responding with attitudes, disrespect, and unfriendly tones such as What do you need now? She stated that she was sick and needed staff to answer her call light. She stated she had been a nurse and knew the staff's task responsibilities and need for having great customer service. She stated the staff needed refresher training on customer services and resident rights. During an interview on 04/23/2026 at 02:25 p.m., Resident #40 stated that her roommate was Resident #21. She stated on 03/04/2026 at 4:00 a.m., Resident #21 woke up crying, pressed the call light, yelled out for help, and then called the facility's front desk from her cellphone for assistance with no response. She stated then Resident #21 called 911 when LVN A entered the room and asked why Resident #21 had called 911 as EMT had responded to the call at the facility. She stated Resident #21 told LVN A she was in pain, but LVN A left the room. She stated Resident #21 called 911 trying to recall the facility's address, when LVN A reentered the room and Resident #21 asked LVN A for the address. LVN A told Resident 21's she did not know address, took the resident's phone and told the 911 operator that everything was okay with the resident, and hung up the phone, and left the room with Resident #21's cellphone. She stated at 5 a.m., LVN A and CNA A got Resident #21 out of bed, into a wheelchair for LVN A to monitor the resident from the nurse's station. She stated from the room, she could hear Resident 21 yelling and saying nurse, nurse, nurse, can you help me. She stated sometime later, she heard the fire alarm go off and then CNA B and CNA C brought Resident #21 back into room and into the bed. She stated that Resident #21 had a lupus diagnosis that required her to be repositioned often, which meant the resident pushed the call light often for assistance. During an interview on 04/23/2026 at 04:26 p.m., SW A stated on 03/09/2026, she followed up with Resident #21 after a behavior of calling 911 twice on 03/04/2026. She stated the resident stated a call was placed to Family B who lived out of town, expressing the need to go to the hospital. She stated the resident stated Family B had not felt the resident needed to go to the hospital. She stated she felt the resident called 911 in an attempt to get Family B's attention on the resident's wellbeing. She stated which was accomplished when the resident made the 911 calls. She stated that nursing staff responded when the resident called 911 on 03/04/2026 and found that the resident had no changes in condition that required emergency services. She stated the resident had not expressed concerns with her cellphone taken by LVN A or being unavailable to hindering her need to call anyone including 911. She stated as the SW it was her responsibility to ensure the resident had not experienced any adverse social issues after the incident. She stated her evaluation found the resident had no adverse effects from the incident and was safe and felt safe. She stated the resident had a psychosocial evaluation on 03/04/2026, that found the resident had no psychosocial changes or (continued on next page)

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

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She stated doing so could hinder the resident's need to call for emergency services and delay higher level care. She stated the ADM was the abuse coordinator who all abuse and neglect allegations were reported to. She stated the facility provided in-service training and ANE routinely and after incidents occur. She stated the last in-service was last week and covered ANE and resident rights. She stated in the event that the abuse coordinator was the perpetrator, she would report the abuse to the DON, corporate's compliance line and/or the state. She named the 5-forms of abuse as: physical, emotional, verbal, sexual, and misappropriation of property. During an interview on 04/23/2026 at 05:33 p.m., ADON A stated she was aware Resident #21 had called 911 and pulled the fire alarm but was not on shift. She was not aware that LVN A had taken the resident's phone. She stated that CNAs made reports that the resident had behaviors when she first admitted in January 2026, but none relating to calling 911, pulling the fire alarm, of from the removal of her cellphone. She stated in the event that a resident reported a nursing staff had taken her cellphone or any personal property, she would report that the ADM immediately as misappropriation of property. She stated taking a resident's cellphone could keep the resident from calling for help, reaching their family, or hinder their need to call 911. She stated if a resident requested to go to the hospital even if there were no obvious changes in the resident's condition, she would immediately notify the resident's MD and report the resident's concerns to the DON. She stated if the MD did no provide a new order to transfer the resident to the hospital, yet the resident insisted on going out, she would not attempt to stop the resident and assist with that transfer. She stated that the ADM was the abuse coordinator. She noted the following as forms of abuse: physical, psychological, mental, verbal, financial, and sexual. She stated the facility provided in-service training on ANE and resident rights every month. During an interview on 04/23/2026 at 05:49 p.m., the DON stated she was aware Resident #21's cellphone had been charged at the nursing station on 03/04/2026. She stated that there was an issue with the cellphone not being charged when it was returned back to the resident, she was not aware the resident had an issue with cellphone being charged at the nurse's station. She stated it had been a common practice for staff to charge resident's cellphones at the nurse's station if the resident did not have a charger in their room. She stated the facility since discontinued that practice to avoid any incidences of a cellphone not being returned. She stated the ADM purchased additional chargers for residents to have in their rooms. She stated she had not been made aware that the resident had any pain issues on 03/04/2026. She stated had the resident had pain issues she would have expected a call from LVN A during that shift. She stated when the resident first admitted in January 2026, the resident was heavy on the call light to the point her previous roommate complained about her using it so much and staff would not respond when the roommate pressed it. She stated they moved Resident #21 to a different room and was not aware there were any issues since. She stated LVN A quit without notice unrelated to Resident #21 incident. She stated that ADM was the abuse coordinator and named the following forms as abuse: physical, mental, financial, verbal, and sexual. She stated the facility provided staff in-service training on ANE, resident rights, and pain management, quarterly, monthly and as needed. During an interview on 04/23/2026 at 09:00 p.m., LVN A stated on 03/03/2026, her shift began at 07:00 p.m. and ended on 03/04/2026 at 07:00 a.m., and Resident #21 was under her care. She stated while making rounds, she went to resident's room when the resident passed her a cellphone saying a family member wanted to (continued on next page)

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She stated when the ADM came on shift at 07:00 a.m., she informed him of the 911 incident and that the resident's cellphone was at the nurse's station to prevent further calls to 911. She stated she asked the ADM were they allowed to take a resident's phone, and the ADM told her they really could not do that. She stated that she told the ADM she would return the phone, but the ADM stated he would handle it. She stated while in the tv area, the resident wheeled her over the wall near the fire alarm. She stated the SC tried to stop the resident from pulling the alarm but was too late. She stated she asked the resident why she pulled the alarm, and the resident stated that she wanted to go home. She stated that CNA B was asked to put the resident back to bed. She stated that the facility provided in-service training on ANE all the time, but she was unaware that she could not take the resident's cell phone, because she thought she was doing the right thing. She stated she quit working for the facility unrelated to the incident with no disciplinary actions ever taken against her. She stated that the ADM was the abuse coordinator who all incidents were reported. During an interview on 04/24/2026 at 10:51 a.m., Resident #21's MD stated that on 03/04/2026 at 11:00 a.m., she was making her routine rounds at the facility and was informed by nursing staff Resident #21 had experienced evaluated anxiety behavior and attention seeking behavior that triggered the resident placing repeated calls to 911 early that morning. She stated the resident had an order for Prozac for anxiety and depression, and Clonazepam for anxiety. She stated nursing staff were monitored the resident's vitals, and she noted the vitals were tracked within range. She stated that the resident had chronic pain, and chronic inflammation due to a Lupus diagnosis and would expect that if the resident was calling 911 and EMS arrived at the facility, the EMTs would evaluate and the nursing staff would lean on the EMT's evaluation to determine if a hospital transfer was necessary. She stated she would not expect the facility staff to turn the EMTs away without evaluating the residents. She stated it was also her expectation that if a resident insisted on being transferred to the hospital that the facility staff assist with that transfer and notify MD and family of the transfer. She would not expect the staff to take the resident's phone as an intervene to avoid the resident making 911 calls. She stated that she could not recall being informed that LVN A had taken the resident's phone. She stated she had not been made aware that the resident had pulled the fire alarm and that the fire department had responded at the facility. She stated again, it was her expectation that if the fire department made the scene, that EMTs would have evaluated the resident before departing the facility. She stated it was not typical that EMS transported residents to the hospital for behaviors, but if the resident was crying, complaining of discomfort, and insisting on transfer it was possible. She stated she had not been informed by the facility of the resident's behavior prior to making her routine rounds. She stated she spoke with Family member A last week and made adjustments to the resident's psych medication at the request of Family member A. During an interview on 04/24/2026 at 01:42 p.m., the DON stated on 03/05/2026, Resident #21 had a positive UTI lab culture with antibiotics that began on 03/06/2026. She stated that confusion and sudden changes in behavior were associated with UTI symptoms. She stated the UTI symptoms could have contributed to the resident exhibiting abnormal and confused behavior She stated during the 03/04/2026 she had not received a call from staff regarding the resident's calls to 911. She stated she reviewed the resident's clinical notes and found that on 03/04/2026, MD assessed the resident and ordered a psychological consultation. She stated she was not made aware that the resident's cellphone was taking