STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675493	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Care Center	8861 Fulton St Houston, TX 77022

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on interview and record review, the facility failed to refer all residents with newly evident or possible serious mental disorders, intellectual disabilities, or a related conditions for level II resident review upon a significant change in status assessment for 1 of 18 residents (Resident #28) reviewed for PASARR evaluations. -The facility failed to refer Resident #28 to the appropriate, State-designated authority when she was diagnosed with schizophreniform disorder. This failure could place residents at risk for not receiving necessary PASARR mental health services, causing a possible decline in mental health. Findings include: Record review of Resident #28's undated face sheet revealed she was a [AGE] year-old female admitted on [DATE], with an original admitted [DATE]. She had diagnoses of heart failure (heart is unable to pump effectively), acute respiratory failure (not enough oxygen in the blood), acute kidney failure (kidneys are not filtering), diabetes mellitus (body does not produce insulin or is resistant to it), cerebral infarction (stroke), and schizophreniform disorder. Schizophreniform disorder had an onset date of 3/8/2020. Record review of Resident #28's Annual MDS dated [DATE] revealed the resident was not considered by the level II PASRR process to have a serious mental illness. The admitted for the episode of care in the facility, per the MDS was 4/12/2019. The resident had a BIMS score of 12 out of 15 which indicated she had moderately impaired cognition. Schizophrenia was marked under active diagnoses. Record review of Resident #28's care plan dated 3/18/21, revealed a Focus: Resident has the potential for behavior problems r/t DX: Schizophreniform disorder. Resident has false beliefs that are not based in reality and refuse to give up even when presented with facts. Resident won't allow the CNA to go help another resident even when she's just waiting for wound care services while lying in bed. (Initiated: 3/16/22). Goal: Encourage resident to allow staff to help other residents. Efforts to be made to identify potential factors and try to resolve them. Efforts to be made to ensure incontinence care to be done with each incontinent episode, check for wetness every 2 hours, and as needed. (Initiated: 3/16/22, Target: 7/4/24). Interventions: Serve diet as ordered (Initiated: 4/22/24). (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #28's medical record revealed only one PASRR Level 1 Screening dated 6/16/2017 that was negative for mental illness. There was no evidence a new one was performed before the admission on 4/12/19 or when she was diagnosed with Schizophreniform disorder in March 2020. Interview on 4/24/24 at 2:01pm with the MDS Coordinator, she said she had been in the position for about a month. She said she was in charge of filling out the PASRR evaluations and was not working at the facility when Resident #28 was diagnosed with Schizophreniform disorder. She said she had been going through all the resident's' charts and cleaning them up and now that she knew, she would re-evaluate the resident. She said if a resident was not re-evaluated for PASRR they could miss out on needed services for mental health. Record review of the facility's Policy and Procedure on Resident Assessment Coordination of PASRR and Assessments (effective: 11/28/20) reflected in part: To provide the appropriate care and services needed to for each resident admitted to the facility . The facility will coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: Incorporating the recommendations from the PASRR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.

