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	08/08/2025

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 0621 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treat residents equally regarding transfer, discharge, and provision of services for all residents, regardless of payment source (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 0621 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 interview and record review, the facility failed to establish, maintain and implement identical policies and practices regarding transfer and discharge and the provision of services for all individuals regardless of source of payment for 1 (Resident #5) of 4 residents reviewed for equal access to quality care. The facility failed to ensure Resident #5's right to stay in the facility and he was transferred to the hospital because his payor source ended. The failure could place residents at risk of a loss of self-determination and dignity. Findings included: Record review of Resident #5's face sheet dated 8/6/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included synovitis and tenosynovitis (painful inflammatory conditions affecting the joints and tendons) of the left ankle and foot, idiopathic aseptic necrosis (the death of bone tissue due to a lack of blood supply) of left ankle, acute kidney failure, morbid obesity, Type 2 Diabetes Mellitus (glucose levels in the blood are higher than normal because the body does not make enough insulin or use it the way it should), long term (current) use of antibiotics, and essential hypertension. Record review of Resident #5's comprehensive MDS assessment dated [DATE] indicated his BIMS score was 15 out of 15 indicating cognition was intact. Further review of the MDS assessment indicated Resident #5 had a recent surgery requiring active SNF care, surgical wounds requiring surgical wound care, he was taking an antibiotic and IV medications. Record review of Resident #5's care plan dated 7/9/25 indicated he was on antibiotic therapy r/t surgical wound infection. Interventions included: administer antibiotic medications as ordered by physician, monitor/document/report PRN adverse reactions to antibiotic therapy, monitor/document/report PRN s/sx of secondary infection r/t antibiotic therapy, report pertinent lab results to MD. Further review of the care plan indicated Resident #5 was on IV ABT r/t surgical infection. Interventions included: if IV is infiltrated- antidote for vesicant/irritant med may be infused into IV catheter prior to removal, stop infusion and thoroughly examine the site. Monitor/document/PRN s/sx of infection at the site and s/sx of leaking at the IV site. Record review of Resident #5's orders indicated the following:-ceFazolin Sodium intravenous solution reconstituted 1 GM, use 1 gram intravenously every 8 hours for MSSA for 54 days. Start date 6/25/25, End date 8/18/25.-Flush IV site with 10 ml normal saline after IV medication administration. Start date 6/25/25, End date 8/18/25.-Change PICC dressing every 7 days. Start date 7/5/25, End date 8/18/25.-Pin site, cleanse each site one by one with wound Dakins solution (cotton tip applicator), pat dry with (cotton tip applicator), wrap with kerlix roll and ace wrap. Daily. Start date 7/8/25, no end date. Record review of Resident #5's progress note dated 8/1/25 at 9:11 AM, read in part . resident discharging to hospital ER to complete IV ABT therapy. VS 159/99, 98, 19, temp 97.9, SatO2 96% on RA. Some discomfort reported to the left foot fixator, scheduled pain medication administered. Medication list reviewed and sent with resident. All personal belongings sent with resident . Record review of Resident #5's progress note dated 8/1/25 at 7:30 PM, read in part . received resident via wheelchair, EMS accompanied. VS obtained, notified DON, on call paged to verify med for re-admit. Resident stable with left foot external fixator in place . In an interview with Resident #5 on 8/6/25 at 10:55 am, he said he was getting discharged this Friday (8/8/25) to a homeless shelter because his work insurance ran out. Resident #5 said he was worried about getting to his doctor's appointment because he did not have any transportation, and he was supposed to receive his antibiotics until 8/18/25. Resident #5 said he did not want to go to a homeless shelter because he did not think it would be sanitary for him. Resident #5 said he was not offered to apply for Medicaid when he first entered the facility, and he was not given a discharge letter for the 8/1/25 discharge. In an interview with Resident #5 on 8/7/25 at 11:13 AM he said he was transferred to the hospital last week (8/1/25) because the Administrator told him the hospital had a program that assisted indigent people. Resident #5 said when he arrived at the hospital, the staff told him there was no program like that offered at the hospital. Resident #5 said he was given a dose of his antibiotic and was brought back to the facility the same day. In an interview with the Social Worker on 8/6/25 at 4:32 PM, she said Resident #5's insurance had cut him off and he was staying at the facility with no payor source. She said his last covered day was 8/1/25. The SW said Resident #5 had no family and he was homeless. She said the only thing she could do was to plead to take Resident #5 in as a charity case. She said Resident #5 had told her he applied for Medicaid, and he got denied. The SW said she did not follow-up with Medicaid. The SW said the MDS coordinator was responsible for issuing discharge letters to the resident. The SW said Resident #5 would stay at the facility until his IV medications were completed per the Administrator. In an interview with the Business Office Manager on 8/7/25 at 9:03

