STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675423	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Gardens	7210 Northline Dr Houston, TX 77076

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. Number of residents sampled: Number of residents cited: Based on interviews and record review, the facility failed to provide residents access to visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident for 1 of 1 facility's.- The facility failed to allow any visitors in the building after 8pm when the doors locked.This failure could place residents at risk for decreased quality of life, sadness, and depression.Findings include: In an interview on 4/30/26 at 9:45am, LVN I said visitation hours were from 8am to 8pm and they did not allow any family members in the facility after 8pm. She said the doors locked at 8pm and the only people that were allowed to come in after that were EMS personnel or family to a resident who was passing away. She said EMS personnel had to ring the doorbell or call the facility on the phone.In an interview on 4/30/26 at 9:49am, the Receptionist said she worked Tuesdays, Thursdays, and Fridays from 8am to 8pm. She said there was another receptionist who worked the other days from 8am to 8pm. The Receptionist said visitation hours were from 8am to 8pm and after that the doors remained locked. She said the only family that were allowed to visit after hours were family that were care planned for a particular reason or if the resident was actively dying.In an interview on 4/30/26 at 1:40pm the Receptionist said family members were not allowed to come after 8pm and they told family they were not allowed to come.In an interview on 5/1/26 at 2:45pm, the Assist ED said the doors locked at 8pm for security reasons but family members were still allowed in. He said family would ring the doorbell and the nurse would go see who it was and let them in. He said if residents were not allowed to see their family members they could get depressed. The Assist ED said his staff were misinformed and family members were allowed to come whenever they wanted to, and he was not sure where they got that information from.Record review of the facility's policy and procedure on Resident Right to Access and Visitation (implemented 10/1/25) read in part: It is the policy of this facility to support and facilitate the resident's right to receive visitors of their choosing, at the time of their choosing. Visitation will be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life .The facility will provide immediate access to any resident by.The resident representative. The facility will provide immediate access to a resident by immediate family and other relatives of the resident.Resident's family members are not subject to visiting hour limitations or other restrictions not imposed by the resident.If familial visits infringe upon the rights of other residents (e.g. family visits late at night when the resident's roommate is already asleep), staff will find a location other than the resident's room for visits. The facility will provide immediate access to a resident by others who are visiting with the consent of the resident.The facility will inform each resident and/or resident representative of his or her visitation rights and related facility policies and procedures, including any clinical or safety restriction or limitation of such rights, in a manner he or she understands.The facility will ensure all visitors enjoy full and equal visitation privileges consistent with resident (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preferences.Keeping the facility locked at night with a system in place for allowing visitors approved by the resident.Record review of the facility's policy and procedures on Resident Rights (revised 12/1/25) read in part: .The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner, that does not impose on the rights of another resident.

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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	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Number of residents sampled: Number of residents cited: Based on observation, interview and record review the facility failed to provide pharmaceutical services which included procedures that assured the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident for 2 of 8 medication carts (Hall 2300/2400 Nurse cart and Hall 2100/2200 Med Aide cart) reviewed for pharmacy services.1. The facility failed to ensure expired medications were not stored with current medications on the 2300/2400 Hall Nurse cart.2. The facility failed to ensure expired medications were not stored with current medications on the 2100/2200 Med Aide cart.These failures could place residents at risk for not receiving therapeutic benefits of the medication and/or worsening health concerns.Findings include: In an observation on 5/1/26 at 9:47 AM of Hall 2300/2400 Nurse cart the following expired medications were found:-Insulin Lispro 100/ml Opened 3/26/26-Insulin Lantus 100/ml Opened 3/17/26-Insulin Lantus 100/ml Opened 3/31/26-Artificial Tears Opened 3/4/26-Pro-Stat (liquid protein) Expired 4/30/26In an interview on 5/1/26 at 9:47 AM, LVN B said the insulin was only good for 28 days after it was opened and the eye drops were good for 30 days after they were opened. She said if expired medications were given to the resident it could be harmful or not be as effective. The nurse said she tried to check her cart every day but there was not an actual policy/procedure for checking the carts for expired medications that she knew of.In an observation on 5/1/26 at 10:10 AM of Hall 2100/2200 Med Aide cart the following expired medications were found:-Brimonidine (lower eye pressure) Solution 0.2% eye drops Opened 3/30/26-Bimatoprost (lower eye pressure) Solution 0.03% eye drops Opened 3/30/26-Latanoprost (lower eye pressure) Solution 0.005% eye drops Opened 3/23/26-Latanoprost Solution (lower eye pressure) 0.005% eye drops Opened 3/28/26-Simbrinza Suspension (lower eye pressure) 1-0.2% eye drops Opened 4/1/26In an interview on 5/1/26 at 10:10 AM, MA C said the eye drops expired 30 days after being opened. She said if the expired medications were given to a resident they would not be as effective. MA C said she checked her cart every morning for expired eye drops.In an interview on 5/1/26 at 2:50 PM, the DON said eye drops were only good for 30 days and insulin was only good for 28 days after they were opened. She said if a resident received expired medications they could have adverse reactions. She said staff were expected to date the bottle as soon as it was opened and then check their cart every morning for expired medications before starting their shift.Record review of the facility's policy and procedures on Medication Storage (implemented 12/1/25) read in part: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels.Record review of the facility's policy and procedures on Medication Administration (revised 12/30/25) read in part: .Keep medication cart clean, organized, and stocked with adequate supplies.Identify expiration date. If expired, notify nurse manager.