STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676334	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chelsea Gardens	4422 Riverstone Blvd Missouri City, TX 77459

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures for 1 of 8 residents (Resident #1) reviewed for reporting of alleged violations.The facility failed to report Resident #1's suspicious death to the State Agency within the required 2-hour timeframe after allegation made by RP and/or suspicion was formed after Resident #1, who required assistance with eating, was found unresponsive in bed with half a sandwich in his hand and chewed food present on the side of his mouth.Resident #1 never regained consciousness after being found unresponsive and was later pronounced deceased at the hospital. Resident #1's RP expressed concerns to facility staff that Resident #1 may have choked prior to being found unresponsive and that the staff's response may have contributed to his deathThe facility's failure to report this incident as required prevented timely investigation of a potential neglect related event and placed residents at risk for unrecognized and ongoing neglect, which could result in serious injury, diminished quality of life, or death.Findings included: Record review of Resident #1's face sheet dated 3/5/2026 revealed he was a [AGE] year-old male originally admitted to the facility on [DATE], readmitted on [DATE], and discharged to an Acute Care hospital on 3/1/2026. Diagnoses included End-Stage Renal Disease (final, permanent stage of chronic kidney disease, where kidneys can no longer function on their own), acquired absence of the right leg (post-traumatic or surgical loss of the limb of the right leg), acquired absence of the left leg (post-traumatic or surgical loss of the limb of the left leg), Type II diabetes mellitus (chronic high blood glucose from insulin resistance and relative insulin deficiency), dysphagia (difficulty swallowing), fatigue (overwhelming physical or mental exhaustion-that does not improve with rest), muscle weakness (a reduced capacity to exert force with muscles), reduced mobility (decline in the ability to move independently), need for assistance with personal care (essential assistance for seniors and individuals with disabilities), and dependence on renal dialysis (long-term reliance on hemodialysis or peritoneal dialysis to replace failed kidney function).Record review of Resident #1's undated dashboard page in the electronic record revealed special instructions stating, .ASSIST RESIDENT IN EATING DUE TO UNABLE TO SEE.Record review of Resident #1's Care Plan revised on 3/27/2024 revealed a focus area for potential nutritional problems (weight gain/loss) related to weakness, diabetes mellitus, dysphagia, and impaired cognition (noticeable declines in memory, language, thinking, and judgment). Interventions included monitoring, documenting, and reporting as needed any signs and symptoms of dysphagia such as pocketing, choking, coughing, drooling, holding food in the mouth, multiple swallowing attempts, refusing to eat, and appearing concerned during meals.Record review of Resident #1's Care Plan revised on 5/19/2025 revealed a focus area for ADL self-care performance deficit related to activity intolerance, confusion, limited (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mobility, left above-knee amputation, right below-knee amputation, ESRD, and impaired range of motion in bilateral upper extremities. Interventions revised on 8/20/2025 indicated the resident required partial/moderate staff assistance with eating.Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 7/15, indicating severely impaired cognition.Further review of the MDS revealed:Adequate visionLimited range of motion in both upper extremitiesRequired partial/moderate assistance with eating The MDS also indicated Resident #1 was:Dependent for sit-to-lying, lying-to-sitting, and chair/bed transfersRequired substantial/maximum assistance to roll left and rightUnable to sit-to-stand or walk 10 feetFurther review indicated the resident was on a mechanically altered and therapeutic diet.Record review of Resident #1's progress note dated 12/18/2025 at 2:06 PM by the Registered Dietitian (RD) revealed the resident's diet remained regular diet, mechanical soft texture, thin/regular consistency, and he continued to require assistance with meal setup and feeding at lunch and dinner due to fatigue. The RD recommended assisting Resident #1 with meal setup and feeding during lunch and dinner.Record review of Resident #1's dietary profile assessment dated [DATE] revealed the resident's diet order remained regular diet, mechanical soft texture with thin liquids, and he required partial assistance with eating.Record review of Resident #1's Care Plan Meeting Summary dated 2/5/2026 revealed RP voiced concern about Resident #1's appetite and her ordering food for him but he is not being fed. Summary further noted that RP was told CNA's will attempt to feed resident, but he refuses to eat.Record review of Resident #1' progress note dated 2/28/2026 at 11:35am by LVN A noted, At about 23:30 (11:30PM), nurse was called from a room where she is attending to 911 situation with 911 dispatcher crew that resident is unresponsive. Nurse assessed resident no breathing, pulse, nurse Call for help and initiate CPR. The 911 dispatcher team that was in the other room came and took over from the nurse. Resident RP and spouse came while 911 team was working on resident. Another 911 call made for the other resident. 