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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** 47572 Based on interview and record review, the facility failed to create a comprehensive resident-centered care plan with measurable objectives for person-centered care for one of three closed records (CR #89) and 1 (Resident #52) of 6 residents reviewed for resident-centered care plans. - CR #89 did not have a documented comprehensive resident-centered care plan. - Resident #52 was a DNR but his care plan had both DNR and Full Code on it. These failures placed residents at risk of not receiving accurate care and services according to their individual needs. Findings include: CR #89 Record review of CR #89' face sheet dated [DATE] revealed an [AGE] year-old woman admitted on [DATE] and discharged on [DATE]. The face sheet reflected her diagnoses included pleural effusion (an excessive collection of fluid in the pleural cavity, the fluid-filled space that surrounds the lungs), atherosclerotic heart disease (condition where the arteries become narrowed and hardened due to buildup of fats in the artery wall), bradycardia (slowness of the heartbeat, so that the pulse rate is less than 60 per minute), type 2 diabetes mellitus (condition results from insufficient production of insulin, causing high blood sugar), Alzheimer's disease (type of brain disorder that causes problems with memory, thinking and behavior), and ESRD (End Stage Renal Disease, condition where the kidney reaches advanced state of loss of function). Record review of CR #89's admission MDS dated [DATE] with an ARD of [DATE] revealed BIMS score of 7 indicating significant cognitive impairment. The MDS reflected she had no impairment of either upper or lower extremities, and she utilized a wheelchair for mobility. Per the MDS CR #89 required assistance with all ADL's except eating. The MDS revealed she received OT, PT, and ST. The MDS reflected CR #89 did not receive dialysis treatments. Record review of the facility's EHR and CR #89' paper file revealed there was no care plan available for review. The physical file included a copy of CR #89's baseline care plan dated [DATE]. Record review of CR #89' initial social service history report dated [DATE] revealed she was admitted on [DATE]. The report reflected her diagnoses were to be determined per clinical documentation. Resident #52 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #52's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE], with an original admitted [DATE]. He had diagnoses of acute respiratory failure with hypoxia (not enough oxygen in the body), acute myocardial infarction (heart attack), anoxic brain injury (brain damage caused by not getting enough oxygen to the brain), cardiac arrest (heart stopped), type 2 diabetes (body does not produce enough insulin or is resistant to it), hemiplegia on left dominant side (paralysis), cerebral infarction (stroke), epilepsy (seizures), and gastrostomy (tube into stomach for nutrition). The face sheet indicated he was a DNR. Record review of Resident #52's Quarterly MDS dated [DATE], revealed a BIMS was unable to be performed due to the resident's condition. The resident was dependent with all ADLs and mobility and was bedbound. He had an indwelling catheter and was always incontinent of bowel. The resident had diagnoses of malnutrition (condition that results from lack of sufficient nutrients in the body), pneumonia (infection of the air sacs in one or both the lungs), sepsis infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever), viral hepatitis (inflammation of the liver caused by a virus), stroke, seizures, heart attack, muscle wasting, and gastrostomy (procedure in which the surgeon makes an opening into the stomach and inserts a feeding tube for feeding or for drainage) marked on the MDS. The MDS revealed the resident used a feeding tube while a resident and received 51% or more of his total calories through the tube feeding. He also received 500ml/day or less of fluid intake per day from the tube feeding. He also used oxygen. Record review of Resident #52's Care Plan dated [DATE], revealed a Focus: Resident has Full Code status (Initiated: [DATE]). Goal: Resident/RP's decision will be honored regarding Full Code status through next review (Initiated: [DATE], Target: [DATE]). Interventions: All aspects of Full Code status will be explained to Resident/RP. In the absence of B/P. pulse and respirations, CPR will be initiated. Social Service to consult with Resident and RP regarding their decision to continue Full Code status. Focus: Resident has a DNR (Initiated: [DATE]). Goal: Resident/RP's decision will be honored regarding DNR status through the next review (Initiated: [DATE], Target: [DATE]). Interventions: All aspects of DNR will be explained to Resident/RP. In the absence of B/P, pulse, respirations, CPR will not be initiated. Resident will be maintained at a level of comfort as ordered by MD. Social Service to consult with Resident and RP regarding their decision to continue DNR. Record review of Resident #52's physical chart revealed an Out-of-Hospital Do-Not-Resuscitate order from [DATE]. There was also a bright red page in the front of the resident's chart that had the words DNR in bold. Record review of Resident #52's Physician's Orders revealed an order for DNR on [DATE] at 11:03am, by MD A. Record review of Resident #52's physical chart revealed a Social Service note from [DATE] at 2:00pm which reflected, Residents advance directive is DNR code status and will remain through next review. Record review of Resident #52's H&P from MD A on [DATE], revealed his code status was a DNR. Record review of Resident #52's H&P from NP A on [DATE], revealed his code status was a DNR. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 12:41 PM with the WCN, he said care plans instructed staff how to care for residents. The WCN said the care plan was the playbook for how to care for the residents. The WCN said if a resident did not have a care plan the facility staff would have to immediately create one. The WCN said it should not be possible for a resident to not have a care plan. The WCN said the care plans in the physical files were printed out from the EHR. The WCN said CR #89's care plan must be in a physical file if it was not in the EHR. Interview on [DATE] at 1:40 PM with the WCN, he said after reviewing CR #89's physical file, he could not locate a care plan, but the baseline care plan was in the physical file. The WCN said the facility was searching the facility's physical and electronic medical records for either the physical paper copy or an electronic record of Resident #89's comprehensive resident-centered care plan. Interview on [DATE] at 1:48 AM the DON said a care plan was a plan for how to care for a resident. The DON said the importance of a care plan was that it provided staff with directions on how to care for a resident. The DON said if a resident did not have a care plan, the resident would still get care, but it may not be provided as ordered. The DON said the care plan in a resident's physical file was the same as in the EHR, but many care plans were being transitioned to the EHR from paper files. The DON said a resident's care plan could be completed on paper first. The DON said the facility had completed care plans on paper in the past. The DON said if a resident was discharged in [DATE], the resident's care plan may have been completed on paper. The DON said CR #89 should have had a totally paper care plan. The DON said if CR #89's care plan was not in her physical file, it could be in the MDS office. The DON said if CR #89's did not have a care plan, she may not have received the care as ordered. Interview on [DATE] at 2:01 PM with the MDS Nurse, she said she had been employed for one month. The MDS Nurse said she was responsible for creating resident care plans, including updating the code status for residents. The MDS Nurse said the importance of a care plan was that it allowed staff to know how to care for a resident and what needs the residents had. The MDS Nurse said if a resident did not have a care plan it would be detrimental to the resident's care. The MDS Nurse said the staff would not know the resident's needs including their medications, diet, or ADL needs. The MDS Nurse said the facility was transitioning from paper files to the EHR, including the residents' care plans. The MDS Nurse said some residents care plans were still done on paper. The MDS Nurse said a resident who was admitted to the facility in [DATE] and discharged in [DATE] would have had a paper care plan. The MDS Nurse said she did not know why CR #89 had no care plan in the EHR or physical file. The MDS Nurse said a resident who had been at the facility for the length of time CR #89 had should have a care plan. The MDS Nurse said she was not employed by the facility when CR #89 was present. The MDS Nurse said if the resident had two different code status' it could be detrimental for the resident because the wrong code could be performed. She said she was in the process of updating care plans and must have overlooked the Full Code status that should have already been changed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:40 PM with the Admin, she said her expectations related to care planning was that care plans should be completed in a timely fashion. The Admin said care plans should be completed with the baseline initially and then as scheduled. The Admin said the social worker scheduled the care plan meetings with the resident and/or the resident's family. The Admin said the social worker then informed the IDT when a care plan meeting was scheduled and who would be in attendance. The Admin said a resident's initial care plan should be completed and implemented immediately following the baseline care plan. The Admin said the baseline care plan was valid for twenty-one days, then a comprehensive care plan would be implemented. The Admin said the importance of a resident's care plan was to ensure the facility had