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for 2 of 4 hallways, (Halls 2400 and Hall 1200), the conference room and Resident #44's room. The facility had live flies, roaches and bed bugs in areas of the facility including Halls 2400, 1200, the conference room and Resident #44's room. This failure could place residents at risk for decreased health, safety and quality of life. Findings included: Record review of Resident #44's Electronic Health Record revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnosesis including idiopathic (a chronic condition characterized by a sudden drop in blood pressure upon standing), Hyperkalemia (excessively high potassium levels in the blood), Cellulitis of right toe and right lower limb, muscle weakness, elevated white blood cell count, Pseudomonas aeruginosa (Gram-negative rod-shaped bacteria known for causing infections). Record review of the Resident #44's Quarterly MDS dated revealed a BIMS score of 09, which indicated moderately impaired. Section GG of the MDS revealed the resident did not use a mobility device and she was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for toileting hygiene, shower/bathe self, putting on/taking off footwear, and roll left and right. Resident #44 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort) for upper body dressing and lower body dressing. Resident #44 required setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating, oral hygiene, and personal hygiene. Record review of Resident #44's progress notes documented by LVN B revealed on 03/27/26, the resident was observed with red raised bumps on bilateral arms, and it was noted that the resident had been scratching red raised bumps and had several scabbed areas on left arm. The resident received an order to start Hydroxyzine 10mg 1 tab PO daily x 7 days. Record review of Resident #44's order summary revealed an order dated 03/28/26 for Hydroxyzine HCl Oral Tablet 10 MG Give 1 tablet by mouth one time a day for itching for 7 days In an observation on 04/28/26 at 09:43am, approximately 2 flies were observed on Hall 1200. In an observation on 04/28/26 at 11:11am, approximately 4 flies were observed on Hall 2400. In an observation on 04/28/26 at 01:58pm, approximately 4 flies were observed in the conference room of the facility. (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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 05/01/26 at 09:40am, a cockroach was observed crawling on the floor in the conference room of the facility. In an interview/observation on 05/01/26 at 09:34am with Resident #44, the resident was observed in her room lying in bed. She stated she was moved out of her room earlier this week and it was deep cleaned and sprayed by maintenance. She stated she kept getting bitten by something and stated the staff was giving her medication., sShe stated this occurred about a month ago. When asked what she was being bitten by, she reported she was being bitten by ants. When asked if it could have been bedbugs, she stated it was not bed bugs, it was ants. The resident reported having ants in her room and being bitten made her feel uncomfortable. The resident reported she was bitten on her shoulder and her leg but reported she no longer had any marks and stated everything had healed. Surveyor observed the resident's shoulder and there appeared to be no open bite marks, there was what appeared to small faded circular scars. that could have possibly been from bit marks. There were no ants or bed bugs observed in the room while surveyor was in the resident's room. In an interview on 05/01/26 at 9:42am with Administrator, he stated the pest could be eliminated in the facility if you could convince the families to do the laundry in house instead of doing laundry at their homes. He stated he had not had any complaints regarding bed bugs. He stated pest control comes out 2 times per month and if there wereare any sightings at the facility, they will come out. He did not provide the risk of having pest in the facility. In an interview on 05/01/26 at 9:50am with the Maintenance Director, he stated he treated Resident #44's room this week. He stated he had the staff bring the resident out so he could check the room. He stated he found some sugar ants and the resident had a lot of things (like snacks) in the dresser, he stated he sprayed the room and the house keepers cleaned the room. He stated since he worked at the facility, he has never seen any bed bugs in the facility. He stated pest control was going to the facility today (05/01/26) to check the resident's room. Record review of the facility's invoice/service ticket number dated 05/01/26 revealed pest control serviced the facility at 11:00am and found 8 bedbugs on back of the mattress. In an interview on 05/01/26 at 2:36pm with the Administrator, he reported that pest control came out to the facility and found active bed bugs in Resident #44's room on back of her mattress. He stated the resident was moved to another room and her room was serviced. Record review of the facility's pest control policy dated 11/01/25 reflected, Facility will utilize a variety of methods in controlling certain seasonal pests, i.e. flies. These will involve indoor and outdoor methods that are deemed appropriate by the outside pest service and state and federal regulations. Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for 2 of 4 hallways, (Halls 2400 and Hall 1200), the conference room, and 1 of 129 resident rooms (Resident #44). The facility had live flies, roaches and bed bugs in areas of the facility including Halls 2400, 1200, the conference room and Resident #44's room. This failure could place residents at risk for decreased health, safety and quality of life. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings included: Record review of Resident #44's Electronic Health Record revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnosesis including idiopathic (a chronic condition characterized by a sudden drop in blood pressure upon standing), Hyperkalemia (excessively high potassium levels in the blood), Cellulitis of right toe and right lower limb, muscle weakness, elevated white blood cell count, Pseudomonas aeruginosa (Gram-negative rod-shaped bacteria known for causing infections). Record review of the Resident #44's Quarterly MDS dated revealed a BIMS score of 09, which indicated moderately impaired. Section GG of the MDS revealed the resident did not use a mobility device and she was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for toileting hygiene, shower/bathe self, putting on/taking off footwear, and roll left and right. Resident #44 required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort) for upper body dressing and lower body dressing. Resident #44 required setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating, oral hygiene, and personal hygiene. Record review of Resident #44's progress notes documented by LVN B revealed on 03/27/26, the resident was observed with red raised bumps on bilateral arms, and it was noted that the resident had been scratching red raised bumps and had several scabbed areas on left arm. The resident received an order to start Hydroxyzine 10mg 1 tab PO daily x 7 days. Record review of Resident #44's order summary revealed an order dated 03/28/26 for Hydroxyzine HCl Oral Tablet 10 MG Give 1 tablet by mouth one time a day for itching for 7 days In an observation on 04/28/26 at 09:43am, approximately 2 flies were observed on Hall 1200. In an observation on 04/28/26 at 11:11am, approximately 4 flies were observed on Hall 2400. In an observation on 04/28/26 at 01:58pm, approximately 4 flies were observed in the conference room of the facility. In an observation on 05/01/26 at 09:40am, a cockroach was observed crawling on the floor in the conference room of the facility. In an interview/observation on 05/01/26 at 09:34am with Resident #44, the resident was observed in her room lying in bed. She stated she was moved out of her room earlier this week and it was deep cleaned and sprayed by maintenance. She stated she kept getting bitten by something and stated the staff was giving her medication., She stated this occurred