911 crew worked on the resident and pulse felt and was transported to hospital at 12:33am. Notification to NP, DON.Record review of Resident #1's progress note dated 2/28/2026 at 11:20pm by LVN A notes, Nurse checked on resident, at the beginning of the shift no discomfort observed. At approximately past 10 PM writer was informed by another staff that resident RP needs to speak with the nurse. Nurse called RP and she asked how resident is doing and that she would like to speak to resident if he needs something to eat so she can order for delivery. Nurse asked the RP to hang up to enable nurse dial RP from resident room. Nurse went to resident room called RP from resident room and put the phone on speaker per resident request and nurse did. RP asked if she should order food for resident. Resident said no that he is okay. Nurse informed RP that the kitchen manager is in the building and met with resident and she is preparing food for resident. RP then said she will visit resident tomorrow. Nurse then asked assigned aide to assist resident with meal when the kitchen manager brings it to resident.Record review of EMS report for Resident #1 dated 3/1/2026 revealed upon assessment at 11:41pm Resident #1's airway was completely obstructed, his pulse and breathing were absent, and he was unresponsive. Also, upon assessment he had fluid loss of 100 - 500ml of emesis. Resident #1's primary impression was noted to be cardiac arrest. EMS report detailed Resident #1 went into cardiac arrest prior to EMS arrival and the arrest was not witnessed, CPR initiated on 2/28/2026 at 11:40pm. Resident #1's first monitored rhythm was Ventricular Fibrillation (a life-threatening heart rhythm emergency where the heart's lower chambers quiver chaotically instead of pumping blood, resulting in sudden cardiac arrest and loss of pulse. It requires immediate CPR and defibrillation (shock) to restore a normal rhythm). Cardiac arrest report further detailed EMS first initiated CPR and use of AED. According to the narrative in the EMS report they were in the facility responding to a call regarding another resident when a staff member entered the room and stated another resident at the facility (Resident #1) was found choking in his room. Resident #1 was found supine on the floor unresponsive, apneic (not breathing), and pulseless. The narrative detailed, .no obvious external injuries or bleeding observed upon visual inspection. Patient is unresponsive. Airway completely obstructed by emesis. hands only CPR was initiated. Oral suctioning performed and I-gel (supraglottic (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance with eating due to vision impairment, but she believed he was able to eat finger foods independently. The Dietary Manager stated she was not aware of Resident #1 having a history of choking on food.Interview on 3/4/2026 at 3:59 PM, LVN A stated she worked the 6:00 PM-6:00 AM shift on 2/28/2026, and Resident #1 was assigned to her. LVN A stated she called Resident #1 RP, who requested to speak with Resident #1. LVN A stated she hung up the phone and then called the RP again from Resident #1's room, allowing them to speak on speakerphone at the resident's request. LVN A stated the RP asked Resident #1 if he wanted her to have food delivered, and Resident #1 said no. LVN A stated she reassured the RP that the Dietary Manager was bringing Resident #1 something to eat. LVN A stated that after Resident #1 finished speaking with the RP, she hung up the phone and left the room. LVN A stated she informed CNA A that the Dietary Manager was bringing food for Resident #1 and that CNA A would need to assist him with eating. LVN A stated that shortly afterward, a resident across the hall required assistance, and she, CNA A, and CMA B went into that resident's room to provide care for approximately 10 minutes. LVN A stated that when she left the room across the hall, she looked into Resident #1's room and did not observe a meal tray in the room at that time. LVN A stated she continued down the hall when RN A approached her regarding Resident #2 experiencing chest pain, and she went to assist in Resident #2's room.LVN A stated she remained in Resident #2's room assisting until EMS arrived. LVN A stated that while she was giving report to EMS, she heard her name being called and went into the hallway where staff directed her to Resident #1's room. LVN A stated she entered Resident #1's room and observed the resident to be unresponsive with no pulse. LVN A stated she performed a mouth sweep, but nothing was removed. LVN A stated she and the CNAs placed a backboard under Resident #1, lowered him to the floor, and she began CPR. LVN A stated a CNA went to retrieve EMS personnel who were in another room, and they arrived shortly afterward and took over the assessment and resuscitation efforts. LVN A stated she did not observe any food in the room or in Resident #1's mouth when she entered. LVN A stated she knew Resident #1 required assistance with eating, but she was not aware of a history of choking on food. LVN A added that Resident #1 had a mechanical soft diet, and she assumed there may have been some issue in the past related to his diet. LVN A stated she did not observe the Dietary Manager bring a tray into Resident #1's room and stated she did not provide Resident #1 with any food that night.Interview on 3/4/2026 at 4:49 PM, CNA A stated after LVN A came out of Resident #1's room and finished talking with him and his RP, she, LVN A, and CMA B went into the room of the resident across the hall to provide care. CNA A stated they remained in that room for approximately 30 minutes. CNA A stated that after finishing with the resident across the hall, she went to retrieve supplies and then went to Resident #1's room to feed him. CNA A stated that when she entered the room, she observed a tray with half of a sandwich on it that had been pushed away from the bed where Resident #1 could not reach it. CNA A stated that as she approached and called Resident #1's name, he did not respond. She stated she observed food sliding down the side of his mouth and the other half of the sandwich in his hand. CNA A stated she did not observe any rise and fall of the resident's chest and could not feel a pulse. CNA A stated she ran into the hallway and told two CNAs in the hall to get the nurse because Resident #1 was unresponsive. CNA A stated she returned to the room along with other staff who came in to assist. CNA A stated staff placed Resident #1 onto a backboard and lowered him to the ground. CNA A stated LVN A arrived and began CPR, and EMS personnel who were in Resident #2's room arrived shortly afterward and took over resuscitation efforts.CNA A recalled that earlier that evening, after