STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47722 Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 out of 6 residents (Resident #40) reviewed for ADL care. - The facility staff failed to provide scheduled showers/baths to Resident #40 on 12/7/24 and 12/14/24. - The facility failed to change Resident #40's shirt for 3 days (12/15/24, 12/16/24, and 12/17/24) when there was debris and stains on it. These failures could place residents at risk of a decline in ADL's. Findings include: Record review of Resident #40's undated face sheet revealed he was a [AGE] year-old male originally admitted to the facility on [DATE], with the most recent admitted [DATE]. He had diagnoses of kidney failure (kidneys stop filtering the blood), dementia neurological conditions that cause a decline in mental abilities that affects daily life), hemiplegia (paralysis) and hemiparesis (numbness) following a stroke, heart failure, diabetes mellitus (body does not produce insulin or resists it), major depression, aphasia (trouble speaking), weakness, convulsions (seizures), and muscle wasting and atrophy. Record review of Resident #40's Annual MDS assessment from 12/10/24 revealed he had a BIMS score of 8 out of 15, which indicated he had moderately impaired cognition. The resident had impairment on one side of his upper and lower extremities. According to the MDS, the resident was dependent (the helper does all of the effort and resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the activity) for showers/baths, toileting hygiene, and lower body dressing. The resident was substantial/max assist (helper does more than half the effort) with oral hygiene, upper body dressing, putting on/taking off footwear, and personal hygiene. According to the MDS, the resident was always incontinent of bowel and bladder. Record review of Resident #40's medical record revealed his care plan was not completed. (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
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review performed on 12/15/24, of the facility's shower schedule, revealed Resident #40's shower days were Tuesday, Thursday, and Saturday morning. In an interview and observation on 12/15/24 at 11:22am with Resident #40 and family, the resident was observed laying on his back in bed. The resident had white debris all over the top part of his shirt, near his collar, and his hair appeared greasy looking. The resident and family revealed he had not had a shower for the past two Saturdays (12/14/24 and 12/7/24). In an interview and observation on 12/16/24 at 1:15pm, Resident #40 said he had just got back from dialysis. His shirt still had not been changed and he had white debris near the collar of his shirt. The resident said the staff did not help him brush his teeth or clean his face. In an interview and observation on 12/17/24 at 10:29am, Resident #40 had the same shirt on with debris near his collar. He said he had asked for his shower when he woke up at 6:10am, but he still had not received it yet. In an interview with CNA J on 12/17/24 at 10:53am, she said she had not given Resident #40 a shower yet, but she would before her shift was over. She said this was the first day she worked the hall the resident was on, and she would have changed his shirt before today if there was debris on it. CNA J said she did not know if the CNAs on that hall brushed the resident's teeth, but Resident #40 would normally ask for a warm cloth for his face if he wanted one. CNA J said there was a binder at the nursing station that had the shower schedules for each resident and they knew how much assistance was needed by looking in the resident's chart and through report handoff. In an interview with the Administrator on 12/16/24 at 1:45pm, she said there were no shower sheets in the EMR because she had not had time to implement it yet. She said she would have to ask the DON who gave showers on 12/7/24 and 12/14/24. In an interview with the DON on 12/17/24 at 11:15am, she said CNA C was supposed to have showered Resident #40 on 12/14/24. She said she did not know she was supposed to check who gave showers for 12/7/24. She said she spoke to CNA J, and she was going to make sure to shower the resident today (12/17/24). She said she would pop in more often on the weekends to ensure showers were given. If showers were not given it could cause infections. Record review of the facility's policy and procedure on Activities of Daily Living (ADL), Supporting (Revised March 2018) read in part: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: Hygiene (bathing, dressing, grooming, and oral care) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observation, interview, and record review, the facility failed to ensure that each resident who was incontinent of bowel/bladder and each resident with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections, for 2 of 6 residents (Resident #18 and Resident #87) reviewed for catheter care. - The facility failed to ensure physician orders for catheter care were entered into the system for Resident #18 and Resident #87 and staff were unable to document care provided from 12/1/24 to 12/17/24. This failure could place residents with foley catheters at risk for urinary tract infections and skin break down. Findings included: 1. Record review of Resident #18's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses of a sacral pressure ulcer (pressure injury on the lower back and tailbone), diabetes mellitus (body does not produce insulin or resists it), quadriplegia (paralysis of upper and lower extremities), colostomy (an opening in the colon, or large intestine, through the abdomen), neuromuscular dysfunction of the bladder (inability to properly control urination), anemia, and anxiety. Record review of Resident #18's Quarterly MDS assessment from 11/6/24 revealed a BIMS score of 10 out of 15, which indicated moderately impaired cognition. The resident had impairment on both sides of his upper and lower extremities. According to the MDS, the resident was dependent (the helper does all of the effort and resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the activity) with all ADLs. Resident #18 had an indwelling catheter and a colostomy. The MDS revealed he had a diagnosis of neurogenic bladder, which required the indwelling catheter. Record review of Resident #18's medical record revealed a foley catheter was not care planned. Record review