a plan to care for the total needs of a resident, including social, nutritional, activity, and medical needs. The Admin said the care plan addressed a resident's whole quality of life. The Admin said if a resident did not have a care plan, the facility would not be completing what was required by statute, and the resident may miss care. The Admin said care plans had been completed on paper, but the facility was integrating to the EHR. The Admin said the former MDS nurse had began imputing resident care plans into the EHR. The Admin said CR #89's care plan should have been in the EHR. The Admin said she did not know why CR #89's care plan was not in the EHR or physical file. The Admin said if CR #89 did not have a written care plan, she would most likely would have had the care required based on physician's orders, the MAR, the TAR, and nurses' notes. The Admin said if there was no documentation the facility completed a care plan for CR #89, it was noncompliance with statutes, but CR #89 would have received care at the facility. Interview on [DATE] at 4:02 PM with the WCN, he said after searching the facility's medical storage, the staff could not locate a comprehensive care plan for CR #89. Record review of the facility's Care Planning-Interdisciplinary Team policy dated [DATE] revealed a policy statement refelcted, Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. The policy documented that a care plan would be developed for each resident within seven days of the resident's MDS. Per the policy, the facility's care planning/interdisciplinary team would create the care plans. Record review of the facility's Care Plans, Comprehensive Person-Centered dated [DATE] revealed a policy statement reflected, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy reflected the care plans were created by the interdisciplinary team and the resident and/or his/her family. Per the policy, the care plan included, measurable objectives and timeframes, describe services that were to be furnished, and identified problem areas. The policy reflected the care plan should reflect the residents expressed wishes and treatment goals. Per the policy, the care plan would be developed within seven days of the completion of the required comprehensive assessment. The policy revealed the care plan should be reviewed and updated when there was a significant change, when the outcome was not met, and at least quarterly.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observations, interviews, and record reviews, the facility failed to ensure that residents received care, consistent with professional standards of care to prevent development of pressure ulcers for 1 of 6 (Resident #16) reviewed for pressure ulcers. -The facility failed to apply Resident #16's physician ordered pressure relieving heel protectors or to off-load his heels. This failure could place residents at risk for developing a pressure ulcer or worsening a pressure ulcer, which could cause pain and infection. Findings include: Record review of Resident #16's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses of peripheral vascular disease (bad circulation in extremities), dementia, anemia (lack of iron/oxygen in the blood), pressure induced deep tissue of left heel, pressure ulcer of right heel, and cirrhosis (liver failure). Record review of Resident #16's Entrance MDS dated [DATE] revealed a BIMS score of 10 out of 15, which indicated moderate cognitive impairment. The resident did not have pressure ulcers as a diagnosis on the entrance MDS. The Entrance MDS revealed the resident was not at risk of developing pressure ulcers/injuries and did not have any at that time. The assessment reflected he had an infection of his foot. However, he had a pressure reducing device for his chair and bed, was receiving pressure ulcer/injury care, and was receiving application of dressings to his feet. Record review of Resident #16's Quarterly MDS dated [DATE] revealed he was dependent with toileting hygiene, shower/baths, and lower body dressing. He was also dependent with sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. He was substantial/max assist with rolling left to right, sit to lying, and lying to sitting on side of the bed. He was always incontinent of bowel and bladder and used a wheelchair. The MDS revealed the resident had a pressure ulcer/injury and was at risk for developing pressure ulcers/injuries. The MDS revealed the resident had a Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer, with pressure ulcer/injury care, application of nonsurgical dressings, and application of dressings to feet. Record review of Resident #16's care plan dated 2/20/24, revealed a Focus: Resident has actual alteration in skin integrity. Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) right heel 3.8 x 3.3 x 0. 