an in-service conducted by the Dietary Manager, the Dietary Manager stated she had spoken with Resident #1's RP and was going to prepare food for Resident #1 and that he would need assistance with eating. CNA A stated she was busy caring for other residents that night and did not observe the tray being delivered to Resident #1's room. CNA A denied providing Resident #1 with any food prior to finding him unresponsive. CNA A stated that based on how she found Resident #1, it appeared that someone had already started feeding him. CNA A stated she was aware Resident #1 required assistance with eating, but she was not aware of the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	specific reason. CNA A stated she knew Resident #1 ate very slowly and that she typically stayed with him while he ate. CNA A stated she did not know who gave Resident #1 the sandwich.Interview on 3/4/2026 at 6:18 PM, the Administrator stated Resident #1 required minimal assistance due to vision impairment and that meals needed to be placed where the resident could see them. The Administrator stated Resident #1 required meal tray setup and believed it would have been safe to leave Resident #1 with a sandwich, as the resident was able to eat finger foods independently. The Administrator explained he was unsure where Resident #1 obtained the food he was eating, stating that family members frequently brought food to the facility or had food delivered for the resident. The Administrator stated he had been informed that the Dietary Manager told a CNA that Resident #1 would need assistance with eating, and that the Dietary Manager later brought a meal tray containing a sandwich to Resident #1's room. The Administrator stated the Dietary Manager reported she placed the tray in a location where Resident #1 could not reach it, and no staff reported feeding Resident #1 the sandwich. The Administrator further stated that the care plan interventions related to monitoring for dysphagia were from a previous issue when the resident had a G-tube removed and were no longer considered a concern. The Administrator stated he was not aware of any prior incidents of Resident #1 choking on food at the facility.Interview on 3/5/2026 at 12:54 PM, the Responsible Party (RP) stated Resident #1 had experienced two previous choking incidents at the facility. The RP stated that during a care plan meeting, she requested that designated staff feed the resident, as she had concerns about Resident #1 choking and not eating. The RP further stated she repeatedly informed the facility that Resident #1 could not feed himself without staff assistance and required monitoring while eating. The RP stated the facility reassured her not to worry and told her they would assign a designated staff member each shift to assist and monitor Resident #1 during meals. The RP stated she was notified that Resident #1 had been found unresponsive and immediately came to the facility. The RP stated that upon her arrival on 2/28/2026, EMS personnel were still providing care to Resident #1. The RP stated she immediately expressed concerns regarding the staff's response after Resident #1 was found unresponsive. The RP stated EMS personnel informed her that it was suspected Resident #1 had been choking and had vomited prior to being found unresponsive. The RP stated she questioned facility staff about how Resident #1 could have choked when he was supposed to be assisted and supervised during meals, but stated the facility did not acknowledge that choking had occurred.Interview on 3/5/2026 at 2:50 PM, CMA B stated she did not work with Resident #1 on 3/28/2026, but she was waved over by CNA A for assistance after CNA A found Resident #1 unresponsive. CMA B stated she entered Resident #1's room to see what was happening and observed him lying in bed with foam coming from his mouth. CMA B stated she immediately ran out of the room and down the hall to get the nurse.Interview on 3/5/2026 at 3:32 PM with the Administrator and DON revealed the Administrator stated he did not believe Resident #1 choked on food on 2/28/2026. The Administrator stated that, based on hospital records and how the resident was found, he believed the resident experienced cardiac arrest. The DON stated he agreed that Resident #1 may have experienced either cardiac arrest or a pulmonary embolism, both of which can occur without warning and result in sudden unresponsiveness. The Administrator further stated that choking is typically a violent event, during which an individual would be thrashing while attempting to clear their airway, and the surrounding environment would likely be disrupted. The Administrator stated that based on this belief, the resident would not have still had the sandwich in his hand if choking had occurred. The DON stated he agreed with the Administrator's statement. The Administrator stated that based on the facility's investigation, Resident #1 experienced cardiac arrest and did not choke, and therefore he did not consider the death to be reportable. The Administrator further stated he was able to access hospital records shortly after the incident, which assisted in his determination not to report the event. The Administrator and DON stated that, based on their recollection, the Responsible Party (RP) was upset regarding the staff's response when Resident #1 was found unresponsive and believed the resident had been left without intervention. They stated they determined this concern to (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety 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. **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 includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment with services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 residents (Resident #1) reviewed for care plans.The facility failed to develop and implement a comprehensive care plan including measurable objectives and timeframes to address meet Resident #1's medical, nursing, and mental and psychosocial needs related to his history of choking on food while eating and requirement for mechanical altered diet.The facility also failed to implement