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	05/22/2026

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 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 observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #5) reviewed for comprehensive care plans. 1. Resident #5's care plan was not followed when he was transferred from his wheelchair to his bed with one-person assist and without a gait belt present on 05/22/2026 when he was care-planned for a two-person transfer with a gait belt. This failure could lead to residents not having their individual medical and physical needs met and lead to a decline in health.Record review of Resident #5's face sheet dated 05/21/2026, reflected he was a [AGE] year-old male initially admitted on [DATE] with hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis and weakness following a stroke), difficulty in walking, generalized muscle weakness and bilateral primary osteoarthritis in hip (pain in bone and joints in both hips) and a urinary tract infection (onset date 05/06/2026). Record review of Resident #5's Comprehensive MDS dated [DATE], reflected he had a BIMS score of 12 indicating moderate cognitive impairment related to thinking and memory. Resident #5 was coded for a wheelchair and walker. Resident #5 was coded as totally dependent on staff for toileting and showering. Record review of Resident #5's care plan dated 05/21/2026, reflected he had the following care areas:-Resident #5 required ADL assistance and therapy services as needed to maintain or attain highest level of function with muscle weakness and difficulty in walking as of 04/04/2026 with interventions including max assist (helper provides more than half to most of the effort) with transfers and with gait belt and to assist with mobility and ADLs as needed.-Resident #5 had an actual fall with no injury r/t weakness and poor balance with interventions including two person assist for all transfers with an initiated date of 04/30/2026 Record review of Resident #5's Kardex (a simplified documentation system which has key information in a resident's care plan) dated 05/22/2026, reflected he required max assist with transfers with gait belt. Interview with Resident #5 on 05/21/2026 at 1:47p.m., he said a nurse was helping him transfer form his wheelchair to the bed one time and she could not hold him up anymore and asked him to sit down. Resident #5 denied hitting his head or being in pain or hurt during hat transfer. Resident #5 said it was a while ago and did not remember the exact date. Resident #5 said he did not hit his head but said his energy goes in and out because he had a history of stroke. Resident #5 said that this only happened one time. Observation and interview on 05/22/2026 at 11:06a.m., revealed CNA M pulled on Resident #5's right arm while getting him out of the wheelchair. CNA M assisted Resident #5 with her arm under his right arm. Resident #5 assisted on his left side by pushing up on the wheelchair. CNA M guided him to the bed primarily by holding onto Resident #5's right arm and sat him down, with Resident #5 assisting with his left arm. During the transfer, LVN G was observed holding on to the wheelchair and assisting with holding his pants up by the pant leg. LVN G was not observed assisting with the physical act of (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transferring Resident #5 from his wheelchair to the bed. There was a gait belt hanging on Resident #5's dresser door. When asked why CNA M did not use a gait belt during the initial transfer from the wheelchair to the bed, CNA M said that she did not see one in the room and if she did not use the belt she could have hurt herself and the resident. CNA M was not aware Resident #5 was a two-person assist and that she would only know if therapy told her. Interview with LVN G on 05/22/2026 at 11:23a.m., LVN G said that she had training on safe transfers and LVN G knew that CNA M should have used a gait belt while transferring Resident #5 because gait belts were used so residents could be safely transferred and that not using a belt could lead to resident and staff injuries. LVN G said she knew Resident #5 was a two-person assist for transfers. When asked why she did not assist CNA M, LVN G said she did grab his pants to pull Resident #5 to the chair and she held the wheelchair but that was it. When asked what could have happened to Resident #5 with her not helping throughout the entire transfer, LVN G said Resident #5 could have fallen and been injured. Interview with the ADON on 05/22/2026 at 12:23p.m., she said doing one-person transfers without a gait belt was not a safe transfer and could lead to falls and injuries. When asked if CNA M and LVN G allowing for a one-person transfer without a gait belt was following Resident #5's care plan, the ADON said no, they did not follow the resident's care plan. Staff would be able to see the amount of supervision residents required in the Kardex which was a type of care plan document available to all staff in the resident's electronic health record. Interview with the MDS Coordinator on 05/22/2026 at 12:50p.m., she said her expectations would be for staff to follow the care plan. The MDS Coordinator said she changed Resident #5's care plan on transfers to two-person transfers with gait belt after his most recent fall. The MDS Coordinator said if the staff did not follow Resident #5's care plan he could have had another fall and that staff all knew and were educated on following resident care plans. Record review of the facility's policy titled Comprehensive Care Plans and Revisions last reviewed on 08/29/2025, reflected, The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. Procedure 1. The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care. Record review of the facility's policy on gait belts last reviewed 09/19/2025, reflected, Policy: The facility will provide Gait Belt Use in accordance with professional standards of practice, Make sure to follow evidence-based fall prevention practices, such as performing a fall risk assessment and instituting fall precautions, to reduce the risk of injury from a fall.