about a month ago. When asked what she was being bitten by, she reported she was being bitten by ants. When asked if it could have been bedbugs, she stated it was not bed bugs, it was ants. The resident reported having ants in her room and being bitten made her feel uncomfortable. The resident reported she was bitten on her shoulder and her leg but reported she no longer had any marks and stated everything had healed. Surveyor observed the resident's shoulder and there appeared to be no open bite marks, there was what appeared to small faded circular scars. that could have possibly been from bit marks. There were no ants or bed bugs observed in the room while surveyor was in the resident's room. (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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/01/26 at 9:42am with Administrator, he stated the pest could be eliminated in the facility if you could convince the families to do the laundry in house instead of doing laundry at their homes. He stated he had not had any complaints regarding bed bugs. He stated pest control comes out 2 times per month and if there were are any sightings at the facility, they will come out. He did not provide the risk of having pest in the facility. In an interview on 05/01/26 at 9:50am with the Maintenance Director, he stated he treated Resident #44's room this week. He stated he had the staff bring the resident out so he could check the room. He stated he found some sugar ants and the resident had a lot of things (like snacks) in the dresser, he stated he sprayed the room and the house keepers cleaned the room. He stated since he worked at the facility, he has never seen any bed bugs in the facility. He stated pest control was going to the facility today (05/01/26) to check the resident's room. Record review of the facility's invoice/service ticket number dated 05/01/26 revealed pest control serviced the facility at 11:00am and found 8 bedbugs on back of the mattress. In an interview on 05/01/26 at 2:36pm with the Administrator, he reported that pest control came out to the facility and found active bed bugs in Resident #44's room on back of her mattress. He stated the resident was moved to another room and her room was serviced. Record review of the facility's pest control policy dated 11/01/25 reflected, Facility will utilize a variety of methods in controlling certain seasonal pests, i.e. flies. These will involve indoor and outdoor methods that are deemed appropriate by the outside pest service and state and federal regulations.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop a comprehensive person-centered care plan for each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 8 residents (Residents #101 and #146) reviewed for comprehensive care plans. -The facility failed to provide Residents #101 and #146 with a comprehensive person-centered care plan to address their diet orders. This failure could place residents at risk of not having personalized plans developed to address their specific care needs. Findings included: Record review of Resident #101's face sheet dated 05/01/2026 revealed a [AGE] year old female with an admission date 05/20/2022 with a primary diagnosis of hypertension (condition where the force of blood against the artery walls is consistently too high). Resident #101 had a secondary diagnosis to include dysphagia (when it's hard to get food or drink from your mouth down to your stomach.) Record review of Resident #101's Quarterly MDS dated [DATE] revealed BIMS score of 15, indicating intact cognition status in section C. In section K revealed that Resident #101 was triggered for a mechanically altered diet (require change in texture of food or liquids e.g., pureed food, thickened liquids). Record review of Resident #101's undated care plan did not reveal a focus, goal, or interventions to address Resident #101's diet. Record review of Resident#101's physician order dated 04/23/2025 with an order summary, Regular Diet: Ground texture, regular/thin consistency, may have baked whole fish. Record review of Resident #146's face sheet dated 04/30/2026 revealed an [AGE] year-old male with an admission date 01/22/2026 with a primary diagnosis of encephalopathy (condition where the brain isn't working properly, causing confusion, memory problems, or changes in behavior). Resident #146 had a secondary diagnosis to include heart failure (condition when the heart does not pump blood as well as it should, so the body does not get enough oxygen and nutrients) and presence of cardiac pacemaker (a device that helps the heart beat in a regular rhythm.) Record review of Resident #146's Quarterly MDS dated [DATE] revealed BIMS score of 07, indicating moderate cognition status in section C. In section K revealed that Resident #146 was triggered for a therapeutic diet (e.g., low salt, diabetic, low cholesterol). Record review of Resident #146's undated care plan did not reveal a focus, goal, or interventions to address Resident #146's diet. Record review of Resident#146's physician order dated 01/22/2026 with an order summary, Liberal Cardiac Diet: regular texture, regular/thin consistency, divided plate with all meals. In an interview on 04/28/206 at 10:27 am Resident#101 said that she did not have concerns overall with her care. She said that the food was often served warm when it should be hot. In an interview on 04/28/206 at 11:28 am Resident#146 said that he did not have concerns overall with his care. He said that the food was not good and was often served cold. In an interview on 05/01/2026 at 12:00pm RN F said that all residents should have a comprehensive person centered care plan. She said that the care plan should have a focus, goal, and interventions for a residents diet. She said that without a comprehensive person centered care plan to address the diet, a residents diet interventions could be missed. She said that Resident#101 had a ground texture diet, and her care plan was not updated to reflect her diet order. She said that Resident#146 had a cardiac diet, and his care plan was not updated to reflect his diet order. She said that she did not know who should update the care plan to address residents diet. She said that any nurse that viewed the care plan should be able to see if there were no diet interventions and have it corrected. In an interview on 05/01/2026 at 12:05pm the Unit Manager said that all residents should have a diet order, the diet should be triggered on the MDS assessment, and there should be diet focus, with goals, and interventions on the care plan. She said that diet interventions could be missed if it were not on the care plan. She said that the MDS Coordinator was responsible for updating the care plans. She said that any nurse that viewed a care plan could have it correct if the diet were missing. She said that Resident#101 had a ground texture diet, and her care (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan was not updated to reflect her diet order. She said that Resident#146 had a cardiac diet, and his care plan was not updated to reflect his diet order. In an interview on 05/01/2026 at 2:11pm the MDS Coordinator said that he managed the care plans and it was his responsibility to ensure that care plans were updated with a focus, goal, and interventions based on the MDS assessment. He said that without a comprehensive person centered care plan a resident may not get the care that was needed. He said that all residents should have a diet order, the diet should be triggered on the MDS assessment, and there should be a diet focus, with goals, and interventions on the care plan. He said that a resident did not have a