STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676381	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Houston Rehabilitation and Healthcare Center	13428 Bissonnet Houston, TX 77083

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure the assessment accurately reflected the status of 3 of 24 residents (Resident #3, Resident #35 and Resident #51) whose assessments were reviewed, in that: -Resident #3's stage 4 pressure ulcer was not documented on his latest Quarterly MDS dated [DATE].- Resident #35's dental condition and any related concerns were not documented in the most recent annual (dated 09/25/2025) and quarterly (03/18/2026) MDS assessments.- Resident #51's significant change MDS assessment did not reflect penile slit on 03/25/2026. This failure could place residents at risk because of their health conditions not reflected in their documentation and potentially not receiving the care and services deemed necessary due to inaccurate assessments.Resident #3Record review of Resident #3's face sheet last captured 04/08/2026 reflected a [AGE] year-old male originally admitted on [DATE] and last re-admitted on [DATE]. He had medical diagnoses including cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery (stroke due to blockage or narrowing of the artery in the brain), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis and weakness after a stroke affecting the right side of the body), cognitive communication deficit, type 2 diabetes mellitus (high blood sugar), and muscle weakness.Record review of Resident #3's care plan last captured 04/08/2026, reflected Resident #3 had a focus care area initiated on 08/05/2025 of a stage 4 pressure injury to the right hip, with interventions including perform treatment per order and report to MD if no improvement within two weeks.Record review of Resident #3's Quarterly MDS dated [DATE], reflected a BIMS was not conducted as he was rarely or never understood. Resident #3 was coded as having short and long-term memory problems. He was totally dependent on staff for all ADLs including eating, oral, personal and toileting hygiene and dressing along with total dependence on staff for bed mobility. In Resident #3's Skin Conditions Section M, he was coded as having a clinical assessment which determined he was at risk for developing pressure ulcers or injuries and had documented that Resident #3 no unhealed pressure ulcers or injuries, including no unstaged pressure ulcers.Record review of Resident #3's Order Summary dated 04/08/2026, reflected the following orders:-Stage 4 wound (an ulcer where there is full-thickness skin damage and loss down to the muscle, bone or tendons) right hip, irrigate or cleanse wound bed with normal saline, pat dry and apply or pack with a start date of 02/19/2026. Record review of Resident #3's skin assessments reflected the following:-On 02/26/2026, Resident #3 had a right hip pressure ulcer, stage 4, measuring 2.6 cm (length), 1.6 cm (width), and 0.1 cm (depth).-On 03/24/2026, Resident #3 had a right hip pressure ulcer, stage 4, measuring 1.2 cm (length), 0.9 cm (width), and 0.1 cm (depth). Record review of Resident #3's wound doctor visit notes, reflected the following:-On 03/05/2026, Resident #3 had a pressure wound on his right hip. It measured 2.6 cm (length), 1.6 cm (width), and 0.1 cm (depth). Healing potential was fair.-On 03/12/2026, Resident #3 had a pressure wound on his right hip. It measured 2.4 cm (length), 1.6 cm (width), and 0.1 cm (depth). Healing potential was fair. Interview with the MDS Coordinator on 04/08/2026 at 12:30pm, she reviewed Resident #3's skin documentation, including admission documentation, weekly skin assessments and the wound doctor visits. She said that Resident #3 had a stage 4 pressure ulcer (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented on 03/05/2026 by the wound doctor and it should have been reflected in Resident #3's Quarterly MDS on 03/07/2026. The MDS Coordinator said she did not do wound observations unless she happened to be there and that she reviewed resident documentation to ensure MDS accuracy. She said there were no risks to residents, and it affected MDS coding. Staff used resident's plan of care to provide information on interventions such as nutrition and positioning in Resident #3's case. The MDS Coordinator said whenever a mistake was found on a resident's MDS she would complete a modification and assessment MDS and get approval for it from her MDS Consultant.Interview with the DON on 04/08/2026 at 2:23pm, she said the MDS Coordinator did MDS assessments and care plans, and she had a consultant that she reported to. Since the MDS Coordinator was in-house, she could see residents, look at physician orders, progress notes, and resident charts. The DON said the MDS Coordinator knew that she could do visual assessments on residents to complete her work. Resident # 35Record review of Resident #35's face sheet dated 04/08/2026 reflected a [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE]. Her medical diagnoses included unspecified dementia (moderate with psychotic disturbance), heart failure (unspecified), morbid (severe) obesity, anemia, respiratory failure, and hypertensionRecord review of Resident #35's Quarterly MDS dated [DATE], reflected a BIMS score of 11, indicating moderate cognitive impairment. She required total assistance with personal hygiene, shower/bath, toileting, footwear, and bed mobility. She required substantial assistance with oral hygiene and upper body dressing, and supervision with