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #5) reviewed for accident hazards. -Resident #5 was transferred by CNA M with a one-person transfer and without a gait belt from wheelchair to bed on 5/22/26. This failure could place residents at risk of injury from unsafe transfers.Record review of Resident #5's face sheet dated 05/21/2026, reflected he was a [AGE] year-old male initially admitted on [DATE] with hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis and weakness following a stroke), difficulty in walking, generalized muscle weakness and bilateral primary osteoarthritis in hip (pain in bone and joints in both hips) and a urinary tract infection (onset date 05/06/2026). Record review of Resident #5's Comprehensive MDS dated [DATE], reflected he had a BIMS score of 12 indicating moderate cognitive impairment related to thinking and memory. Resident #5 was coded for a wheelchair and walker. Resident #5 was coded as totally dependent on staff for toileting and showering. Record review of Resident #5's care plan dated 05/21/2026, reflected he had the following care areas:-Resident #5 required ADL assistance and therapy services as needed to maintain or attain highest level of function with muscle weakness and difficulty in walking as of 04/04/2026 with interventions including max assist with transfers and with gait belt and to assist with mobility and ADLs as needed.-Resident #5 had an actual fall with no injury r/t weakness and poor balance with interventions including two person assist for all transfers.Record review of Resident #5's Kardex (a simplified documentation system which has key information in a resident's care plan) dated 05/22/2026, reflected he required max assist with transfers with gait belt. Interview with Resident #5 on 05/21/2026 at 2:00p.m., Resident #5 said he was weak on one side due to a stroke. Resident #5 said he had a fall a while back. He was assisted by an aide from his wheelchair to his bed when he lost strength in his legs and the aide told him she was going to bring him down to the ground. Resident #5 said he did not hit his head but said his energy goes in and out because he had a history of stroke. Resident #5 said that this only happened one time. Observation and interview on 05/22/2026 at 11:06a.m., revealed CNA M pulled on Resident #5's right arm while getting him out of the wheelchair. CNA M assisted Resident #5 with her arm under his right arm. Resident #5 assisted on his left side by pushing up on the wheelchair. CNA M guided him to the bed primarily by holding onto Resident #5's right arm and sat him down, with Resident #5 assisting with his left arm. CNA M guided him to the bed and sat him down all done without a gait belt on. LVN G assisted with holding Resident #5's pants up and held onto Resident #5's wheelchair while CNA M assisted Resident #5. There was a gait belt hanging on Resident #5's dresser door which was not used during the transfer. When asked why CNA M did not use a gait belt during the initial transfer from the wheelchair to the bed, CNA M said that she did not see one in the room. CNA M said she could have hurt Resident #5 if she did not use it during the transfer. CNA M said she was not aware Resident #5 was a two-person assist and that therapy educated staff on how much assistance residents needed for safe transfers. Interview with LVN G on 05/22/2026 at 11:23a.m., LVN G said that she had training on safe transfers and LVN G knew that CNA M should have used a gait belt while transferring Resident #5 because gait belts were used so residents could be safely transferred and that not using a belt could lead to both resident and staff injuries. LVN G said she knew Resident #5 was a two-person assist for transfers. When asked why she did not assist CNA M, LVN G said she did grab his pants to pull Resident #5 to the chair and she held the wheelchair but that was it. When asked what could have happened to Resident #5 with her not helping throughout the entire transfer, LVN G said Resident #5 could have fallen and been injured. Interview with the ADON on 05/22/2026 at 12:23p.m., the ADON said that doing one-person transfers (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without a gait belt was not a safe transfer and could lead to falls and injuries. When asked if CNA M and LVN G allowing for a one-person transfer without a gait belt was following Resident #5's care plan, the ADON said no, they did not follow the resident's care plan. Staff would be able to see the amount of supervision residents required in the Kardex which was a type of care plan document available to all staff in the resident's electronic health record. Interview with the MDS Coordinator on 05/22/2026 at 12:50p.m., she said her expectations would be for staff to follow the care plan. The MDS Coordinator said she changed Resident #5's care plan on transfers to two-person transfers with gait belt because he had a fall. The MDS Coordinator said if the staff did not follow Resident #5's care plan he could have had another fall and that staff should know to read and follow the plan. Record review of the facility's policy and procedures manual on transferring from bed to wheelchair, last reviewed on 05/19/2025 reflected, For a patient with diminished or absent lower-body sensation or one-sided weakness, immobility, or injury, transfer from a bed to a wheelchair may initially require partial support to full assistance by at least two people. Subsequent transfer of a patient with generalized weakness may be performed by one nurse; however, the weight and size of the patient may require the use of an assistive device to provide a more secure process for lifting, transferring, or repositioning the patient. Optional: gait belt, other personal protective equipment, pillows, supplies for fall precautions, transfer board. ImplementationVerify the practitioner's order.Review the patient's medical record for history of injuries, surgeries, weakness, paralysis or other neurologic deficits, and contraindications to transferring to a wheelchair, such as activity restrictions, instability, or an inability to sit in a wheelchair.Gather and prepare the necessary equipment and supplies. Make sure to follow evidence-based fall prevention practices, such as performing a fall risk assessment and instituting fall precautions, to reduce the risk of injury from a fall. Record review of the facility's policy on gait belts last reviewed 09/19/2025, reflected, Policy: The facility will provide Gait Belt Use in accordance with professional standards of practice, Make sure to follow evidence-based fall prevention practices, such as performing a fall risk assessment and instituting fall precautions, to reduce the risk of injury from a fall.