4cm related to decreased mobility (Initiated: 3/7/24). Goal: Efforts will be made to heal current alterations in skin integrity through next review. Efforts will be made to prevent s/s of infection through next review. Efforts will be made to prevent further skin breakdown through next review (Initiated: 3/7/24, Target: 6/5/24). Interventions: Off-load Wound; Float Heels in bed. Record review of Resident #16's Physician Orders on 4/22/24, revealed the following orders from MD A: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Off-Load Wound; Float Heels in Bed every shift. Ordered on 2/14/24 at 9:20am. -Verify resident is wearing pressure offloading boots every 8hrs. Ordered on 3/5/24 at 9:12am. -Stage 4 Right Heel, Cleanse w/ Wound Cleanser, N/S or Vashe, Pat Dry, Apply Calcium Alginate w/ Silver, Border Island Dressing, Gauze Roll (Kerlix) 3.4, every day for wound healing. Ordered on 4/18/24. In an observation of Resident #16 on 4/22/24 at 10:00am, revealed the resident was lying on his back in bed. His heels were not floated and were on the mattress. His pressure offloading boots were on his nightstand. In an observation of Resident #16 on 4/23/24 at 9:01am, revealed he was lying on his back in bed. His heels were not floated and were on the mattress. His pressure offloading boots were on his nightstand. In an observation of Resident #16 on 4/23/24 at 1:50pm, he was laying on his back in bed. His heels were not floated and were on the mattress. His pressure offloading boots were on his nightstand. CNA R and CNA Z were finishing providing incontinence care. In an observation of Resident #16 on 4/23/24 at 2:00pm, revealed he was lying on his back in bed. His heels were not floated and were on the mattress. His pressure offloading boots were on his nightstand. CNA R and CNA Z did not put his pressure offloading boots on or offload his heels. Interview on 4/24/24 at 12:30pm with the Wound Care Nurse, he said he was in charge of treating the wounds and performing skin assessments. He said he performed his wound treatments at 4:00am when the CNAs were turning/changing the residents so everything could be done at one time. He said Resident #16 used to refuse the pressure offloading boots but now he's okay with wearing them. He said he refused them a month or two ago, but he did not have a problem with them now. The Wound Care Nurse said if the boots were not on him on 4/22/24 and 4/23/24, then whoever changed him probably did not put them back on. He said the pressure ulcer could get worse if the boots were not on or if his heels were not off-loaded, but he also had an air mattress and that helped with preventing further break down. Record review of the facility's policy and procedure on Quality of Care: Skin Integrity/Pressure Sores (effective 11/28/17) read in part: To provide the appropriate care and services needed for each resident admitted to the facility . The facility must provide care for a resident, consistent with professional standards of practice, to prevent pressure ulcers and so that resident does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. The facility must provide the necessary treatment and services to a resident with pressure ulcers, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

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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** 38644 Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent (%) or greater. The facility had a medication error rate of 8% based on 3 errors out of 35 opportunities, which involved 1 of 5 residents (Resident #3) reviewed for medication errors. -MA B administered the incorrect dose of Famotidine (a medication used to reduce stomach acid and treat ulcers), Furosemide (a medication used to treat fluid retention and high blood pressure), and Polyethylene Glycol 3350 (also known as Clearlax which is used to treat occasional constipation) to Resident #3 according to physician's orders. These failures could place residents at risk of inadequate therapeutic outcomes, increased negative side effects, and a decline in health. Findings included: Record review of Resident #3's face sheet dated 4/24/24 revealed a [AGE] year-old male admitted on [DATE]. His diagnoses included hyperkalemia (high potassium levels in the blood), acute kidney failure, hypertensive crisis (a very high blood pressure that happens without warning and can damage organs), and rhabdomyolysis (a muscle injury where muscles break down and release toxic components into the blood and kidneys). Record review of Resident #3's annual MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. He required supervision to full dependence from staff for ADL care. Record review of Resident #3's order summary report for April 2024 revealed orders for: Famotidine 40 mg give 40 mg by mouth one time a day for heartburn and acid indigestion, order date 1/23/24. Furosemide 20 mg give 1 tablet by mouth one time a day for fluid retention, order date 8/23/23. Polyethylene Glycol 3350 oral packet 17 gm give 1 packet by mouth one time a day for constipation mix with 8-10 oz water, order date 12/31/23. Record review of Resident #3's paper Medication Administration Record for April 2024 revealed: Famotidine 40 mg give 40 mg by mouth one time a day for heartburn and indigestion; Furosemide 20 mg give 1 tablet by mouth one time a day for fluid retention. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 4/24/24 at 9:20 a.m. with MA B revealed she prepared morning medication for Resident #3 which included Famotidine 20 mg 1 tablet, Furosemide 40 mg 1 tablet, chewable Aspirin 81 mg, Vitamin B12 500 mcg, Vitamin D 1000 IU, Hydralazine 25 mg, Clonidine 0.1 mg, Metoprolol tartrate 50 mg, Gabapentin 300 mg, Baclofen 5 mg, Fluoxetine 40 mg, Nifedipine ER 90 mg, and Losartan 100 mg. She entered the room and administered the medications to Resident #3. MA B returned to the medication cart and compared Resident #3's paper MAR to the medications administered to Resident #3 with the Surveyor. MA B looked through the paper MAR and saw that she did not administer Resident #3's Polyethylene Glycol 3350 oral packet 17 gm. MA B retrieved Clearlax 3350 powder (same as Polyethylene Glycol 3350) for administration. Observation of the inside of the Clearlax measuring top revealed there was the number 17 and an up arrow that pointed to the top of a white area. MA B poured the medication to the line at the halfway mark of the measuring top, which was below the 17-gram line. MA B mixed the powder with water and administered it to Resident #3. MA B said staff from a different facility taught her to pour the powder to the line in the middle of the cap. She said she just started passing medications at the facility and did not pay attention to the Furosemide dosage indicated on the paper MAR. She said she was focused on the medication name and administration time. She said for the Famotidine, she should ensure to review the dosage on the bottle (which was 20 mg). Interview on 4/24/24 at 10:56 a.m. the ADON said nursing staff must verify the medication name and strength of the blister pack. She said if it did not match the MAR, the MA should alert the nurse who would clarify with the MD. She said staff never said anything to her. She said an in-service was needed on reading the MD orders thoroughly. She said Furosemide was for urine retention and if more was prescribed Resident #3 could become dehydrated. She said she would notify Resident #3's MD. Interview on 4/24/24 at 11:29 a.m. the DON said when administering medications staff should compare the MAR to the blister pack and check for the right dose, medication, patient, and route for accuracy. He said Clearlax powder was for constipation and should be poured to the top of the white area. He said Resident #3 received half of the dosage prescribed by the MD for the Famotidine and Clearlax. He said if the resident did not receive what was ordered by the MD, he would not get the desired therapeutic effect. Record review of the facility's Pharmacy Services Free of Medication Error Rate of 5% or Greater . policy dated 11/28/2017 reflected in part, .Objective: to provide the appropriate pharmacy services and safe and effective medication use for each resident admitted to the facility . Policy: The facility medication error rate is not 5 percent or greater Record review of the facility's Administering Medications dated December 2012 read in part, . Medications shall be administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation . 3. Medications must be administered in accordance with the orders . 7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675493	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Care Center	8861 Fulton St Houston, TX 77022

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observation, interview, and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and systematically organized for 1 (Resident #52) of 6 residents reviewed for accurate medical records. -The facility failed to correctly transcribe and clarify with the physician orders for Resident #52's PEG tube (tube into stomach for nutrition) feeding rate. -The facility failed to maintain Resident #52's April 2024 MAR for his PEG tube (tube into stomach for nutrition) feeding. This failure could place residents at risk receiving the wrong rate of feeding and water flush which can cause malnutrition and dehydration/fluid overload. Findings include: Record review of Resident #52's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE], with an original admitted [DATE]. He had diagnoses of acute respiratory failure with hypoxia (not enough oxygen in the body), acute myocardial infarction (heart attack), anoxic brain injury (brain damage caused by not getting enough oxygen to the brain), cardiac arrest (heart stopped), type 2 diabetes (body does not produce enough insulin or is resistant to it), hemiplegia on left dominant side (paralysis), cerebral infarction (stroke), epilepsy (seizures), and gastrostomy (hole in stomach). Record review of Resident #52's Quarterly MDS dated [DATE], revealed a BIMS (used to assess cognition) was unable to be performed due to the resident's condition. The resident had diagnoses of malnutrition and gastrostomy marked on the MDS. The