

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675493	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2025
NAME OF PROVIDER OR SUPPLIER Highland Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8861 Fulton Street Houston, TX 77022	

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)
<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0692</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to maintain acceptable parameters of nutritional status in such as usual body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicate otherwise for 1 of 8 (Resident #67) residents reviewed for weight loss. -The facility failed to ensure Resident #67 was monitored for weight loss resulting in a 14.5% or 24.8 pounds in a 3-month period. An Immediate Jeopardy (IJ) was identified on 6/6/25. The IJ template was provided to the facility on 6/6/25 at 3:16pm, While the IJ was removed on 6/8/25, the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm the facility continued to monitor the implementation and effectiveness of their corrective systems. This failure could place residents at risk of malnutrition and medical complications due to severe weight loss. Finding included:Record review of Resident #67's admission Record generated on 6/8/25 revealed she was admitted to the facility on [DATE] with diagnoses of chronic venous hypertension (improper functioning of the vein valves in the leg, causing swelling and skin changes) with ulcer of bilateral lower extremity (refers to the lower legs and feet), schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly and may result in a mix of hallucinations, delusions disorganized thinking and behavior) and malignant neoplasm of breast (breast cancer). She was [AGE] years of age. Record review of Resident #67's care plan (undated) revealed the following focuses, goals and interventions: - Focus: Resident #67 would participate in liberalized dining. Resident received a regular diet, regular texture and thin consistency liquids. Goal: Resident #67 would make acceptable food choices based on diseases and diagnoses. Target date: 7/21/25. Interventions: Resident #67 would be educated on nutrition as it related to her diagnosis and serve diet as ordered. - Focus: Resident #67 has behavior of resisting activities of daily living related to a diagnosis of schizophrenia. Goal: Efforts would be made to lessen episodes of behaviors with use of medication and redirection. Target date: 7/21/25. Interventions: Be firm, not forceful, encourage compliance with care, and monitor and document behaviors. - Focus: Resident #67 had a nutritional problem or potential nutritional problem. Goal: Resident #67 would comply with recommended diet for weight reduction daily through review date. Target date: 7/21/25. Interventions: Administer medications as ordered, monitor/document/report to physician as needed for signs and symptoms of dysphagia (difficulty swallowing foods or liquids), including pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals.- Focus: Resident #67 is at risk for weight loss related to 'weight loss abnormal.' Goal: Efforts would be made to prevent significant changes in weight and provide adequate nutrition. Target date: 7/21/25. Interventions: Assist Resident #67 with meals, verbally and physically as needed. Feed Resident #67 if needed, and dietary consult as needed. Record review of Resident #67's quarterly MDS assessment dated [DATE] revealed she had a BIMS of 10, indicating moderate cognitive impairment. She had behaviors of inattention and disorganized thinking. She rejected care 1-3 days of 7 days. She required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating. She had no weight loss and was no on a therapeutic or mechanically altered diet. Record review of Resident #67's Weight Summary (undated) revealed she weighed 171 pounds on 3/5/25 when measured using a mechanical lift. Record review of Resident #67's POC Legend Report generated on 6/6/25 revealed the following: - It was documented that the resident ate less than 25% of her meal on 4 occasions between 3/1/25 and 4/30/25. - It was documented that the resident ate between 26% and 50% of her meal on 25 occasions between 3/1/25 and 4/30/25. - There was no record of percentage of meal eaten (missed documentation) for 3 morning meals, 11 noon meals, and 22 evening meals between 3/1/25 and 4/30/25. Record review of Resident #67's laboratory results dated [DATE] revealed she had a low albumin level of 2.7 g/dL (low albumin levels in the blood can be a result of liver disease, kidney disease or malnutrition). The reference range indicated it should have been between 3.5-5.7 g/dL. Her blood glucose level was critically low at 42 mg/dL (low glucose levels in the blood can be a result of hormonal imbalance, liver disease, kidney disease or malnutrition). The reference range indicated it should have been between 65-110 mg/dL. Her sodium level was high at 147 mmol/L (high sodium levels in the blood can be a result of dehydration or excessive sodium intake). The reference range indicated it should be between 136-145 mmol/L. Her potassium level was low at 3.2 mmol/L (low potassium levels in the blood can be a result