away, or was being changed at the nurse's station, nor that (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	documented on an audit tool. Beginning 4/25/26 and going forward, the Director of Nursing /designee will review 24hr report and change-in-condition for potential abuse and neglect situations, as well as reports of distress, uncontrolled pain, removal of personal property without resident permission, provision of access to emergency services and timely physician notification will be reviewed for appropriate actions each weekday morning. Findings will be documented on an audit tool. On 4/25/26, An Ad Hoc QAPI meeting was held with the Medical Director, Facility Administrator, Director of Nursing, Regional Clinical Specialist and Regional VP of Operations to review the plan of removal. During an interview on 04/26/2026 at 01:26 p.m., CNA D stated she worked for the facility on the 3:00 p.m. to 11:00 p.m., shift. She stated that on this date she received an in-service training on ANE, and resident rights that covered the resident's right to call 911, answering call-lights as soon as possible, and reporting changes in a resident's behavior to the charge nurse as soon as possible. She stated she was to document all behaviors in POC the clinical part of a resident's charge that CNAs document. She stated that staff had previously charged resident's phones at the nurse's station, but because a resident could accuse the staff of taking the phones without permission, they were no longer allowed. She stated staff were to provide a resident with a phone charger in the resident's room. She stated that the facility and purchased new phone chargers for resident's use. She stated the ADM was the abuse coordinated that all forms of abuse were to be reported. She stated in the event the ADM was unavailable or the perpetrator of abuse, she would report the abuse to the charge nurse, and DON. She named the following as forms of abuse: misappropriation of property, neglect, verbal, physical, seclusion, sexual, and mental/emotion. During an interview on 04/26/2026 at 01:36 p.m., LVN B stated she worked 7:00 a.m. to 7:00 p.m. on a rotating day shift. She stated she received in-service training on 04/25/2026 on ANE and not taking resident's cellphones to charge, that all phone charging was to take place in a resident's room. She stated that the ADM was the abuse coordinator and in the event that the ADM was the preparator she would report the abuse to the DON, HR, and the company's compliance hot line. She stated the following were forms of abuse to report: physical, mental, emotional misappropriation, and sexual. During an interview on 04/26/2026 at 01:41 p.m., LVN D stated she worked 7:00 a.m. to 7:00 p.m. on a rotating day shift. She stated she received in-service training on 04/25/2026 ANE, not taking personal belongings, and answering call lights timely. She stated staff were not to take any personal belongings from a resident including their cellphone even for charging purposes. She stated staff could provide the residents a charger to use in their room. She stated if she witnessed abuse or exploitation, she would make sure the resident was safe and notify the ADM who was the abuse coordinator, nurse supervisor, residents RP, MD, and DON immediately. She stated she would then complete a change of condition report, documenting the abuse and or misappropriated items, her witnessed observation, and notes from the resident's statement. She stated in the event that the ADM was the preparator she would report the abuse to the corporate's compliance hot line anonymously if she feared retaliation. She stated the following were forms of abuse to report to the abuse coordinator immediately: physical, verbal, sexual, misappropriation, neglect, and emotional. During an interview on 04/26/2026 at 01:49 p.m., ADON A stated she worked for the facility on a rotating shift. She stated she received in-service training on 04/25/2026 covering ANE, not taking a residents possession including their phone even for charging, provide the a resident with a charger to use in the resident's room, and reporting all changes of a resident's behavior to the MD, RP, and DON. She stated in the event that a resident made repeated calls to 911 to be sent to the hospital, she would complete a behavioral assessment, notify the MD and RP and send the resident to the hospital. She stated once transferred she would follow up with the hospital on the resident's condition and update the resident's MD, RP, and the DON. She stated the following were forms of abuse that were to be reported to the ADM who was the abuse coordinator: physical, financial, emotional, psychological, verbal, and sexual. She stated if the ADM was the abuser or she feared retaliation from reporting, she would report to the corporate compliance line and the state anonymously. During an interview on 04/26/2026 at 01[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026
NAME OF PROVIDER OR SUPPLIER Memorial City Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to ensure that pain management was provided to Resident #21's who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The facility failed to monitor and address Resident #21's pain on 03/04/2026 from 3:00 a.m. to 11:00 a.m., when Resident #21 pressed her call light, cried out in pain, called 911 twice, and pulled the fire alarm requesting to go to the hospital. An IJ was identified on 04/27/2026. The IJ template was provided to the facility on [DATE] at 02:45 p.m. While the IJ was removed on 04/28/2026 at 10:43 a.m., the facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure had the potential to place residents at risk for delayed treatment, pain, and actual harm. The findings included: Record review of Resident #21's face sheet dated 04/23/2026 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included systemic lupus erythematosus, epilepsy, anxiety disorder, obesity, pain in unspecified joint, stiffness of unspecified joint, muscle wasting and atrophy, cognitive communication deficit, and need for assistance with personal care. Record review of Resident #21's Comprehensive MDS, dated [DATE], reflected the resident had a BIMS score of 15 which indicated the resident had intact mental cognition. Record review of Resident #21's care plan reflected, the resident was risk for pain and discomfort r/t lupus date initiated 01/21/2026 and revised on 02/05/2026. Record review of Resident #21's order dated 01/22/2026 at 08:00 a.m., reflected MD ordered Hydroxychloroquine sulfate oral table 200 mg by mouth one time a day for lupus. Record review of Resident #21's order dated 02/18/2026 at 05:00 p.m., reflected MD ordered Acetaminophen-Codeine Oral Tablet by mouth two times a day for pain (D/C 04/20/2026). Record review of Resident #21's order dated 03/04/2026 at 02:13 p.m., reflected MD ordered Gabapentin 300 mg TID for pain. Record review of Resident #21's order dated 03/04/2026 at 02:13 p.m., reflected MD ordered 2-view x-ray of lumbar spine r/t pain. Record review of Resident #21's order dated 03/04/2026 at 02:18 p.m., reflected a MD ordered a two view lumber spine x-ray, performed a complete pain assessment, resident denied any pain or discomfort at that moment, and resident was to continue with her scheduled pain medications. Record review of Resident #21's pain evaluation dated 03/04/2026 at 02:35 p.m., revealed ADON A completed an evaluation finding the resident had complaints of pain in her back and pain medication administered to alleviate pain. Record review of Resident #21's March 2026 MAR reflected resident received, Acetaminophen-Codeine Oral Tablet 300-30 mg 1 tablet given by mouth two times a day for pain and degenerative joint disease beginning 02/18/2026 at 05:00 p.m. and D/C on 04/20/2026 at 01:24 p.m. check and note pain levels at 09:00 a.m. and 05:00 p.m. administration. No pain levels were recorded on 03/03/2026 and 03/04/2026. Record review of Resident #21's March 2026 MAR reflected resident received, Gabapentin Capsule 300 mg capsule to be given by mouth three times a day for Pain beginning, 03/04/2026 at 05:00 p.m. To be administered at 09:00 a.m., 05:00 p.m. and 09:00 p.m. Resident received her first dose on 03/04/2026 05:00 p.m. Record review of Resident #21's March 2026 MAR reflected resident to have pain monitored every shift use 0-10 scale, (a) for alert residents use pain and (b) for confused. Document which pain scale used to assess residents pain rating. every shift starting 01/21/2026 at 07:00 a.m. No pain levels were recorded on 03/03/2026 and 03/04/2026. Record review of Resident #21's change of condition dated 03/04/2026 at 02:26 p.m., reflected the resident reported pain that started on 03/04/2026. Vitals checked and noted within range. Change in mental status was noted as new or worsening behavioral symptoms and pain medication administered. Suggested request for lab work and x-ray. New order for Gabapentin 200 mg TID. ADON A received the resident at the nurse's station as resident was up having behavior and making 911 calls. Resident was then taken to her room at the resident's request and was placed to bed. ADON A, (continued on next page)

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

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	called Family Member A to inform him of the resident's behavior with no response. During an interview on 04/22/2026 at 10:52 a.m., Resident #21 stated at she had a diagnosis of Lupus, and the symptoms caused her chronic pain in her joints and back, and the need for frequent repositioning. She stated she relied on staff for that repositing and to provide her with her PRN pain medication. She stated all too often, when she pressed the call light for assistance with repositioning there was a delay in staff responds and sometimes that would not come at all until meals were passed. She stated because she frequently pressed the light for assistance, the staff often were mad with her, responding with attitudes, disrespect, and unfriendly tones. She stated staff would respond with, What do you need now? She stated that she was sick and needed staff to answer her call light. She stated she was a nurse and knew the staff's task responsibilities and need for great customer service. She stated the facility staff needed refresher training on customer services and resident rights. She stated she had concerns that there were only 2-CNAs for 50-residents on hall she resided. She stated she had not reported the incident to the staff or the ADM who was the abuse coordinator because they were all aware of the incident. During an interview on 04/23/2026 at 2:25 p.m., Resident #40 stated that her roommate was Resident #21. She stated on 03/04/2026 at 4:00 a.m., Resident #21 woke up crying in pain, pressed the call light, yelled out for help, and then called the facility's front desk from her cellphone, with no response. She stated then Resident #21 called 911 when LVN A came into the room and asked Resident #21 why she had called 911 as EMS had responded to her call as was at the facility. She stated Resident #21 told LVN A she was in pain, but LVN A then left the room. She stated again, Resident #21 dialed 911 who asked for the address to the facility. She stated Resident #21 was only able to provide the street name, when LVN A