Resident #1's care plan intervention of assistance with eating and monitoring for signs of dysphagia on 2/28/2026 evidenced by Resident #1 being left alone to eat a sandwich which resulted in Resident #1 being found by CNA A unresponsive in his room with the sandwich in his hand and food leaking from his mouth.EMS had to clear Resident #1's airway by suctioning emesis (vomit) from his airway and vocal cords, initiate CPR and intubate him. Life saving measures were continued for Resident #1 as he was transported to the hospital and was pronounced deceased .An Immediate Jeopardy (IJ) was identified on 3/6/2026. The IJ template was provided to the facility on 3/6/2026 at 7:15 pm. While the IJ was removed on 3/9/2026, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.This failure could place residents who require supervision and assistance with meals at risk for experiencing hospitalization, choking and/or death.Findings included:Record review of Resident #1's face sheet dated 3/5/2026 revealed he was a [AGE] year-old male originally admitted to the facility on [DATE], readmitted on [DATE], and discharged to an Acute Care hospital on 3/1/2026. Diagnoses included End-Stage Renal Disease (final, permanent stage of chronic kidney disease, where kidneys can no longer function on their own), acquired absence of the right leg (post-traumatic or surgical loss of the limb of the right leg), acquired absence of the left leg (post-traumatic or surgical loss of the limb of the left leg), Type II diabetes mellitus (chronic high blood glucose from insulin resistance and relative insulin deficiency), dysphagia (difficulty swallowing), fatigue (overwhelming physical or mental exhaustion-that does not improve with rest), muscle weakness (a reduced capacity to exert force with muscles), reduced mobility (decline in the ability to move independently), need for assistance with personal care (essential assistance for seniors and individuals with disabilities), and dependence on renal dialysis (long-term reliance on hemodialysis or peritoneal dialysis to replace failed kidney function).Record review of Resident #1's undated dashboard page in the electronic record revealed special instructions stating, .ASSIST RESIDENT IN EATING DUE TO UNABLE TO SEE.Record review of Resident #1's Care Plan revised on 3/27/2024 revealed a focus area for potential nutritional problems (weight gain/loss) related to weakness, diabetes mellitus, dysphagia, and impaired cognition (noticeable declines in memory, language, thinking, and judgment). Interventions included monitoring, documenting, and reporting as needed any signs and symptoms of dysphagia such as pocketing, choking, coughing, drooling, holding food in the mouth, multiple swallowing attempts, refusing to eat, and appearing concerned during meals. Further review of care plan did not note a focus section referencing dysphagia diagnosis, previous choking history or RP concern for monitoring Resident when being fed.Record review of Resident #1's progress note dated 11/28/2024 at 9:46 AM noted the resident was coughing and possibly choking while being assisted with breakfast. It was further noted that upon assessment, resident was coughing and continued to spit up particles of food. The progress note (continued on next page)

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	676334	A. Building B. Wing	03/09/2026

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administrator's statement.Interview on 3/5/2026 at 4:04 PM, EMS stated that while they were assisting another resident in the facility, a staff member entered the room and informed them that another resident was choking and requested assistance. EMS stated he immediately followed facility staff to Resident #1's room, where Resident #1 was observed lying on the ground on a backboard with facility staff surrounding him. EMS reported that Resident #1 was unresponsive, without a pulse, and not breathing. EMS further stated that when he assessed Resident #1's airway, it was completely obstructed by large amounts of vomit. EMS reported he had to obtain suction equipment to clear the airway and suctioned large white, creamy chunks from Resident #1's mouth, airway, and vocal cords. The EMS technician stated that the large white, creamy chunks did not appear to be gastric contents or bodily fluids, but instead appeared to be food material. EMS stated that based on how Resident #1 was found and the presence of food lodged in the airway and vocal cords, it was very likely the resident had been choking prior to going into cardiac arrest.Interview on 3/6/2026 at 8:22 AM, CNA A stated she has access to the care plans at nurse station on the computer. CNA A stated if Resident # 1 did not want to eat or had any concerns she would verbally report to the nurse and was not aware of any documentation requirement for choking or monitoring for risk of choking. CNA A stated she was not aware of Resident # 1's diagnosis of dysphagia and did not know all his conditions. CNA A stated the only charting she was aware of was on the wall system or the nurses station at the computer and CNA's would click that an ADL was completed like a bath, or incontinent care. CNA A stated she was only told to feed Resident #1 however was not told why or of any previous history of choking.Interview on 3/6/2026 at 11:31AM, the MDS Coordinator stated Resident # 1 next care plan review date would be April 2026 and his diet for mechanical soft would not be added in the care plan because it was not a treatment. The MDS Coordinator stated if there was a progress note about Resident # 1 diagnosis of dysphagia and the mechanical soft diet being a part of that diagnosis, then the information would be added to the care plan under a new focus or section. The MDS Coordinator stated diagnoses that are active are care planned and if there is a treatment for that diagnosis it is also included. The MDS Coordinator stated if she was aware of previous choking history with Resident # 1, she would have noted the progress note of the incident and added the goals and/or interventions in the care plan. The MDS Coordinator stated the care plan