STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676263	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerbrook Skilled Nursing and Rehab Center	9250 Humble-Westfield Rd Humble, TX 77338

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure appropriate information was communicated to the receiving health care institution prior to discharge for 1 of 6 residents (Resident #1) reviewed for transfer or discharge. The facility failed to ensure that the discharge destination and continuing care provider could meet the resident's needs prior to the discharge.Resident #1 was discharged on 09/29/25 without ensuring the provider could meet the residents' needs. This failure placed residents at risk of not getting the necessary care and services to meet physical and psychological needs. A record review of Resident #1's admission record dated 11/20/2025 revealed an [AGE] year-old male admitted [DATE] with diagnoses which included muscle wasting and atrophy (the loss of muscle mass and strength), other abnormalities of gait and mobility (the specific way a person walks and moves), muscle weakness (the loss of strength in one or more muscles), and dementia (a decline in memory). A record review of Resident #1's quarterly Minimum Data Set assessment dated [DATE] reflected Resident #1 had a BIMS score of zero which could not be assessed which indicated a severe cognitive impairment. During an interview on 11/18/25 at 1:12pm, the Social Worker revealed Resident #1 was considered for transfer for an evaluation due to aggressive behaviors. The Social Worker stated it was her responsibility to submit clinicals for approval to the receiving provider. She stated on 9/29/25, a referral was sent to a behavioral hospital for review to admit Resident #1. She stated when she left for the day on 9/29/25, Resident #1 was not accepted yet. She stated she was informed in the morning meeting on 9/30/25, Resident #1 was transferred to a medical center instead. She stated the DON solely facilitated the transfer to the medical center for Resident #1. During an interview on 11/18/2025 at 12:37pm, the ADON stated the resident was transferred to a medical center 9/30/25 but was transferred back to the facility a few hours later. She stated the medical center was unaware why Resident #1 was transported there. She stated she informed the medical center Resident #1 was transported due to uncontrolled aggressive behaviors including kicking, biting, hitting, and threatening staff. During an interview on 11/20/2025 at 11:00am, the Clinical Services Director revealed a referral was sent on behalf of Resident #1 to the medical center, 09/30/25, but confirmation of acceptance was not received. He stated Resident #1 was transported anyway which was not according to policy. He stated once Resident #1 arrived, the staff at the receiving medical center was unaware why Resident #1 was there. He stated the ADON informed the medical center Resident #1 needed psychiatric services. He stated since the psychiatric team at the medical center was not aware prior to transfer, Resident #1 was transported back to the facility. He stated the DON should have waited for acceptance before transferring Resident #1. He stated the importance of acceptance before transfer was to avoid confusion and ensure residents received the help needed. An interview on 11/20/25 at 12:30pm with the Administrator revealed the DON no longer worked at the facility. The Administrator stated the DON informed her Resident #1 was kicking, biting, hitting, and threatening to kill them and needed to be sent out for his safety and the safety of others. She stated she was unaware Resident #1 was transferred without prior acceptance. She stated the expectation regarding transfer involved the acceptance of the receiving facility prior to transfer of the resident. The Administrator stated without prior acceptance, the receiving facility was unaware of the residents' needs, and residents could be traumatized due to the transfer back to the facility. The Administrator stated prior acceptance minimized the resident's anxiety. Record review of the facility's policy, Transfer or Discharge, Emergency revised date December 2016 read in part . Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: Notify the receiving facility that the transfer is being made.