reentered the room. She stated Resident #21 asked LVN A for the facility's address, but LVN A told Resident 21's she did not know the address, took the resident's phone to tell the 911 operator that everything was okay with the resident, and hung up the call. She stated that LVN A then left the room with Resident #21's cellphone. She stated that Resident #21 yelled out for assistance until 5 a.m., when LVN A and CNA A entered the room and got Resident #21 out of bed and into a wheelchair. She stated LVN A stated she would monitor the resident from the nurse's station. She stated that while Resident #21 was in the hall, she could hear the resident saying nurse, nurse, nurse, can you help me. She stated sometime later, she heard the fire alarm go off and then CNA B and CNA C brought the resident back to the room and put her into the bed. She stated that Resident #21 required a lot of care, specifically repositing due to the resident's Lupas diagnosis that caused the resident severe pain. She stated that Resident #21 pushed her call light frequently for assistance due to pain and the need for pain medication. She stated anything longer than an hour of Resident #21 sitting in a wheelchair caused the resident increased pain. She stated on 03/04/2026, the staff had the resident sitting in her wheelchair for more than an hour. She stated she had not reported the incident to any staff or the ADM because they were all aware. She stated the ADM was the abuse coordinator, but she would not report abuse to him because he was a liar and could not be trusted to do what was best for the residents. During an interview on 04/23/2026 at 04:26 p.m., SW A stated on 03/09/2026, she followed up with Resident #21 after a behavior of calling 911 twice on 03/04/2026. She stated Resident #21 had neurological issues that limited her ability to remember the 911 event, date, and times. She stated the resident explained to her on 03/04/2026, she wanted to go to the hospital and called Family Member B's who had not agreed with the resident's need to go to the hospital. She stated the resident told her she wanted to go to the hospital and go to another facility, but the resident could not provide a reason why. SW A stated she believed, the resident called 911 in an attempt to get Family B's attention on her wellbeing. SW A stated which was accomplished and with the focus on the resident, the resident felt better. She stated that LVN A responded to the resident's need to call 911 but found that the resident had no changes in condition that required hospital transfer. She stated she had not heard the resident had concerns with back pain or any pain on 03/04/2026 as the reasoning for calling 911. She stated it had been her expectations had the nursing staff been made aware of any pain concerns, they (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	would have assessed the resident and made a decision how to proceed thereafter. She stated it had also been her expectation that staff not to hinder a resident's request to be transferred to the hospital. She stated failure hinders hospital transfer could delay a resident's need for higher levels of care. She stated she was not aware that the resident had also pulled the fire alarm nor that the fire department had responded. She stated at a recent care plan meeting with the resident and Family A, neither made mention of any pain management issues. She stated after speaking to the resident, the resident told her she no longer wanted to go to another facility and was safe and felt safe. She stated the facility provided in-service training on reporting a change of condition related to pain management to the resident's nurse, DON, and the resident's MD. During an interview on 04/23/2026 at 05:33 p.m., ADON A stated she was aware Resident #21 had called 911 and pulled the fire alarm, but she had not been on shift. She stated that CNAs had reported to her that the resident had behaviors when the resident first admitted in January 2026 but had not called out for the need to go to the hospital. She stated the resident had often complained of pain due to her diagnosis, but the resident could not specify the exact location, only that pain was present. She stated on 4/20/2026, MD D/C the resident's scheduled medication due to the resident experiencing nauseous and a new PRN medication was ordered. She stated she never knew the resident to cry out in pain. She stated that when the resident received pain focused assessments, the resident denied pain or denied the assessments all together. She stated if the nurse insisted on completing the pain assessments, the resident would insult the nurse. She stated in the event that a resident reported pain, she would immediately notify the resident's MD and contact the DON. If the resident insisted on going to the hospital, she would not attempt to stop the resident. She stated the facility provided in-service training on resident rights and properly caring for a resident which covered pain management, every month. During an interview on 04/23/2026 at 05:49 p.m., the DON stated LVN A quit without notice after a casual conversation unrelated to the 911 calls with Resident #21. She stated the facility provided staff in-service training on pain management quarterly, monthly and as needed. During an interview on 04/23/2026 at 09:00 p.m., LVN A stated on 03/03/2026, her shift began at 07:00 p.m. and ended on 03/04/2026 at 07:00 a.m. and she was assigned to care for Resident #21's on that shift. She stated while making rounds check in on the resident to find she wanting to pass her a cellphone. She stated when she got on the phone, a 911 operator asked what type of emergency assistance the resident had needed. She stated she told 911 that the resident was fine before disconnecting the call. She stated the resident had normal vitals and there was nothing voiced by the resident to be concerned nor was there anything visibly wrong with the resident. She stated a short time later; CNA A brought her the resident's phone answering the resident's call light. She stated she took the phone saying hello, and again, 911 was on the line asking what emergency services the resident needed and again she told 911 that the resident was fine. She stated at 07:00 a.m. her and CNA A got the resident out of bed as an intervention to the resident's behaviors. She stated she also took the resident's cellphone and placed it at the nurse's station as an intervention to keep the resident from calling 911. She stated when the ADM came on shift at 07:00 a.m., she told him she had taken the resident's phone and asked if they were allowed to do that. She stated the ADM told her they really could not do that, and she said OKAY she would return the phone, but the ADM stated he would handle it. She stated while in the tv area, the resident wheeled her over the wall near the fire alarm. She stated the SC tried to stop the resident from pulling the alarm but was too late. She stated she asked the resident why she pulled the alarm, and the resident stated that she wanted to go home. She stated that CNA B was asked to put the resident back to bed. She stated at no time had the resident complained of pain, cried out, or expressed any discomfort. She stated she had heard nothing further on the incident, was unaware if the resident received a pain assessment or a new order for pain medication. She stated that the facility provided in-service training on pain management all the time. She stated she quit working for the facility unrelated to the incident and had no disciplinary actions taken against while with the facility. During an interview on 04/24/2026 at 10:51 a.m., the MD stated (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	that on 03/04/2026 at 11 a.m. she visited Resident 21's during routine rounds at the facility. She stated she learned from staff that the resident had placed repeated calls to 911 early that morning after experiencing evaluated anxiety and attention seeking behavior. She stated that the resident had chronic pain and inflammation associated with the Lupus diagnosis, along with chronic pain from a compression fracture and surgery to the resident's lower back. She stated during that visit, the resident expressed having severe and sharp pain that was more than usual. The MD stated she ordered new labs, a lumbar x-ray, and added Gabapentin to accompany the existing scheduled pain medication of Tylenol with codeine. She stated labs and x-rays confirmed existing inflammation and previous fractures that contributed to the resident's ongoing pain, but no new/acute issues. She stated the resident called 911 due to chronic pain. The MD stated the nursing staff had tracked and monitored the resident's vitals during that time frame, noting all were within range. She stated she was not aware when the resident called 911 that EMS had arrived at the facility and had been turned away without evaluating the resident. She stated it was her expectation if EMS made the scene, that the resident should have been evaluated and the staff should have relied on the EMT's evaluation to determine if resident had pain that justified a hospital transfer. She stated it was also her expectation that if a resident insisted on being transferred to the hospital that the facility would assist with that transfer, notify MD, and the resident's family. She stated it was her expectations that the nursing staff do not minimize residents' pain. She stated she had not been made aware staff transferred the resident from her bed to a wheelchair as an intervention and deterrent from calling 911. She stated sitting the resident up could elevate pain. She stated she had not been made aware that the resident had also pulled the fire alarm and that the fire department had responded at the facility. She stated she would have also expected the facility staff to allow the fire department's EMTs to evaluate the resident before departing the facility. She stated she had not received a call prior to making rounds of the incidents with the resident. She stated had any of the physician staff been made aware that the resident had called 911 due to the pain, crying in pain, and insisting to be sent to the hospital they would have immediately ordered a hospital transfer. She stated on stated that on 04/20/2026, the resident's Tylenol order was D/C and replaced with Tramadol a stronger pain medication. During an interview on 04/24/2026 at 01:42 p.m., the DON stated on 03/04/2026, she had not received a call from staff regarding Resident #21 calling 911 repeatedly due to pain. She stated at the morning meeting on 03/04/2026 she learned the resident had behaviors during the night shift and called 911 and pulled the fire alarm. She stated there was no mention of pain during the meeting. She stated after reviewing the resident's clinical notes she found that on 03/04/2026, the MD completed a pain assessment, ordered x-rays of the resident's spinal lumbar, and added a new order of Gabapentin 3-times a day. During an interview on 04/24/2026 at 01:51 p.m., the ADM stated he was on shift on 03/04/2026 before LVN A's shift ended at 07:00 a.m. He stated he was on shift and when Resident #21 pulled the fire alarm and called 911 repeatedly after behaviors contributed to the resident's UTI diagnosis. He stated the fire