eating. Resident #35's Section L (Oral/Dental Status) of the MDS was not completed.Record Review of Resident #35's Annual MDS Section L (Oral/Dental Status) dated 09/25/2025, indicated that none of the listed conditions were present. The options provided but not selected included: (A)Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose); (B) No natural teeth or tooth fragment(s) (edentulous); (C) Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn); (D) Obvious or likely cavity or broken natural teeth; (E) Inflamed or bleeding gums or loose natural teeth; (F) Mouth or facial pain, discomfort or difficulty with chewing; and (G) Unable to examineRecord review of Resident #35's last progress note regarding dental care, on 01/28/2025 at 8:40am documented Resident has been referred to dentist for eval/treat.Record review of Resident #35's x-ray and dental recommendations from dental visit dated 02/06/2025 reflected findings indicated severe calculus (also known as tartar which is a hardened form on dental plaque/buildup on the teeth and gum on which bacteria can develop into more serious issues of infection and damage) and plaque build-up, poor oral hygiene, poor gum health, gross decay, bone loss, non-restorable, loose-all teeth. The recommendations suggested extraction of tooth # 3,5,6,7,8,9,10,11,12,13,20,21,22,23,24,25,26,27,28,29.Interview on 04/07/2026 at 3:36pm with MDS Nurse, she said if a resident is admitted , she usually inputs allergies, admitting diagnosis, sometimes diet, fall risk, pressure ulcer, nutrition, and psychotropic meds. She said she will care plan what she sees. She reported that the baseline care plan is done by another team member. The MDS nurse said she would document refusals, and nurses and the Social Worker can document refusals as well. The MDS nurse was asked about Resident #35 and stated the resident can propel the wheelchair, has not complained about anything recently, and has a pureed diet. The MDS nurse did not know why Resident #35 was on a pureed diet at the time of the interview. The MDS Nurse said Resident #35 never complained about her teeth. When shown a picture of Resident #35's teeth and x-ray from dental visit dated 02/06/2025, the MDS nurse acknowledged that someone did not do a good job on the MDS assessment but stated she was not the MDS Nurse at the facility at the time.Interview and observation on 04/05/2026 at 3:45pm with Resident #35, revealed her teeth were brownish, and some teeth were broken and chipped. A strong oral odor was observed. Resident #35 said she has not been to the dentist in a long time and reported she wants to go. Resident #35 reported sometimes she has tooth/oral pain. She said she told the Social Worker that she wanted to go to the dentist about a month ago but has not heard back. She stated her nurse is aware of her oral pain and is given Tylenol to help ease the pain. Resident #51Record review of Resident #51's face (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sheet dated 4/8/26 reflected a [AGE] year-old male originally admitted on [DATE] and was re-admitted on [DATE] with medical diagnoses of obstructive and reflux uropathy (obstructive uropathy is a condition where urine flow is blocked, causing a damming effect that can damage the kidneys, while reflux uropathy is a condition where urine flows backward (the wrong way) in the urinary tract), indwelling urethral catheter (a common type of thin, flexible tube that a doctor or nurse puts into the bladder to continuously drain and collect urine), schizophrenia (is a serious, long-term brain disorder that causes people to interpret reality in an abnormal way, making it difficult to distinguish between what is real and what is imaginary), type 2 diabetes mellitus and morbid (severe) obesity due to excess calories.Record review of Resident #51's significant change MDS dated [DATE], revealed his BIMS score was 15, indicating no cognitive impairment. He required total assistance with toileting. He was continent for bladder and incontinent of bowel. He had an indwelling catheter. The MDS did not contain any concerns related to skin conditions, including no documentation that Resident #51 had a penile slit.Record review of Resident #51's care plan dated 03/26/2026, reflected interventions were to follow physician orders for catheter insertion, changes, and maintenance, monitor site for signs and symptoms of infection or skin breakdown - report any noted to MD, notify the physician of any adverse findings/changes. Resident #51's care plan did not address Resident #51's penile slit and the use of straps to secure his catheter.Record review of Resident #51's order summary dated 1/7/26 revealed he had orders for: use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate site of securement daily. (order date 10/10/25). Monitor for potential complications of indwelling urinary catheter use such as redness, irritation, s/s of infection, obstruction, urethral erosion (tissue damage to the duct where urine leaves the body and the surrounding penile tissue due to catheter use). (start date 12/8/2025).Record review of nurse's notes dated 3/28/26 reflected Resident #51 complained of penis pain due to the catheter and was medicated.Observation of Resident #51's incontinent and foley catheter care on 04/08/2026 at 10:03 am with CNA DD and CNA BB, revealed there was no leg strap or Statlock (stabilization device for a foley catheter) to secure the catheter. There was a slit to the penis.Observation on 4/8/26 at 4:11 PM revealed the penile slit was measured by