STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675671	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace Healthcare Center of Houston	7887 Cambridge St Houston, TX 77054

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a person-centered baseline admission care plan for 1 of 3 residents (Resident #2) reviewed for baseline care plans in that:-The facility failed to develop a baseline care plan with goals, interventions, treatments, and psychosocial needs within 48 hours of admission for Resident #2.This failure could have affected new admission residents by not having their individual, medical, functional, and psychosocial needs identified and could cause a physical or psychosocial decline in health.Record review of Resident #2's face sheet dated [DATE] revealed she was an [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included: fracture of the lower end of radius (broken wrist injury), hypertension (high blood pressure), and dementia (decline in mental ability).Record review of Resident #2's 15-day MDS assessment dated [DATE] revealed a BIMS score of 00 out of 15, indicating severely impaired cognition. Further review revealed Resident #2 needed extensive assistance to total care with ADL care with one staff assistance.Record review of Resident #2's care plan revealed the resident care plan was cancelled on [DATE]. It also revealed an entry on [DATE] with a status of full code by ADON.Record review of Resident #2's out-of-hospital DNR revealed the form was dated [DATE], a day before Resident #2 was discharged back to the facility from the hospital.During an interview on [DATE] at 1:19 p.m., the MDS Coordinator said she was not sure who canceled Resident #2's care plan. She said when a resident went to the hospital, the resident's orders would be discontinued, and the care plan would say canceled. The MDS Coordinator said when Resident #2 was readmitted on [DATE], the admitting nurse would have initiated the baseline care plan UDA, and that would have triggered the comprehensive care plan. She said the ADON entered the DNR manually on the old care plan after she had cancelled the previous DNR on [DATE] when Resident #2 was readmitted , and she did not communicate that she manually wrote on the previous care plan and changed Resident #2's code from DNR to full code. She said because the baseline care plan was not done, she would manually put the care areas back to the previous care plan, and she said she still needed to complete the comprehensive care plan. She said Resident #2's DNR paperwork was signed on [DATE], a day before she was discharged from the hospital, and she did not know why the ADON put full code. She said the DNR paperwork usually came with discharge paperwork. She said if the resident's baseline care plan UDA was not done, it could have affected the care provided for Resident #2.During an interview on [DATE] at 2:00 p.m., the DON said when Resident #2 was readmitted , the baseline care plan UDA was not triggered. When the DON was asked why the baseline care plan did not trigger, she said it was a question for PCC(Point Click Care is an electronic system used for documentation). The DON said that SW was involved in the DNR, and when the paperwork was uploaded on ([DATE]), the SW should have notified someone in nursing so the nursing staff would have changed the full code to DNR. The DON said Resident #2 would not have received the care because the care for the resident was not in the care plan. The DON said if the resident had a cardiac incident, the facility would have provided CPR, which was not what the resident wanted.During an interview on [DATE] at 2:10 p.m., the ADON said she did not know why the (continued on next page)