department arrived at the facility and were informed that it was a false alarm. He stated that he was not made aware that the resident had reported pain to LVN A. He stated that LVN A was a nice night nurse that lacked confidence. He stated LVN A had no calls, no show and never returned to work at the facility. He stated LVN A had no disciplinary actions write-ups on her. He stated that night shift staff received in-serviced training on notifying physicians of change in a resident's condition. During an interview on 04/24/2026 at 2:32 p.m., the DON stated on 03/04/2026, she was made aware of the resident's 911 calling behavior and addressed the behavior and the pain concerns were evaluated. She stated at the time of the incident she was focused on trying to figure out what caused the resident to have the behavior. She stated staff never communicated with her in the moment that the resident was calling 911, otherwise, she would have addressed the behavior immediately. She stated the facility provides in-services training on changes of condition that addresses pain management monthly, and off cycles as needed due to events. During an interview on 04/24/2026 at 5:25 p.m., Resident #21 stated when the staff prevent her from calling 911 and would (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	not address her pain, she had anxiety, felt horrible, and mistreated. She stated she was currently receiving tramadol to manage the pain. During an interview on 04/26/2026 at 01:26 p.m., CNA D stated she worked the 03:00 p.m. to 11:00 p.m., shift at the facility. She stated that on this date she received an in-service training on reporting changes of condition to the charge nurse including resident's voicing pain or exhibiting pain like behavior as soon as possible. She stated she was to document the changes POC noting what abnormal conditions were observed and what was known that could have caused the changes. She stated the ADM was the abuse coordinator that all forms of abuse were to be reported. She stated in the event the ADM was unavailable or the perpetrator of abuse, she would report the abuse to the charge nurse, and DON. She named the following as forms of abuse: misappropriation of property, neglect, verbal, physical, seclusion, sexual, and mental/emotion. During an interview on 04/26/2026 at 01:36 p.m., LVN B stated she worked 7:00 a.m. to 7:00 p.m. on a rotating day shift. She stated she received in-service training on 04/25/2026 on reporting changes of condition and of pain to the charge nurse, resident's MD and RP, and the DON immediately. She stated the in-service also covered if a resident insists on going to the hospital sent the resident and inform the MD, RP, and DON, and complete all required transfer documentation in the resident's clinical chart. She stated that the ADM was the abuse coordinator and in the event that the ADM was the preparator she would report the abuse to the DON, HR, and the company's compliance hot line. She stated the following were forms of abuse to report: physical, mental, emotional misappropriation, and sexual. During an interview on 04/26/2026 at 01:41 p.m., LVN D stated she worked 7:00 a.m. to 7:00 p.m. on a rotating day shift. She stated she received in-service training on 04/25/2026 ANE, answering call lights timely, reporting change of condition, and pain immediately. She stated if she witnessed abuse, she would make sure the resident was safe and notify the abuse coordinator immediately, perform skin and pain assessment, notify the nurse supervisor, family, MD, ADM, and DON. She stated she would then complete the change of condition document noting finding from her assessments, witnessed observation, and interview from the resident. She stated that the ADM was the abuse coordinator who all allegations of abuse were reported. She stated in the event that the ADM was the preparator she would report the abuse to the corporate's compliance hot line anonymously if she feared retaliation. She stated the following were forms of abuse to report to the abuse coordinator immediately: physical, verbal, sexual, misappropriation, neglect, and emotional. She stated if a resident insisted on going to the hospital despite the lack of MD orders, she was to notify the MD, RP, and DON of the transfer and complete the required transfer documentation. During an interview on 04/26/2026 at 01:49 p.m., ADON A stated she worked for the facility on a rotating shift. She stated she received in-service training on 04/25/2026 covering changes in a resident's pain. She stated she would administer any PRN medication, report the pain the MD, RP, and DON, complete a pain assessment, and send the resident to the hospital. She stated once transfer was complete, follow up with the hospital and report the resident's status to the resident's MD, RP, and the DON. She stated the following were forms of abuse that were to be reported to the ADM who was the abuse coordinator: physical, financial, emotional, psychological, verbal, and sexual. She stated if the ADM was the abuser or she feared retaliation from reporting abuse, she would report the abuse to the facility's corporate compliance line and the state anonymously. During an interview on 04/26/2026 at 01:55 p.m., LVN E stated she worked for the facility on a rotating shift from 07:00 a.m. to 07:00 p.m. She stated she received in-services on 04/25/2026 on resident rights to call 911 and comply with the resident's request and right to go to the hospital, reporting the resident's pain change of condition to the resident's MD, RP, and the DON, completing pain assessments, and the staff's responsibility to assist with hospital transfers even if the resident will not share the need to go to the hospital. She stated that the ADM was the abuse coordinator and named the following as forms of abuse: verbal, physical, psychosocial, restraining, financial, seclusion, and sexual. She stated if abuse was reported to her, she would first stop and intervene to ensure the resident was safe and identify who, what and where the abuse took place. She stated and in the event that the ADM was the abuse coordinator, she (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	would report the abuse to the DON, contact the police, call the compliance line, and any department manager. She stated if she feared retaliation from reporting abuse, she would call the compliance line anonymously. During an interview on 04/26/2026 at 8:27 p.m., CNA B stated she worked shifts that covered 7:00 a.m. to 07:00 p.m. and 7:00 p.m. to 07:00 a.m. She stated she received in-service training on 04/25/2026 on She stated she was to report changes to a resident's condition to include reporting a resident's pain to the unit manager immediately. She stated she also had ANE in-service training and stated the following were forms of abuse: verbal, misappropriation of funds, physical, mental, seclusion, and sexual that were to be reported to the ADM who was the abuse coordinator. She stated if she feared retaliation from reporting abuse, she would call the compliance line and report to her on call manager. During an interview on 04/27/2026 at 10:24 a.m., CNA B stated she worked on 03/04/2026 beginning her shift at 07:00 a.m. She stated Resident #21 who was sitting in a wheelchair across from the nurse's station with no events out the ordinary. She stated ADON A instructed her to transfer the resident to the bed and CNA C assisted with that transfer. She stated she could not recall any more details from event, but had the resident exhibited tearfulness, pain, discomfort, or complaints or desires to go to the hospital, she would have reported those behaviors immediately to the resident's nurse. She stated she was not made aware on 03/04/2026, the resident pulled the fire alarm and called 911. An IJ was determined on 04/27/2026 at 02:45 p.m., the ADM and DON were notified. The ADM was provided and signed the IJ template on 04/27/2026 at 02:50 p.m. The following plan of removal was submitted by the facility and was accepted on 04/28/2026 at 08:09 a.m. Immediate Jeopardy (the facility) On April 27, 2026, the Facility was notified by the surveyor that immediate jeopardy had been called and the Facility needed to submit a letter of removal. The Facility respectfully submits this Plan of Removal pursuant to Federal and State regulatory requirements. The immediate jeopardy is as follows: F 697 The facility failed to monitor and address Resident #1's pain on 03/04/2026 from 3 a.m. to 7:00 a.m. when Resident #1 pressed her call light, cried out in pain, called 911 twice, and pulled the fire alarm requesting to go to the hospital. Actions for Resident Involved On 04/25/26, Resident #1 was assessed by a licensed nurse for pain, physical condition and no complaints of pain and with current pain regimen. On 4/25/26, The Social Worker conducted psychosocial assessments with no concerns noted. On 4/25/26, Resident #1 MD was notified by Director of Nursing of event with no new orders made. On 4/25/26, Responsible Party was notified by Administrator. The Resident's personal cellphone was returned to Resident #1 by the Administrator on 3/4/26. A psychiatric consultation was completed on 3/4/26. The care plan was updated to reflect individualized interventions for pain management and resident preferences regarding emergency response on 4/25/26 by Director of Nursing. LVN A was not employed at the time of survey. LVN A last date of employment 3/13/26 due to no call no show. Facility's abuse/neglect policy/procedure reviewed with no changes made. Identify residents who could be affected: On 4/24/26, the Director of nursing and/or designee reviewed progress notes for past 30 days to identify concerns related to abuse and neglect, to include signs or reports of distress, denial of access to emergency care and removal of personal property without resident permission to ensure concerns were addressed by completion of appropriate assessments, interventions, MD notifications and state reporting as indicated. There were no concerns identified during this review. Progress note review completed and documented using printed progress notes for each current resident. Pain evaluations completed on all residents with no concerns identified. Pain management policy reviewed with no updates. On 4/25/26, Social Worker/designee conducted resident safe survey interviews with interviewable residents related to abuse and neglect to include reports of distress, uncontrolled pain, and removal of personal property without their permission with no concerns noted. Interviews consisted of abuse and neglect questions and documentation on questionnaires. On 04/25/26, Licensed nurses/designee conducted facility rounds on non-interviewable residents to observe for the presence of abuse and/or neglect by signs of distress, pain symptoms, with no concerns noted. Completion date: 04/2620/26 Action Taken/ System Change: On April 25, 2026, the Regional Clinical Specialist reeducated the (continued on next page)

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