the LVN treatment nurse and it was 3.00 cm in length and 1.5cm in width.In an interview with MDS Coordinator on 4/8/26 at 4:40PM, she looked at Resident#51's MDS and said his penile slit being omitted from the MDS and care plan was an oversight on her part. She would do a modification on Resident #51's MDS and care plan.In an interview with DON on 4/8/26 at 4:32 PM regarding Resident #51's indwelling catheter, DON said the expectation would be that the MDS assessments and care plans would be accurate to ensure continuity of resident care.Record review of the facility's policy on MDS Assessments titled Assessment Frequency and Timeliness last revised on 04/2024, it read in part, The purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI Manual.9. A significant correction assessment will be completed no later than the 14th calendar day after determination that a significant error in a prior OBRA assessment occurred.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 describing services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 16 residents (Residents #51, #73 and #91) reviewed for comprehensive care plans.1. The facility failed to care plan Resident #51, Resident #73 and Resident #91 for leg straps.2. The facility failed to care plan Resident #51's penile slit and any related interventions. This failure could lead to residents not having their individual, medical, functional, and psychosocial needs identified and cause a physical, mental or psychosocial decline in health.Resident #51Record review of Resident #51's face sheet dated 4/8/26 reflected a [AGE] year-old male originally admitted on [DATE] and was re-admitted on [DATE] with medical diagnoses of obstructive and reflux uropathy (obstructive uropathy is a condition where urine flow is blocked, causing a damming effect that can damage the kidneys, while reflux uropathy is a condition where urine flows backward (the wrong way) in the urinary tract), indwelling urethral catheter (a common type of thin, flexible tube that a doctor or nurse puts into the bladder to continuously drain and collect urine), schizophrenia (is a serious, long-term brain disorder that causes people to interpret reality in an abnormal way, making it difficult to distinguish between what is real and what is imaginary), type 2 diabetes mellitus and morbid (severe) obesity due to excess calories.Record review of Resident #51's significant change MDS dated [DATE], revealed his BIMS score was 15, indicating no cognitive impairment. He required total assistance with toileting. He was continent for bladder and incontinent of bowel. He had an indwelling catheter. Record review of Resident #51's care plan dated 03/26/2026, reflected interventions were to follow physician orders for catheter insertion, changes, and maintenance. Monitor site for signs and symptoms of infection or skin breakdown - report any noted to MD. Notify the Physician of any adverse findings/changes. The care plan did not address Resident #51's penile slit or the use of straps to secure his catheter.Record review of Resident #51's order summary dated 1/7/26 revealed he had orders for: use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate site of securement daily. (order date 10/10/25). Monitor for potential complications of indwelling urinary catheter use such as redness, irritation, s/s of infection, obstruction, urethral erosion. (start date 12/8/2025). There were no orders for straps.Record review of nurse's notes dated 12/22/25 and 3/28/26 reflected Resident #51 complained of penis pain due to the catheter and was medicated.Record review of MD's notes on 10/21/2025, reflected Resident #51 was sent to the ER for bleeding from a chronic penile wound; returned the same day with a prescription for cefpodoxime (antibiotic) for UTI. Ongoing mild oozing at the wound site. There were no documents reflecting penile slit.Observation and interview during Resident #51's incontinent and foley catheter care on 04/08/2026 at 10:03 am with CNA DD and CNA BB, revealed there was no leg strap or Statlock (stabilization device for a foley catheter) to secure the catheter. There was a slit to the penis. Resident #51 did not verbalize that he was in pain or display any facial grimacing while staff cleaned the indwelling catheter. C NA DD and C NA BB were asked why the Resident did not have a strap to secure his indwelling catheter. CNAs said the nurses secured the indwelling catheter. CNA DD and CNA BB said they had not seen the slit on the resident's penis before. Resident #51 said he the urologist placed a tape on his right thigh which Resident #51 removed when he changed his catheter about 5 days ago because the tape partially came off during shower and it was sticking to his left thigh and it always pulled his skin. When asked if he had tried any other different securing strap, he said no one had offered him any other strap. He said he had pain to the catheter site and sometimes (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was very uncomfortable. He always requested for pain medication, and it helped. Resident #51 did not remember the exact time when the penile slit started but believed it was around October or September 2025. He said he would love to try another securing strap that would not stick to his skin.Observation on 4/8/2026 at 4:11 PM of the penile slit, revealed LVN treatment nurse measured Resident #51's slit which was 3.00 cm in length and 1.5cm in width. Resident #73Record review of Resident #73's face sheet dated 04/08/2026 reflected a [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE]. Her medical diagnoses included dementia (memory loss), type 2 diabetes mellitus (high blood sugar), and neuromuscular dysfunction of the bladder (nerve damage affecting bladder control).Record review of Resident #73's Comprehensive MDS dated [DATE], she had a BIMS score of 00 indicating severe cognitive impairment. Resident #73 was coded for an indwelling catheter. She was coded for having a neurogenic bladder (the nervous system affecting bladder function).Record review of Resident #73's care plan last captured 04/08/2026, she had a focus area of unwanted behavior for removing her foley catheter on 04/01/2026. There were no focus areas specifically for her catheter and no interventions documented for catheter care to be provided. Resident #91Record review of Resident #91's face sheet dated 04/08/2026, he was a [AGE] year-old male originally admitted on [DATE] and last re-admitted on [DATE]. He had diagnoses of dementia (memory loss), chronic kidney disease (stage 4, severe) and obstructive and reflux uropathy (a blockage in someone's urinary system). Record review of Resident #91's most current Quarterly MDS dated [DATE], he had a BIMS score of 13, indicating high cognitive intactness. He was care-planned for indwelling catheter and was coded for having renal insufficiency/renal failure or End Stage Renal Disease and having obstructive uropathy.Record review of Resident #91's care plan last captured 04/08/2026, he had a focus area of having an indwelling catheter dated 11/26/2025 with interventions positioning the catheter bag and tubing below the bladder and in a privacy bag, checking the tubing for kinks and monitoring for signs and symptoms of discomfort on urination and frequency and urinary output. There were no interventions for leg straps or means of securing the catheter. Observation of catheter secured straps reflected the facility had 2 kinds:1: Foley cath-secure plus-water Resistant multi-purpose tube holder Resident #51 did not like this one2: Foley catheter holder - with dual-locking tab non-sterile, Resident #51 was okay for it use. Interview with the DON on 04/08/2026 at 4:32pm, she said Resident #51 had a care plan for his in-dwelling catheter and refusal to use a strap.Interview with the MDS Coordinator on 04/08/2026 at 5:25pm, she said residents who had a catheter would have it care planned and have interventions in place including the diagnosis related to the presence of the catheter, the goals and interventions for the catheter like copying down physician orders, checking for a stat lock to keep the catheter in place and prevent pulling or trauma. It was the MDS Coordinator's job to document and sometimes nursing management will document. The MDS Coordinator found that Resident #73 had a catheter due to obstructive uropathy and found that there were no interventions for leg straps. Resident #91 had a care plan for catheter due to neuromuscular dysfunction and had a behavior of removing her catheter which required re-insertion. Interview with the Medical Director on 04/08/2026 at 5:41pm, she was aware of Resident #51's condition and his penile split and said she did not remember the exact date but it had been a year. The Medical Director expected his condition of penile split and how the facility should care for it to be in his care plan. Interview with the Administrator and DON on 04/08/2026 at 6:41pm, the Administrator said he expected staff to provide proper treatment. The DON said she was not aware staff had attempted to provide a leg strap for Resident #51 5 days ago. The DON said she did not know exactly when Resident #51's penile slit began and said Resident #51's catheter should have been secured. Staff should have measured it when he was admitted . The DON's expectations for staff would be for staff to document any injury in Resident #51's records. Record review of the facility's policy on baseline care plans last revised on 01/2026, it read in part, .2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	representative, if applicable.Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives.Interventions shall be initiated that address the resident's current needs including:Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk.Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living.Any special needs such as for IV therapy, dialysis, or wound care.Once established, goals and interventions shall be documented in the designated format .8. In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes shall be incorporated into an updated summary provided to the resident and his or her representative, if applicable. This will be provided by the MDS nurse/designee by the completion date of the comprehensive care plan.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to assist residents in obtaining routine and 24-hour emergency dental care and in making appointments with 1 of 10 residents (Resident #35) reviewed for dental care. -The facility failed to assist the resident in making a follow-up dental appointment.-The facility failed to provide documentation of the extenuating circumstances that led to the delay in Resident #35 not having routine and follow-up dental appointments.