MDS revealed the resident used a feeding tube while a resident and received 51% or more of his total calories through the tube feeding. He also received 500ml/day or less of fluid intake per day from the tube feeding. Record review of Resident #52's Care Plan dated 8/19/22, revealed a Focus: Resident has nutritional problem or potential nutritional problem (protein calorie malnutrition) r/t G-Tube (tube in stomach for nutrition) status (Initiated: 8/19/22). Goal: Resident will maintain adequate nutritional status as evidenced by maintaining weight within 3% of 130lbs, so s/sx of malnutrition, and consuming at least (X)% if at least (X) meals daily through review date (Initiated: 8/19/22, Target: 4/26/24). Interventions: G-tube (tube in stomach for nutrition) feeding as ordered. Weight as ordered. Report weight loss of greater than 3% to MD. (Initiated: 8/19/22). Focus: Resident requires tube feeding r/t dysphagia (trouble swallowing). Enteral Feed: Diabetisource. (Initiated: 3/15/24). Goal: Resident will be free of aspiration (inhaling food) through the review date (Initiated: 3/15/24, Target: 4/26/24). Interventions: Monitor/document/report to MD PRN: Aspiration-fever, SOB, tube dislodged, infection at tube site, tube dysfunction or malfunction, abdominal distention . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 4/23/24 of Resident #52's Physician's Orders transcribed in the EMR, revealed the following orders: -Enteral (passing through the intestine) Feed Order, every shift Diabetisource to run at 50cc/h and flush with water at 30ml every 3 hours. Ordered on 4/11/24 at 9:43am, to start on 4/12/24. -Enteral Feed Order, every shift Diabetisource AC 60ml/hr with 45ml water flush every 1hr continuously. Ordered on 4/12/24 at 11:54pm, to start on 4/13/24. Record review on 4/23/24 of Resident #52's actual Physician's Orders, revealed the following orders from MD A: -Order Clarification: D/C all water flushes per PEG and give 30ml H2O flush Q 3hrs to prevent clogged PEG. Ordered on 4/1/24. -Change Tube Feeding Diabetisource AC to 60ml/hr continuous. Ordered on 4/12/24. In an observation on 4/22/24 at 10:16am, revealed Resident #52 was lying on his back asleep in bed. He had a PEG tube running Isosource AC at 60ml/hr with the water flush 30ml Q3hr. In an observation on 4/23/24 at 8:45am, revealed Resident #52 was lying on his back and was receiving Diabetisource AC at 60ml/hr with water flush 30ml Q3hr. Interview with NP A on 4/24/24 at 10:39am, she said the PEG tube order for Resident #52 should be 60ml/hr with water flush 30ml Q3hr, with either the Diabetisource AC or the Isosource AC. She said she did not have access to the EMR, so all of her orders were in the paper chart. Interview with the DON on 4/24/24 at 1:50pm, he said he did not know why there would be two orders for the PEG tube feeding and why they would be wrong. He said if the orders were wrong it could cause a medication error. He said the nurses input the orders into the EMR from what the MD/NP wrote in the chart. Record review of Resident #52's April 2024 MAR binder that LVN H had on 4/24/24 at 2:00pm, revealed there was not a page in the binder for his PEG feeding order for the whole month of April. Interview and observation with the ADON on 4/24/24 at 2:15pm, the ADON did not know there were two separate orders for the PEG feeding in the EMR for Resident #52. She said there should only be one order and she corrected the order according to the physician's order in the paper chart. She also was not aware that the April 2024 MAR for the PEG feeding on Resident #52 could not be found. The ADON and LVN H looked all through the MAR binder and could not find it. The ADON did not know what could have happened to it, so she printed a new one and put it in the April 2024 MAR binder. Interview with LVN H on 4/24/24 at 2:17pm, she said she knew the right PEG feeding and the right rate for Resident #52 even though the MAR was not in the binder, because she knew the resident really well and took orders for him all the time. She said a medication error could happen if the MAR is not in the chart. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy and procedure on Physician/Medication Orders (no revision date) reflected in part: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders .A current list of orders must be maintained in the clinical record for each resident. Orders must be written and maintained in chronological order . Medication Orders - When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered. A placebo is considered a medication and must also have specific orders . Enteral Orders - When recording orders for enteral tube feedings, specify the type of feeding, amount, frequency of feeding and rationale if prn. The order should always specify the amount of flush following the feeding . Record review of the facility's policy and procedure on Resident Records-Identifiable Information (Effective 11/28/17) reflected in part: .In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized .

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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** 47722 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #16) of 6 residents viewed for infection control. -CNA R and CNA Z did not wear appropriate PPE when changing Resident #16 during incontinence care, when he was on Enhanced Barrier Precautions. This failure could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building. Findings include: Record review of Resident #16's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses of peripheral vascular disease (bad circulation in extremities), dementia, anemia (lack of iron/oxygen in the blood), pressure induced deep tissue of left heel, pressure ulcer of right heel, and cirrhosis (liver failure). Record review of Resident #16's Quarterly MDS dated [DATE] revealed he was dependent with toileting hygiene, shower/baths, and lower body dressing. He was also dependent with sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. He was substantial/max assist with rolling left to right, sit to lying, and lying to sitting on side of the bed. He was always incontinent of bowel and bladder and used a wheelchair. This MDS revealed the resident had a pressure ulcer/injury and was at risk for developing pressure ulcers/injuries. The MDS revealed the resident had a Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer, with pressure ulcer/injury care, application of nonsurgical dressings, and application of dressings to feet. Record review of Resident #16's care plan dated 2/20/24, revealed a Focus: Resident has actual alteration in skin integrity. Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) right heel 3.8 x 3.3 x 0. 4cm related to decreased mobility (Initiated: 3/7/24). Goal: Efforts will be made to heal current alterations in skin integrity through next review. Efforts will be made to prevent s/s of infection through next review. Efforts will be made to prevent further skin breakdown through next review (Initiated: 3/7/24, Target: 6/5/24). Interventions: Off-load Wound; Float Heels in bed. Focus: Resident requires Enhanced Barrier Precautions r/t wounds (Initiated: 4/7/24). Goal: Resident will remain free from active infection of MDRO through the review date (Initiated: 4/7/24, Target: 6/5/24). Interventions: Post signs outside of resident's room that state the required precautions. Wear gowns and gloves when during high contact activities. In an observation on 4/22/24 at 9:57am, revealed Resident #16 had a posting on his door to his room that refelcted he was on Enhanced Barrier Precautions, which required staff to wear gowns and gloves when they performed patient care due to the wound he had. In an observation on 4/23/24 at 1:50pm, revealed CNA R and CNA Z performed incontinence care to Resident #16, and neither wore gowns, and were only wearing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/23/24 at 2:00pm with CNA R and CNA Z, they said they were the ones who provided incontinence care to Resident #16. They said Enhanced Barrier Precautions meant they had to wear PPE when they provided resident care, like changing a resident, because of the resident's wound. They said if they did not wear the PPE the bacteria could get on them and they could transfer it to another person and cross contamination could occur. They did not think that Resident #16 was on Enhanced Barrier Precautions and thought it was for the other resident in the room. Interview with the Wound Care Nurse on 4/24/24 at 12:30pm, he said residents with Enhanced Barrier Precautions meant staff had to gown up for any resident care. He said if PPE was not worn in a resident's room who was on Enhanced Barrier Precautions, he would have to have a talk with them and they would be in trouble because I'm one of the Infection Preventionists also. He would not say what the effect to the resident could be. Record review of the facility's policy and procedure on Infection Prevention and Control (effective 11/28/17) reflected in part: To effectively investigate, control and/or prevent infections. The facility shall investigate, control and/or prevent infections through implementation of an Infection Prevention & Control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections utilizing current state, federal, and CDC guidelines as indicated. Isolation and/or enhanced barrier precaution (EBP) practices are included and used when required .