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Facility Administrator (Abuse Coordinator) and Director of Nursing on the facility's abuse, neglect and Misappropriation policy and procedure with emphasis that residents cannot be denied access to emergency services if requested, physician notification of changes in condition such as signs and reports of distress, uncontrolled pain, and removal of personal property without their permission. Reeducation included actions to take in the event abuse, neglect and/ or misappropriation were suspected. Comprehension of training was verified by having to voice understanding of the training and repeat back training contents. Comprehension of Training verification obtained by a signed written re-education form indicates understanding. All staff re-educations began on 4/24/26 conducted by the Director of Nursing or Designee on the following. Comprehension of training was verified by having nurses voice understanding of the training and repeat back training contents. Completion date 4/26/26 o Abuse, Neglect and Misappropriations with emphasis that residents cannot be denied access to emergency services if requestedo Physician notification and documentation when a resident requests hospital transfer or exhibits unresolved change in condition such as signs or reports of distress, uncontrolled pain and other distressing behaviors identified.o The facility reinforced the removal of resident personal property, including communication devices to be charged at bedside, without resident permission. Beginning 4/25/26, any facility staff on PRN/FMLA/LOA/PTO will be reeducated by the Administrator and/ or Director of Nursing and/ or designee on all re-education detailed below prior to accepting assignment for their next scheduled shift. Staff who have not completed training will not be permitted to provide direct care services until training is complete. Beginning 4/25/26 and ongoing, newly hired Nursing staff will receive this training during orientation prior to providing care to the residents. Staff who have not completed training will not be permitted to provide direct care services until training is complete. The training will include the above-stated educational components Completion date: 4/26/26 Monitoring: Beginning 4/25/26 and going forward, the Administrator and/ or designee will monitor compliance with abuse and neglect to include addressing reports of distress, uncontrolled pain, personal property taken without their permission and access to emergency services if requested by rounding and record reviews. Findings will be documented on an audit tool. Beginning 4/25/26 and going forward, the Director of Nursing /designee will review 24hr report and change-in-condition for potential abuse and neglect situations, as well as reports of distress, uncontrolled pain, removal of personal property without resident permission, provision of access to emergency services and timely physician notification will be reviewed for appropriate actions each weekday morning. Findings will be documented on an audit tool. On 4/25/26, An Ad Hoc QAPI meeting was held with the Medical Director, Facility Administrator, Director of Nursing, Regional Clinical Specialist and Regional VP of Operations to review the plan of removal. During an interview on 04/27/2026 at 03:35 p.m., CNA A stated on 03/03/2026 she worked from 7:00 p.m. to 7:00 a.m. on 03/04/2026. She stated she was responsible for Resident #21's care and at 04:00 a.m., she responded to the resident's call light who wanted a snack and drink. She stated again she responded to the resident's call-light and the resident asked to get out of bed. She stated LVN A was informed and LVN A responded it was too early for the resident to get up. She stated that the resident insisted on getting up LVN A assisted her transferring the resident into a wheelchair. S[TRUNCATED]

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record reviews and interviews, the facility failed to ensure each resident is offered the COVID-19 (infectious respiratory illness caused by the corona virus) vaccine unless the immunization is medically contraindicated, or the resident has already been immunized for all residents.The facility failed to offer COVID vaccine to its residents upon admission to the facility. This failure could place residents at risk of COVID. The findings are: During an interview on 04/24/2026 at 10:13 a.m., the ICPN stated the facility did not offer COVID vaccines to its residents. She stated residents and residents' representatives always declined the COVID vaccination, so the facility stopped offering the vaccine. She stated she was unaware the facility should have offered the vaccine to its residents and they could accept or refuse to receive it. She stated she did not recall when the facility stopped offering the vaccine to its residents. She stated if the facility did not offer the vaccine to residents, they could be at a higher risk of COVID disease. During an interview on 04/24/2026 at 10:25 a.m., The DON stated she was unaware the facility should have offered the COVID vaccine to its residents and they could accept or refuse to receive it. She stated she did not recall when the facility stopped offering the vaccine to its residents. She stated if the facility did not offer the vaccine to residents, they could be at risk of COVID. During an interview on 04/24/2026 at 10:29 a.m., The MD stated he was unaware the facility should have offered the COVID vaccine to its residents and they could accept or refuse to receive it. He stated if the facility did not offer the vaccine to residents, they could be at a higher risk of COVID disease. During an interview on 04/24/2026 at 1:20 p.m., The administrator stated he was unaware the facility should have offered the COVID vaccine to its residents. He stated he did not recall when the facility stopped offering the vaccine to its residents. He stated if the facility did not offer the vaccine to residents, they could be at risk of COVID disease. Record review of the facility's Infection Control Policy, dated 05/13/2023, reflected, Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.Policy Explanation and Compliance Guidelines: 8. COVID-19 Immunization:a. Residents and staff will be offered the COVID-19 vaccine when vaccine supplies are available to the facility.b. Residents and staff will be screened prior to offering the vaccination for prior immunization, medical precautions and contraindications to determine candidacy for the vaccination.c. Education about the vaccine, risks, benefits, and potential side effects will be given to residents or resident representatives and staff prior to offering the vaccine.d. Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination, and change their decision based on current guidance. Record review of CDC (U.S. government agency responsible for protecting public health) ACIP (a CDC-chartered group of medical experts that develops recommendations for vaccine use in the U.S. civilian population) recommendations, dated October 2024, revealed .In October 2024, ACIP recommended that all persons aged ˆ65 years receive a second 2024-2025 COVID-19 vaccine dose 6 months after their last dose. What are the implications for public health practice?Adults aged ˆ65 years should receive 2 doses of 2024-2025 COVID-19 vaccine Record review of CDC COVID Recommendations, dated 11/19/2025, revealed, .The COVID-19 vaccine helps protect you from severe illness, hospitalization, and death.It is especially important to get your 2025-2026 COVID-19 vaccine if you are ages 65 and older.Vaccine protection decreases over time, so it is important to get your 2025-2026 COVID-19 vaccine.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 8 residents (Resident #38) reviewed for call light placement. The facility failed to ensure Resident #38's call light was within reach on 04/24/2026, while he was lying in bed. These failures could place residents at risk of not receiving immediate assistance when needed. Findings include: Record review of Resident #38's Face Sheet, dated 04/24/2026, reflected, a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #38 had diagnoses which included cerebral infarction (when blood flow to part of the brain is blocked), muscle weakness and history of falling. Record review of Resident #38's admission MDS (a standardized, mandatory assessment tool used by nursing homes to evaluate the health, functional status, and care needs of residents), dated 04/08/2026, reflected, the resident had a BIMS of 0, which indicated the resident had severe cognitive impairment. He used a wheelchair for mobility. He was dependent on staff with personal hygiene, toileting hygiene, showering, upper body dressing and lower body dressing. He was always incontinent with bladder and bowel. Record review of Resident #38's Care Plan dated 04/03/2026, reflected the resident had an ADL self-care performance deficit r/t cerebral infarction. The resident was at risk for falls r/t cerebral infarction and muscle weakness. Record review of Resident #38' Progress Note, dated 04/03/2026, reflected the resident incontinent of bowel and bladder, bed to be in lowest position and call light within reach. During an observation and an interview on 04/24/2026 at 9:54 a.m., revealed Resident #38 was lying in his bed with the call light out of reach, on the head of his bed. Resident #38 said he could not reach his call light. The resident said his call light was out of his reach most of the time. The resident stated he was doing okay and was not aware as to when or who placed his call light on the head of his bed. During an interview on 04/24/2026 at 10:00 a.m., CNA Q stated he was unaware of how Resident #38's call light was placed out of reach, on the head of his bed. He stated in the morning the resident's call light was close to the resident. He stated he checked residents call lights placement every morning at the beginning of his shift and whenever he went to residents' rooms when they needed help. He stated the call light needed to always be within reach in the event the resident needed to call for help. He stated he received in-service training on call lights last week. During an interview on 04/24/2026 at 10:12 a.m., RN Q stated she was unaware of why Resident #38's call light was not within his reach. She stated she checked residents' call lights when she provided care to them. She said Resident #38's call light not being within his reach could increase his chances of falling on the floor if he needed to reach out to something and was not able to. She stated she received in-service training on call lights last week. During an interview on 04/24/2026 at 01:07p.m., the DON stated residents' call lights were to always be within reach for residents to call for assistance. She stated a resident could fall at any moment reaching for an item they may need. She stated failure to place a call light within reach could result in a resident experiencing a fall. She stated she expected CNAs and nurses to round on residents every 2 hours and ensure call lights were within reach. She stated she checked residents call lights placement weekly.She stated the facility provided call light positioning, answering, and personal items within reach at bedside in-service training last week. Record review of in-service training, dated 03/21/2026 and 04/24/2026, titled Call Lights reflected All staff members are responsible for answering call lights. If you answer a light and it's not in your scope or field. Notify the nurse in charge and a unit nursing manager. Direct care staff, after providing care make sure the call light is attached to the patient or in reach, whichever is the patient's preference. Call lights should be answered timely. Communication is key if you can't provide care at that moment let the patient know when to expect you back. If you're overwhelmed or too busy notify your charge nurse or team member so they assist where needed. If a clamp is missing put it in (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	TELS (digital maintenance request platform) so maintenance can replace it. Signed by multiple facility staff, conducted by DON The in-service included the staff identified to care for Resident #38. Record review of the facility's Call Lights: Accessibility and Timely Response policy. dated 10/13/2022 reflected, Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.Policy Explanation and Compliance Guidelines.6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.9. Ensure the call system alerts staff members directly or goes to a centralized staff work area.10. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that a written notice of transfer or discharge, was provided to the resident and/or their representative contained all federally mandated elements for 1 of 4 residents (Resident #40) reviewed for discharge notices. The facility failed to ensure that Resident #40's written notice of transfer or discharge, including a safe discharge location. The facility failed to ensure that Resident #40's written notice of transfer or discharge, contained the Ombudsman's name and email address. These failures could place the residents at significant risk by bypassing critical safeguards meant to ensure their safety and continuity of care.Findings included: Record review of Resident #40's face sheet dated 04/26/2026, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included, lesion of radial (dysfunction in the arm, leading to symptoms like wrist drop, weak triceps, and numbness on the back of the hand) of left upper limb. Record review of Resident #40's MDS dated [DATE] reflected the had a BIMS score of 00 indicating the resident had sever impaired cognition. Record review of Resident #40's progress Notes dated 06/12/2025 at 10:11 a.m., created by SW B reflected, SW B called several hotels and found Resident #40 had resided at one and the owner confirmed he had the resident's belongings. The owner confirmed that they had no first floor availability at that time for the resident to return, when asked. SW B would go see the resident to ascertain if there were other hotel room availabilities for the resident to discharge. Record review of Resident #40's progress Notes dated 10/16/2025 at 09:24 a.m., created by SW B reflected, while making safety check rounds was told by Resident #40 said she had a vacate notice about and up and coming in a PCH. SW B inquired about the PCH choice for the pending discharge, as SW B wanted to assist the resident in locating a PCH. The resident said it was early; she had just woken up, and asked SW B to come back in the afternoon. Record review of Resident #40's progress notes dated 10/20/2025 at 04:52 p.m., created by SW B reflected, resident assured SW the resident would notify staff of any concerns regarding the pending 30-day notice for discharge and hearing notification. None noted. Record review of Resident #40's progress notes dated 11/12/2025 at 02:30 p.m., created by MD B, reflected, resident seen laying in the bed. Staff reported the resident would not cooperate in discharge planning. Resident would not cooperate with exam when asked to raise her legs, stated that I am working on it. When asked to raise her upper left upper extremity, resident claimed it is better. When encouraged to get out of the room, the resident said she was working on some things in the room. MD B noted the resident provided vague responses to MD B's questions. Resident denied any pain during the evaluation. Resident was on Tylenol, PRN for pain. Previously, the resident had been difficult to work with in terms of finding placement. The resident had been resistant to taking gabapentin despite recommendations. Resident had complained of wearing splint on left wrist and forearm and had reported feeling better with pain managed by Tylenol as needed. Social History: Resident was living in hotel, no family support. Vacate notice imminent. Planned discharge to a PCH; SW B assisting with placement. Ongoing challenges with discharge planning and placement. Staff reported the resident had not been cooperating with discharge planning, placement efforts, and had been difficult to place. SW B had previously engaged regarding housing and PCH options; patient requested a later return for further discussion. Record review of Resident #40's progress notes dated 11/20/2025 at 09:30 a.m., created by PA-C, reflected, resident had ongoing challenges with discharge planning and placement; not cooperating with SW B regarding facility's needs and potential discharge/placement planning. Psychiatric: Normal appearance and behavior, calm during examination, not agreeable to leaving room with discharge planning. Resident noncompliance with other medical treatment and regimen. Will continue to work with nursing staff and social services to address placement issues. All medications, allergies and problems discontinued on this date. Record review of Resident #40's progress notes (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 01/28/2026 at 04:34 p.m., created by SW A reflected, resident acknowledged receipt of 30 notice of discharge for non-payment for services. Resident was adamant of not needing assistance; that resident understood the rights relative to discharge notice. Resident very verbal relative to not trusting others; stated plan of not being able to walk out of here. SW A to follow up with referral to APS regarding the resident's 30-day notice of discharge and lack of plans and cooperation for assistance. Record review of Resident #40's progress notes dated 1/30/2026 at 11:08 a.m., created by SW A reflected, contact to APS regarding resident with 30-day notice of discharge; unknown status as to resident's discharge plans; failure to comply with facility staff assistance with access to services. Case will be referred to local ombudsman office. Record review of Resident #40's progress notes dated 04/10/2026 at 08:00 a.m., created by PA-C reflected, resident declined follow-up visit. Hospital Course: Resident was a [AGE] year-old female with history of sciatica (uses crutches) sustained a mechanical fall resulting in an open left distal humerus fracture, a left femoral neck (hip) fracture, and bilateral displaced superior pubic rami fractures. Orthopedic surgery performed irrigation and debridement with ORIF of the left distal humerus, with subsequent removal/revision of prior ORIF on 05/06/2025 and application of a wound vacuum with low suction. Radial nerve injury was noted; preoperative integrity was unclear. Resident elected non-operative management for the femoral neck and pelvic fractures. Resident was stabilized and transferred from the hospital to the facility for rehabilitation. Resident declined her follow-up on 04/07/2026 and again on this date. Resident stated she was fine and does not need to be checked. The resident was not assessed on this date due to her refusal of the visit. Previously, the patient had demonstrated an ongoing pattern of noncompliance with medical treatment and refusal of assessments, including refusal of right shoulder evaluation, treatment options, and diagnostic imaging. Resident had been managing chronic pain with Tylenol 650 mg every 6 hours as needed. Resident had a history of right shoulder pain, left femoral neck fracture and left pubic fracture both healing with conservative management, and left radial nerve injury with splint. Resident had been difficult to work with regarding discharge and placement planning, and has been resistant to gabapentin despite recommendations. Record review of Resident #40's discharge notice titled Nursing Home Transfer and Discharge Notice reflected, the resident was not receiving Medicare, the resident was her own RP, with an out of state address, with an anticipated discharge date of 02/27/2026. The reason for discharged listed: Your bill, for services at this facility, has not be pained after reasonable and appropriate notice to pay. The following reasons require either this form be signed by a physician or a physician's written order for discharge or transfer be attached. The signing physician may be the resident's attending or treating physician, the facility medical director, or a nurse practitioner or physician's assistant as a physician designee. Your health has improved sufficiently so that you no longer need the services provided by this facility. The notice failed to outline the Ombudsman's name and email address. During an interview on 04/23/2026 at 2:25 p.m., Resident #40 stated when she admitted to the facility she came for OT and PT services to assist with walking and mobility strength. She stated during therapy services she was encouraged to walk, but the attempts caused her too much pain and added new sciatic nerve pain. She stated she cannot walk, nor get into a shower chair due to pain from the bone break. She stated that the facility staff thought she was being difficult because she refused care, but it had been due to fear of pain and reactivating pain. She stated she can feed herself and she was able to give herself a bed bath with the assistance of staff providing her soap and water. She stated that the staff change her bedding daily, provider her with incontinent care, and repositing assistance. She stated she does not take medication because the MD discontinued the pain order. She stated because she had refused nursing care due to pain the facility had labeled her difficult. She stated that she had no trust of the ADM, DON, BOM, SW, Ombudsman, and others she had not named because they had lied on her saying she was difficult and refused because she could not pay for her stay in advance. She stated that she refused nursing care due to pain and pain fears, not to be difficult. She stated that since the facility staff labeled her difficult, she does not share information or communicate with them. She stated that (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had not applied for Medicare services, but she may and did not want the help of facility because they had all lied on her. Email received from Resident #40's on 04/23/2026 at 02:52 p.m., Resident #40 stated she received a 30-day notice of involuntary discharge in January 2026 from the facility that she stated was defective and invalid because the facility could not show a safe discharge location for her to transfer. She stated instead of exhausting all administrative remedies including correcting the invalid discharge notice, the ESQ. filed an eviction notice in the Justice of the Peace court. During an interview on 04/23/2026 at 04:26 p.m., SW stated in or around May 2025, Resident #40 was living in a hotel room, got out of the shower, and was already using crutches, and one of the crutches slipped and the resident fell and fractured her hip. She stated the resident went to the hospital for surgery and was sent to the facility under a LOA