-The facility failed to notify Resident #35's guardian of the dental recommendations. These failures could place residents at risk of oral complications, dental pain, and diminished quality of life.Record review of Resident #35's face sheet dated 04/08/2026 reflected a [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE]. Her medical diagnoses included unspecified dementia (moderate with psychotic disturbance), heart failure (unspecified, morbid (severe) obesity, anemia, respiratory failure, hypertension, and muscle weakness.Record review of Resident #35's Quarterly MDS dated [DATE], reflected a BIMS score of 11, indicating moderate cognitive impairment. She required total assistance with personal hygiene, shower/bath, toileting, footwear, and bed mobility. She required substantial assistance with oral hygiene and upper body dressing, and supervision with eating. Resident #35's Section L (Oral/Dental Status) of the MDS was not completed.Record Review of Resident #35's Annual MDS Section L (Oral/Dental Status) dated 09/25/2025, indicated that no dental conditions were present.Record review of Resident #35's last progress note regarding dental care, on 01/28/2025 at 8:40am documented Resident has been referred to dentist for eval/treat.Record review of Resident #35's weights, revealed she did not have weight loss for the last 6 months. Resident #35 had weight gain. Resident #35 was put on a pureed diet due to swallowing and respiratory concerns, not because of her teeth. Tooth/oral pain had not been documented.Record review of Resident #35 x-ray and dental recommendations from dental visit dated 02/06/2025 indicated severe calculus (hard layer of plaque under gum line) and plaque build-up, poor oral hygiene, poor gum health, gross decay, bone loss, non-restorable, loose-all teeth. The recommendations suggested extraction of tooth # 3,5,6,7,8,9,10,11,12,13,20,21,22,23,24,25,26,27,28,29.Interview and observation on 04/05/2026 at 3:45pm with Resident #35 she reported she has been at the facility for a long time and is ready to get out. Resident #35 stated she does not know why she is on a pureed diet and does not eat her food because she does not like eating pureed food. Resident #35's teeth were brownish color, some teeth were broken, chipped, and rotten. A strong oral odor was observed. Resident #35 said she has not been to the dentist in a long time and reported she wants to go to the dentist. Resident #35 reported sometimes she has tooth/oral pain. She said she did not remember how often she had tooth pain, but said it was not every day. She said she told the Social Worker that she wanted to go to the dentist about a month ago but had not heard back. She stated her nurse is aware of her oral pain and she is given Tylenol to help ease the pain. She said the pain was not unbearable and the Tylenol was effective with easing the pain. Resident #35 said her CNA helped her brush her teeth in the mornings. Resident #35 said her teeth did not stop her from eating whatever she wanted. Resident # 35 was observed in the common area and dining room of the facility interacting and socializing with other residents and staff.Interview on 4/7/26 at 10am with Social Worker, when asked if Resident #35 ever told him that she needed to go to the dentist, the SW reported the resident has never asked him to schedule any appointments for her. The SW reported that the resident was not seen by the dentist last time because she refused services. SW stated the resident last saw the dentist on 2/6/25 for x-rays. When asked if there was any follow-up after that visit the SW reported no because Resident #35 refused dental services. In a later interview at 10:20am, when relayed to the SW that Resident #35 reported not remembering she ever refused dental services, the SW said he was just on the phone trying to get the dental appointment scheduled for Resident #35.Interview and observation on 4/7/26 at 10:10am of Resident #35, revealed she was in her wheelchair in the hallway attempting to (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	maneuver to the common area to watch TV. Resident #35 said she was feeling okay. Surveyor informed Resident #35 that she spoke with the social worker about her interest in dental appointments. Surveyor asked the Resident #35 if she had refused dental services in the past. Resident #35 said no.In a telephone Interview on 4/8/26 at 12:32pm with Resident #35's RP, when asked if she was aware of Resident #35 refusing dental care, the RP said, No, and reported that she had just heard about the dental recommendations that day. She reported that the SW and DON called her about 2 hours prior on 04/08/2026 asking her if she received an email from the dentist's office. The RP said she told them no because she never received anything from the dental office. She reported coming to the facility regularly and was never asked about an email from the dental office prior to 4/8/26. The RP said she never refused dental treatment for Resident #35. The RP reported the Social Worker forwarded her dental information via email that day (4/8/26). The RP reported she asked the DON why they were just telling her about dental recommendations from over a year ago, she stated the DON told her the dental treatment was going to cost over $1400 out of pocket and did not think the RP wanted to pay that much for the treatment. The RP reported she did not know why the DON would think that. The RP said she really wanted Resident #35 to get her teeth fixed. The RP said Resident #35 had complained of oral pain before but was told the pain was managed with medication.Interview on 4/8/26 at 12:53pm with Social Worker. He said he called Resident #35's RP today to ask if she received the dental recommendations from the visit dated 2/6/25. He said the RP said she never got it, and she confirmed her email and address