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections for 1 of 5 residents (Resident #5) reviewed for incontinent care. -CNA M and LVN G provided incontinent care for Resident #5 without changing gloves and sanitizing their hands in-between cleaning Resident #5's penis during wiping. These failures could cause residents to be at risk of urinary tract infection, pain, injury, poor hygiene, and hospitalization.Record review of Resident #5's face sheet dated 05/21/2026, reflected he was a [AGE] year-old male initially admitted on [DATE] with hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis and weakness following a stroke), difficulty in walking, generalized muscle weakness and bilateral primary osteoarthritis in hip (pain in bone and joints in both hips) and a urinary tract infection (onset date 05/06/2026). Record review of Resident #5's Comprehensive MDS dated [DATE], reflected he had a BIMS score of 12 indicating moderate cognitive impairment related to thinking and memory. Resident #5 was coded for a wheelchair and walker. Resident #5 was coded as totally dependent on staff for toileting and showering. Record review of Resident #5's labs, reflected he had a sample collected on 04/27/2026 and he tested positive for an abnormal urine culture which identified the organism as E. coli, a group of bacteria that could be spread by not wiping properly after incontinence episodes and could cause infections in the urinary tract. Record review of Resident #5's progress notes, reflected he had the following notes entered:-05/04/2026 at 1:27p.m., his UA orders were received and reviewed by his physician and came back positive for UTI and E. coli and was placed on antibiotics.-05/05/2026 at 12:54p.m., Resident #5's urologist called and ordered to discontinue his previous antibiotic nitrofurantoin and place him on a new order for 20 days of Bactrim for E.coli UTI.-05/17/2026 at 6:54p.m., Resident #5 complained of continued pain related to UTI during the shift. The RP expressed concerns the current medication might not be effective and requested a review of treatment plan along with request for another culture. Record review of Resident #5's care plan dated 05/21/2026, reflected he had the following care areas:-Resident #5 had a Urinary Tract Infection with interventions including checking at least every two hours for incontinent, washing, rinsing and drying soiled aeras and give antibiotic therapy as ordered until 05/26/2026. Observation and interview on 05/22/2026 at 11:06a.m., revealed LVN G touched the trash can with her gloves and used the same gloves to remove Resident #5's brief without removing gloves or sanitizing hands in between. CNA M used wipes to clean Resident #5's penis and then used the same soiled gloves to grab more wipes and proceeded to change gloves multiple times without proper hand hygiene. CNA M then wiped Resident #5 one more time and used the soiled gloves and grabbed baby powder. LVN G and CNA M used dirty gloves to pull Resident #5's clothes on, touched the wheelchair, Resident #5's shoes, and pulled back his curtain. There was a hand sanitizing station in Resident #5's room near the door and neither CNA M nor LVN G were observed utilizing the dispenser. CNA M said that every time there is a glove change staff should sanitize their hands to prevent infection and germs. LVN G was asked if she noticed the items she touched in the room with her gloves and what could occur from touching them during incontinent care and she replied that it could have spread infection. Interview with LVN G on 05/22/2026 at 11:23a.m., LVN G said that not using hand sanitizer between glove changes was not acceptable and she told Housekeeping already. LVN G said not following hand sanitizing protocols could lead to infections. LVN G said staff did spot checks once a shift. LVN G said her last in-service on hand hygiene was in March. LVN G said she requested Housekeeping refill the hand sanitizer in Resident #5's room when she left the room after incontinent care. Interview with the ADON on 05/22/2026 at 12:23p.m., the ADON said not changing gloves and hand sanitizing was not acceptable practice and a negative outcome would be infections for residents. The ADON said she had done (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	training and spot checks for peri-care and infection control and PPE. Record review of the facility's policy titled Urinary Incontinence Management last revised 01/20/2026, reflected, Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal bladder function as possible.to prevent urinary tract infections and to restore continence to the extent possible.Procedure: 1. A resident should be assessed at admission regarding continence status and whenever there is a change in urinary tract function.It is importance when completing the comprehensive assessments in the EHR to consider the following: a.history of urinary incontinence, including onset, duration and characteristics.previous treatment and/or management, including the response to the interventions and the occurrence of persistent or recurrent UTI.g. Functional and cognitive capabilities that could enhance urinary continence and limitations that could adversely affect continence.