of medication use</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care and services, including oxygen administration was provided such care, consistent with professional standards of practice for 1 of 3 residents (Resident #43) reviewed for respiratory therapy in that: The facility failed to ensure Resident #43 received continuous oxygen and nebulizer treatments to meet her respiratory needs, resulting in Resident #43 experiencing oxygen saturations of 90 on 6/3/25 and 80 on 6/5/25. Resident #43 was experiencing anxiety and a change to her daily routine as a result. The facility failed to ensure Resident #43 was administered oxygen per the physician's order resulting in the resident receiving oxygen at a rate higher than what was prescribed placing her at risk of medical complications. An Immediate Jeopardy (IJ) was identified on 6/26/25. The IJ template was provided to the facility on 6/26/25 at 12:00pm, While the IJ was removed on 6/27/25, the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm the facility continued to monitor the implementation and effectiveness of their corrective systems. This failure could place residents at risk of respiratory distress, anxiety and decline in quality of life. The findings included: Record review of Resident #43's admission Record generated on 6/8/25 revealed she was admitted to the facility on [DATE] with diagnoses of respiratory failure, schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly), parkinsonism (characterized by tremor, rigidity and postural instability), dementia (decline in mental ability severe enough to interfere with daily life), dysphagia (difficulty swallowing foods or liquids), insomnia (a sleep disorder where people struggle to fall asleep), tremor, cellulitis (bacterial skin infection), morbid obesity, generalized anxiety disorder, chronic obstructive pulmonary disease (COPD .a progressive lung disease that makes it difficult to breath). She was [AGE] years of age. Record review of Resident #43's quarterly MDS assessment dated [DATE] revealed she had a BIMS of 10, indicating moderate cognitive impairment. She had a PHQ-9 score of 6, indicating she had mild depression symptoms. She had behaviors of delusions and verbal behaviors that occurred 1-3 days of 7 days. It further indicated she required partial/moderate assistance with person hygiene tasks, including combing hair, shaving, applying makeup and washing/drying face and hands. She used a wheelchair for mobility and required partial/moderate assistance with transfers from sitting to standing, chair to bed, toilet and tub/shower transfers. She did not have signs of shortness of breath. Record review of Resident #43's care plan (undated) revealed the following focuses, goals and interventions: - Focus: Resident #43 had a diagnosis of COPD. Goal: Resident #43 would be free from signs and symptoms of respiratory infections. Target Date: 6/1/25. Interventions: Give oxygen therapy as ordered by the physician, monitor for difficulty breathing on exertion. Remind resident not to push beyond endurance. - Focus: Resident #43 exhibited signs and symptoms of anxiety. Goal: Resident #43 would have no side effects from medication. Target date: 6/1/25. Interventions: Administer medications as ordered, monitor for side effects of medications. - Focus: Resident #43 had oxygen therapy related to hypoxia. Goal: Resident #43 will have no signs or symptoms of poor oxygen absorption through the review date. Interventions: Give medications as ordered by physician. Monitor for signs and symptoms of respiratory distress and report to physician as needed. - Focus: Resident #43 had shortness of breath. 11/4/24 Albuterol Sulfate Inhalation solution as ordered. Goal: Resident #43 would have no complications related to shortness of breath. Target date: 6/1/25. Interventions: Monitor/document changes in orientation, increased restlessness, anxiety, and air hunger, monitor/document breathing patterns, report abnormalities to physician including nasal flaring, respiratory depth changes, altered chest excursion, use of accessory muscles, pursed-lip breathing, or prolonged expiratory phase. Record review of Resident #43's Order Summary Report generated on 6/4/25 revealed she had an order for Oxygen at 3 L/min by nasal cannula continuously for a diagnosis of hypoxia (an absence of enough oxygen in the tissues to sustain bodily function), and an order for Albuterol Sulfate Inhalation Nebulization Solution (2.5 mg/3mL) 0.083%, inhale 3 mL orally by nebulizer every 4 hours as needed for shortness of breath. Record review of Resident #43's Progress Note completed by NP B dated 5/28/25 revealed her baseline oxygen saturations were above 93% (oxygen saturations refer to the percentage of hemoglobin in your blood that was carrying oxygen, and was a measure of how well oxygen was being transported to your body's tissues. Normal oxygen saturation levels for healthy individuals typically range from 95% to 100%). Record review of Resident #43's Treatment Administration Record dated May 2025 revealed Albuterol Sulfate Inhalation Nebulization Solution was not administered during the month of May 2025. Record review of Resident #43's</p>		