with Social Worker. The Social Worker acknowledged it would have been best to follow up with the RP sooner but said he was busy with a lot of residents. He said he expected the dentist to follow-up. He said he usually would document when he receives correspondence from the dentist, but he did not. The Social Worker admitted that if he did not hear from the dentist or RP, dental care could go unnoticed. Surveyor asked was the refusal of dental service documented. The Social Worker said that Resident #35 did not refuse dental services. He said initially he had Resident #35 confused with another resident that did refuse. The Social Worker acknowledged that if dental care and recommendations are not followed up, it could cause disease and other health risks.Interview on 4/8/26 at 2:23pm with DON, she said the Social Worker called the dental company on 04/08/2026 regarding Resident #35's last dental appointment dated 02/06/2025 and was told Resident #35's RP never responded by email. The DON said she called Resident #35's RP on 04/08/2026 and verified her email, address, and telephone number and all of those were correct. The DON said Resident #35 was considered a full vendor, and the RP would have to pay for those services. She said the dental company sent a payment plan and the Social Worker got a letter from the dental company saying the family never responded. DON said if the RP wanted Resident #35 to be seen by the dentist, the guardian is responsible and should have been keeping up. DON said the Social Worker helps set up dental services. She said the RP knew Resident #35 was going for the examination. The DON said the dentist communicated with the facility what they are going to do and she said she assumed the dental company called the RP about the dental service. The DON acknowledged that the facility should have followed up with the RP to confirm whether the dental company followed up or not. The DON said she will find out when the dental company informed the RP.Dental policy requested from Administrator on 4/8/26 at 5:14pm. The DON said they did not have a specific dental policy.

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	676381	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Houston Rehabilitation and Healthcare Center	13428 Bissonnet Houston, TX 77083

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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 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** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 4 residents (Resident #51) reviewed for incontinent care. 1.The facility failed to ensure Resident #51's indwelling catheter was secured and penile slit documented. Resident #51 had a slit on his penis measuring 3 cm length by 1.5 cm width on 04/08/2026. These failures could place residents at risk for pain, infection, injury, and hospitalization.Findings included: Record review of Resident #51's face sheet dated 4/8/26 reflected a [AGE] year-old male originally admitted on [DATE] and was re-admitted on [DATE] with medical diagnoses of obstructive and reflux uropathy (obstructive uropathy is a condition where urine flow is blocked, causing a damming effect that can damage the kidneys, while reflux uropathy is a condition where urine flows backward (the wrong way) in the urinary tract), indwelling urethral catheter (a common type of thin, flexible tube that a doctor or nurse puts into the bladder to continuously drain and collect urine), schizophrenia (is a serious, long-term brain disorder that causes people to interpret reality in an abnormal way, making it difficult to distinguish between what is real and what is imaginary), type 2 diabetes mellitus and morbid (severe) obesity due to excess calories. Record review of Resident #51's significant change MDS dated [DATE], revealed his BIMS score was 15, indicating no cognitive impairment. He required total assistance with toileting. He was continent for bladder and incontinent of bowel. He had an indwelling catheter. Record review of Resident #51's care plan dated 03/26/2026, reflected interventions were to follow physician orders for catheter insertion, changes, and maintenance. Monitor site for signs and symptoms of infection or skin breakdown - report any noted to MD. Notify the Physician of any adverse findings/changes. The care plan did not address Resident #51's penile slit and the use of straps to secure his catheter. Record review of Resident #51's order summary dated 1/7/26 revealed he had orders for: use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate site of securement daily. (order date 10/10/25). Monitor for potential complications of indwelling urinary catheter use such as redness, irritation, s/s of infection, obstruction, urethral erosion (the wearing away, tearing, or damage of the tissue lining the urethra start date 12/8/2025). Record review of Resident #51's skin assessment on admission on [DATE] reflected no penile slit. Further skin assessments dated 4/2/26, 3/17/26, 2/24/26, and 1/24/26 did not address the slit on the penis. The skin assessments documented that Resident #51's skin was intact. Record review of MD's notes on 10/21/2025, reflected Resident #51 was sent to the ER for bleeding from a chronic penile wound; returned the same day with a prescription for cefpodoxime (antibiotic) for UTI. Ongoing mild oozing at the wound site. There were no documents reflecting penile slit. Record review of nurse's notes dated 12/22/25 and 3/28/26 reflected Resident #51 complained of penis pain due to the catheter