goal and/or intervention would include swallow evaluations and that Resident #1 diet was downgraded. The MDS Coordinator stated care plan meetings include Therapy Services, RN, Dietary, Activities, CNA, Social Worker, Administrator however she is not present in the meetings and looks at the notes after the care plan meeting is completed.Record review of facility undated Comprehensive Care Plans policy revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. An IJ was identified on 3/6/2026 at 7:15pm. The IJ template was provided to the Administrator on 3/6/2026 at 7:15pm and a Plan of Removal was requested. The following Plan of Removal submitted by the facility was accepted on 3/8/2026 at 2:22pm.Plan to remove immediate jeopardy8 March 2026Facility ActionsF-656The facility failed to develop and implement a plan of care to include goals and interventions related to Resident #1's diagnosis of dysphagia or meal assistance.Resident #1 had a history of choking on food, a diagnosis of dysphagia and required assistance with eating.An emergency AD HOC QAPI meeting was held, and the issues thoroughly discussedAssociate medical Director informed. Completed 6 March 2026. Outcome: In-services for: Therapeutic Diet Orders, Meal S

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	676334	A. Building B. Wing	03/09/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 adequate supervision to prevent avoidable accidents for 1 of 8 residents reviewed for accidents (Resident #1) in that: Resident #1 who had a history of choking on food, a diagnosis of dysphagia and required supervision and assistance with eating was given a sandwich and left alone in his bedroom. Approximately 24 minutes after Resident #1 was left alone with a sandwich, he was found by CNA A unresponsive in his room with the sandwich in his hand and food leaking from his mouth. EMS had to clear Resident #1's airway by suctioning emesis (vomit) from his airway and vocal cords, initiated CPR and intubated him. Life saving measures were continued for Resident #1 as he was transported to the hospital and was pronounced deceased . An Immediate Jeopardy (IJ) was identified on 3/6/2026 at 7:15pm. While the IJ was removed on 3/9/2026, the facility remained out of compliance at a severity level of no actual harm that is not an Immediate Jeopardy and a scope of isolated as the facility continued to monitor the implementation and effectiveness of their plan of removal. This failure could place residents at risk for experiencing worsening of condition, hospitalization, choking and/or death.Findings included:Record review of Resident #1's face sheet dated 3/5/2026 revealed he was a [AGE] year-old male originally admitted to the facility on [DATE], readmitted on [DATE], and discharged to an Acute Care hospital on 3/1/2026. Diagnoses included End-Stage Renal Disease (final, permanent stage of chronic kidney disease, where kidneys can no longer function on their own), acquired absence of the right leg (post-traumatic or surgical loss of the limb of the right leg), acquired absence of the left leg (post-traumatic or surgical loss of the limb of the left leg), Type II diabetes mellitus (chronic high blood glucose from insulin resistance and relative insulin deficiency), dysphagia (difficulty swallowing), fatigue (overwhelming physical or mental exhaustion-that does not improve with rest), muscle weakness (a reduced capacity to exert force with muscles), reduced mobility (decline in the ability to move independently), need for assistance with personal care (essential assistance for seniors and individuals with disabilities), and dependence on renal dialysis (long-term reliance on hemodialysis or peritoneal dialysis to replace failed kidney function).Record review of Resident #1's undated dashboard page in the electronic record revealed special instructions stating, .ASSIST RESIDENT IN EATING DUE TO UNABLE TO SEE.Record review of Resident #1's Care Plan revised on 3/27/2024 revealed a focus area for potential nutritional problems (weight gain/loss) related to weakness, diabetes mellitus, dysphagia, and impaired cognition (noticeable declines in memory, language, thinking, and judgment). Interventions included monitoring, documenting, and reporting as needed any signs and symptoms of dysphagia such as pocketing, choking, coughing, drooling, holding food in the mouth, multiple swallowing attempts, refusing to eat, and appearing concerned during meals.Record review of Resident #1's progress note dated 11/28/2024 at 9:46 AM noted the resident was coughing and possibly choking while being assisted with breakfast. It was further noted that upon assessment, resident was coughing and continued to spit up particles of food. The progress note indicated the NP was informed and ordered Zofran as needed for nausea and vomiting, as well as a diet change to mechanical soft and a Speech Evaluation.Record review of Resident #1's progress note dated 11/30/2024 at 1:47 PM noted, With regard to the incident of the resident choking on food, family is requesting the resident be supervised during meals at all times.Record review of Resident #1's progress note dated 12/1/2024 at 7:01 PM by SLP noted two attempts were made to assess the resident's swallowing skills; however, the resident refused lunch, and when the SLP attempted to observe dinner, the resident had already eaten. The SLP documented that nursing staff informed her the diet had been changed to mechanical soft by the NP, and the NP requested the resident be monitored during meals for safety.Record review of Resident #1's physician order initiated on 5/12/2025 revealed an order for a regular diet with mechanical soft texture and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	thin/regular consistency.Record review of Resident #1's Care Plan revised on 5/19/2025 revealed a focus area for ADL self-care performance deficit related to activity intolerance, confusion, limited mobility, left above-knee amputation, right below-knee amputation, ESRD, and impaired range of motion in bilateral upper extremities. Interventions revised on 8/20/2025 indicated the resident required partial/moderate staff assistance with eating.Record review of Resident #1's Speech Screening dated 6/12/2025 revealed he was screened after readmission from the hospital and was not recommended for speech therapy services because the assessment indicated he was at his previous baseline with no changes. The screening documented he tolerated his prescribed diet of regular texture with chopped meat. The screening further noted Resident #1, .continues to present similar oral dysphagia with regular texture without chopped meat due to prolonged chewing, reduced bolus formation, and delayed oral transit time. Chopped meat facilitates reduced time for the patient to manipulate food prior to swallowing.Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 7/15, indicating severely impaired cognition.Further review of the MDS revealed:Adequate visionLimited range of motion in both upper extremitiesRequired partial/moderate assistance with eating The MDS also indicated Resident #1 was:Dependent for sit-to-lying, lying-to-sitting, and chair/bed transfersRequired substantial/maximum assistance to roll left and rightUnable to sit-to-stand or walk 10 feetFurther review indicated the resident was on a mechanically altered and therapeutic diet. Record review of Resident #1's progress note dated 12/18/2025 at 2:06 PM by the Registered Dietitian (RD) revealed the resident's diet remained regular diet, mechanical soft texture, thin/regular consistency, and he continued to require assistance with meal setup and feeding at lunch and dinner due to fatigue. The RD recommended assisting Resident #1 with meal setup and feeding during lunch and dinner.Record review of Resident #1's dietary profile assessment dated [DATE] revealed the resident's diet order remained regular diet, mechanical soft texture with thin liquids, and he required partial assistance with eating.Record review of Resident #1's Care Plan Meeting Summary dated 2/5/2026 revealed RP voiced concern about Resident #1's appetite and her ordering food for him but he was not being fed. Summary further noted that RP was told CNAs will attempt to feed resident, but he refuses to eat.Record review of Resident #1' progress note dated 2/28/2026 at 11:35 pm by LVN A noted, At about 23:30 (11:30PM), nurse was called from a room where she is attending to 911 situation with 911 dispatcher crew that resident is unresponsive. Nurse assessed resident no breathing, pulse, nurse Call for help and initiate CPR. The 911 dispatcher team that was in the other room came and took over from the nurse. Resident RP and spouse came while 911 team was working on resident. Another 911 call made for the other resident. 911 crew worked on the resident and pulse felt and was transported to hospital at 12:33am. Notification to NP, DON.Record review of Resident #1's progress note dated 2/28/2026 at 11:20pm by LVN A notes, Nurse checked on resident, at the beginning of the shift no discomfort observed. At approximately 10 PM writer was informed by another staff that resident RP needs to speak with the nurse. Nurse called RP and she asked how resident is doing and that she would like to speak to resident if he needs something to eat so she can order for delivery. Nurse asked the RP to hang up to enable nurse dial RP from resident room. Nurse went to resident room called RP from resident room and put the phone on speaker per resident request and nurse did. RP asked if she should order food for resident. Resident said no that he is okay. Nurse informed RP that the kitchen manager is in the building and met with resident and she is preparing food for resident. RP then said she will visit resident tomorrow. Nurse then asked assigned aide to assist resident with meal when the kitchen manager brings it to resident.Record review of EMS report for Resident #1 dated 3/1/2026 revealed upon assessment at 11:41pm Resident #1's airway was completely obstructed, his pulse and breathing were absent, and he was unresponsive. Also, upon assessment he had fluid loss of 100 - 500ml of emesis. Resident #1's primary impression was noted to be cardiac arrest. EMS report detailed Resident #1 went into cardiac arrest prior to EMS arrival and the arrest was not witnessed, CPR initiated on 2/28/2026 at 11:40pm. Resident #1's first monitored rhythm was Ventricular Fibrillation (a life-threatening heart (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	requested a soda with his meal, and she told him she would retrieve one and that the CNA would be in shortly to assist him with eating.The Dietary Manager stated that as she walked down the hall to get the soda, she heard a resident in the 100 hall calling for help. She stated the resident calling for help was her mother (Resident #2). The Dietary Manager stated she immediately went to the room to check on her mother, who was complaining of chest pain, and she alerted a nurse for assistance. The Dietary Manager stated she remained with Resident #2 while she was being assessed, and 911 was called. The Dietary Manager stated she remained at her mother's bedside until EMS arrived at approximately 11:15 PM. The Dietary Manager stated that while EMS was stabilizing her mother, MA B entered the room and asked if one of the paramedics could come with her because Resident #1 had been found unresponsive when CNA went to feed him. The Dietary Manager stated one paramedic left the room with the CNA to check on Resident #1, while the remaining paramedic later wheeled Resident #2 down the hall to Resident #1's room so he could also assist. The Dietary Manager stated additional paramedics later arrived and transported Resident #2 to the hospital, while the original EMS crew remained with Resident #1. The Dietary Manager stated that to her knowledge, Resident #1 required assistance with eating due to vision impairment, but she believed he was able to eat finger foods independently. The Dietary Manager stated she was not aware of Resident #1 having a history of choking on food.Interview on 3/4/2026 at 3:59 PM, LVN A stated she worked the 6:00 PM-6:00 AM shift on 2/28/2026, and Resident #1 was assigned to her. LVN A stated Resident #1 had gone to dialysis