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	07/23/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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 each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 111 residents (Resident #1) reviewed for abuse and neglect. The facility failed to ensure Resident #1 was free from sexual abuse when Resident #1's was kissed by CNA A and her hand came in to contact with CNA A's penis on 7/13/25. The noncompliance was identified as Past Non-Compliance immediate jeopardy (IJ). The IJ began on 7/13/25 and ended on 7/17/25. The facility corrected the noncompliance before the survey began. This failure placed facility residents at risk of experiencing abuse and neglect. Findings include: Record review of Resident #1's admission Record dated 07/14/2025 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with major depressive disorder (mental health disorder characterized by persistently depressed mood). Record review of Resident #1's admission MDS (minimum data set) dated 7/1/25 revealed she had a BIMS score of 15 out of 15 indicating she was cognition was intact. She was coded as having a lower extremity limitation in range of motion and used both walker and wheelchair for mobility. She also required the supervision of at least 1 staff member for most ADL's including, hygiene, toileting, bathing, and transfers. Record review of Resident #1's baseline care plan dated 06/27/2025 revealed: * Communication: Can the resident communicate easily with staff? Yes.Does the resident understand the staff? Yes.and Primary Language English. Record review on 7/21/25 at 3:38 pm of Resident #1's Weekly Skin Observation Tool dated 7/14/25 and signed as completed by LVN B revealed: Right elbow Bruising. Right thigh (front) Scar. 2. Other Skin Condition Description Skin WDI, small bruise on upper right arm, post-surgical scar on right hip. Record review of Psychiatric Subsequent assessment dated [DATE] revealed: Reason for Referral: Depression, Sleep Disturbance, Cognitive Testing For Medical Necessity, Other; Eval of cognition. Chief Complaint: (sic) i'm still anxious. Medical Necessity for visit: Patient seen today for multiple chronic conditions requiring prescription management. Reason: increase Zoloft and melatonin. History of Presenting Illness: Pt seen for follow up visit. Last seen on 7/8/25, started Zoloft and Melatonin. On exam, pt is in room, laying in bed awake. (sic)Behavior's assessed and the response to psychotropic medications monitored. Patient appears calm and in no acute distress. Denies issues with sleep and appetite. Endorses anxiety symptoms. Several incidents happened this weekend with staff members. Continues to endorse anxiety and depressive symptoms. Review of History: Psychiatric Hx: Includes: Anxiety; Depression; PTSD; Past Medications: Zoloft, xanax.Social Hx: home health, 2 kids, widowed, Non (sic)Demonational, GED, CNA. Alcohol use: None Drug use: addicted to opioids was on suboxone Smoking: Past Smoker. Mental Status Examination Appearance:; Speech: Fluent,; Mood: Depressed,: Affect: Mood Congruent, Though Process: Logical Linear, Associations: Intact Association,; Thought Content: WNL,; Suicidal Ideation: Suicidal Ideation no plan; Homicidal Ideation: None Risk of Aggression: None; Insight: Fair; Judgement: Fair; Attention: WNL,; Short Term Memory: Intact,; Long Term Memory: Intact; Language: WNL; Fund of Knowledge: WNL. Record review of social services note dated 7/18/25 at 2:11pm revealed: SW met with resident on 7/17/25 to interview regarding allegation over weekend regarding a male CNA. SW obtained clarification about what occurred involving male CNA. Resident is able to clearly give her narrative of events including date/time and details of interaction. Resident voices she does not now or previously have any concerns having male aides assist her. She reports despite this incident she feels safe at facility and loves it here.' She had some noted disappointment and sadness about the reported information but feels much better knowing she did the right thing and letting others know what happened. She was pleasant and easy to converse with and displayed non s/s anxiety during our discussion. Voiced no desire to leave facility and remains also on psych services for on going support overall. Record review of Psychiatric Subsequent assessment dated [DATE] revealed: Reason for Referral: Depression, Sleep Disturbance, Cognitive Testing For Medical Necessity, Other; Eval of cognition. Chief Complaint: the depression is easing up. Medical Necessity for visit: Patient seen today for multiple chronic conditions requiring prescription management. Reason: increase Zoloft. History of Presenting Illness: Pt seen for follow up visit. Last seen on 7/15/25, increase Zoloft and Melatonin. On exam, pt is in broom, sleeping in bed. (sic)Behavior's assessed and the response to psychotropic medications monitored. Patient appears calm and in no acute distress. Denies issues with sleep and appetite. Denies worsening feelings of hopelessness, restlessness, helplessness, worthlessness, poor mood, or anxiety. The depression is easing up. I'm sleeping