program where the hospital paid 6-weeks of the resident's short-term care for the resident to obtain therapy services. She stated since that time, the resident had been living at the facility for free. She stated that the resident will not provide any family, financial earning information, or apply for financial benefits to cover the resident's financial obligation for the care provided by the facility. She stated the facility suggested referring the resident's case to the guardianship program to see assign someone to get involved applying for financial services for the benefit. She stated that she does not believe that the resident will qualify under the programs guidelines because the resident was cognitively intact. She stated that the resident refuses all care services, had no active medication orders, and refused to allow staff to get her out of bed and get her well. She stated the resident would also not participate in psychological services or assessments as the facility thought the resident's refusals and failure to provide family and financial information could have been psych related. She stated that the resident was simply comfortable being in the bed. She stated 2-weeks ago, the ADM participated in a facility indicated court hearing in eviction court receiving an eviction ruling in the favor of the facility to evict Resident #40. She stated that the constables would be to the facility any day to remove the resident from the facility. She stated at the end of the day, the resident had not provided the facility with enough information for the resident to have a safe discharge. She stated the facility had been in contact with APS who they were assuming will step in once the resident's eviction was complete to ensure that the resident found a safe placement. During an interview on 04/25/2026 at 02:36 p.m., RRN B stated that the IDT met to discuss and determine Resident #40's need for discharge. She stated that the IDT attempted to discuss with the resident her ideal discharge plans, but the resident refused to take part in the planning by refusing to share information for a safe discharge location. She stated the BOM attempted to obtain financial information and the resident's participation in applying for Medicaid benefits, but the resident refused to provide information and assist in the application process. She stated the IDT reviewed the resident's nurse's notes, medications, progress notes, and ADLs and determined the resident no longer required skilled or long term care services. She stated the resident was not taking any medications, refused therapy, activates, and psychology services. She stated the resident was only accepting meals and incontinent care at times. She stated as a result, the IDT determined the resident was ready for discharge and the discharge notice was sent to the resident on 01/27/2026 with an anticipated discharge on or before 02/27/2026. She stated she reviewed the resident's progress notice after the discharge notice was sent and found that the facility had not made contact with any family or individual who lived at the out of state address listed on the discharge notice. She stated the facility had not confirm as to whom the resident would receive care and support from if discharged to the out of state location. She stated based on having no contact with the individuals at that out of state address, she could not consider the out of state address as a safe discharge location. She stated she was not aware of the name of the Ombudsman or if the Ombudsman was aware or involved in supporting the resident thought the discharge process. She stated after reviewing the discharge notice she found that there was no Ombudsman name or email address listed on the notice and the facility was in the process reinitiating a new discharge notice that would give them additional time to find the resident a safe discharge location. Email received (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from Resident #40's on 04/26/2026 at 10:22 a.m., Resident #40 stated she came to the facility after a fall, fracture to her pelvis in two locations, hip, and arm. She stated after 3-surgeries she was discharged from the hospital after 3 weeks to the facility. She stated at the hospital that she received rehabilitation services, but after the second week, it was extremely difficult to push up with all her weight on uninjured leg without causing pelvic and sciatic nerve pain. She stated at the end of the 3-weeks, she was in no condition to leave the facility, but the ADM was trying to force her to for lack of insurance. She stated she tried to set up a payment plan, but the ADM wanted all money up front a month in advance, which she could not do. She stated shortly thereafter she received a 30-day notice of discharge. She stated that the notice lacked an address for a safe discharge location and the Ombudsman's contact name and email address. She stated, ESQ. who specialized in nursing home defense, filed an eviction in the Justice of the Peace court for her removal from the facility. During an interview on 04/26/2026 at 03:30 p.m., the ESQ. stated that she was outside counsel for the facility. She stated Resident #40's was admitted to the facility from the hospital with a 30-days LOA for the hospital to pay for that 30-day stay. She stated the resident refused to provide the facility with information to assist in applying for Medicaid benefits or offering any financial information to pay for her stay. She stated the facility had been trying to figure out where the resident could discharge since the resident's MD medically cleared the resident for discharge. She stated the facility submitted their 30-days discharge notice to the resident on 01/27/2026 to be effective on 02/27/2025. She stated the resident was from out of state and that address used on the discharge notice was addressed to the out of state address. She stated the discharge notice provided the resident with an opportunity to appeal the decision. She stated that the resident had not appealed, and with no appeal, the facility assured the out of state address was a safe discharge location. She stated that the facility had given the resident plenty of time to discharge on her own. She stated the facility had done everything they needed to do administratively to discharge the resident, and with no corporation from the resident, and decided to evict the resident through eviction court proceedings. She stated the court ruled in the facility's favor to evict the resident. She stated the resident attempted to appeal, but the court denied the resident's appeal. She stated that she had issued a wit to possess (summons to notify the resident of her eviction timeframe) with the constable's office, and the constables office would be placing a notice on the resident's room door this week. She stated once the notice was placed, the resident had 24-hours to vacate before the constables physically removed the resident from the facility. She stated the facility had made contact with APS informing them of their decisions to remove the resident. She stated that APS could not step in and assist with placement until the resident was out of the facility. She stated once the resident was officially out of the facility, the facility would call APS in hopes that they would step in immediately with a safe placement for the resident. During an interview on 04/27/2026 at 08:59 a.m., the Ombudsman stated that she visited the facility residents every Monday morning and had a few attempts to visit with Resident #40 who had refused to communicate with the Ombudsman. She stated she knows that the resident came from out of state, fell while in a hotel, and came to the facility for rehabilitation services. She stated the resident had not engaged with staff, nor shared family or financial information to assist with paying for the stay, and refused to assist with the facility in completing a Medicare application. She stated that the facility had not provided her with a copy of the resident's discharge notice and the Ombudsman's office had not received the notice either. She stated the facility was supposed to send an email to the main Ombudsman's email address and the Ombudsman's secretary was to forward the notice to her. She stated once an email was received from a facility, the notice was usually forwarded the same day, directly to her email. She stated she had never received a discharge notice from this facility for any of the residents. She stated had she received the resident's discharge notice, she would review the notice to ensure that it was properly initiated, check with the BOM, discharge manager, resident, and ADM to discuss the improper notice and discharge plans for resident. Email received from Resident #40's on 04/27/2026 at 11:06 a.m., Resident stated ESQ. obtained a court (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order to physically remove her on 04/28/2026 or 04/29/2026, even though the facility's 30-day notice of involuntary discharge was invalid. During an interview on 04/27/2026 at 11:41 a.m., the ESQ. stated she was the facility's outside legal counsel. She stated that she sent Resident #40 a new discharge notice and that the facility would hold off on the resident's eviction for at least 40-days. She stated even though the out of state address listed on the resident's discharge notice was assumed to be a safe discharge location, because the resident had not appealed, the ADM had made contact with a group home in the area to assure the resident had a safe discharge from the facility. She stated a new discharge notice was reinitiated and planned to be send out on this date to the resident. Record review of policy titled Transfer and Discharge (including AMA) dated 03/05/2025, reflected: Policy: It is the policy of this facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source. Policy Explanation and Compliance Guidelines:1. The facility will evaluate and determine the level of care needed for the resident prior to admission to ensure the facility's ability to meet the resident's need.2. Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions:a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the service provided by the facility.c. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.d. The health of individuals in the facility would otherwise be endangered.e. The resident has failed, after reasonable and appropriate notice, to pay or have paid under Medicare or Medicaid for his or her stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.3. The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided:a. The specific reason and basis for transfer or discharge.b. The effective date of transfer or discharge.c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged .d. An explanation of the right to appeal the transfer or discharge to the State.e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests.f. Information on how to obtain an appeal form.g Information on obtaining assistance in completing and submitting the appeal hearing request.h. The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman.4. Generally, the notice must be provided at least 30 days prior to a transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because:a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident;.