diet focus on their care plan it was an oversight. He said that any clinical staff that viewed the care plan could have had the error corrected. In an interview on 05/01/2026 at 2:21pm with the DON while the ASSIST ED was present, DON said that care plans should be comprehensive person centered, and without focus for care areas care could be missed. She said that the MDS Coordinator was ultimately responsible of updating the care plans. She said care plans should be updated with a focus, goal, and interventions based on the MDS assessment. She said that care plans should have a focus for a diet. She said that if a resident did not have a focus for a diet it would have been an oversight by the MDS Coordinator. She said that she was not aware of Resident#101 or #146 to not have a focus for their diet. She said that any clinical staff could that viewed the care plan could have caught and corrected the error. Record review of the facility policy titled, Comprehensive Care plans, dated 10/01/2025 read in part, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview and record review the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 3 (Resident #97) residents reviewed for tube feeding. LVN A failed to check for placement of the G-tube before giving Resident #97 his morning medications on 4/30/26.This failure could place residents at risk for the medications going into the abdominal cavity, pain, infection, and hospitalization.Findings include:Record review of Resident #97's, undated, face sheet revealed a [AGE] year old male who was admitted to the facility on [DATE]. Resident #97 had diagnoses which included sepsis (infection throughout body), type 2 diabetes (body does not produce insulin or resists it), cerebral infarction (stroke), metabolic encephalopathy (change in brain due to underlying condition), epilepsy (seizures), and pressure ulcer of unspecified site and stage.Record review of Resident #97's admission MDS assessment, dated 4/20/26, revealed a BIMS score of 00 out of 15, which indicated severely impaired cognition. The resident was substantial/max assist (helper does more than half the effort) for all ADLs. The assessment revealed the resident had a feeding tube, received 51% or more calories through it, and received 501cc/day or more of fluid intake through it. Record review of Resident #97's Care Plan, dated 4/13/26, revealed a Focus: Resident #97 required tube feeding due to dysphagia. Interventions included checking for tube placement per facility protocol and record, hold feed if greater than 60cc when aspirated. In an observation on 4/30/26 at 8:48 AM, LVN A was observed giving the morning medications to Resident #97. He gave the following medications to Resident #70 without checking for placement of the g-tube first:-Vitamin C 500mg 1 Tablet crushed via g-tube-Aspirin 81mg 1 crushed via g-tube-Multi-Vite 5ml via g-tube-Modafanil 200mg 1 crushed via g-tube-Valproic Acid 250mg 2 capsules via g-tube-Lisinopril 20mg 1 crushed via g-tubeIn an interview on 4/30/26 at 9:35 AM, LVN A said to check for placement with g-tubes he checked for residual (pulling back on the syringe to get the feeding in the syringe). He said he did not check for placement because it was hard to check residual with the type of g-tube Resident #97 had. LVN A said it was easier to give an air bolus (syringe full of air) to check for placement with Resident #97. He said he did not check for placement by residual or air bolus because he was used to Resident #97, so he felt like it was safe to go ahead and give him his medications without checking for placement. LVN A said if the g-tube was not checked for placement it could be in the wrong place, and it could be fatal.In an interview on 4/30/26 at 10:13 AM, NP A said g-tube placement should be checked prior to giving medications through it and the nurse's should follow the facility's policy. She said the risk to the resident would be low if the g-tube was older than 6 mths. NP A said there was a higher risk of the g-tube migrating out of place if it was less than 6mths old.In an interview on 4/30/26 at 10:32 AM, the DON said the facility policy for checking g-tube placement was checking the residual. She said if the residual was not checked and medications were given; they could potentially go to the wrong place.Record review of Resident #97's Physician Orders as of 5/1/26 revealed the following orders from the Medical Director:-Enteral Feed Order every shift Diabetasource @ 75cc/hr via feeding tube to run continuously x 22 hrs. May remove for care and services. Ordered 4/21/26.-G Tube - Check Tube Placement every shift Check tube for proper placement by auscultation (listen with stethoscope) of injected air or visual inspection of aspirated stomach contents prior to instilling (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675423	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Gardens	7210 Northline Dr Houston, TX 77076

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication, and/or initiating a feeding. Ordered 4/13/26.Record review of the facility's policy and procedures on Medication Administration via Enteral Tube (Implemented 11/1/25) read in part: It is the policy of this facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practice guidelines.Enteral tube placement must be verified prior to administering any fluids or medication.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview and record review the facility failed to ensure that the medication error rate was not five percent (5%) or greater. The facility had a medication error rate of 18%, based on 5 errors out of 27 opportunities, which involved 2 of 3 residents (Resident #70 and Resident #97) and 2 of 3 staff (MA K and LVN A) observed during medication administration reviewed for medication errors.- MA K failed to give Resident #70 his Supplement Pass (provides protein) 90ml during his morning medication administration on 4/29/26.- MA K failed to give Resident #70 his Aspirin 81mg during his morning medication administration on 4/29/26. - LVN A failed to give Resident #97 his Vitamin C 500mg/5ml in the right dose and right form during his morning medication administration on 4/30/26.- LVN A failed to give Resident #97 his Valproic Acid (seizure medication) 250mg/5ml in the right dose and right form during his morning medication administration on 4/30/26.- LVN A failed to give Resident #97 his Insulin Glargine [controls blood sugar] 100u/ml during his morning medication administration on 4/30/26.These failures could place residents at risk for not receiving the therapeutic effects of their prescribed medications and possible adverse reactions.Finding include: 1. Record review of Resident #70's, undated, face sheet revealed a [AGE] year old male who was admitted to the facility on [DATE]. Resident #70 had diagnoses which included multiple myeloma (cancer of cells in the bone marrow), protein-calorie malnutrition, high blood pressure, acute atopic conjunctivitis of right eye (eye infection), heart burn, high cholesterol, weakness, and depression.Record review of Resident #70's Quarterly MDS assessment, dated 1/30/26, revealed a BIMS score of 15 out of 15, which indicated normal cognition. The resident was partial/moderate assistance (helper does less than half the effort) for all ADLs and used a rollator (walker with wheels) for mobility. Resident #70 was occasionally incontinent of urine and never incontinent of bowel. The resident required a mechanically altered diet (change in texture of food or liquids) while a resident.Record review of Resident #70's Care Plan, dated 1/18/25, revealed a Focus: Resident #70 was at risk for nutritional decline