and was medicated. Record review of Resident #51's nurses' notes dated 12/22/2025, reflected the nurse documented Resident #51 was Sent to ER (Emergency) after catheter-related pain with subsequent hematuria (blood in the urine) heart rate was 102, and low O2 saturation. Resident #51 returned on 12/26/2025 on cefdinir (antibiotic) for 7 days. Observation and interview during Resident #51's incontinent and foley catheter care on 04/08/2026 at 10:03 am with CNA DD and CNA BB, revealed there was no leg strap or Statlock (stabilization device for a foley catheter) to secure the catheter. There was a slit to the penis. Resident #51 did not verbalize that he was in pain or display any facial grimacing while staff cleaned the indwelling catheter. C NA DD and C NA BB were asked why the Resident did not have a strap to secure his indwelling catheter. CNAs said the nurses secured the indwelling catheter. CNA DD and CNA BB said they had not seen the slit on the resident's penis before. Resident #51 said he took off the tape the urologist placed on his right thigh when he changed his catheter about 5 days (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ago because the tape was coming after shower and it was sticking to his left thigh and it always pulled his skin. When asked if he had tried another securing strap, he said no one had offered him any other strap. He said he had pain to the catheter site and sometimes was very uncomfortable. Resident #51 said he always requested for pain medication and it helped. Resident #51 did not remember the exact time when the penile slit started but he was thinking around October or September 2025. He said he would love to try another securing strap that would not stick to his skin . Observation on 4/8/2026 at 4:11 PM of the penile slit, revealed LVN treatment nurse measured the slit which was 3.00 cm in length and 1.5cm in width. Observation on 4/8/26 at 4:15 PM of catheter secured straps reflected the facility had 2 kinds:1: Foley cath-secure plus-water Resistant multi-purpose tube holder Resident #51 was shown both straps, he did not Foley cath-secure plus-water Resistant multi-purpose one. 2: Foley catheter holder - with dual-locking tab non-sterile, Resident #51 was fine with it use. Interview with LVN OO on 4/8/2026 at 3:37 PM she said Resident #51's skin was intact when he came back from the hospital, and he did not want the strap to his right thigh, because it irritates him. LVN OO said she made sure he was not in any pain and penile site was not irritated. The facility uses Foley cath-secure plus-water Resistant multi-purpose strap with tape and that irritates him. She knew not putting the strap to secure the catheter would cause pulling and tension. She will now talk to DON and scheduler to find an alternative strap. She saw the penis; there were no signs of infection. Interview with Treatment Nurse LVN on 4/8/26 at 3:45 PM, She said she worked in the facility for a year. She does treatment for all residents and head to toe assessment. She said she did an assessment when Resident #51 came back from the hospital on 3/17/26. He did not come back with pressure ulcer and the penile slit looks old. Telephone interview with the MD on 4/8/26 at 4:00 PM regarding Resident #51's penile slit, she said she was aware of it and he was referred to urologist for consult for possible supra pubic catheter. Resident #51 wanted a laser surgery, and his insurance did not approve it. MD said the facility should have measurements of the penile slit and documented it in his care plan. Interview with DON on 4/8/26 at 4:32 PM regarding Resident #51's indwelling catheter, DON said Nurses should check to make sure straps are in place. They should check every shift and as needed. They are checking to make sure the catheter is in place and so it does not come out. If residents do not want to use secure straps, the facility should have care plans for secure strap refusal, and it was the resident's right to refuse treatment and that the facility educated him. DON said she knew not securing the catheter could result in trauma. The DON's expectation is all nurse aides would notify the nurse to place the securing strap in the right position. Record review of the facility's policy for Catheter Care revised 04/2026: Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.6. Leg bags will be attached to the resident's thigh or calf, making sure to have slack on the on the tubing to minimize pressure and tension. Ensure straps are snug but not tight.Kinks: Ensure the catheter tubing remains free from any kinks that might obstruct urine flo

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 2 of 4 residents (Residents #27 and #48) reviewed for respiratory care.