STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676264	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lev at Winchester	1112 Smith Dr Alvin, TX 77511

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (continued on next page)

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

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the residents were given the right to participate in the development and implementation of their plans of care for 1 of 9 residents (Resident #1) reviewed for participating in care planning. The facility did not conduct a meeting nor invite Resident #1 to participate in resident care planning meetings after his quarterly review assessments on 5/23/25, 8/22/25 and 10/29/25. This failure could place residents at risk for a loss of independence, psychosocial well-being and the opportunity for them to participate in the planning of their care. Findings Included: Record review of Resident #1's admission record generated on 12/5/25 revealed she was admitted to the facility on [DATE] and had diagnoses of mental disorder (characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior), vascular dementia (a decline in thinking skills due to reduced blood flow to the brain, often from strokes or damaged blood vessels, affecting memory, planning, judgment, and attention), multiple sclerosis (a chronic autoimmune disease of the central nervous system (brain, spinal cord, optic nerves) where the immune system mistakenly attacks myelin, the protective sheath around nerve fibers, disrupting nerve signals), and major depressive disorder (a serious mood disorder causing persistent sadness, loss of interest, and impacts daily life). She was [AGE] years old. Record review of Resident #1's MDS assessments revealed the facility staff completed quarterly assessments on 5/23/25, 8/22/25 and 10/29/25. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 14, indicating no cognitive impairment. Record review of Resident #1's care plan report (undated) included the following focus' and revision dates:- The focus of oral/dental health problems related to missing crowns (a tooth-shaped cap that covers and restores a damaged, decayed, weak, or misshapen tooth) was initiated on 8/3/25 and revised on 10/29/25. - The focus of psychotropic medication use (a medication that affects a person's mental state) was revised on 9/9/25.- The focus of antidepressant medication use was initiated on 6/23/25 and revised on 9/9/25. Record review of Resident #1's Assessments dated between 2/28/25 to 12/3/25 in her electronic medical record revealed only one Care Plan Conference was listed. The Care Plan Conference was dated 3/3/25. Record review of Resident #1's nursing progress notes revealed there was no mention of a care plan meeting after 3/3/25 and before 12/3/25. In an interview on 12/4/25 at 11:00am, Resident #1 said she had never attended a care plan meeting to discuss her care. She said she was not sure what type of assistance they were providing, and she was not sure why she was still living there. She said she wanted help so she could be discharged . Further, she stated a dentist messed up her teeth and she was very upset with how they look. She was unsure what the facility was doing to help her fix her teeth. In an interview on 12/5/25 at 1:10pm, Unit Manager said, with the assistance of the DON, she set up the care plan meetings for new admissions. She said the MDS Nurse tracked the quarterly care plan meetings. She said she could not remember if they had a quarterly care plan meeting with Resident #1. She said when she first admitted , they had a meeting with her family members. In an interview on 12/5/25 at 1:55pm, the MDS Nurse said she completed the resident's care reviews every 3 months. She said they had a care plan meeting if a family member requested one. She said they would call the family member to complete the meeting. She said she was unsure of the facility's policy regarding care plan meetings. She said she could remember one meeting for Resident #1 when her family members attended. She said they speak to Resident #1 frequently. She said she was not sure which conversations were part of a care plan meeting or whether they were just talking. In an interview on 12/5/25 at 2:15pm, the DON said the MDS Nurse would let her know when a resident required a quarterly care plan meeting. She said if a resident's family member requested a care plan meeting, they would schedule one. She said they try to stay on top of it. She said they had not had a full-time social worker in a while. She said she was unsure of the requirements for care plan meetings. In an interview on 12/5/25 at 3:40pm, the Administrator stated they try to have care plan meetings, but it was a little harder to get them planned and completed. She said they were focused on baseline care plans for residents who were newly admitted . She said they had impromptu meetings when families request them and as often as they can. Record review of the facility's policy for Care Planning-Resident Participation (undated) read in part, This facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment.the facility will inform the resident, in a language he or she can understand, of his or her rights regarding planning and implementing care, including the right to be informed of his or her total health status, the facility will encourage and assist the resident