STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676490	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sylan Shores Health and Wellness	3950 Underwood Rd LA Porte, TX 77571

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 2 (Resident #3 and Resident #6) of 6 residents reviewed for quality of care.The facility failed to ensure Resident #3's fall on 10/09/2025 and Resident #6's fall on 11/07/2025 were in their respective care plan s.This failure placed residents at risk of not receiving appropriate care and interventions to meet their needs. Resident #3Record review of Resident #3's face sheet dated 11/24/2025, she was a [AGE] year-old female originally admitted to the facility on [DATE] and last re-admitted on [DATE] with medical diagnoses including Alzheimer's disease (a progressive brain disease that cause memory loss), hypertension (high blood pressure), repeated falls, Major Depressive Disorder (a mental illness characterized by prolonged periods of sadness and feelings of worthlessness, dysphagia (difficulty swallowing) and generalized anxiety disorder (mental illness characterized by excessive worry).Record review of Resident #3's Comprehensive MDS (a resident assessment and care screening tool) dated 09/30/2025, Resident #3 did not have a BIMS score completed and was marked as rarely or never understood. Resident #3 had short and long-term memory problems and was marked as severely impaired with daily decision making. Resident #3 had no falls since admission/entry. Resident #3 required substantial/maximal assistance with toileting and personal hygiene and was totally dependent on staff for showering and required substantial assistance with mobility in bed such as sitting to lying and bed-to-chair transfer.Record review of Resident #3's care plan dated 11/24/2025, Resident #3's fall on 10/09/2025 was not care-planned. Resident #3 had actual falls care-planned on 07/21/2025 for a fall on 07/19/2025 with interventions including therapy to screen, determine and address causative factors of the fall, and monitor/document/report PRN x 72 h to MD for s/sx: pain, bruises, change in mental status, new onset of confusion, sleepiness, inability to maintain posture, agitation. Record review of Resident #3's change in condition assessment dated [DATE], she had a fall documented. Resident #3 had no status change and no change in condition noted.Observation and attempted interview with Resident #3 on 11/24/2025 at 10:40am, she was sitting in a wheelchair outside her room. She appeared well-groomed and comfortable and in no apparent distress. Resident #3 did not respond to questions and looked away. Resident #6Record review of Resident #6's face sheet dated 11/24/2025, he was an [AGE] year-old male originally admitted on [DATE] and last re-admitted on [DATE]. His medical diagnoses included Alzheimer's Disease (a progressive brain disease that cause memory loss), schizophrenia (a serious mental illness characterized by a range of symptoms including delusions, hallucinations, and incoherent thoughts and affects a person's ability to think clearly, manage emotions, make decisions, and relate to others), type 2 diabetes mellitus (high blood sugar), COPD (lung diseases that cause airflow obstruction and breathing problems), muscle weakness, and generalized anxiety disorder (mental illness characterized by excessive worry).Record review of Resident #6's Comprehensive MDS (a resident assessment and care screening tool) dated 11/02/2025, Resident #6 did not have a BIMS score completed (a brief interview to gauge cognitive patterns) and was marked as rarely or never understood. Resident #3 had short and long-term memory problems and was marked as severely impaired with daily decision making. Resident #6 had no falls since admission/entry. Resident #6 required substantial/maximal assistance with toileting, personal hygiene and showering and required substantial assistance with mobility in bed such as sitting to lying and bed-to-chair transfer.Record review of Resident #6's care plan dated 11/24/2025, he was not care-planned for the fall on 11/7/2025. Resident #6 was care-planned for a fall on 12/31/2024 with interventions including administering pain medication, resident being assisted back to bed per his request and therapy to screen resident. Resident #6 was care-planned for being at risk for falls r/t ataxic gait (unsteady walking pattern), confusion, incontinence, with interventions including anticipating and meeting the resident's needs, bilateral fall mat while resident was in bed and scoop mattress. Record review of Resident #6's progress notes, on 11/07/2025 at 10:00 a.m., Resident #6 had an unwitnessed fall in the hallway. Resident #6 was found on the floor with reason for fall not evident. Resident #6 had bruising on his forehead and was sent to the ER.Record review of Resident #6's change in condition assessment, on 11/7/2025 he had a fall. Resident #6 was observed with a large bump on left side of the forehead and would be going to the hospital for further evaluation. Resident #6 had general weakness. Observation and attempted interview with Resident #6 on 11/24/2025 at 4:00 p.m., he appeared to be sleeping in his room with rise and fall of his chest observed, well-groomed and in no