earlier that day, and when he returned he was tired and did not want to eat. LVN A stated that later that night she was informed by the Dietary Manager that she needed to call Resident #1's Responsible Party (RP). LVN A stated she immediately called the RP, who requested to speak with Resident #1. LVN A stated she hung up the phone and then called the RP again from Resident #1's room, allowing them to speak on speakerphone at the resident's request. LVN A stated the RP asked Resident #1 if he wanted her to have food delivered, and Resident #1 said no. LVN A stated she reassured the RP that the Dietary Manager was bringing Resident #1 something to eat. LVN A stated that after Resident #1 finished speaking with the RP, she hung up the phone and left the room. LVN A stated she informed CNA A that the Dietary Manager was bringing food for Resident #1 and that CNA A would need to assist him with eating. LVN A stated that shortly afterward, a resident across the hall required assistance, and she, CNA A, and MA B went into that resident's room to provide care for approximately 10 minutes. LVN A stated that when she left the room across the hall, she looked into Resident #1's room and did not observe a meal tray in the room at that time. LVN A stated she continued down the hall when LVN B approached her regarding Resident #2 experiencing chest pain, and she went to assist in Resident #2's room.LVN A stated she remained in Resident #2's room assisting until EMS arrived. LVN A stated that while she was giving report to EMS, she heard her name being called and went into the hallway where staff directed her to Resident #1's room. LVN A stated she entered Resident #1's room and observed the resident to be unresponsive with no pulse. LVN A stated she performed a mouth sweep, but nothing was removed. LVN A stated she and the CNAs placed a backboard under Resident #1, lowered him to the floor, and she began CPR. LVN A stated a CNA went to retrieve EMS personnel who were in another room, and they arrived shortly afterward and took over the assessment and resuscitation efforts. LVN A stated she did not observe any food in the room or in Resident #1's mouth when she entered. LVN A stated she knew Resident #1 required assistance with eating, but she was not aware of a history of choking on food. LVN A added that Resident #1 had a mechanical soft diet, and she assumed there may have been some issue in the past related to his diet. LVN A stated she did not observe the Dietary Manager bring a tray into Resident #1's room and stated she did not provide Resident #1 with any food that night.Interview on 3/4/2026 at 4:49 PM, CNA A stated that on 2/28/2026 she observed LVN A in Resident #1's room speaking on the phone with Resident #1's Responsible Party (RP) on speaker. CNA A stated she entered the room to inform LVN A that the resident across the hall needed assistance. CNA A stated LVN A told her she would come after she finished in Resident #1's room. CNA A stated she then (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#1 choking and not eating. The RP further stated she repeatedly informed the facility that Resident #1 could not feed himself without staff assistance and needed to be monitored while eating. The RP stated the facility reassured her not to worry and told her they would assign a designated staff member each shift to assist and monitor Resident #1 during meals.Interview on 3/5/2026 at 1:56 PM, the MD stated that given Resident #1's history, staff should not leave or walk away from the resident while he was eating, as he required monitoring to ensure he did not choke.Interview on 3/5/2026 at 2:20 PM, the Administrator stated that based on what staff had told him about Resident #1, it would have been safe to leave Resident #1 alone with a sandwich. The Administrator stated Resident #1 only required assistance with meal tray setup, including placing the tray within his line of sight and assistance with utensils. The Administrator further stated that Resident #1 was able to eat finger foods independently. The Administrator stated he was not aware of any previous choking or coughing incidents related to food involving Resident #1.Interview on 3/5/2026 at 2:50 PM, MA B stated she fed Resident #1 when she worked with him because Resident #1 became weak and tired after dialysis and would fall asleep while trying to eat. MA B stated she would not want him to fall asleep while eating because he could choke. MA B stated she did not work with Resident #1 on 2/28/2026, but she was waved over by CNA A for assistance after CNA A found Resident #1 unresponsive. MA B stated she entered Resident #1's room to see what was happening and observed him lying in bed with foam coming from his mouth. MA B stated she immediately ran out of the room and down the hall to get the nurse.Interview on 3/5/2026 at 3:32 PM with the Administrator and Director of Nursing (DON) revealed the Administrator stated he did not believe Resident #1 choked on food on 2/28/2026. The Administrator stated that, based on the hospital records and how the resident was found, he suspected the resident went into cardiac arrest. The DON stated he agreed that Resident #1 may have either experienced cardiac arrest or a pulmonary embolism, both of which can occur without warning and cause sudden unresponsiveness. The Administrator further stated that when someone is choking, it is typically a violent event in which the person is thrashing while attempting to clear their airway, and their surrounding environment would likely be disrupted. The Administrator stated that, based on this belief, the resident would not have still had the sandwich in his hand if choking had occurred. The DON stated he agreed with the Administrator's statement.Interview on 3/5/2026 at 4:04 PM, EMS stated that while they were assisting another resident in the facility, a staff member entered the room and informed them that another resident was choking and requested assistance. EMS stated he immediately followed facility staff to Resident #1's room, where Resident #1 was observed lying on the ground on a backboard with facility staff surrounding