of Resident #18's History and Physical from MD L on 10/8/24 revealed the resident had a foley catheter. Record review of Resident #18's order summary report dated 12/01/24-12/17/24 revealed no orders for a foley catheter. Record review of Resident #18's medical record on 12/17/24, revealed no documentation of foley catheter care. In an observation and interview with Resident #18 on 12/17/24 at 9:00am, the resident was lying on his back in bed with no obvious foley catheter or colostomy visible. The resident said he had a foley catheter and a colostomy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #87's undated face sheet revealed a [AGE] year-old male admitted on [DATE] with diagnoses of neuromuscular dysfunction of the bladder (inability to properly control urination), paraplegia (paralysis of both upper or lower extremities), sepsis (infection throughout body), schizophrenia (mental illness that affects how a person thinks, feels, and behaves), pressure ulcer of the sacrum (pressure injury on the lower back and tailbone), muscle weakness, and muscle wasting and atrophy. Record review of Resident #87's Quarterly MDS assessment from 11/20/24 revealed a BIMS score of 10 out of 15, which indicated moderately impaired cognition. The resident had impairment on both sides of his lower extremities. According to the MDS the resident was substantial/max assist with toileting hygiene (helper does more than half the effort). Resident #87 had an indwelling catheter. The MDS revealed he had a diagnosis of neurogenic bladder, which required the indwelling catheter. Record review of Resident #87's medical record revealed a foley catheter was not care planned. Record review of Resident #87's order summary report dated 12/01/24-12/17/24 revealed no orders for a foley catheter. Record review of Resident #87's medical record on 12/17/24, revealed no documentation of foley catheter care. In an observation on 12/15/24 at 12:59pm, Resident #87 was lying on his back in bed and had a foley catheter clipped to the side of the bed. In an interview and observation with Unit Manager D on 12/17/24 at 10:35am, she checked Resident #18 and Resident #87's medical record for a foley catheter or foley care order and there were none. She said they were still trying to fix orders that did not come over correctly or that were missed all together since they switched to a new EMR on 12/1/24. In an interview with the DON on 12/17/24 at 11:15am, she said the orders should have been in the system when the order was obtained. The staff should have reviewed the orders with the provider and then the provider verified the orders. She said there was always a chance to miss treatment if the order was not in the system. She said staff were trained on order entry and in-serviced prior to her coming. She said the ADON and Unit Manager conducted 24-hour chart checks to verify orders. She said the floor staff and managers were responsible for ensuring orders were in the system. The DON said the orders for the foley catheter and the foley care should have been in the EMR. She said the nursing staff should have seen the resident had a foley catheter and noticed there were no orders for it, then asked the MD to put orders in. She said if there were no orders, care could be missed. In an interview with LVN S on 12/17/24 at 11:29am she said Resident #18 and #87 both had foley catheters. She said she had not provided foley care yet, but she was going to before her shift was over. She said she knew to provide foley care because she had had the residents for a while before. She said this was her first day back with them, so she did not know if the nurses before her provided foley care. She said if the nurse did provide foley care and there were no orders, there would not be a place to document that it was done, and no one would know if the care was done or not. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy and procedure on Catheter Care (Revised March 2019) read in part: . Cleanse area at catheter insertion well, taking care not to pull on catheter or advance further into urethra. All debris must be removed from catheter at insertion site .Ensure leg strap in place to secure tubing .Date, time, procedure, condition of the perineum and catheter insertion site .signature and title. Record review of the facility's policy and procedure on Charting and Documentation (Revised July 2017) read in part: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .The following information is to be documented in the resident medical record: .Treatments or services performed .Documentation of procedures and treatments will include care-specific details, including: the date and time of the procedure/treatment was provided; the name and title of the individual(s) who provided the care; the assessment data and/or any unusual findings obtained during the procedure/treatment .the signature and title of the individual documenting . Record review of the facility's policy and procedure on Physician Orders (Revised January 2020) read in part: It is the policy of the facility that physician orders are maintained per state and federal regulations. All physicians' orders shall be recorded on the Patients Medical Record and must be signed electronically by the attending/prescribing physician .Physician orders include: .Treatments .Special medical procedures required for the safety and well being of the Patient .Others as necessary and appropriate .Medications, diets, therapy, or any treatment may not be administered to the Patient without a written order from the attending physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observation, interview, and record review the facility failed to ensure residents who needed colostomy care were provided such care, consistent with professional standards of practice for 1 of 6 residents (Resident #18) reviewed for ostomies (surgical opening from an area inside the body to the outside). - The facility failed to ensure physician orders for colostomy care were entered into the system for Resident #18 and staff were unable to document care provided from 12/1/24 to 12/17/24. This failure could place residents at risk of infection, skin break down, or discomfort. Findings included: Record review of Resident #18's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses of a sacral pressure ulcer (pressure injury on the lower back and tailbone), diabetes mellitus (body does not produce