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 (Resident #2) of 7 residents reviewed for care plans. The facility failed to ensure Resident #2's care plan was updated to reflect the need for feeding assistance according to his primary care provider on 11/19/2025. This failure could place residents at risk for choking and unwanted weight loss. Findings included:Record review of Resident #2's quarterly MDS assessment, dated 09/01/25, revealed Resident #2 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. His diagnoses included hypertension (elevated blood pressure), type 2 diabetes (elevated blood sugar), Parkinson's Disease (a progressive brain disorder causing unintended or uncontrollable movements like shaking, stiffness, and balance problems), anxiety disorder (a mental health condition characterized by excessive and overwhelming fear and worry that interferes with daily life), muscle weakness, and lack of coordination. Resident #2 had a BIMS score of 8 out of 15 which indicated moderate cognitive impairment. Functional ability for eating was coded (5) Setup or clean-up assistance. Record review of Resident #2's care plan, dated 09/02/25, revealed, Problems: [Resident#2] has Parkinson's. Goal: Will remain free of further s/sx, discomfort or complications related to Parkinson's disease through review date. Intervention/Tasks: Diet as ordered. Record review of the primary care provider order summary dated 05/30/25 revealed Place head of the bed elevated not greater than 30 degrees when eating. Please make attempts to feed him when possible.In an observation on 11/19/25 at 09:50 AM Resident#2 was up in wheelchair in the dining area. Resident#2 was eating his breakfast that was served in a regular plate (scrambled eggs with pieces of bacon, and a piece of bread toast). Resident#2 was observed unable to get food onto the and lifting an empty spoon to his mouth. In an observation on 11/19/25 at 11:49 AM Resident#2 was in his bed, with the head of the bed elevated. Resident#2 was eating his lunch that was served on a regular plate (buttered rice, and a piece of toast). Resident#2 was observed unable to get food onto the spoon, and the food spilled on the bedside table. In an interview on 11/19/25 at 2:16 p.m. PPS MDS Coordinator stated there was a note under nutrition, that mentioned the risk of dysphasia and choking. The PPS MDS Coordinator stated she was not aware of the order dated 05/30/2025, indicating Resident #2's change in the ability to feed himself and it was the responsibility of the nurses to bring it to her attention. She stated when she reviewed the care plan in September 2025 and overlooked the order. She stated, they do dysphagia diet, and she would go and add that order now that it was brought to her attention. In an observation and interview on 11/20/25 at 09:29 a.m. Resident #2 was in his bed, with the head of the bed elevated. Resident#2 was eating chocolate cookies in a plastic container brought from home by his kids. Resident #2 stated he was able to get some good sleep last night, because he could control his bed movement. In an interview on 11/20/25 at 09:37 AM, LVN D stated Resident #2 needed assistance with meals. LVN D stated it was the responsibility of the nurses working with Resident #2 to report his inability to self-feed to the MD, and the IDT to revise the care plan. LVN D stated the risk to the resident was not having the nutrition he needed. In an interview on 11/20/25 at 12:24 PM the Administrator stated the nurses should assess the resident and give him the proper plate to help him feed himself. She stated if the resident refused assistance with eating, it should be care planned. She stated the PPS MDS Coordinator was responsible for updating the care plan. She stated the 05/30/25 MD order was overlooked by the nurse/unit manager, the ADON and DON. Record review of the facility's Policy titled Care Plans, Comprehensive-Person Centered dated December 2016 revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.14 The Interdisciplinary Team must review and update the care plan:a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly, in conjunction with the required quarterly MDS assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 1 of 7 residents (Resident#3) reviewed for ADLs. The facility failed to ensure Resident #3 was provided fingernail care. This failure could place residents at risk for infections and a decreased quality of life. Record review of Resident #3's quarterly MDS assessment, dated 10/10/25, revealed an [AGE] year-old male admitted on [DATE], and readmitted on [DATE]. His diagnoses included Non-Alzheimer's Dementia (Vascular Dementia, Lewy Body Dementia [including Parkinson's dementia], and Frontotemporal Dementia), Cerebrovascular Accident (a stroke that occurs when blood flow to the brain is interrupted, either by a blockage or a ruptured blood vessel, causing brain cells to die), hypertension (Elevated blood pressure), and muscle weakness. Resident#3 had a BIMS score of 03 out of 15 which indicated severe cognitive impairment. She required assistance from staff with ADL care.Record review of Resident #3's care plan, dated 10/14/25, revealed, Focus: [Resident#3] has an ADL self-care performance deficit r/t muscle weakness. Will be cleaned, well-groomed, appropriately dressed.through next review date. Intervention/Tasks: [Resident#3] requires setup or clean-up assistance with oral hygiene and partial/moderate assistance with personal hygiene.Observation on 11/19/25 at 07:53 a.m. Resident #3 was lying in bed. His fingernails on both hands were about 0.3 cm long and appeared dirty with a brown substance underneath the nails. He stated he liked long nails but he would like his nails cleaned.Interview on 11/19/25 at 07:58 a.m. CSD looked at Resident #3's fingernails and said they were not clean