him. EMS reported that Resident #1 was unresponsive, without a pulse, and not breathing. EMS further stated that when he assessed Resident #1's airway, it was completely obstructed by large amounts of vomit. EMS reported he had to obtain suction equipment to clear the airway and suctioned large white, creamy chunks from Resident #1's mouth, airway, and vocal cords. The EMS technician stated that the large white, creamy chunks did not appear to be gastric contents or bodily fluids, but instead appeared to be food material. EMS stated that based on how Resident #1 was found and the presence of food lodged in the airway and vocal cords, it was very likely the resident had been choking prior to going into cardiac arrest.Record review of e-mail sent by surveyors on 3/4/2026 at 6:59pm to Administrator and BOM requested policies for Supervision, Monitoring, Accidents and Hazards. The facility provided policies on 3/5/2026 that did not address supervision of residents or information relevant to failures.An IJ was identified on 3/6/2026 at 7:15pm. The IJ template was provided to the Administrator on 3/6/2026 at 7:15pm and a Plan of Removal was requested. The following Plan of Removal submitted by the facility was accepted on 3/8/2026 at 2:22pm. Plan to remove immediate jeopardy8 March 2026Facility ActionsF-689The facility failed to adequately supervise Resident #1 while the resident ate a sandwich.Resident #1 had a history of choking on food, a diagnosis of dysphagia and required assistance with eating.An emergency AD HOC QAPI meeting was held, and the issues thoroughly discussed.Associate medical Director informed. Completed 6 March 2026. Outcome: In-services for: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676334	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chelsea Gardens	4422 Riverstone Blvd Missouri City, TX 77459

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Therapeutic Diet Orders, Meal Supervision and Assistance, Care Planning - IDT, Accessing Resident Care Information in resident electronic health records, Accessing the Resident Care Plan in resident electronic health records, Administrator, DOR, DON and their Designee reviewed supervision policies and outcome: Policy of Determination of Resident Supervision Needs During Meals and new process to assist staff in quickly identifying residents who require supervision or assistance during meal times. Administrator was in-serviced on: Therapeutic Diet orders, Care Planning, Accessing Resident Care Information in the CNA Kardex/POC, Accessing the Resident Care Plan in PCC by NP /RN on 6 March 2026.Resident #1 is no longer a resident at the facility.The facility has determined that all residents have the potential to be affected.Assessments and care plans for all Residents were reviewed to address chewing and swallowing difficulties, positioning, and supervision needs during meals. Revisions were made to reflect all current supervision and safety interventions. The revised assessments and care plans were reviewed with staff involved in the care of each resident. Will be Completed 7 March 2026, DON/Designee completed the audit. No additional residents were found to be affected.MDS, DON, Administrator, Nursing, CNA were in-serviced on the care plans. DON, Administrator and their designee will complete the in-services started 6 March 2026 and completed by 11 March 2026.New Policy: Determination of Resident Supervision Needs During MealsPolicy: Determination of Resident Supervision Needs During MealsPurpose:To ensure residents who require supervision during meals are identified promptly and appropriate safety measures are implemented until comprehensive assessments are completed.Policy:Upon admission or readmission to the facility, available clinical documentation will be reviewed to determine whether a resident requires supervision during meals. An initial determination will be made by the Director of Nursing (DON), Therapy, Administrator, or their designee based on the information available at the time of admission.Residents who are determined to require supervision during meals will be identified within the PointClickCare (PCC) system by being placed in Position 2 of the room assignment. This designation serves as a visual identifier for staff and will populate in multiple areas of the electronic medical record, including but not limited to: Resident list Resident chart eMAR Point of Care (POC)This process assists staff in quickly identifying residents who require supervision or assistance during meal times.If a resident is initially determined not to require supervision but staff later identify a concern related to the resident's ability to safely eat independently unsupervised, any staff member may notify the DON, Therapy, Administrator, or their designee for review. The resident may be placed under supervision status pending further clinical assessment and evaluation.Dietary Communication:Any change to a resident's diet type, food texture, liquid consistency, or supervision status during meals must be communicated to Dietary. A Dietary Communication Form will be completed, signed, and provided to the Dietary Department to ensure appropriate updates are made within the dietary system and that correct meal service is provided.Follow-Up Assessments:Further assessments by Nursing and/or Therapy will be completed as appropriate to determine the resident's ongoing needs for supervision or assistance with eating.Staff Responsibility During Meal Service:The identification of a resident as requiring supervision during meals through the PointClickCare (PCC) system and/or the dietary meal ticket system serves as a communication tool for staff. However, direct care staff assigned to the resident remain responsible for ensuring appropriate supervision and diet is provided during meal service.Staff will verify the resident's diet order, texture, liquid consistency, and supervision requirements prior to meal service. Any discrepancies identified will be immediately reported to the DON, charge nurse, Therapy, Administrator, or designee for review and correction. Completed 7 March 2026 Policy was cr