related to swallowing difficulty. Interventions included assisting with meals, consulting with a dietician, and consulting with speech therapy.In an observation on 4/29/26 at 9:12 AM, revealed MA K gave the morning medications to Resident #70. She gave the following medications to Resident #70:1. Gabapentin 300mg 1 PO2. Protein Liquid 30ml PO3. Lidocaine Patch 1 topically4. Bumetanide 0.5mg 1 PO5. Famciclovir 500mg 1 PO6. Miralax 17g PO7. Mupro 128 eye ointment 1 gtt R eye8. Senna 8.6mg/50mg 1 PO9. Sulfamethoxazole-Trimethoprim Tablet 800-160 mg 1 PO10. Norco 325mg/5mg 1 PO11. Iron 325mg 1 PO12. Fluticasone Nasal Spray 1 spray each nostril13. Multivitamin Gummies 2 POIn an interview on 4/29/26 at 9:12 am, MA K stated there were nine pills in her medicine cup before she gave the cup of medicine to Resident #70. She did not have the Supplement Pass 90ml and said she would have to go look in the medication storage room for a bottle of it. MA K was not observed giving Aspirin 81mg to Resident #70. MA K said she would get the State Surveyor once she went and found a bottle of Supplement Pass. In an interview and observation on 4/29/26 at 11:30 AM, MA K gave the Supplement Pass 90ml to Resident #70. She said it would be counted as the lunch dosage since he was supposed to get it TID, and the morning administration was counted as not given. MA K said she did not realize she did not give the Aspirin and said she must have checked it off and not realized it. She said she normally popped out the pill first and then checked off the medication, so she was unsure of what happened. MA K said if the resident did not get the medication, they would not get the benefit of the medication.Record review of Resident #70's Physician Orders as of 5/1/26 revealed the following orders from the Medical (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director:- Aspirin Oral Capsule 81 MG (Aspirin), 1 PO QD for Anticoagulant. Ordered 4/7/25.- Supplement Pass TID related to Mild Protein-Calorie Malnutrition, Give 90ml. Ordered 12/4/25.- Bumetanide Oral Tablet 0.5mg, 1 PO BID for Edema (swelling) BLE. Ordered 8/4/25.- Famciclovir Oral (antiviral) Tablet 500 MG (Famciclovir), 1 PO QD for therapy. Ordered 9/24/25.- Ferrous Sulfate Oral Tablet 325 (65 Fe) MG (Ferrous Sulfate), 1 PO BID for Anemia. Ordered 7/10/25.- Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal) 1 spray in both nostrils QD for Allergic Rhinitis (runny nose). Ordered 9/15/25.- Gabapentin Oral Capsule 300 MG (Gabapentin), 1 PO Q8hr for NEUROPATHY (burning in extremities). Ordered 3/17/26.- HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) 1 PO Q6hr related to LOW BACK PAIN. Ordered 1/21/26.- Lidocaine External Patch 4 % (pain relief) (Lidocaine) Apply to back topically QD for pain and remove per schedule. Ordered 9/15/25.- Miralax Powder 17 GM/SCOOP (Polyethylene Glycol Phone 3350) Give 17 gram PO QD for constipation Mix 1 cap full with 6-8 ml liquid. Ordered 4/29/26.- Muro 128 Ophthalmic Solution 5 % (antibiotic) (Sodium Chloride Hypertonic) Instill 1 gtt R eye 4xday for Eye Surgery related to CONJUNCTIVITIS, RIGHT EYE for 14 Days. Ordered 4/13/26.- Senna S Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) Give 1 PO QD day for constipation. Ordered 1/21/26.- Sulfamethoxazole-Trimethoprim (antibiotic) Tablet 800-160 MG, Give 1 PO QD every Mon, Wed, Fri for Multiple Myeloma. Ordered 8/5/26.- Multivitamin Gummies 200 mcg chewable tablet, take 2 PO QD for supplement. Ordered 10/8/25. 2. Record review of Resident #97's, undated, face sheet revealed a [AGE] year old male who was admitted to the facility on [DATE]. Resident 97 had diagnoses which included sepsis (infection throughout body), type 2 diabetes (body does not produce insulin or resists it), cerebral infarction (stroke), metabolic encephalopathy (change in brain due to underlying condition), and pressure ulcer of unspecified site and stage.Record review of Resident #97's admission MDS assessment, dated 4/20/26, revealed a BIMS score of 00 out of 15, which indicated severely impaired cognition. The resident was substantial/max assist (helper does more than half the effort) for all ADLs. The assessment revealed the resident had a feeding tube, received 51% or more calories through it, and received 501cc/day or more of fluid intake through it. Resident #97 was taking hypoglycemics and anticonvulsants.Record review of Resident #97's Care Plan, dated 4/13/26, revealed a Focus: Resident #97 required tube feeding due to dysphagia (trouble swallowing). Interventions included monitoring for s/sx of infection at tube site and providing care to the g-tube site. Focus: Resident #97 had Diabetes Mellitus w/ current treatment Insulin Glargine SQ Solution 100u/ml and Insulin Lispro Injection Solution 100u/ml. Interventions included giving diabetes medication as ordered by the doctor. Focus: Resident #97 was on anticonvulsant therapy Valproic Acid Oral Solution 250mg/5ml and Divalproex Sodium Oral Tablet Delayed Release 500mg. Interventions including giving the medications per order.Record review of Resident #97's MRR revealed on 4/15/26 the Consultant Pharmacist recommended discontinuing Divalproex DR (seizure medication) Tablet 500mg BID via g-tube because there was an order for Valproic Acid Oral Solution 250mg/5ml 4xday via g-tube. NP A agreed with the recommendation, however the blister pack was not removed from the medication cart.In an observation and interview on 4/30/26 at 8:48 AM, revealed LVN A gave the morning medications to Resident #97. He gave the following medications to Resident #70:1. Vitamin C 500mg 1 Tablet crushed via g-tube2. Aspirin 81mg 1 crushed via g-tube3. Multi-Vite 5ml via g-tube4. Modafanil (for sleepiness) 200mg 1 crushed via g-tube5. Insulin Lispro 4u SQ6. Valproic Acid 250mg 2 capsules via g-tube7. Lisinopril (blood pressure) 20mg 1 crushed via g-tubeIn an interview on 4/30/26 at 8:48 AM, LVN A stated he had 6 pills in his medicine cups before he crushed the medications for Resident #97. LVN A said there was not any liquid Valproic Acid and that was why he was crushing the capsules trying to get the liquid out. He said the pharmacy did not have any liquid Valproic Acid. He did not attempt to look in the medication cart or ask anyone about it. LVN A was not observed giving Insulin Glargine 10u, the Vitamin C was ordered to be given in liquid form 500mg/5ml, and the Valproic Acid was ordered to be given in liquid form 250mg/5ml. LVN A also gave a double dose of Vitamin C and Valproic Acid.In a phone interview on 4/30/26 at 11:00 AM, an (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unknown Pharmacist at [pharmacy] said a 280ml bottle of Valproic Acid for Resident #97 had been sent to the facility on 4/14/26.In an interview on 4/30/26 at 11:29 AM, LVN A said he did not see the order for Insulin Glargine 10u and it did not flag on his MAR. LVN A said he did not have the liquid Valproic Acid or the liquid Ascorbic Acid, without looking anywhere. LVN A was told a bottle of liquid Valproic Acid for Resident #97 was sent to the facility so he started looking for it. He and the State Surveyor looked in the two medication storage rooms and did not find it. We looked in the nurse cart for the 2400 hall, because the resident had moved from that hall, and the medication was not there. The State Surveyor asked LVN A if he looked in his medication cart and he said he had and it was not there. The State Surveyor looked in his medication cart and the Valproic Acid liquid was found at the bottom of his cart, where all the other liquid medications were stored. LVN A said he gave the wrong dosage of Valproic Acid because he looked at the dosage for the