and needed care. She stated it was the responsibility of all residents' care staff to make sure residents' fingernails were cleaned and trimmed to residents' liking. She stated the risk to residents was development of infection. In an interview on 11/20/25 at 10:59 a.m. the CSD said the CNAs were responsible for monitoring and cleaning nails during showers. He said the nurses should cut the nails if the resident was diabetic. He said if nails were not clipped and cleaned it could cause injury and have an effect on infection control and hygiene. He said residents could get sick or injure themselves. In an interview on 11/20/25 at 12:24 p.m. the Administrator stated nail care should be completed as needed and every time CNAs washed the residents' hands. The Administrator stated nails should be observed daily. The Administrator stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The Administrator stated she expected CNAs to offer to cut and clean nails if they were long and dirty. The Administrator stated residents having long and dirty nails could be an infection control issue. Record review of the facility's Care of Fingernails/Toenails policy revised April 2007 revealed in part, .the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections . 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide special eating equipment and utensils for residents who needed them and appropriate assistance to ensure that the resident could use the assistive devices when consuming meals for 1 resident (Resident #2) of 6 residents reviewed for food and nutrition services.The facility failed to assess and provide Resident #2 with an assistive device to help prevent food from accidentally being pushed off the plate while eating during meal service to minimize food spillage. This failure could place residents at risk for harm by weight loss, diminished independence, and self-esteem. Record review of Resident #2's quarterly MDS assessment, dated 09/01/25, revealed Resident#2 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. His diagnoses included hypertension (elevated blood pressure), type 2 diabetes (elevated blood sugar), Parkinson's Disease (a progressive brain disorder causing unintended or uncontrollable movements like shaking, stiffness, and balance problems), anxiety disorder (a mental health condition characterized by excessive and overwhelming fear and worry that interferes with daily life), muscle weakness, and lack of coordination. Resident#2 had a BIMS score of 8 out of 15 which indicated moderate cognitive impairment. Functional ability for eating was coded (5) Setup or clean-up assistance.Record review of Resident #2's care plan, dated 09/02/25, revealed, Problems: [Resident#2] has Parkinson's. Goal: Will remain free of further s/sx, discomfort or complications related to Parkinson's disease through review date. Intervention/Tasks: Diet as ordered. Record review of the primary care provider order summary, dated 05/30/25, revealed, Place head of the bed elevated not greater than 30 degrees when eating. Please make attempts to feed him when possible. Record review on 11/19/25 of Resident#2's weight log for the last six months (May 2025-November 2025) revealed his weight stable at 141 lbs . In an observation and interview on 11/19/25 at 09:50 AM Resident#2 was up in wheelchair in the dining area. Resident#2 was eating his breakfast that was served in a regular plate (scrambled eggs with pieces of bacon, and a piece of bread toast). Resident#2 was observed unable to get food onto the spoon, and lifting an empty spoon to his mouth. In an observation on 11/19/25 at 11:49 AM Resident#2 was in his bed, with the head of the bed elevated. Resident#2 was eating his lunch that was served on a regular plate (buttered rice, and a piece of toast). Resident#2 was observed unable to get food onto the spoon, and the food spilled on the bedside table. In an observation on 11/20/25 at 09:29 a.m., Resident#2 was in his bed, with the head of the bed elevated. Resident#2 was eating chocolate cookies in a plastic container brought from home. In an interview on 11/20/25 at 09:37 a.m., LVN D stated Resident#2 needed assist with meals. LVN D stated sometimes he did not like to eat his meal, because the family would bring him pizza and he could handle it with his hands. She stated Resident #2 was not referred to OT/ST for assistive devices. She stated a divider play would be good for him. LVN D stated the risk to no resident help was not having the nutrition he needed. In an interview on 11/20/25 at 12:24 PM the Administrator stated her expectation was that if the resident needed assistance with eating the staff should assist him. She stated the nurses should assess the resident and give him the proper plate to help him feed himself. She stated the risk to the resident he could experience weight loss and malnutrition because he was not eating proper nutrition. Record review of a facility's Assistance with Meals policy, dated 07/2017 indicated Residents shall receive assistance with meal in a manner that meets the individual needs of each resident . 