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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** Based on observation, interview, and record review, the facility failed to keep confidential all information contained in the resident's records, regardless of the form or storage method of the records and safeguard medical record information against loss, destruction, or unauthorized use for 1 of 5 residents (Resident #2) observed for privacy. -RN V left Resident #2's empty blister pack on the medication cart which could be observed by anyone walking by on 05/22/2026. This failure could put residents at risk of their personal health information being exposed to unauthorized personnel.Record review of Resident #2's face sheet dated 05/22/2026, reflected she was an [AGE] year-old female initially admitted on [DATE] with medical diagnoses including acute respiratory failure with hypoxia (not enough oxygen), muscle weakness, malignant neoplasm of unspecified site of left female breast (cancer in the left breast) and chronic kidney disease. Record review of Resident #2's physician's order summary dated 05/22/2026, reflected she had an active order with a start date of 04/24/2026 for Gabapentin Oral Capsule 300 mg, give 1 capsule by mouth one time a day for neuropathy (damage or dysfunction of the nerves, with symptoms including muscle weakness and shooting/burning pain). Observation and interview on 05/22/2026 at 9:22a.m. in the hallway near the nurse's station on Resident #2's hall, revealed Resident #2's blister pack for Gabapentin of 15 capsules and instructions to Give 1 capsule by mouth one time a day for neuropathy (nerve pain) with a pack date of 04/10/2026 and a fill date of 05/06/2026 was observed stuck between binders out in the open on a medication cart near the nurse's station. The blister pack was empty and had Resident #2's name and medication number on it. RN V was down the hall at another medication cart, and she walked down and saw the blister pack and took it and brought it to the medication room. RN V said that she was gathering empty blister packs for multiple residents to shred all at once and that she was going to dispose of Resident #2's blister pack as well but answered a call light and forgot to come back to grab the pack. RN V said that it should not have been left out and that anyone could get resident's information off of the pack. RN V stated she had training on HIPAA and resident rights to privacy. Interview with the ADON on 05/22/2026 at 12:23p.m., she said the blister pack being out in public view was not acceptable and it should have been checked and that it was a HIPAA violation because that was resident information. The ADON said staff were trained on protecting resident privacy. Interview with the Administrator on 05/22/2026 at 1:19p.m., the Administrator said that medication being left out to be seen by others was not acceptable practice because of HIPAA violation and patient safety and that her staff were trained on HIPAA. Record review of the facility's policy titled Notice of Privacy Practices last revised 02/13/2026, reflected, Understanding what is in your record and how your health information is used helps youto: ensure its accuracy better understand who, what, when, where, and why others may assess your health information make more informed decisions when authorizing disclosure to others. Our ResponsibilitiesThe facility is required to: maintain the privacy of your health information. provide you with a notice as to our legal duties and privacy practices with respect to informationwe collect and maintain about you. abide by the terms of this Notice of Privacy Practices. notify you if we are unable to agree to a requested restriction. notify you following a breach of unsecured health information.