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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 0641 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 the assessment accurately reflected the resident's status for 2 (Resident#27 and Resident #31) of 14 residents reviewed for accuracy of assessments. The facility failed to ensure Resident#27's significant change MDS assessment dated [DATE] accurately reflected her lack of natural teeth in her oral cavity. The facility failed to ensure Resident #31's comprehensive MDS assessment dated [DATE] accurately reflected her decaying and lack of natural teeth in her oral cavity. This failure could place residents at risk for receiving inadequate care and services due to inaccurate assessments. The findings included: Record review of Resident #27's face sheet dated 08/06/25 revealed an [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE]. Her diagnoses included Dementia, history of falling, major depressive disorders, lack of coordination, generalized anxiety, psychotic disturbance, and mood disturbance. Review of Resident #27's Significant change MDS assessment dated [DATE], revealed her BIMS score was 7 out of 15 reflective of severe cognitive impairment. Review of the section on oral dentures indicated she had all her natural teeth without problem. Observation on 08/06/2025 at 9:37 AM revealed Resident # 27 was sitting outside her door clean and dry. She was alert and oriented. Observation indicated she had no teeth in her oral cavity. She did not speak much. She said she was doing well and started looking at what she was holding. Observation and interview on 08/06/2025 at 12:20 PM, revealed Resident #27 was in her room, alert and oriented. Diet observation indicated she had a mechanical chopped diet. She said she did not want the food because she could not eat what was served. She said someone stole her dentures at the facility. She said she was hungry but was unable to chew the meat. She said she wanted something soft. She requested a peanut butter and jelly sandwich which was provided. Record review of Resident # 27's care plan dated 01/31/22 with a revision date of 04/01/25 indicated she was care planned for dental problem related to missing dentures resident stated the hospital lost dentures on admission.Goal Resident will be free of infection, pain or bleeding in the oral cavity by revision date 04/01/25.Intervention: Coordinate arrangements for dental care, transportation as needed/as ordered.Date Initiated: 01/31/2022-revision 04/15/24.Record review of Resident #31's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: mental disorder, history of falling, vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain), multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), major depressive disorder (a serious mental illness characterized by persistent sadness, loss of interest in activities, and other symptoms that interfere with daily life), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), and hypertension. Record review of Resident #31's comprehensive MDS assessment dated [DATE] indicated her BIMS score was 6 out of 15 reflective of severe cognitive impairment. Further review of the comprehensive MDS assessment under Section L- oral/dental status indicated no issues with her natural teeth. Record review of Summary Report by Dental Hygienist dated 7/25/25 indicated Resident #31 had a missing crown-upper anterior and several decayed teeth. During an interview on 8/5/25 at 1:54 PM, Resident #31 said she had lived at the facility since February. Resident #31 said she wanted to see a dentist because her teeth caused her pain but was told by the facility that her insurance did not cover dental. Resident #31 covered her mouth as she was speaking because she said her front tooth was missing. During an interview on 08/06/25 at 2:20PM, the MDS coordinator said she was not responsible for Resident #27's and Resident #31's MDS assessments because they were long term residents. She acknowledged that both MDS assessments were coded wrong. During an interview with the Corporate MDS nurse on 08/07/25 at 5:30pm, she said the MDS was coded wrong, and she would complete an amendment to correct the MDS. She said inaccurate assessment may delay or prevent residents from getting needed services. Record review of the facility's policy on accuracy of MDS undated dated titled Accuracy of MDS Assessments revealed: Purpose: To ensure that all Minimum Data Set (MDS) assessments are completed accurately, timely, and in accordance with state and federal regulations. Accurate MDS data is essential for care planning, quality measures, and reimbursement. Policy: All MDS assessments completed at this facility shall reflect an accurate and comprehensive assessment of each resident's physical, mental, and psychosocial status. MDS data must be supported by documentation in the medical record and completed in accordance with CMS RAI User's Manual and Texas Health and Human Services (HHSC) requirements.