3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity. Residents Who May Benefit from Assistive Devices: 1- Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. They may include devices such as silverware with enlarged/padded handles, plate guards, and or special cups.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain 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 for 1 of 7 residents (Resident #6) reviewed for infection control. CNA B failed to wear a gown when she performed incontinent care for Resident#6 who was on EBP on 11/18/25.CNA B failed to change gloves and perform hand hygiene when going from dirty to clean during Resident #6's incontinent care on 11/18/25.This failure could place residents at risk of cross-contamination and infections.Record review of Resident #6's quarterly MDS assessment, dated 11/07/25, reflected Resident #6 was an [AGE] year-old male admitted [DATE]. Resident #6 had a BIMS score of 10, meaning his cognition was moderately impaired. He was completely dependent on staff for incontinent care. Resident #6's active diagnoses included heart failure (a condition where the heart cannot pump blood effectively enough to meet the body's needs), hypertension (elevated blood pressure), diabetes mellitus and CVA (occurs when blood flow to a part of the brain is interrupted by a blockage or a burst blood vessel, causing brain cells to die).Record review of Resident #6's care plan, dated 11/10/25, revealed he was on Enhanced Barrier Precautions - At risk for infection r/t indwelling medical device, wounds. Goal: Will reduce risk of infection through next review. Interventions: wearing gloves and gown during high-contact care activities for a resident with indwelling medical devices, wounds and colonized (a germ is present and multiplying on or in the body without causing symptoms) or infection with a CDC targeted MDRO. Sanitize hands before entering and leaving the resident's room.During an observation on 11/18/25 at 09:28 a.m. , CNA B entered Resident #6 's room to do his incontinent care. There was EBP signage on the door, and PPE supplies (gown, gloves.) stored on a cart inside the room to the right side of the entrance. CNA B washed hands, wore gloves but did not wear a gown. CNA B opened Resident #6's brief, cleaned Resident #6's front area using disposable wipes. CNA B helped Resident #6 turn to his right side. CNA B cleaned Resident #6's buttocks area, removed the dirty brief, and put it in the trash can. CNA B got the clean brief and put it under Resident#6 without changing her gloves or performing any kind of hands hygiene. CNA B put the clean brief on Resident #6. CNA B removed gloves, washed hands, and exited the room.In an interview on 11/18/25 at 09:41 a.m. CNA B demonstrated an understanding of EBP signage, explaining that PPE was required for any resident with wounds, catheters, or external devices. She stated she forgot to wear a gown. She stated she was supposed to change gloves and sanitize her hands going from dirty to clean task, but she was nervous and forgot. She stated the risk of not wearing appropriate PPE, and not following proper use of gloves was increased risk of infection and possible cross contamination to the residents.In an interview on 11/20/25 at 10:59 AM with the CSD, he said he expected staff to follow the policies for EBP and proper use of PPE. He said they were supposed to wear a gown and gloves when performing high contact care for the residents (transfer, incontinent care.). He said the purpose was to protect the residents from being exposed to an infection and from staff getting an infection.In an interview on 11/20/25 at 12:24 PM with the Administrator, she said she expected staff to wear a gown and gloves when doing resident care and follow proper use of gloves. She said staff were supposed to wear a gown, gloves, and change gloves with hand hygiene going from dirty to clean when performing incontinent care, because it prevented the spread of MDROs.Record review of the facility's policy and procedure on Enhanced Barrier Precautions, dated 04/01/24, revealed in part: This policy outlines the guidelines and procedures to implement enhanced barrier precautions to prevent the spread of infectious diseases among residents and staff. Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities . EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. EBP are indicated for residents with any of the following: . Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: .incontinent care .Record review of the facility's policy Infection Control Guidelines for All Nursing Procedures (revised 2012) revealed in part: .3. Employees must wash their hands. under the following conditions. f. Before moving from a contaminated body site to a clean body site during