liquid order. He said Resident #97 could have side effects due to getting a double dose of Valproic Acid. He said the medication should always be given in the ordered form so medication errors did not happen.In an interview on 4/30/26 at 12:02 PM, the DON said the Valproic Acid should have been given in liquid form because the wrong dose could be given. She stated the Insulin Glargine 10u should have been given as well.In an interview on 4/30/26 at 12:10 PM, NP A said a one-time extra dose of Valproic Acid would not affect Resident #97. She said if the resident was over dosed she would look for a decrease in alertness and a change in vital signs.In an interview on 4/30/26 at 12:40 PM, the DON said she had a one-on-one in-service with LVN A and relieved him of his duties for that day. She said they were also performing STAT labs on Resident #97 and monitoring his vital signs. She said they had already notified the provider and his RP, and the wrong dosage of Valproic Acid had already been removed from the medication cart.Record review of Resident #97's chart revealed a Change in Condition, dated 4/30/26 at 2:11 PM. The Change in Condition was for a medication error. According to the report, there had not been any changes in the resident's status. A complete assessment of Resident #97 was completed which included a head to toe assessment and vital signs. The resident was going to be monitored over 72hr for any adverse effects and a STAT Valproic Acid was drawn.Record review of Resident #97's Physician Orders as of 5/1/26 revealed the following orders from the Medical Director:- Enteral Feed Order every shift Diabetasource @ 75cc/hr via feeding tube to run continuously x 22 hrs. May remove for care and services. Ordered 4/21/26.- Valproic Acid (Depakene) SENT Uncollected 5/1/2026 7:37 AM one time only related to EPILEPSY, UNSPECIFIED. Ordered 5/1/26.- Ascorbic Acid Liquid 500 MG/5ML Give 2.5 ml via G-Tube BID related to PRESSURE ULCER OF UNSPECIFIED SITE. Ordered 4/21/26.- Aspirin Tablet Chewable 81 MG Give 1 tablet via G-Tube QD for Prophylaxis related to CEREBRAL INFARCTION. Ordered 4/13/26.- Insulin Glargine Subcutaneous Solution 100 UNIT/ML (insulin Glargine) Inject 10 unit SQ QD related to TYPE 2 DIABETES MELLITUS. Hold for BS less than 100. Ordered 4/13/26.- Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject 4 unit SQ Q6hr related to TYPE 2 DIABETES MELLITUS. Hold for BS less than 100. Ordered 4/13/26.- Lisinopril Tablet 20 MG Give 1 tablet via G-Tube QD related to HYPERTENSION Hold for BP less than 110/60 or Pulse less than 60bpm. Ordered 4/13/26.- Modafinil Oral Tablet 200 MG (Modafinil) Give 1 tablet by mouth QD related to EPILEPSY, UNSPECIFIED. Ordered 4/25/26.- Multivitamin Liquid (Multiple Vitamins-Minerals) Give 5 ml via G-Tube QD related to PRESSURE ULCER OF UNSPECIFIED SITE. Ordered 4/14/26.- Valproic Acid Oral Solution 250 MG/5ML (Valproate Sodium) Give 5 ml via G-Tube 4xday related to EPILEPSY, UNSPECIFIED. Dose must equal 250mg total. Ordered 4/13/26.- Divalproex Sodium Oral Tablet Delayed Release 500mg, Give 1 tablet via G-tube BID related to EPILEPSY, UNSPECIFIED. Ordered on 4/14/26 and discontinued on 4/20/26.Record review of the facility's policy and procedures on Medication Errors (implemented 10/2025) read in part: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (continued on next page)

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Ashford Gardens	7210 Northline Dr Houston, TX 77076

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services. Medication error rate is determined by calculating the percentage of errors observed during a medication administration observation. The numerator is the total number of errors that is observed, both significant and non-significant. The denominator consists of the total number of observations or opportunities of error and includes all the doses observed being administered plus the doses ordered but not administered. The equation for calculating a medication error is as follows: Medication Error Rate = Number of Errors Observed divided by the Opportunities for Errors (doses given + doses ordered but not given) x 100. The facility shall ensure medications will be administered as follows: According to physician's orders.The facility must ensure that it is free of medication error rates of 5% or greater as well as significant medication error events.The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: Medication administered not in accordance with the prescriber's order. Examples include, but not limited to: Incorrect dose, route of administration, dosage form, time of administration; Medication omission.To prevent medication errors and ensure safe medication administration, nurses should verify the following information: Right medication, dose, route, and time of administration.If a medication error occurs, the following procedure will be initiated: The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. Document actions taken in the medical record. Once the resident is stable, the nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report.Record review of the facility's policy and procedures on Medication Administration (revised 12/30/25) read in part: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.Right dosage, Right route. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Do Not Crush Medications: Slow release Enteric coated.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review the facility failed to ensure residents were free from any significant medication errors for 1 of 3 (Resident #97) residents reviewed for pharmacy services.1. LVN A failed to give Resident #97 the correct dose of Valproic Acid (seizure medication) and gave the resident a double dose during his morning medication administration on 4/30/26. 2. LVN A failed to give Resident #97 the correct form of Valproic Acid and gave it in capsule form instead of liquid form during his morning medication administration on 4/30/26.3. LVN A failed to give Resident #97 his Insulin Glargine during his morning medication administration on 4/30/26.These failures could place residents at risk of side effects due to an increase in dosage, toxicity, and overdose.Findings include:Record review of Resident #97's, undated, face sheet revealed a [AGE] year old male who was admitted to the facility 4/13/26. Resident #97 had diagnoses which included sepsis (infection throughout body), type 2 diabetes (body does not produce insulin or resists it), cerebral infarction (stroke), metabolic encephalopathy (change in brain due to underlying condition), epilepsy (seizures), and pressure ulcer of unspecified site and stage.Record review of Resident #97's admission MDS assessment, dated 4/20/26, revealed a BIMS score of 00 out of 15, which indicated severely impaired cognition. The resident was substantial/max assist (helper does more than half the effort) for all ADLs. Resident #97 was marked for having a seizure disorder. The assessment revealed the resident had a feeding tube, received 51% or more calories through it, and received 501cc/day or more of fluid intake through it. Resident #97 was taking hypoglycemics and anticonvulsants.Record review of Resident #97's Care Plan, dated 4/13/26, revealed a Focus: Resident #97 required tube feeding due to dysphagia. Interventions included monitoring for s/sx of infection at tube site and providing care to the g-tube site. Focus: Resident #97 had diabetes mellitus w/ current treatment Insulin Glargine SQ 100u/ml, Insulin Lispro SQ 100u/ml. Interventions included diabetes medication as ordered by the doctor. Focus: Resident #97 was on anticonvulsant therapy Valproic Acid Oral Solution 