insulin or resists it), quadriplegia (paralysis of upper and lower extremities), colostomy (an opening in the colon, or large intestine, through the abdomen), neuromuscular dysfunction of the bladder (inability to properly control urination), anemia, and anxiety. Record review of Resident #18's Quarterly MDS assessment from 11/6/24 revealed a BIMS score of 10 out of 15, which indicated moderately impaired cognition. The resident had impairment on both sides of his upper and lower extremities. According to the MDS, the resident was dependent (the helper does all of the effort and resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the activity) with all ADLs. Resident #18 had a colostomy. Record review of Resident #18's medical record revealed a colostomy was not care planned. Record review of Resident #18's History and Physical from MD L on 10/8/24 revealed the resident had a colostomy. Record review of Resident #18's order summary report dated 12/01/24-12/17/24 revealed no orders for a colostomy. Record review of Resident #18's medical record on 12/17/24, revealed no documentation of colostomy care. In an observation and interview with Resident #18 on 12/17/24 at 9:00am, the resident was lying on his back in bed with no obvious foley catheter or colostomy visible. The resident said he had a foley catheter and a colostomy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Unit Manager D on 12/17/24 at 10:35am, she checked Resident #18's medical record for a colostomy or colostomy care order and said there were none. She said they were still trying to fix orders that did not come over correctly or that were missed all together since they switched to a different EMR on 12/1/24. In an interview with the DON on 12/17/24 at 11:15am, she said the orders should have been in the system when the orders were obtained. The staff should have reviewed the orders with the provider and then the provider verified the orders. She said there was always a chance to miss treatment if the order was not in the system. She said staff were trained on order entry and in-serviced prior to her coming. She said the ADON and Unit Manager conducted a 24-hour chart check to verify orders. She said the floor staff and managers were responsible for ensuring orders were in the system. The DON said the orders for the colostomy/colostomy care should have been in the EMR. She said the nursing staff should have seen the resident had a colostomy and noticed there were no orders for it and asked the MD to put orders in. She said if there were no orders, care could be missed. In an interview with LVN S on 12/17/24 at 11:29am she said Resident #18 had a colostomy. She said she had not provided colostomy care yet, but she was going to before her shift was over. She said she knew to provide colostomy care because she had had the resident for a while before. She said this was the first day back with him, so she did not know if the prior nurses provided colostomy care. She said if the nurse did provide colostomy care and there were no orders, there would not be a place to document it was done, and no one would know if the care was done or not. Record review of the facility's policy and procedure on Colostomy/Ileostomy Care (Revised October 2010) read in part: The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter .Remove drainage bag .Cleanse skin .Evaluate skin .Replace drainage bag . The following information should be recorded in the resident's medical record: The date and time the colostomy/ileostomy care was provided. The name and title of the individual(s) who provided the colostomy/ileostomy care. Any breaks in resident's skin, signs of infection .or excoriation of skin .The signature and title of the person recording the data . Record review of the facility's policy and procedure on Charting and Documentation (Revised July 2017) read in part: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .The following information is to be documented in the resident medical record: .Treatments or services performed .Documentation of procedures and treatments will include care-specific details, including: the date and time of the procedure/treatment was provided; the name and title of the individual(s) who provided the care; the assessment data and/or any unusual findings obtained during the procedure/treatment .the signature and title of the individual documenting . Record review of the facility's policy and procedure on Physician Orders (Revised January 2020) read in part: It is the policy of the facility that physician orders are maintained per state and federal regulations. All physicians' orders shall be recorded on the Patients Medical Record and must be signed electronically by the attending/prescribing physician .Physician orders include: .Treatments .Special medical procedures required for the safety and well being of the Patient .Others as necessary and appropriate .Medications, diets, therapy, or any treatment may not be administered to the Patient without a written order from the attending physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 of 5 residents (Resident #59) reviewed for pharmaceutical services. - The facility failed to ensure Resident #59's order for Potassium Chloride was accurately transcribed when the order was entered as unsupervised self-administration. Staff documented the medication as unsupervised self-administration from 12/07/24-12/17/24 although Resident #59 did not self administer Potassium Chloride. This failure could place the resident at risk of not receiving their medication or receiving the medication more than once. Findings included: Record review of Resident #59's undated face sheet revealed she was a [AGE] year-old female admitted on [DATE] with diagnoses of kidney failure (kidney stops filtering the blood), cardiac arrhythmia (heart does not beat regularly), respiratory failure (not enough oxygen in the blood), pneumonia (infection in the lungs), and heart failure. Record review of Resident #59's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 6 out of 15, which indicated severely impaired cognition. The resident was supervision and set up with all ADLs. Resident #59 was frequently incontinent of urine and always continent of bowel. The resident did not have any pressure ulcers or skin issues. Record review of Resident #59's medical record revealed her Potassium Chloride was not care planned. Record review of Resident #59's order summary report dated 12/01/24-12/17/24 revealed an order for Potassium Chloride Capsule 10meq ER, Give 1 tablet orally QD, unsupervised self-administration. Do not crush, dissolve in water. Ordered on 12/6/24. Record review of Resident #59's December 2024 MAR revealed from 12/7/24-12/17/24 the Potassium Chloride 10meq was signed off as U-SA by several different staff members. Record review of Resident #59's medical record on 12/17/24 revealed there were no assessments performed for self-administration of medication. In an observation on 12/16/24 at 8:29am Med Aide G gave Resident #59 her morning medications which were Norco, Eliquis, Spironolactone, and Pantoprazole, but not the Potassium Chloride. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/17/24 at 8:30am with Resident #59, she said she did not take any medications on her own and she only took whatever the staff gave her. She did not take her own Potassium Chloride. In an interview on 12/17/24 at 8:35am with Med Aide K she said she did not know the Potassium Chloride order said unsupervised self-administration and she did not question the order. She said the medication popped up on her MAR and she gave it to the resident. She did not question the resident about taking Potassium Chloride on her own or ensure she did not give the resident a double dose. In an interview and observation on 12/17/24 at 10:35am with Unit Manager D, she said they did not give unsupervised medications for self-administration. She said Resident #59's Potassium Chloride order was wrong, and someone must have checked the wrong box for self-administration on accident when they received the order. Unit Manager D was observed as she fixed the order. She said they were still trying to go through all the orders to ensure they were correct, from the old EMR to the new one that occurred on 12/1/24. In an interview with the DON on 12/17/24 at 11:15am, she said the orders should have been in the system when the orders were obtained. The staff should have reviewed the orders with the provider and then the provider verified the orders. She said there was always a chance to miss treatment if the order was not in the system. She said staff were trained on order entry and in-serviced prior to her coming. She said the ADON and Unit Manager conducted a 24-hour chart check to verify orders. She said the floor staff and managers were responsible for ensuring orders were in the system. The DON said the Potassium Chloride was on the Med Aide and the Nurse's orders so either one could have given the medication. She said on 12/16/24 the nurse had already given the medication to the resident. Record review of the facility's policy and procedure on Pharmacy Services Overview (revised April 2019) read in part: The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications .Pharmaceutical services consist of: the process of receiving and interpreting prescriber's orders; .dispensing .distributing, administering .using and/or disposing of all medications .Medications are .administered .according to all applicable state and federal laws and consistent with standards of practice. Record review of the facility's policy and procedure on Physician Orders (revised January 2020) read in part: It is the policy of this Facility that physician orders are maintained per state and federal regulations. All physicians' orders shall be recorded on the Patients Medical Record and must be signed electronically by the attending/prescribing physician. Verbal or telephone orders are considered to be in writing when dictated by the attending physician and later signed by him/her electronically once the Licensed nurses enter the order into the EMR. Orders must be signed electronically within a timely manner. Physician orders include: All medications .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on observation, interview, and record review the facility failed to maintain medical records in accordance with accepted professional standards and practices that were complete, accurately documented, readily accessible, and systematically organized for 3 of 6 residents (Resident #151, Resident #18, and Residetn #27) reviewed for medical records. - The facility failed to document Resident #151's treatments into his electronic record from 12/14/24 to 12/15/24. - The facility failed to have current care plans for Resident #18 and Resident #27 in the electronic health system. This failure could cause missed treatments and a decline in health. Findings included: 1. Record review of Resident #151's face sheet dated 12/17/24 revealed a [AGE] year-old male who readmitted on [DATE]. His diagnosis included convulsions (rapid involuntary muscle contractions), malnutrition, and benign prostatic hyperplasia (an enlarged prostate). Record review of Resident #151's undated baseline care plan indicated he was lethargic and cognitively impaired. He had a history of skin integrity issues. Record review of Resident #151's Braden scale for predicting pressure ulcer risk evaluation dated 12/13/24 revealed a score of 11 which indicated he was high risk. Record review of Resident #151's paper Physician's Telephone/Verbal Order dated 12/13/24 revealed the following order: Wound is almost healed; please keep clean and cover with provided bordered gauze dressing, order date 12/13/24. Record review of Resident #151's nursing note dated 12/13/24 (unknown author) read in part, .Residents arrive to facility via [name] transport . bed bound. Total care . R thumb laceration cleaned .R/L thigh wounds cleaned w/NS and dressed w/border gauze. Record review of Resident #151's nursing note dated 12/14/24 (unknown author) read in part, .LATE ENTRY: resident received wound care with dry dressing to left hip, right hip, and right hand. No s/s of pain noted. Notified [hospice] for clarification on wound care was told a nurse would be in to visit to clarity [sic] orders. Record review of Resident #151's nursing notes revealed there was no documentation of treatments on 12/15/24. Record review of Resident #151's nursing note dated 12/16/24 (unknown author) read in part, .notified [name], nurse with [name] Hospice, need for nurses visit for clarity of orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #151's order summary report dated 12/17/24 revealed the following treatment orders were entered 3 days after admission: -Wound treatment - dry dressing every day shift cleanse wound to left