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure all patient care equipment was in safe operating condition for 1 resident (Resident#2) of 7 residents reviewed for safe operating patient care equipment. The facility failed to ensure Resident #2's bed had a working remote control.This failure could place residents at risk of living in an unsafe and un-homelike environment. Record review of Resident #2's quarterly MDS assessment, dated 09/01/25, revealed Resident#2 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. His diagnoses included hypertension (elevated blood pressure), type 2 diabetes (elevated blood sugar), Parkinson's Disease (a progressive brain disorder causing unintended or uncontrollable movements like shaking, stiffness, and balance problems), anxiety disorder (a mental health condition characterized by excessive and overwhelming fear and worry that interferes with daily life), muscle weakness, and lack of coordination. Resident #2 had a BIMS score of 8 out of 15 which indicated moderate cognitive impairment. Record review of Resident #2's care plan, dated 09/02/25, revealed, Problems: [Resident#2] has Parkinson's. Goal: Will remain free of further s/sx, discomfort or complicationsrelated to Parkinson's disease through review date. Intervention/Tasks: Observe for risk of falls. Record review of Resident#2 primary care provider order summary , dated 05/30/25, revealed Place head of the bed elevated not greater than 30 degrees when eating. Please make attempts to feed him when possible.Record review of Resident#2 LVN E progress note , dated 11/19/25 at 4:21 a.m. , revealed, Res ident refused to be changed because bed is broken. In an observation and interview on 11/19/25 at 08:03 a.m. of Resident #2 revealed he was lying flat in bed and holding the bed remote in his hands attempting to elevate the head of the bed to a sitting position. Observed Resident #2 pressed buttons on the bed remote, and the bed did not move. Resident #2 stated staff were aware his bed did not work but was unsure who the staff were. Resident#2 stated he could not eat or sleep since 7:00 p.m. the night before (11/18/25), because the bed remote was not functioning. The bed was in the highest position. The ADON walked into Resident #2's room and tried to reset the bed remote control without success. In interview on 11/19/25 at 08:06 a.m., the ADON stated she was not aware Resident #2's bed remote control was not working. The ADON stated it was everyone's responsibility to ensure call lights were with in reach. She stated the midnight nurse reported the bed remote was not working. She stated the morning nurse logged it in the electronic system for documenting requests for maintenance repairs. The ADON stated the night shift staff should swap Resident #2's bed with one with working conditions. She stated the risk to the resident was shock, being uncomfortable, unable to sleep and the resident's rights to be able to control the function of the bed.Observation on 11/19/25 at 08:50 a.m. revealed Resident #2 did not eat his breakfast yet because of the bed remote control issue. Observation on 11/19/25 at 09:25 a.m. revealed Resident #2 was up in wheelchair in the dining area eating his breakfast, and in his room was the Maintenance Director fixing Resident #2's bed. Record review of the facility meal schedule revealed the schedule for breakfast was 07:30 a.m.-08:30 a.m.In an interview and observation on 11/19/25 at 10:30 a.m., the Maintenance Director stated he was not aware of any issues with Resident #2's bed remote control, and it was reported to him this morning. The Maintenance Director stated he fixed Resident #2's bed remote control. The Maintenance Director stated he was responsible for monitoring the residents' bed and ensuring they worked properly. The Maintenance Director stated if the bed was not working the staff should put the resident in a working bed, the facility had plenty of them and report the issue to him or log it in electronic computer system for maintenance repairs . The Maintenance Director stated the risk to the residents was not able to control their bed and their needs not met. The Maintenance Director stated it was the responsibility of every staff that worked or entered the resident's room to report when there were problems with equipment so he could fix them.In an interview and observation on 11/20/25 at 10:59 a. m., the CSD stated it was the responsibility of the CNAs and nurses working with the resident to report the problem of the bed remote not functioning to the Maintenance Director. He stated the night shift staff should move the resident with his permission to another room with a functioning bed until his bed was fixed. He stated the risk to the resident was infringing on the Resident rights, because he did not have the control over his bed functioning and being able to be in the position he liked to sleep on.In an interview and observation on 11/20/25 at 12:24 p.m., the Administrator stated, she expected the nurse to call for the bed to be fixed, or get the resident out of that bed, and put the Resident in bed that work, they should not leave the resident in a flat bed. She stated the risk the Resident was lying flat he could be unable to breathe, safety issue serious