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

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitting nurse did not initiate the baseline care plan UDA for Resident #2. The ADON said she entered full code for Resident #2 manually. She said she did not have the out-of-hospital DNR at the time she entered full code. She said if the baseline UDA was not started, Resident #2 may not have had care provided appropriately. She said she was not aware the resident had an out-of-hospital DNR, and if the resident was provided with CPR, then the resident was not provided care according to the resident's wishes. The DON said if the baseline care plan was not initiated, then the MDS coordinator would not have known to complete the comprehensive care plan in 14 days.Record review of the facility policy on care planning, comprehensive, and routine updates issued: [DATE], review [DATE] revealed in part .Completion and implementation of the baseline care plan within 48 hours of a resident's admission was intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that were most likely to occur right after admission.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, and a system of medication records that enabled periodic accurate reconciliation and accounting of all controlled medications to meet the needs of 1 of 3 residents (Resident #1) reviewed for pharmacy services, in that:The facility failed to ensure Resident #1's control count sheet matched with the actual Lacosamide liquid medication.This failure could have placed residents at risk of not receiving their adequate dose of medication and drug diversion. Findings included:Record review of Resident #1's face sheet dated 4/06/26 revealed she was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had diagnoses which included: diabetes mellitus (high blood sugar levels), hypertension (high blood pressure), and cerebral infarction (blockage in an artery supplying the brain blood).Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score of 10 of 15, indicating moderately impaired cognition. Further review revealed Resident #1 needed extensive assistance to total care with ADL care with one staff assistance.Record review of Resident #1's April 2026 order summary report revealed in part, Lacosamide oral solution 10MG/ML, give 5ML two times a day for epilepsy. Ordered date 03/17/26.Record review of Resident #1's control count sheet for Lacosamide oral solution 10MG/ML, give 5ML two times a day revealed 45ML. Record review of Resident #1's MAR for April 2026 revealed Lacosamide oral solution 10MG/ML, give 5ML two times a day was administered last on 04/02/26 in AM and it was administered by LVN A.During observation of the nurse medication cart on unit E with the ADON and LVN A on 04/02/26 at 1:45 p.m., it was revealed Resident #1's Lacosamide 10mg/ML liquid medication count sheet reflected 45 ML while the medication bottle had 65 ML of liquid medication.During an interview on 04/02/26 at 1:46 p.m., the ADON said Resident #1's Lacosamide 10mg/ML usually came overfilled. She said the facility did not correct the count to match the total dosage on the medication label. She said she could not tell how much the bottle was overfilled from the 180 ML on the medication label and the count sheet for the medication. The ADON said it could be considered drug diversion when the liquid medication did not match the count sheet. She said she did not know how the medication would be corrected to match the count sheet, and none of the nurses had told her the liquid control medication did not match the count sheet. The ADON said she could guess the difference from the medication in the bottle was about 10 ML more than what was documented on the count sheet. The surveyor pointed out that the lines with numbers on the medication bottle increased by 40 ML and the middle line between the numbered lines increased by 20 ML. She did not respond or verify the variances by checking the lines and numbers on the medication bottle.During an interview on 04/02/26 at 3:02 p.m., LVN A said Resident #1's Lacosamide 10mg/ML liquid medication had more medication in the medication bottle than what was on the count sheet. LVN A said when the liquid medication did not match, as a nurse, she should have reported it to the DON and ADON. LVN A said she did not report it to the nurse managers, but she thought another nurse reported it. She said the nurse management said the liquid sometimes came with more medication than what was written on the bottle. She said the DON and ADON were supposed to verify the count of liquid control medication, and she was not sure what nurse managers were supposed to do. LVN A said when she counted the medication when she can to work today , and the medication was over and she signed the count sheet with the outgoing nurse because the medication had been over from 03/18/26 and all the nurses were aware. LVN A said when the documentation on the count sheet did not match the amount of medication left in the bottle, it was a discrepancy which had to be reported to prevent drug diversion.During an interview on 04/06/26 at 1:52 p.m., the DON said Resident #1's Lacosamide 10mg/ML may had come overfilled, and the nurses would continue to administer (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication until the nurse gave the quantity that was on the label, and then the overage was destroyed. She said she was waiting for the pharmacy to give her directions on what to do. The DON said it could be drug diversion if there was a discrepancy between the control count sheet and actual medication. She said sometimes the medication came overfilled, and none of the nurses had told her Resident #1's Lacosamide 10mg/ML was overfilled.During an interview on 04/06/26 at 2:56 p.m., the Administrator said she was not clinical and she could not say if Resident #1's Lacosamide 10mg/ML was over than what was written on the paper. She said she was going to call the corporate nurse for more information on control liquid medication. She said she talked to the pharmacist and she said liquid medication came overfilled.Record review of the facility policy on drug diversion prevention program revised 12/04/2023 and revised 12/03/2025 revealed in part .To minimize the threat of drug diversion, incorporates clear-cut policies and practices that demonstrate a hardline, zero-tolerance approach to diversion to improve safety and quality of care for the residents. procedure #1.2. Facility should ensure the incoming and outgoing nurses counted all Schedule controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and documented the results on a ?Controlled Substance Count Verification/Shift Count Sheet'. Facility should:1.2.1 Reconcile the total number of controlled medications on hand, pursuant to the Controlled Substance Verification/Shift Count Sheet; and1.2.2 The facility should routinely reconcile the number of doses remaining in the package to the number of doses recorded on the Controlled Substance Verification/Shift Count Sheet to the medication administration record.