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transmit encoded, accurate, and complete MDS data to the Center for Medicaid/Medicare System (CMS) System for 1 of 6 closed records (CR #154) reviewed for Minimum Data Set (MDS) transmission. - The facility failed to complete and retransmit CR #154's MDS discharge assessment within 14-days of CR #154's discharge when the anticipated return had not resulted in a readmission. This failure could place residents at risk of not having assessments completed and submitted in a timely manner as required. The findings were: Record review of CR #154's face sheet dated 04/23/2026, reflected, CR admitted to the facility on [DATE] and discharged on 01/23/2026. CR's had diagnoses which included pain in right shoulder, unspecified fall, pain in unspecified joint, muscle wasting and atrophy, multiple sites, cognitive communication deficit, need: assistance with personal care, dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record Review of CR #154's Comprehensive MDS assessment dated [DATE] reflected, CR had a BIMS score of 08 which reflected CR had moderate impaired cognition. Record Review of CR #154's Discharge MDS assessment dated [DATE] reflected, CR had unplanned discharge with anticipated return due to a short-term hospital transfer. Record Review of CR #154's Change of Condition Communication Form dated 01/20/2026 at 02:13 p.m., reflected CR had s/sx of a reported cough that started on 01/20/2026. Since the start of the condition, the symptoms stayed the same with medication making the symptoms better. Vitals: pulse 83 (regular), respiration 18, most recent temperature 97.3, most recent weight 135 mm, and most recent O2 sats 97. Family D had a concern with CR coughing and wanted to talk to the doctor to send CR to the hospital. NP was notified and a new order was given for stat CXR Guaifenesin (an over-the-counter (expectorant used to thin and loosen mucus in the airways, making coughs more productive and clearing chest congestion)100ml q 4hr PRN and DuoNeb inhalation solution used to treat airway narrowing) q 4hrs PRN. Record Review of CR #154's progress notes created by LVN F and dated 01/23/2026 at 12:30 a.m., reflected Family C requested CR's hospital transfer r/t a cough. The DON informed. Record Review of CR #154's progress notes created by LVN F and dated 01/23/2026 at 01:12 p.m., reflected CR was transported by EMS to hospital. CR's face sheet and medication sheet were given to EMS. Record Review of CR #154's progress notes created by LVN G dated 01/23/2026 at 01:29 p.m., reflected that CR's NOMNC issued 01/09/2026 was received and sent to Family C. Per Family C, he continued to maintain that CR had covered Medicare benefits, the insurance made a mistake, and CR won her last appeal. LVN G reiterated that the NOMNC was issued and coverage ending notice stayed as is (01/09/2026) and CR had been private pay as of 01/10/2026. Family became upset and asked for more time to fix issues. Family was instructed to talk with BOM and SW to finalize financial obligation and discharge plan. Record Review of CR #154's progress notes created by CMA dated 01/24/2026 at 01:43 p.m., reflected, CR out on pass. Record Review of CR #154's progress notes created by CMA dated 01/25/2026 at 01:15 p.m., reflected CR was at the hospital. Record Review of the facility's admission, transfer, discharge log reflected CR #154 was admitted on [DATE] and discharging on 01/23/2026. Record Review on 04/23/2026 at 10:58 a.m., reflected CR #154's quarterly/annual MDS was 77-days overdue. During an interview on 04/25/2026 at 12:54 a.m., the MDS Nurse stated that she was responsible for transmitting the MDS discharges for the facility. She stated CR #154 discharged on 01/23/2026 with an anticipated return and she completed CR's discharge MDS assessment on 01/23/2026. She stated the care plan was to be closed out if CR had not returned with 30-days. She stated that the dashboard should have shown a notification at the end of that 30-days to close out CR's care plan. She stated because the care plan was not closed, the care plan remained open and the MDS quarterly/annual review showed 79-days overdue. She stated without the notification the only way anyone would have known the care plan (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was still opened would have been to simply go into CR's clinicals. She stated she ran a report to show any open care plans and MDS's but CR had not reflected on the report as open or incomplete. She stated she was not sure how the discharge was missed. She stated because CR was no longer an active resident, no adverse effects would transpire from the care plan remaining open. She stated with CR no longer in the facility, the system would not allow anyone to add or reduce information on the care plan. She stated she was not aware of a written policy on MDS and discharges. She stated she was trained by corporate over a year ago. During an interview on 04/28/2026 at 11:29 a.m., RRN A stated that when a resident discharges from the facility with an anticipated return that does not result in a readmission, the facility must manually complete a discharge deletion so that the care plan closes out and no further MDS tasks trigger for completion. He stated it was the facility's responsibility to track CR #154's progress after discharging to the hospital to determine where the resident when once released. He stated he could not see in the CR's progress notes where the resident was once discharged from the hospital. He stated since it appears that tracking had not occurred, it explained why CR's discharge was not manually changed from anticipated returned to returned not anticipated. He stated it was his understanding that the facility as well as RRN should have been triggered after CR had not readmitted within 30 days. He stated he was not aware why no triggers were initiated. He stated that there were no negative or financial effects from the lack of correcting the discharge assessment, only paper compliance with CMS. Record review of policy titled Policy Assessment Frequency/Timeliness Date Implemented: and dated 10/24/2022 reflected, Policy: The purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI Manual. 9. A significant correction assessment will be completed no later than the 14th calendar day after determination that a significant error in a prior OBRA assessment occurred. 11. Part A PPS discharge assessment must be completed within 14 days after the end date of the most recent Medicare stay (14 calendar days). If combined with an OBRA discharge assessment, it must be completed 14 days after the ARD of the OBRA discharge date .

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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. 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 2 of 10 residents (Resident #30, Resident #41) reviewed for medication storage and labeling.The facility failed to ensure nurses dated Residents #30 and 41's opened insulin glargine (a medication prescribed to help the body manage blood sugar levels) pens and discarded them within 28 days of opening, on 04/24/2026.This failure could place residents at risk of receiving medications that were less effective or expired and the risk of contamination or chemical degradation (change of a substance into something else, often making it weaker, useless, or harmful).Findings included: Record review of Resident #30's Provider Orders dated 04/09/2026, revealed an active order to receive insulin glargine 100 units/ml multiple-dose pen. Inject 20 units SQ (under the skin) one time a day for diabetes (a disease in which the body cannot make or properly use insulin).Record review of Resident #41's Provider Orders dated 03/11/2026, revealed an active order to receive insulin glargine 100 units/ml multiple-dose pen. Inject 30 units SQ one time a day for diabetes.During an observation of Hall 100's medication cart and interview on 04/24/2026 at 12:08 p.m., revealed, staff opened and dated 2 insulin glargine, 100 units/ml multiple-dose pens and kept them in the medication cart beyond 28 days of the opening date. The insulin pens belonged to Resident #30 and #41. Staff opened and dated both insulin pens on 03/23/2026.RN Q stated she should have checked the insulin pens opening dates before each administration and discarded them after 28 days of opening. RN Q added if nurses kept using the insulin pens after 28 days of opening, residents could receive insulin that was less effective in controlling their blood sugar levels, RN Q stated she was unaware the insulin pens were expired.During an interview on 04/24/2026 at 1:04 p.m., the DON stated she expected all nurses to check insulin pens for opening dates before each administration and discard them after 28 days of opening. The DON stated she spot checked insulin pens for expiration dates weekly. The DON stated she spot checked the facility's medication carts for expired medications last week. The DON added if nurses kept using the insulin pens after 28 days of opening, residents could receive insulin that did not work as prescribed.Record review of the facility's Insulin Pen Policy dated 07/03/2023, revealed .Policy: It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge.Policy Explanation and Compliance Guidelines:9. Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation.Procedure:e. Check the expiration date on the pen. Discard if expired.Record review of the most current manufacturer's guide for insulin glargine pens dated August 2022, revealed staff must throw away all opened pens after 28 days of first use, even if there is insulin left in the pen.