hip with normal saline or skin cleanser. Pat dry. Cover with dry dressing, order date 12/16/24 -Wound treatment - dry dressing every day shift cleanse wound to right hip with normal saline or skin cleanser. Pat dry. Cover with dry dressing, order date 12/16/24. In an observation on 12/15/24 at 12:04 p.m. Resident #151 was lying in bed with towels in both hands. He did not respond to this Surveyor's questions. In an observation on 12/16/24 at 9:37 a.m. Resident #151 was lying in bed. His right hand was wrapped and dated 12/16/24. In an interview on 12/16/24 at 3:02 p.m. LVN G said she worked with Resident #151 on 12/13/24. She said she did his head-to-toe skin assessment and LVN S helped her do the wound care. She said he had a shunt on the left side that went to his stomach, two red areas on the inside of his knees, an area to his right thumb, and a pressure sore to the left thigh/hip. She said the areas did not look infected, only red and they applied a simple dry dressing change and left it open. She said he was admitted from the hospital, and they did not send any orders for his wounds and was not alerted to any wounds. She said she could not remember if she contacted anyone about his wound orders. She said she would normally contact hospice about the wounds and treatments and hospice would send orders over. She said she reported the areas to the Unit Manager who said she would help her put the orders in. LVN G said she was not able to put the orders in because she got busy. She said whatever they do not complete they pass on to the next nurse. She said she notified the next nurse about the wounds and that there were no orders for them yet. She said she was trained on admissions and entering orders into the system. In an interview on 12/16/24 at 3:19 p.m. LVN V said she worked with Resident #151 on 12/14/24. She said she did a full body assessment, changed his bandage on his hand, hip, and sacrum, and documented the wound care on a note. She said his hospice orders were in the medical records bin and posted in his room, but the order did not specify the areas. She said she received report from the night nurse on Saturday morning and was informed how to do the wound care for the resident. She said the orders were normally in the system, but the facility recently changed to a new electronic record system, and it was acting up. She said she called hospice to determine the wounds and orders but did not get a response. She said she did not document the notification. She said the orders should be inputted in the system during admission and if the orders were not in the system the facility should check with the MD. She said she did not put the actual order in the system because it was not specific, and hospice did not answer back. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/17/24 at 9:17 a.m. the Wound Care Nurse said she was notified of Resident #151's wounds on 12/16/24 by the floor nurse. She said he had a left and right hip wound and scar tissue/redness to the sacrum. She said the areas did not look infected and there were dressings on all the areas from the previous day. She said Resident #151 had a note, but the order was confusing and not specific to the resident. She said the floor nurse verified the order with hospice and they wanted the facility to clean the areas and cover with dry dressing. She said everything had to be verified with Hospice and if hospice could not be reached, clean the areas and cover with a dry dressing. She said the order would have to be in the system because it was an order and nursing staff would either document in a nursing note and sign out in the MAR/TAR. In an interview on 12/17/24 at 9:57 a.m. LVN S said she conducted a head-to-toe assessment on Resident #151 with LVN G on 12/13/24. She said she identified a wound to the left hip/thigh, a small rash to the right side of leg, redness behind the knee, and a right laceration from piercing his thumb. She said the hospice nurse put orders on the resident's wall for normal saline and dry dressing. She said she was training LVN G and assumed LVN G put the orders in the system for the wound. LVN S said she should have checked behind LVN G to ensure the orders were in the system. She said orders should be in the system so the next nurse and wound care nurse would know what to look for. She said she received an in-service on putting orders into system and had been trained before. In an interview on 12/17/24 at 10:55 a.m. the DON said the staff questioned the orders for Resident #151, so they did not enter them in the system. She said the Hospice orders were posted on the wall, staff saw the orders, did the actual treatment, and communicated through shift change but were waiting for clarification from hospice. She said orders should be in the system when the order is obtained and if hospice did not respond within the hour, staff should go up the chain of command. She said the orders should have been put in the system even if staff were waiting for clarification so they could follow the order. She said the ADON put the orders in on Sunday 12/15/24. She said there was always a chance to miss treatment orders if the order was not in the system. She said staff were trained on order entry and in serviced prior to her coming. She said the floor staff and managers were responsible for ensuring orders were in the system. In an attempted interview on 12/17/24 at 11:27 a.m. with Resident #151's hospice nurse was unsuccessful. In an interview on 12/17/24 at 1:17 p.m. Unit Manager D said she put Resident #151's treatment orders in the system on 12/15/24. She said she called the NP and was instructed to continue orders as directed which was: Clean and cover with dry dressing. In an interview on 12/17/24 at 1:51 p.m. the Administrator said she spoke with Resident #151's Hospice nurse about tightening up the process for implementation of orders. She said the order provided by Hospice was the way family and hospice did the treatment and clarification was needed. She said the order should have been in the system to ensure the service was not missed, and to document what service was done. She said the DON provided reeducation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #151's hospice clinical charts note dated 12/17/24 written by Resident #151's hospice nurse revealed a skilled nurse daily visit was made for respite care. Respite stay from 12/13 - 12/18. Patient lying in hospital bed with head of bed elevated. Dressing is clean, dry and intact. Pressure wound to left hip is improving dramatically since the use of low air loss mattress. Wound still has some slough and mild drainage with no odor. Wound is 75% smaller now than at time of injury. Patient resting comfortably. Showing no signs of pain or discomfort at this time. Spoke with facility staff who report no unmanaged issues at this time. Updated facility staff on plan of care and encouraged them to call with any questions, concerns, change in patient condition or falls. 