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676263	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerbrook Skilled Nursing and Rehab Center	9250 Humble-Westfield Rd Humble, TX 77338

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident's bedside and toilet and bathing facilities were adequately equipped to allow all residents to call for staff assistance through a communication system which relayed the call directly to a staff member or a centralized staff work area for 2 of 7 residents (Resident#4, and Resident#5) reviewed for residents' call system.The facility failed to provide a working communication system, that was easily at reach, that would allow Resident #4 and Resident#5 the ability to safely call for staff for assistance.This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for daily living.Findings included:1. Record review of Resident #5's quarterly MDS assessment, dated 09/19/25, reflected Resident #5 was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypertension(elevated blood pressure), cerebrovascular Accident(a stroke that occurs when blood flow to the brain is interrupted, either by a blockage or a ruptured blood vessel, causing brain cells to die), Bipolar Disorder (a chronic mental health condition characterized by extreme mood swings, energy level shifts, and difficulty with activity levels, ranging from manic episodes to depressive episodes), and Schizophrenia (a chronic brain disorder that causes a person to lose touch with reality, leading to symptoms like hallucinations, delusions, and disorganized thinking and behavior), muscle weakness, and difficulty walking. Resident #5 had a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Under section GG, functional ability, reflected Resident #5 was coded as dependent for lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer.Review of Resident #5's Comprehensive Care Plan, dated 09/22/25, reflected the following: Focus: [Resident #5] has had an actual fall r/t cognitive impairment. Poor balance. Unsteady gait. Goal: Will resume usual activities without further incident through the review date. Intervention/Tasks: Call light in reach while in bed.During an observation and interview on 11/19/25 at 07:22 a.m. Resident #5 was lying in bed, and the call light button was on the floor under the head of the bed. Resident #5 stated he liked to call for help to get some coffee, but he did not know where his call light button was. During an observation and interview on 11/19/25 at 07:23 a.m., UM A entered Resident #5 located the call light cord and button on the floor. UM A picked up the call light button and put it within Resident #5's reach. She stated the call light was on the floor, and not next to Resident #5. She stated the problem was he would not be able to call for help and anything could happen to him. UM A stated if Resident #5 was incontinent or had an emergency, he could not call for help.2.-Record review of Resident #4's quarterly MDS assessment, dated 09/17/25, reflected Resident #4 was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Her diagnoses included Psychotic Disorder (a serious mental illness characterized by a loss of contact with reality, known as psychosis), Schizophrenia (a chronic brain disorder that causes a person to lose touch with reality, leading to symptoms like hallucinations, delusions, and disorganized thinking and behavior), muscle weakness, and unsteadiness on feet. Resident #4 had a BIMS score of 03/15, indicating severe cognitive impairment. Section J1800 reflected: Any Falls Since Admission/Entry or Reentry the answer was coded (1) yes.Review of Resident #4's Comprehensive Care Plan, dated 09/11/25, reflected the following: Focus: [Resident #4] is at risk for falls r/t dementia, gait/balance problems, incontinence, psychoactive drug use. Goal: Resident will be free of injury from falls through the review date. Intervention/Tasks: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests forassistance.During an observation on 11/19/25 at 07:50 a.m., Resident #4 was sleeping in bed, and the call light button was on the floor under the head of the bed. During an observation and interview on 11/19/25 at 07:53 a.m., revealed CNA C entered Resident #4's room and located the call light cord and button on the floor. CNA C picked up the call light button and put it within Resident #4's reach. She stated the call light was on the floor, and not next to Resident #4. She stated the problem was Resident #4 was not be able to call for help and anything could happen to her. CNA C stated if she was incontinent, she could not call for assistance and if there was an emergency she could not call for help.Interview with the CSD on 11/20/25 at 10:59 AM revealed the expectation for call light placement was residents should always have the call light within reach, and the call light should be placed on the resident's dominant side. He stated the risk to residents of not having had their call lights within reach was delayed care, and possible fall and injury. Interview on 11/20/25 at 12:24 PM the Administrator stated her expectation was the call light button should always be within residents' reach