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident receives an accurate assessment reflecting the resident's status for 3 of 23 residents reviewed for assessment accuracy (Residents #7, #58, #63, #99).Bed rails used for positioning and turning were coded on the MDS as physical restraints for Residents #7, #58, #63, #99. These failures placed residents at risk of having inaccurate assessments and receiving improper care and services. Findings include: Resident #7Record review of Resident #7's face sheet revealed admission date 1/31/23 with diagnoses including Alzheimer's disease (loss of memory and mental functions), heart disease, major depressive disorder (depression or loss of interest affecting daily life), hypertension (high blood pressure), Myocardial infarction (decreased blood flow to the heart), cerebral infarction (stroke). Record review of Resident #7's Quarterly MDS dated [DATE] revealed short -and long -term memory loss, moderately impaired cognitive skills, assistance for ADL's including maximum assist for dressing and toileting, partial assist for hygiene, and dependent on staff for shower/bathing. The Restraints/Alarms section coded bed rails, used daily, as physical restraints. Record review of Resident #7's care plan, initiated 7/22/25, revealed resident uses mobility/enabler bar in bed for bed mobility. Resident #58Record review of Resident #58's face sheet revealed admission date 9/27/22 with diagnoses including Parkinson's disease (nerve cell damage affecting movement), Rheumatoid arthritis (chronic inflammatory disorder affecting small joints), Diabetes (high blood glucose), heart failure (inability of heart to pump blood effectively, hypertension (high blood pressure), anxiety disorder (worry, anxiety, feat affecting daily life). Record review of Resident #58's Annual MDS dated [DATE] revealed modified independence in cognitive skills, assistance for ADL's including supervision in hygiene, moderate assistance for dressing, and maximum assistance for toileting and shower. The Restraints/Alarms section coded bed rails used daily as physical restraints. Record review of Resident #58's care plan, initiated 5/22/24, revealed resident uses mobility/enabler bar on bed for better bed mobility, not as a restraint. Observation of Resident #58 on 7/23/25 at 1:15pm revealed she was resting in bed, and there were 1/4 side rails attached to the head of the bed. Interview at that time revealed she uses the side bar to help her turn or move up in bed, and she demonstrated how she could reach for it to help her move in bed. Resident #99Record review of Resident #99's face sheet revealed admission date 4/11/25 with diagnoses including dementia (loss of memory and intellectual functioning), hypertension (high blood pressure), hemiplegia and hemiparesis (muscle weakness and paralysis on one side of the body), cerebral infarction (stroke), Diabetes (high blood glucose). Record review of Resident #99's Quarterly MDS dated [DATE] revealed BIMS 08 indicating moderately impaired cognitive skills, assistance with ADL's including supervision for toileting and hygiene, moderate assistance for showers/bathing, and set-up for dressing. The Restraints/Alarms section coded bed rails used daily as physical restraints. Record review of Resident #99's care plan, initiated 4/25/25, revealed resident uses side rails to enhance positioning and mobility. Observation of Resident #99 on 7/23/25 at 1:40pm revealed he was resting in bed and there were 1/4 side rails attached to the head of the bed. Interview at that time revealed he uses the left side bar to help him turn and move up in bed and does not use the right-side bar since his right arm is paralyzed. Interview with the MDS nurse on 7/23/25 at 2:30 pm revealed the facility uses the RAI manual as a guideline to complete the MDS using resident information from the staff. She said they are using a new questionnaire to help with the coding of restraints, and in the question about bed rails as an enablers is answered yes, it would not be coded as a physical restraint. She said the MDS for Residents #7, #58, #99 was incorrectly coding bed rails as physical restraints, and would be corrected. Interview with the DON on 7/23/25 at 2:30 pm revealed bed rails used as enablers for turning and repositioning should not be coded as physical restraints and said they would be corrected. Record review of facility policy on Minimum Data set revealed, in part, .as a policy the facility completes an MDS and codes the Minimum Data Set (MDS) per the RAI manual and coding is based upon clinical assessments, interviews, interventions, etc. Record review of the RAI manual revealed, in part: a restraint is any manual method, or physical or mechanical device attached or adjacent to the body.restricts freedom of movement or normal access to the body.bed rails are considered a restraint when they are used to intentionally prevent a person from getting in and out of bed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review, the facility failed to ensure medications were stored in accordance with currently accepted professional