2. Record review of Resident #18's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses of a sacral pressure ulcer (pressure injury on the lower back and tailbone), diabetes mellitus (body does not produce insulin or resists it), quadriplegia (paralysis to all 4 extremities), colostomy (opening in the colon, or large intestine, through the abdomen), neuromuscular dysfunction of the bladder (inability to properly control urination), anemia, and anxiety. Record review of Resident #18's Quarterly MDS assessment from 11/6/24 revealed a BIMS score of 10 out of 15, which indicated moderately impaired cognition. The resident had impairment on both sides of his upper and lower extremities. According to the MDS, the resident was dependent (the helper does all of the effort and resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the activity) with all ADLs. Resident #18 had an indwelling catheter (a tube into the bladder to drain urine) and a colostomy. The MDS revealed he had a diagnosis of neurogenic bladder, which required the indwelling catheter. The resident was on Hospice care. According to the MDS, the resident had 5 Stage 4 (tissue loss with exposed bone, tendon or muscle) pressure ulcers. Record review of Resident #18's History and Physical from MD L on 10/8/24 revealed the resident had a foley catheter, a colostomy, Hospice services, and pressure ulcers. Record review of Resident #18's medical record revealed a Wound Evaluation and Management Summary from 11/22/24 from MD T, which indicated he had 5 pressure ulcers. Record review of Resident #18's medical record on 12/17/24, revealed his foley catheter, colostomy, hospice, and pressure ulcers were not care planned . In an observation and interview with Resident #18 on 12/17/24 at 9:00am, the resident was laying on his back in bed with no obvious foley catheter or colostomy visible. The resident said he did have a foley catheter and a colostomy. 3. Record review of Resident #87's undated face sheet revealed a [AGE] year-old male admitted on [DATE] with diagnoses of neuromuscular dysfunction of the bladder (inability to properly control urination), paraplegia (paralysis of either the upper or lower extremities), sepsis (infection throughout body), schizophrenia (mental illness that affects how a person thinks, feels, and behaves), pressure ulcer of the sacrum (pressure injury on the lower back and tailbone), muscle weakness, and muscle wasting and atrophy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #87's Quarterly MDS assessment from 11/20/24 revealed a BIMS score of 10 out of 15, which indicated moderately impaired cognition. The resident had impairment on both sides of his lower extremities. According to the MDS the resident was substantial/max assist with toileting hygiene (helper does more than half the effort). Resident #87 had an indwelling catheter. The MDS revealed he had a diagnosis of neurogenic bladder, which required the indwelling catheter. Resident #87 had a Stage 4 pressure ulcer. Record review of Resident #87's medical record revealed his foley catheter, pressure ulcer, and wound vac (treatment that uses suction to help heal wounds) were not care planned. Record review of Resident #87's order summary report dated 12/01/24-12/17/24 revealed the following orders: - Wound Vac-Placement and Patency Check, every shift. Wound Vacuum @ 125mmHg, Check placement and ensure patency. If dislodged, re-enforce dressing or change if necessary. Ordered on 12/1/24. - Wound Treatment: Cleanse Sacrum Wound with wound cleanser or normal saline; pat dry cover with calcium alginate (type of wound treatment) and collagen sheet (type of wound treatment). Cover with Island Gauze w/ border dressing-PRN when wound vac is not in use, as needed for wound healing. Ordered on 12/1/24. - Wound Vac -Apply to Sacrum- M-W-F at -125mmhg; Cleanse with wound cleanser or normal saline; pat dry; apply wound vac foam dressing and cover with film when vac not in use refer to PRN Wound Care Order, every shift Cleanse wound with Normal Saline or Skin Cleanser. Pat dry. Apply Wound Vacuum Dressing as instructed. Apply Wound Vacuum @-125 mmHg. Ordered on 12/1/24. In an observation on 12/15/24 at 12:59pm, Resident #87 was lying on his back in bed and had a foley catheter clipped to the side of the bed. In an observation on 12/16/24 at 1:00pm, Resident #87 was lying on his back in bed and had a wound vac draining bloody drainage from his pressure ulcer to his sacrum. In an interview on 12/17/2024 at 12:45pm with RN S, he said he was responsible for completing the entrance and discharge care plans for the long-term care side and stated if the resident's care plan was not updated, the resident would fall through the cracks and proper care would not be provided. RN S also stated the annual, admissions, and discharge care plans were the responsibility of the MDS nurse. He said the acute care plans were the responsibility of the ADON and unit manager. In an interview on 12/17/2024 at 1:10pm with LVN A, she said she assisted with care plans, but it had not been further discussed and was something they had not been trained in the past to do. LVN A also stated if a care plan was not updated or completed timely something would be missed such as daily ADLs for a resident or the treatment could not be completed. Staff was made aware of care plan changes by the morning huddle and nurses pulled a report that would verify any changes to inform other staff members who also provided care to residents. LVN A said if the Care Plans were not up to date, the expectation was to meet with the DON, MDS Nurse, and the Unit Manager to develop a plan on how the care plans would be brought up to compliance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/17/2024 at 1:24pm with the ADON, she stated if a care plan was not updated for a resident, the resident would fall by the