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 (Resident #58) of 7 residents reviewed for quality of care. -Resident #58 developed a sacral (bone at the base of the spine and the surrounding area) wound on 08/01/25 and the facility did not get physician orders to treat the sacral wound until 08/05/25. This failure placed resident at risk for further skin breakdown to the sacral wound, infections, and pain.Findings: Record review of Resident #58's face sheet dated 08/05/26 revealed an [AGE] year-old female admitted to the facility on [DATE]. Resident diagnoses included right fracture femur (thigh bone), dementia (brain disorder that causes problems with thinking, memory, and behavior), depression, and fibromyalgia (pain, fatigue, sleep problems, mood issues, and difficulty concentrating). Record review of Resident #58's quarterly MDS dated [DATE] revealed a BIMS score of 12 indicating the resident's cognition was moderately impaired. Further review of section GG-Function Abilities-Mobility revealed that the resident required substantial/maximal assistance. Section H (Bladder Bowel) revealed that the resident was always incontinent. Section M-Skin Condition reflected that the resident was at risk of developing pressure ulcers, with no pressure wounds.Record review of Resident #58's Comprehensive Care Plan dated 02/26/25 reflected the resident was care planned for potential for skin impairment integrity and risk for pressure injury r/t dementia and incontinence. The intervention included follow facility protocols for treatment of injury. Record review of Resident #58's Physician Order Summary Report for the month of August 2025 reflected the following orders: -Dated 08/05/25 Cleanse ulcer to sacrum stage 2 (a break in the skin that involves the top and second layer of the skin) with wound cleanser, apply calcium alginate (a type of wound dressing made from seaweed fibers to promote healing) and Bactroban (topical antibiotic ointment or cream applied to the skin) to wound bed, cover with dry dressing daily until healed. -Dated 08/06/25 May have low air mattress to aid in the prevention actual/potential skin breakdown. Record review of Resident #58's TAR revealed that the facility was following Physician orders. Record review of Resident #58's Nursing Progress Notes: -Dated 07/30/25 CNA rounded on resident and reported sacral redness at this time. Applied moisture barrier and pillows for comfort .notified ADON . -Dated 08/01/25 Skin issue: Sacrum wound acquired in-house, wound is new.pending wound consult.-Dated 08/05/25 Wound Care Doctor gave new order for sacrum: cleanse wound with wound cleanser, apt dry, apply alginate and Bactroban and cover with dry dressing. Record review of Wound Care Doctor Progress Notes dated 08/07/25 regarding stage 2 sacral wound reflected the following: -1cm (unit of measurement used for measuring the length of an object) in length, 0.4cm in width, 0. 1cm depth, with moderate exudate (healthy stage in healing process), color clear and serous (clear watery fluid that is a normal part of the wound healing process). Observation on 08/06/25 at 11:17AM revealed wound care was provided for Resident #58's sacral wound by the Wound Care Nurse/ADON. The date on the resident's sacral wound dressing was 08/05/25. Observation of the resident's sacral wound revealed redness to the surrounding area. There was a small opening to the sacral region. The Wound care Nurse/ADON cleansed the resident's wound bed with wound cleanser, patted the wound bed dry, and applied Bactroban ointment followed with calcium alginate, and covered the wound with a 4x4 dressing securing with a border dressing. In an interview on 08/06/25 at 2:42PM with the DON regarding Resident #58's sacral wound she said she discovered on 08/05/25 after reviewing resident records that the resident's sacral region was documented as a reddened area. The DON said on 08/01/25 LPN D documented on the morning shift that the resident's skin to the sacral region had opened but did not inform the wound care nurse or the physician for treatment orders, and instead kept placing barrier cream on the wound. The DON said the facility protocol was if a resident had a break in skin, the following people needed to be notified: physician, wound care nurse, and the family. The DON said it was not until 08/05/25 that the facility realized that the physician had not been called for a treatment plan regarding the resident's sacral wound. The DON said this placed the resident at risk for the wound getting worse and becoming infected. The DON said she had done a one-on-one in-service with LPN D and had initiated in-services with the Nursing Department regarding wounds. In an interview on 08/07/25 at 11:45AM LPN D said she worked at the facility full time on the morning shift. LPN D said she documented in Resident #58's Nursing Progress Notes that the resident had skin breakdown to the sacrum. LPN D said she did not report this to the physician or wound care nurse