250mg/5ml, Divalproex Sodium Oral Tablet Delayed Release 500mg. Interventions included giving medications per order, monitoring labs, and monitoring for signs of seizure.Record review of Resident #97's MRR revealed on 4/15/26 the Consultant Pharmacist recommended discontinuing Divalproex DR Tablet 500mg BID via g-tube because there was already an order for Valproic Acid Oral Solution 250mg/5ml 4xday via g-tube. NP A agreed with the recommendation, however the blister pack was not removed from the medication cart.In an observation on 4/30/26 at 8:48 AM, LVN A was observed crushing and giving the following medication to Resident #97. -Valproic Acid 250mg 2 capsules via g-tubeIn an interview on 4/30/26 at 8:48 AM, LVN A said there was not any liquid Valproic Acid and that was why he was crushing the capsules trying to get the liquid out. He said the pharmacy did not have any liquid Valproic Acid. LVN A did not attempt to look in the medication cart or ask anyone about it. LVN A was not observed giving Insulin Glargine 10u, and the Valproic Acid was ordered to be given in liquid form 250mg/5ml. LVN A also gave a double dose of Valproic Acid.In a phone interview on 4/30/26 at 11:00 AM, an unknown Pharmacist at [pharmacy] said a 280ml bottle of Valproic Acid for Resident #97 had been sent to the facility on 4/14/26.In an interview on 4/30/26 at 11:29 AM, LVN A said he did not see the order for Insulin Glargine 5u and it did not flag on his MAR. LVN A said he did not have the liquid Valproic Acid without looking for it. LVN A was informed a bottle of liquid Valproic Acid for Resident #97 was sent to the facility. LVN A and the State Surveyor looked in the two medication storage rooms and did not find it. LVN A looked in the nurse cart for the 2400 hall, because the resident had moved from that hall, and the medication was not there. The State Surveyor asked LVN (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A if he looked in his own medication cart and he said he had and it was not there. The State Surveyor looked in LVN A's medication cart and the Valproic Acid liquid for Resident #97 was found at the bottom of his cart, where all the other liquid medications were stored. LVN A said he gave the wrong dosage of Valproic Acid because he gave the capsules but looked at the dosage for the liquid order. He said Resident #97 could have side effects due to getting a double dose of Valproic Acid. The nurse said the medication should always be given in the ordered form so medication errors did not happen.In an interview on 4/30/26 at 12:02 PM, the DON said the Valproic Acid should have been given in liquid form because the wrong dose could be given. She stated the Insulin Glargine 10u should have been given as well.In an interview on 4/30/26 at 12:10 PM, NP A said a onetime extra dose of Valproic Acid would not affect Resident #97. She said if the resident was over dosed she would look for a decrease in alertness and a change in vital signs.In an interview on 4/30/26 at 12:40 PM, the DON said she had a one on one in-service with LVN A and relieved him of his duties for that day. She said they were also performing STAT labs on Resident #97 and monitoring his vital signs. She said they had already notified the provider and his RP, and the wrong dosage of Valproic Acid had already been removed from the medication cart.Record review of Resident #97's chart revealed a Change in Condition, dated 4/30/26 at 2:11 PM. The Change in Condition was for a medication error. According to the report, there had not been any changes in the resident's status. A complete assessment of Resident #97 was completed which included a head to toe assessment and vital signs. The resident was going to be monitored over 72hr for any adverse effects and a STAT Valproic Acid was drawn.Record review of Resident #97's Physician Orders as of 5/1/26 revealed the following orders from the Medical Director:- Enteral Feed Order every shift Diabetasource @ 75cc/hr via feeding tube to run continuously x 22 hrs. May remove for care and services. Ordered 4/21/26.- Valproic Acid (Depakene) SENT Uncollected 5/1/2026 7:37 AM one time only related to EPILEPSY, UNSPECIFIED. Ordered 5/1/26.- Insulin Glargine Subcutaneous Solution 100 UNIT/ML (insulin Glargine) Inject 10 unit SQ QD related to TYPE 2 DIABETES MELLITUS. Hold for BS less than 100. Ordered 4/13/26.- Valproic Acid Oral Solution 250 MG/5ML (Valproate Sodium) Give 5 ml via G-Tube 4xday related to EPILEPSY, UNSPECIFIED. Dose must equal 250mg total. Ordered 4/13/26.- Divalproex Sodium Oral Tablet Delayed Release 500mg, Give 1 tablet via G-tube BID related to EPILEPSY, UNSPECIFIED. Ordered on 4/14/26 and discontinued on 4/20/26.Record review of the facility's policy and procedures on Medication Errors (implemented 10/2025) read in part: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services. Medication error rate is determined by calculating the percentage of errors observed during a medication administration observation. The numerator is the total number of errors that is observed, both significant and non-significant. The denominator consists of the total number of observations or opportunities of error and includes all the doses observed being administered plus the doses ordered but not administered. The equation for calculating a medication error is as follows: Medication Error Rate = Number of Errors Observed divided by the Opportunities for Errors (doses given + doses ordered but not given) x 100. The facility shall ensure medications will be administered as follows: According to physician's orders.The facility must ensure that it is free of medication error rates of 5% or greater as well as significant medication error events.The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: Medication administered not in accordance with the prescriber's order. Examples include, but not limited to: Incorrect dose, route of administration, dosage form, time of administration; Medication omission.To prevent medication errors and ensure safe medication administration, nurses should verify the following information: Right (continued on next page)

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	675423	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Gardens	7210 Northline Dr Houston, TX 77076

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication, dose, route, and time of administration.If a medication error occurs, the following procedure will be initiated: The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. Document actions taken in the medical record. Once the resident is stable, the nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report.Record review of the facility's policy and procedures on Medication Administration (revised 12/30/25) read in part: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.Right dosage, Right route. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Do Not Crush Medications: Slow release Enteric coated.Record review of the facility's policy and procedures on Medication Administration via Enteral Tube (implemented 11/1/25) read in part: It is the policy of this facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practice guidelines.Pharmacy will be notified that an order to give medications through enteral tube has been received and suspensions for medications will be supplied when possible.Prior to crushing tablets, nurses will consult the Medications Not to Be Crushed list (from pharmacy) or the manufacturer's labeling/package insert.Sublingual, enteric coated, or modified release medications will not be administered through the enteral tube. Pharmacy will be notified for more appropriate dosage form.