wayside and would miss the opportunity to receive appropriate care. She said the care plans were updated by herself. The ADON said there had not been a chance to view the care plans and training had not been provided, since the position was just filled two weeks ago. She said the training would to be given by the DON in the upcoming weeks. As of right now, the ADON said during the transition of roles and new staff, MDS was supposed to update and complete care plans. Record review of the facility's policy on, Care Plans, Comprehensive Person-Centered, updated, March 2022 revealed, 2. The comprehensive, person-centered plan is developed within (7) days of the completion of the required MDS assessments (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 6. If the participation of the resident and his/her representative in developing the residents care plan is determined to not be practicable, an explanation is documented in the residents' medical record. The explanation should include what steps were taken to include the resident or representative in the process. 7e. The comprehensive, person-centered care plan reflects currently recognized standards of practice for problem areas and conditions. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just the symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Record review of the facility's Patient Care Management System 1, Skin policy dated July 2022 read in part, . 1. A head-to-toe skin assessment will be completed on day of admission and documented by the Admitting Nurse upon admission (including re-admission) of every patient. In addition, the Admitting Nurse will notify the physician and patient representative of any identified areas, implement treatment/interventions and document in Electronic Medical Record (EMR). Record review of the facility's Charting and Documentation policy dated July 2017 read in part, .all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . Policy Interpretation and Implementation . 1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record: . b. medications administered; c. treatments or services performed . Record review of the facility's Physician Orders dated January 2020 read in part, .all physicians' order shall be recorded on the patients medical record and must be signed electronically by the attending/prescribing physician . 4.The admission physician order will remain in the patient's chart at all times . 47722

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on interview, and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 1 residents (Resident #18) reviewed for hospice services, in that: - The facility failed to ensure Resident #18's Hospice order was in the EMR from 12/1/24-12/17/24. This failure could place residents who receive hospice services at-risk of receiving inadequate end-of-life care, coordination of care and communication of resident needs. Findings included: Record review of Resident #18's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses of a sacral pressure ulcer (pressure injury on the lower back and tailbone), diabetes mellitus (body does not produce insulin or resists it), quadriplegia (paralysis of upper and lower extremities), colostomy (an opening in the colon, or large intestine, through the abdomen), neuromuscular dysfunction of the bladder (inability to properly control urination), anemia, and anxiety. Record review of Resident #18's Quarterly MDS assessment from 11/6/24 revealed a BIMS score of 10 out of 15, which indicated moderately impaired cognition. The resident had impairment on both sides of his upper and lower extremities. According to the MDS, the resident was dependent (the helper does all of the effort and resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the activity) with all ADLs. Resident #18 had an indwelling catheter (a tube into the bladder to drain urine) and a colostomy. The MDS revealed the resident was on Hospice care. Record review of Resident #18's medical record revealed hospice was not care planned. Record review of Resident #18's History and Physical from MD L on 10/8/24 revealed the resident was on hospice. Record review of Resident #18's order summary report dated 12/01/24-12/17/24 revealed no orders for hospice. In an interview with Unit Manager D on 12/17/24 at 10:35am, she checked Resident #18's medical record for a hospice order and said there was not one. She said she knew the resident was on hospice and looked in the previous EMR. She said the order was in the previous EMR for hospice services. The Unit Manager said they were still trying to fix orders that did not come over correctly or that were missed all together since they switched to a different EMR on 12/1/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 12/17/24 at 11:15am, she said the orders should have been in the system when the orders were obtained. The staff should have reviewed the orders with the provider and then the provider verified the orders. She said there was always a chance to miss treatment if the order was not in the system. She said staff were trained on order entry and in-serviced prior to her coming. She said the ADON and Unit Manager conducted a 24-hour chart check to verify orders. She said the floor staff and managers were responsible for ensuring orders were in the system. Record review of the facility's policy and procedure on Hospice Services (dated November 2016) read in part: It's the policy of this facility to provide hospice services through an agreement with one or more Medicare-certified hospices .The facility must meet the following requirements: .Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the facility before hospice care is furnished to any resident. The written agreement must set out at least the following: The services the hospice will provide. The hospice's responsibilities for determining the appropriate hospice plan of care. The services the facility will continue to provide based on each resident's plan of care. A communication process, including how the communication will be documented between the facility and the hospice provider, to ensure that the needs of the Patient/Resident are addressed and med 24 hours per day .Obtain the following information from the hospice: The most recent hospice plan of care specific to each patient/resident. Hospice election form. Physician certification and recertification of the terminal illness specific to each patient/resident. Names and contact information for hospice personnel involved in hospice care of each patient/resident. Instructions on how to access the hospice's 24-hour on-call system. Hospice medication information specific to each patient/resident. Hospice physician and attending physician (if any) orders specific to each patient/resident . Record review of the facility's policy and procedure on Charting and Documentation (Revised July 2017) read in part: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .The following information is to be documented in the resident medical record: .Treatments or services performed .Documentation of procedures and treatments will include care-specific details, including: the date and time of the procedure/treatment was provided; the name and title of the individual(s) who provided the care; the assessment data and/or any unusual findings obtained during the procedure/treatment .the signature and title of the individual documenting . Record review of the facility's policy and procedure on Physician Orders (Revised January 2020) read in part: It is the policy of the facility that physician orders are maintained per state and federal regulations. All physicians' orders shall be recorded on the Patients Medical Record and must be signed electronically by the attending/prescribing physician .Physician orders include: .Treatments .Special medical procedures required for the safety and well being of the Patient .Others as necessary and appropriate .Medications, diets, therapy, or any treatment may not be administered to the Patient without a written order from the attending physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 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** 47722 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 6 residents (Resident #23) reviewed for Infection Control. Med Aide G failed to sanitize the blood pressure cuff between residents on 12/16/24. The blood pressure cuff was used on a Resident #250 who was on EBP and then placed on Resident #23 without being sanitized first. - This failure could place residents at risk of cross-contamination and development of infections. Findings included: 1. Record review of Resident #250's undated face sheet, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of extradural and subdural abscess (types of brain infections), bacterial meningitis (infection around the brain and spinal cord), MSSA (bacterial infection that can range from mild skin infections to more serious conditions), hemiplegia (paralysis) affecting right side following a stroke, aphasia (trouble speaking), dysphasia (trouble swallowing), neurofibromatosis (genetic disorder that causes tumors to grow in the nervous system), endocarditis (infection of the heart), epilepsy (seizures), and TIA (mini strokes). Record review of Resident #250's Admission MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15, which indicated moderately impaired cognition. The resident had impairment on both sides of his lower extremities and one side of his upper extremities. According to the MDS, the resident was substantial/max assist with all ADLs (helper does more than half the effort). Resident #250 was always incontinent of bowel and bladder. The MDS had diagnoses of bacterial meningitis, and MSSA. The resident had an unhealed Stage 2 (shallow open ulcer with a red or pink wound bed, without debris or intact/open blister.) pressure ulcer, according to the MDS. Resident #250 was also receiving IV antibiotics. Record review of Resident #250's medical record revealed his EBP and IV antibiotics were not care planned. Record review of Resident #250's History and Physical dated 12/9/24 from NP N, revealed the resident was at the hospital on 11/18/24 for a subdural empyema (brain infection) and had an evacuation with CSF (removal of spinal fluid) which was growing MSSA, and had endocarditis. The resident was going to need 6wks of IV antibiotics starting 11/22/24. Record review of the facility's Resident Matrix, printed on 12/15/24, revealed Resident #250 was on IV antibiotics. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 12/16/24 at 8:48am, Resident #250 had an EBP sign outside of his room. Med Aide G was observed as she took Resident #250's blood pressure with an electronic blood pressure cuff on his left wrist. She then took the blood pressure cuff and set it on the medication cart without cleaning it. 2. Record review of Resident #23's undated face sheet revealed she was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of altered mental status, anxiety, urinary tract infection, atrial fibrillation (heart does not beat regularly), and type 2 diabetes mellitus (body does not produce insulin or resists it). Record review of Resident #23's Admission MDS assessment dated [DATE] revealed a BIMS score of 11, which indicated moderately impaired cognition. The resident was supervision and set up with all ADLs. Resident #23 was always continent of bowel and bladder. According to the MDS, she had no pressure ulcers or skin issues. She was receiving PT/OT and was at the facility for rehabilitation after getting weak from a UTI. In an observation on 12/16/24 at 8:51am, Med Aide G was observed applying the blood pressure cuff on Resident #23's left wrist without disinfecting it first. In an interview on 12/16/24 at 9:11am with Med Aide G, she said she forgot to clean the blood pressure cuff. She said without cleaning the blood pressure cuff, it could cause cross contamination. In an interview on 12/16/24 at 9:15am with RN K, she said Resident #250 was on EBP and the blood pressure cuff should have been disinfected after each use to prevent cross contamination and for infection control. In an interview on 12/16/24 at 3:00pm with the DON, she said she in-serviced Med Aide G on infection control. She said the blood pressure cuff should have been cleaned and staff had just been in-serviced a few days earlier on EBP. Record review of the facility policy, Infection Control dated November 2017 read in part, .1. The facility must establish an infection prevention and control program (IPCP) that must include: a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all patients, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment .If there are signs and/or symptoms of an infection or positive culture, standard and transmission-based precautions must be put into place to prevent the spread of infection .