principles for 1 of 1 medication fridges and 1 of 4 medication carts reviewed for storage. The facility failed to ensure that medication fridges and medication carts were free of expired medications. The failure could place residents at risk of receiving expired medications. Findings included:Observation and interview with ADON A on 7/21/25 at 3:25 p.m. of the facility's medication room revealed expired medications in the medication refrigerator. The expired medications were as follows:*one dose of Ceftriaxone 2 mg/100 ml with expiration date of 7/13/25, *two doses of Meropenem 500 mg/100 ml with expiration date of 6/19/25, and *three doses of Meropenem 500 mg/100 ml with expiration date of 6/14/25.ADON A said regarding the Meropenem the resident labeled to that medication had been in the hospital a long time. ADON A said they usually checked the medication refrigerator once a week for expired medications. ADON A said those types of antibiotics (referring to the expired medications) went out of date really quickly. ADON A said an adverse reaction a resident could experience if they received expired medications was that the resident might not receive the full therapeutic dose.Observation on 7/22/25 at 10:50 a.m. of Hallway-100 medication aide medication cart revealed expired medications. The medications were as follows: *Zinc 50 mg with best by date of April 2025, *Slow-Release Iron with expiration date of May of 2025, and *Geri-Dryl Diphenhydramine HCL 25 mg with expiration date of June of 2024. The expired medications were immediately removed from the medication cart by LVN A. During interview on 7/22/25 at 1:15 p.m., the DON said the ADONs checked the medication room for expired medications daily. The DON said the ADONS checked the medication carts every Friday, she believed. The DON said the medication aides and nurses should be checking the medication carts whenever they were in the cart to administer medications. The DON said she did not know what kind of training the staff received regarding medications because the staff had been here before she started which was 6/2/2025 but medication training was discussed in orientation. The DON said an adverse effect that could occur if a resident received an expired medication depended on the medication but could be an adverse effect. The DON said the Pharmacist checked the medication room and medication carts.During interview on 7/22/2025 at 1:20 p.m., ADON A said regarding medication training for staff they talk about medications in orientation and on the floor during orientation. ADON A said the Pharmacist walked with staff and educated about the importance of cart audits and checking the over the counter medications/blister packs before administering medications. ADON A said she checked the medication carts every week for cleanliness and expired medications. ADON A said she checked the #300 and #400 hallway medication carts. ADON A said the Pharmacist checked the medication room and medication carts but unsure how thorough she was. ADON A said we have asked the medication aides and nurses to check the medication carts every Friday and every time they were in the medication cart to pull a medication. During interview on 7/22/2025 at 1:35 p.m., ADON B said she usually split the facility with ADON A with ADON B covering the hallways 100 and 200 and ADON A covering the hallways 300 and 400. ADON B said both ADONS check the medication fridge, and the DON checked sometimes. ADON B said she tried to check the medication fridge weekly but at least every other week. ADON B said her and ADON A checked the medication carts depending on the hall weekly but at least every other week to do full audits. ADON B said the medication aides and nurses knew to check the medication carts as well. ADON B said the Pharmacist watched medication pass and audited a random cart but unsure if they checked all the medication carts. ADON B said regarding staff training they have a lot of in-services regarding medication administration and have yearly medication pass that was observed. ADON B said the facility did in-services if they saw anything or a complaint. ADON B said she had found expired blister packs and responded by taking them off the cart to be destroyed. ADON B said if a resident expired then they took their medications off the cart to be destroyed. During interview on 7/23/2025 at 10:08 a.m., the Pharmacist said she had come to the facility about 2 1/2 years. the Pharmacist said she did one medication cart audit and medication room checks when she came to the facility monthly. The Pharmacist said during the audits she looked for outdated medications and anything she found she pulled and gave to the nurse. The Pharmacist said she usually found expired medications during her monthly checks and the findings were part of the facility's audit report. The Pharmacist said the expired medications were usually not that old. The Pharmacist said staff must be routinely checking and pulling over the counter medications. The Pharmacist said over the counter medications could go over the best by date if stored properly but our goal was to have