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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** Number of residents sampled: Number of residents cited: Based on observations, interviews, and record reviews, 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 2 out of 28 resident rooms (Resident #42 and Resident #97) reviewed for infection control. - LVN AB failed to wear appropriate PPE while giving G-tube (tube into stomach for nutrition) medications to Resident #42, when she was on Enhanced Barrier Precautions.- LVN A failed to wear appropriate PPE while giving G-tube medications to Resident #97, when he was on Enhanced Barrier Precautions.These failures could place residents and staff at risk for cross contamination and infection.The findings included:Record review of Resident #42's undated face sheet revealed she was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses of acute kidney failure (kidneys are not filtering), aphasia (trouble speaking), diabetes mellitus (body does not produce insulin or resists it), pressure ulcer of sacrum (tailbone), dysphagia (trouble swallowing), and gastrostomy (tube into stomach for nutrition).Record review of Resident #42's Annual MDS assessment dated [DATE] revealed a BIMS score of 00 which indicated severely impaired cognition. The resident had impairment on both sides of her upper and lower extremities. Resident #42 was dependent (helper does all of the effort and resident does none of the effort) for all ADLs. The assessment revealed the resident had a feeding tube, received 51% or more calories through it, and received 501cc/day or more of fluid intake through it.Record review of Resident #42, Care Plan dated 12/9/24 revealed a Focus: Resident #42 was at risk for infection related to gastrostomy status *Enhanced Barrier Precautions* (Initiated: 1/8/25). The interventions included initiating appropriate isolation precautions and staff to follow standard precautions including proper hand washing. Focus: Enhanced Barrier Precautions implemented r/t G-tube feeding, pressure ulcer (Initiated: 12/9/25). Interventions included implementing enhanced barrier precautions.Record review of Resident #42's Physician Orders as of 5/1/26 revealed the following orders from the Medical Director:- Enhanced Barrier Precautions every shift Follow Facility Policy - **USE for patients with any of the following (when Contact Precautions do not otherwise apply}: Wounds or indwelling medical devices, regardless of MDRO (antibiotic resistant bacteria) colonization status Infection or colonization with an MDRO**. Ordered 1/7/25.- Wound care consult. Ordered 7/7/25.- Wound Treatment - Hydrocolloid Dressing [type of wound care] as needed, apply to sacrum (tailbone) as needed. Ordered 7/17/25.- Enteral Feed Order, every shift Jevity 1.2 at 55 ml/hr via feeding tube. To run continuously until total volume of 1210ml administered x 22 hours. May remove 2 hours for care and services. Ordered 2/27/26.- Wound consult with Skilled Wound care [company] until wounds resolve. Ordered 3/17/26.In an observation on 4/28/26 at 10:25am, Resident #42 had an EBP sign on her door. The resident was lying in bed with Jevity 1.2 (type of g-tube feed) running at 55ml/hr via PEG tube. The resident was non-verbal.In an observation on 4/29/26 at 9:12am, LVN AB performed a medication pass on Resident #42. Resident #42 was on EBP with a sign on her door. LVN AB did not wear a gown during the medication administration.In an interview on 4/29/26 at 9:49am, LVN AB said EBP was to protect the resident from any infection from staff and to protect herself from infection from the resident. She said EBP was used for any indwelling lines and wounds and she should have had a gown on when giving G-tube meds but she forgot.In an interview on 4/30/26 at 10:32am, the DON said there was EBP signs outside the resident's doors and over their beds. She said EBP was to protect residents and staff from outside infections and were for any devices/wounds the residents were not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	born with. She said examples were a foley catheter (tube into bladder to drain urine), g-tubes, wounds, trachs (hole in throat for breathing), etc. The DON said PPE would be worn when staff provided close care to the resident, where they were touching the resident. She said giving g-tube meds would require the PPE to be worn. Record review of Resident #97's undated face sheet revealed he was a [AGE] year old male who admitted to the facility 4/13/26 with diagnoses of sepsis (infection throughout body), type 2 diabetes (body does not produce insulin or resists it), cerebral infarction (stroke), metabolic encephalopathy (change in brain due to underlying condition), and pressure ulcer of unspecified site and stage.Record review of Resident #97's admission MDS assessment dated [DATE] revealed a BIMS score of 00 out of 15, which indicated severely impaired cognition. The resident was substantial/max assist (helper does more than half the effort) for all ADLs. The assessment revealed the resident had a feeding tube, received 51% or more calories through it, and received 501cc/day or more of fluid intake through it. Resident #97 also had one stage 3 (full thickness tissue loss with subcutaneous fat visible) unhealed pressure ulcer and one unstageable (unknown due to dead tissue covering the wound) pressure ulcer.Record review of Resident #97's Care Plan dated 4/13/26 revealed a Focus: Resident #97 required tube feeding due to dysphagia (trouble swallowing). Interventions included monitoring for s/sx of infection at tube site and providing care to the g-tube site. Focus: Enhanced Barrier Precautions implemented r/t feeding tubes, wounds. Interventions included implementing enhanced barrier precautions and monitoring for s/sx of infection. Focus: Resident #97 had pressure ulcers: Stg 3 sacrum (tailbone), Stg 3 R ischium (hip)-resolved. Interventions included treatment to pressure ulcer per doctor's orders, turning/repositioning, and weekly head to toe assessment.Record review of Resident #97's Physician Orders as of 5/1/26 revealed the following orders from the Medical Director:- Enhanced Barrier Precautions DX: Wounds/G - tube every shift Follow Facility Policy - **USE for patients with any of the following (when Contact Precautions do not otherwise apply): Wounds or indwelling medical devices, regardless of MDRO colonization status Infection or colonization with an MDRO**. Ordered 4/13/26.- Wound Treatment - Dry Dressing every day shift Cleanse wound to _Sacrum ____ with Normal Saline or Skin Cleanser. Pat Dry apply Medi honey and calcium alginate (type of wound care) Cover with Dry Dressing. Ordered 4/14/26.- Wound Supplement one time a day related to PRESSURE ULCER OF UNSPECIFIED SITE, UNSPECIFIED STAGE (L89.90) 30 ml via G-Tube. Ordered 4/16/26.- Enteral Feed Order every shift Diabetasource @ 75cc/hr via feeding tube to run continuously x 22 hrs. May remove for care and services. Ordered 4/21/26. In an observation and interview on 4/30/26 at 9:35am, LVN A performed a medication pass on Resident #97. Resident #97 was on EBP and there was a sign over his bed indicating it. LVN A did not wear a gown during the medication administration. LVN A said EBP was for g-tubes, wounds, and any indwelling devices. He said he was supposed to wear a gown during g-tube care and giving medications because it protected the resident and himself from infection. He said he forgot to put a gown on.Record review of the facility's policy and procedures on Enhanced Barrier Precautions Policy (revised 12/30/25) read in part: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions.An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers [wounds due to poor circulation] and/or indwelling medical devices (e.g., central lines [tube inserted into large vein ending near the heart], urinary catheters, feeding tubes, tracheostomy/ventilator tubes [breathing machine], hemodialysis catheters [tube into large vein for dialysis], PICC lines [tube inserted into large vein (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ending near the heart], midline catheters [tube inserted into vein longer than regular IV]) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors [monitors blood sugar], insulin pumps, or ostomies [opening to outside where stool collects] without an associated indwelling medical device are not an indication for EBP.).PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room.High-contact resident care activities include.Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters.Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.Record review of the facility's policy and procedures on Infection Prevention and Control Program (revised 12/1/25) read in part: This facility has established and maintains 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 as per accepted national standards and guidelines.All staff are responsible for following all policies and procedures related to the program.All staff shall use personal protective equipment (PPE) according to the established facility policy governing the use of PPE.