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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 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** Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 (Resident #5) of 5 residents observed for infection control. -There was a breakfast tray left out in an open dining area on 05/21/2026 at 1:36p.m. -CNA M and LVN G provided incontinent care for Resident #5 without changing gloves and sanitizing their hands in-between cleaning Resident #5's penis and touching Resident #5's personal and physical environment and Resident #5's skin. These failures could have placed residents at risk by exposing them to care that could have led to the spread of infections, secondary infections, or communicable diseases.Record review of Resident #5's face sheet dated 05/21/2026, reflected he was a [AGE] year-old male initially admitted on [DATE] with hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis and weakness following a stroke), difficulty in walking, generalized muscle weakness and bilateral primary osteoarthritis in hip (pain in bone and joints in both hips) and a urinary tract infection (onset date 05/06/2026). Record review of Resident #5's Comprehensive MDS dated [DATE], reflected he had a BIMS score of 12 indicating moderate cognitive impairment related to thinking and memory. Resident #5 was coded for a wheelchair and walker. Resident #5 was coded as totally dependent on staff for toileting and showering. Record review of Resident #5's care plan dated 05/21/2026, reflected he had the following care areas:Record review of Resident #5's care plan dated 05/21/2026, reflected he had the following care areas:-Resident #5 had a Urinary Tract Infection with interventions including checking at least every two hours for incontinent, washing, rinsing and drying soiled aeras and give antibiotic therapy as ordered until 05/26/2026. Observation and interview on 05/21/2026 at 1:36p.m., revealed there was breakfast food left out in a large open area dining room behind the nurse's station with 80% full plate of oatmeal, eggs and liquids. CNA L came over and saw the tray and said it should not have been there, and it could be a cross-contamination issue and took it and walked toward the kitchen. Observation and interview on 05/22/2026 at 11:06a.m., revealed LVN G touched the trash can with her gloves and used the same gloves to remove Resident #5's brief without removing gloves or sanitizing hands in between. CNA M used wipes to clean Resident #5's penis and then used the same soiled gloves to grab more wipes and proceeded to change gloves multiple times without proper hand hygiene. CNA M then wiped one more time and used the soiled gloves and grabbed baby powder. LVN G and CNA M used dirty gloves to pull Resident #5's clothes on, touch the wheelchair, Resident #5's shoes and pulled back his curtain. CNA M said that every time there is a glove change staff should sanitize their hands to prevent infection and germs. LVN G was asked if she noticed the items she touched in the room with her gloves and what could occur from touching them during incontinent care and she replied that it could have spread infection. There was a hand sanitizer dispenser in the room which was empty neither CNA M nor LVN G accessed during incontinent care. Interview with LVN G on 05/22/2026 at 11:23a.m., LVN G said that not using hand sanitizer between glove changes was not acceptable and she told Housekeeping already. LVN G said not following hand sanitizing protocols could lead to infections. LVN G said staff did spot checks once a shift. LVN G said her last in-service on hand hygiene was in March. LVN G said the hand sanitizer dispenser was empty and that it was Housekeeping's responsibility to ensure it was filled. Interview with the ADON on 05/21/2026 at 4:20p.m., the ADON said residents could grab the tray and eat it after it was left out for a prolonged period of time and that it could have been an infection control concern. On 05/22/2026 at 12:23p.m., the ADON said not changing gloves and hand sanitizing was not acceptable practice and a negative outcome would be infections for residents. The ADON said she had done training and spot checks for peri-care and infection control and PPE. Interview with the Housekeeping Supervisor on 05/22/2026 at 1:10p.m., she said that it was housekeeping staff to check on the hand sanitizer machine when (continued on next page)

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	05/22/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they enter the room and to let the Supervisor know to refill them and she said the staff must have forgotten to tell her about Resident #5's room needing a refill. The Housekeeping Supervisor said she checked the machines in rooms on 05/21/2026 and at random. Interview with the Administrator on 05/22/2026 at 1:19p.m., she said food items should have been taken back to the kitchen. When asked if it was an infection control concern or safety concern, she said that food was not left in the resident area and it was not located anywhere where patient care was occurring and residents did not go into that area. When asked if residents still had access to the area, the Administrator said they still could have gone into the area but that the area was not utilized. Record review of the CDC's printout on handwashing dated 02/16/2024, reflected, many diseases and conditions are spread by not washing hands with soap and clean, running water. Handwashing with soap is one of the best ways to stay healthy. Key times to wash hands. after using the toilet.after changing diapers. If soap and water are not readily available, you can use an alcohol-based hand sanitizer that contains at least 60% alcohol. Record review of the facility's policy titled Infection Prevention and Control Program (IPCP) and Plan last revised on 05/22/2026, reflected, .The facility must 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.Written standards, policies, and procedures for the program, which must include, but are not limited to: . (iii) Standard and transmission-based precautions to be followed to prevent spread of infections. (v). The circumstances under which the facility must prohibit associates with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by associates involved in direct resident contact.Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.