-The facility failed to ensure Resident #27's and Resident #48's oxygen humidifier bottle on the oxygen concentrator had enough water in the bottle to function properly.These failures could place residents who required respiratory treatments at risk of receiving inadequate respiratory treatments and could result in a decline in health.Resident #27Record review of Resident #27's undated face sheet revealed she was an [AGE] year-old female who was admitted to the facility on [DATE] and was readmitted on [DATE]. Her diagnoses included hypertension (high blood pressure), atrial fibrillation (irregular or rapid heartbeat), congestive heart failure (when the heart does not pump blood effectively), chronic obstructive pulmonary disease (difficulty breathing) and chronic respiratory heart failure with hypoxia (a condition where the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body).Record review of Resident #27's admission MDS dated [DATE] Section CO500 revealed a BIMS of 15 indicating the resident was cognitively intact. Section: O 0110 reflected the resident was coded as having oxygen therapy. Record review of Resident #27's care plan dated 2/06/2026 revealed:Focus: Resident #27 requires the use of O2 via nasal canula.Goal: Resident #27 will maintain optimal breathing and evidence s\s of respiratory distress through the next review.Intervention: Allow rest periods during all tasks-do not rush. Apply O2 via nasal canula as ordered. Monitor O2 sats as needed, notify MD of any abnormalities.Observation on 4/05/2026 at 4:00pm revealed Resident #27 was in bed and her O2 was infusing at 4 Lper minute. The humidifier bottle was dated 3/30/2026 and the bottle was empty.In an interview on 4/5/2026 at 4:00pm with Resident #27 revealed that staff normally do not check the water bottle on the humidifier. She said she always had to tell them the humidifier bottle had no water and they took a long time to change the bottle whenever it was empty. Further interview with Resident #27 regarding how she was feeling she said she was okay, but her nostril was a little dry.In an interview on 4/5/2026 at 4:03pm LVN D said she checked the water at the beginning of her shift and there was a small amount of water in the bottle but had not checked it since. She said she was going to look at it and change it. Further interview with LVN D revealed the water on the humidifier was changed weekly and as needed. She said whenever the bottle was empty it should be changed. She said the water should be checked at the beginning of each shift to ensure everything was working properly. She said if there was no water in the bottle it could cause dryness in the resident nose and nosebleed. She said she should check the humidifier, but it was overlooked. Resident #48Record Review of the undated face sheet for Resident #48 revealed she was a [AGE] year-old, female who was admitted to the facility on [DATE] and readmitted [DATE]. Her diagnoses included hypertension (high blood pressure), atrial fibrillation (rapid heart rate that causes poor blood flow), chronic obstructive pulmonary disease (difficulty breathing) and chronic respiratory heart failure with hypoxia (a condition where the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body).Record review of Resident #48's quarterly MDS dated [DATE] Section CO500 revealed a BIMS score of 15 indicating the resident was cognitively intact. Section O: Special treatment revealed the resident was coded as receiving respiratory treatment and oxygen therapy.Record Review of the care plan dated 6/23/23 revealed Resident #48 was care-planned for oxygen therapy at 2-5LPM continuously for sats below 92%.Record review of the physician's orders dated 2/20/23 revealed Resident #48 was to receive 02 at 2L/m via NC Continuously every shift. Additional order dated 6/4/24 revealed Oxygen at 2-4 LPM via nasal cannula continuously. Monitor 02 sat. every shift.Observation on 4/5/26 at 4:50pm revealed Resident #48 lying in bed with the canula in her nostrils and O2 infusing at 4.5 liters per minute. Observed the oxygen tank humidifier water bottle (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was dated 3/29/2026 with no water in the bottle.During an interview on 4/5/26 at 4:50pm with Resident #48 she said water on the humidifier was supposed to be changed once a week. She said they never usually come to change the water on the humidifier as they should. She said she will tell them, but sometimes they take a long time. She said that morning the nurse checked the nebulizer, but she did not check the humidifier. In an interview on 4/5/2026 at 4:55pm with LVN B revealed she was the nurse assigned to Resident #48. She said she went to the resident's room and checked the water bottle. She said the water was low, but she had not checked it since. She said she was going to change the water bottle. LVN B stated having no water in the bottle could cause shortness of breath, may cause sinus problems and could cause residents to have mental confusion.In an interview on 4/5/2026 at 5:45pm with the DON, she said the responsibility of the nurses was to make rounds and check the humidifier. She said the nurses should check the water, or the entire oxygen tank during their rounds. When the water bottles were empty, they were required to replace them. The DON stated the oxygen flow without water could lead to resident nose bleeding, oxygen issues and cause nose dryness.Record review of the undated Policy for Oxygen Administration implemented 10/2022 and revised 1/2026, revealed: Policy:Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive centered care plans, and the resident's goal and practices.Definition:Oxygen therapy is the administration of oxygen at concentration greater than in ambient air (20.9%) with the intent of treating or preventing the symptoms and manifestation of hypoxia. Policy Explanation and Compliance Guidance5. Staff shall perform hand hygiene when administering oxygen or when in contact with oxygen equipment.c. Change humidifier bottle when empty, or per facility policy, or as recommended by the manufacturer. Use only sterile water for humification.Types of delivery systema. Nasal Canula- Oxygen is administered through plastic cannulas in the nose. Effective for low oxygen concentration less than 40%. Requires humidification at flow rate greater than 4 liters/minutes.