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to use the services of a registered nurse for at least eight consecutive hours a day, 7 days a week for 4 of 5 months (January, February, April, and May of 2025) reviewed for nursing services. The facility failed to ensure a registered nurse worked on 1 day out of 31 days in January of 2025.The facility failed to ensure a registered nurse worked on 3 days out of 28 days in February of 2025 The facility failed to ensure a registered nurse worked on 1 day out of 30 days in April 2025. The facility failed to ensure that a registered nurse worked 2 days out of 31 days in May of 2025 These failures could place residents at risk by leaving staff without supervisory coverage for RN specific nursing activities and for coordination of events such as emergency care and disasters.Findings included: Record review of the CMS PBJ Staffing Data Report for FY Quarter 2 2025 (January 1- March 31) with run date 07/28/2025 revealed, the facility was triggered for four or more days within the quarter for no RN hours on the following days in 2025: 01/25/2025 (SA); 02/15/2025 (SA), 02/22/25 (SA) and on 02/23/25 (SU) Record review of the facility provided payroll records for quarter 2, dated 01/01/25 -03/31/25 and Quarter 3 dated 04/01/25 -06/30/25 revealed no RN worked on the following Saturdays & Sundays: January 01/25/25-Saturday. February 15th 2025 Saturday February 22nd 2025 Saturday.February 23th 2025 Sunday. April 26/2025 Saturday May 10, 2025 Saturday and May 18 2025-Sunday.In an interview on 08/06/25 at 3:50 PM, the Administrator and the Corporate nurse said corporation was aware of the RN coverage problem. The Administrator said the problem was due to staff called in and no showed. She said the facility had hired two permanent RNs for weekend coverage. The Administrator said the facility was expected to maintain 8 hours of continuous RN coverage to ensure that there was staff present with the skills necessary to provide patient care. She said failure to have an RN on duty could place residents at risk of not being able to receive needed care and services in an emergency. Record review of facility's policy dated October 2022 Revision-revealed Nursing Services-Registered Nurse (RN) Policy: It is the intent of the facility to comply with Registered Nurse staffing requirements. Definitions: Full-time is defined as working 40 or more hours a week. Charge Nurse is a licensed nurse with specific responsibilities designated by the facility that may include staff supervision, emergency coordinator, physician liaison, as well as direct resident care. Policy Explanation and Compliance Guidelines:1. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week. 2. The facility will designate a Registered Nurse to serve as the Director of Nursing on a full-time basis.3. The Director of Nursing may serve as a charge nurse only when the facility has average daily occupancy of 60 or fewer residents.4. The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll-Based Journal (PBJ) system.

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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. **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 disease and infections for 1 (Resident #65) of 7 residents reviewed for infection control.-LVN F was carrying soiled linen in hand from Resident #65's room up the hallway and placed it inside of the soiled barrel on the hallway. This failure placed residents, staff members, and visitors at risk for cross contamination and infections. Findings:Record review of Resident #65's face sheet dated 08/06/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and again on 07/14/25. Resident diagnoses included heart failure, hypertension (high blood pressure), chronic kidney disease, neuromuscular dysfunction of the bladder (nerve damage that impairs the bladder's ability to store and release urine properly), type 2 diabetes mellitus (when the body has trouble controlling blood sugar and using it for energy), and major depression. Observation on 08/05/25 at 10:08AM revealed LVN F exited Resident #65's room wearing one glove and carrying a large towel. LVN F walked up the hall with the towel and placed the soiled towel inside of a barrel that was on Hall 300.In an interview on 08/05/25 at 10:10AM LVN F said she worked the morning shift full time from 6AM-6PM. LVN F said she was providing care for Resident #65 and some liquid had spilled on the floor. LVN F said she used the towel to clean the floor. LVN F said she was supposed to transport soiled linen in a bag for infection control. LVN F said she must have been moving too fast and forgot to place the soiled towel in a bag. LVN F said her last in-service on infection control was approximately 2 months ago. In an interview on 08/06/25 at 1:53PM the facility Infection Control Preventionist said soiled linen should be transported in a bag to prevent cross contamination. Record review of the facility policy on Infection Prevention and Control Program copyright 2024 reflected in part: .This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable disease and infections as per accepted national standards and guidelines.Standard precautions: all staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Record review of the facility policy on soiled linen handling and disposal of linen not dated reflected in part: .To ensure the safe handling, transport, and laundering of soiled linen to prevent cross-contamination, protect staff and residents from infections. [KS1]Check grammar