STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675789	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Wood	8810 Long Point Dr Houston, TX 77055

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44591 Based on observation, interview and record review the facility failed to ensure medical care of each resident was supervised by a physician and a physician, physician assistant, nurse practitioner, or clinical nurse specialist provided orders for the resident's immediate care and needs for one of seven residents (Resident #98) reviewed for physician services . The facility failed to ensure Resident #98 had an order for blood sugar parameters for when to report blood glucose levels to the physician according to their policy. This failure placed residents at risk for potential lack of medical supervision by a physician. The findings were: Record review of Resident #98's face sheet dated 03/27/2025 reflected a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included: Type 2 diabetes mellitus (the body cannot use insulin correctly and sugar builds up in the blood), chronic kidney disease (kidneys aren't working properly and are beginning to lose their function), hemiplegia (is a symptom that involves one-sided paralysis). Record review of Resident #98's quarterly MDS, dated [DATE], reflected Resident #98 had a BIMS score that was 09 out of 15 which suggested moderate cognitive impairment. He had limited range of motion of upper and lower extremities and needed partial/moderate assistance with oral hygiene, needed substantial/maximal assistance with dressing, and was dependent with personal hygiene, toileting, bathing. Review of Resident #98's Care Plan date initiated 01/06/2025, Revision date 03/25/2025 revealed: Focus: Resident #98 has Diabetes Mellitus. Goal: The resident will have no complications related to diabetes through the review date. Intervention: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Monitor/document/report PRN any signs and symptoms of hypoglycemia : sweating, tremor, increased heart rate (tachycardia), nervousness, confusion, slurred speech, lack of coordination, staggering gait. Record review of Resident #98's physician order dated 01/01/2025 review report reflected: Insulin glargine Solution 100 unit/ml Inject 6 units subcutaneously one time a day for diabetes HOLD FOR BLOOD GLUCOSE<100. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #98's physician order dated 01/01/2025 review report reflected: Glucose Oral Tablet Chewable 4 gram give one tablet by day every 24 hours as needed for DM2 for low blood sugar < 70 . Record review of Blood Sugar Summary dated: 03/17/2025 23:09 blood sugar 178 mg/dl 03/17/2025 18:16 234.0 mg/dl 03/17/2025 07:28 blood sugar 330 mg/dl 03/17/2025 05:05 98.0 mg/dl 03/17/2025 00:23 112.0 mg/dl 03/18/2025 23:01 blood sugar 208 mg/dl 03/18/2025 18:00 blood sugar 324 mg/dl 03/18/2025 14:14 blood sugar 284 mg/dl 03/18/2025 07:27 blood sugar 284 mg/dl 03/18/2025 06:00 blood sugar 154 mg/dl 03/19/2025 07:13 blood sugar 254 mg/dl 03/19/2025 07:07 blood sugar 254 mg/dl 03/20/2025 10:35 blood sugar 148 mg/dl 03/21/2025 07:39 blood sugar 329 mg/dl 03/22/2025 08:12 blood sugar 302 mg/dl 03/23/2025 07:36 blood sugar 329 mg/dl 03/25/2025 18:28 blood sugar 315 mg/dl Record review of Resident #98's progress notes dated 03/17/2025-03/25/2025, reflected notification of high blood glucose was not reported to guardian or physician until 03/25/2025. In an observation on 03/25/25 at 09:38 AM with Resident #98. Tube feeding was present, and resident was sleeping, wearing gown. Resident appeared to be resting comfortably. Resident did not wake up during surveyor's conversation with roommate. Linens and resident appeared clean, no odors noted from bed. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/27/2025 at 3:00 pm with ADON #2, Resident #98 receives Lantus (insulin for diabetes) 8 units-daily. ADON #2 stated blood sugar between 200 mg/dl -250 mg/dl should be reported to the doctor. Blood sugar of 310 mg/dl was noted on 3/24/25 and ADON #2, stated there were no high blood sugar parameters ordered to report to the doctor or family. ADON #2 stated for blood sugar greater than 300 mg/dl the doctor should've been notified and perhaps a short acting insulin order could have been obtained. ADON #2 stated adverse effects of not reporting blood sugar of greater than 300 mg/dl are possible worsening of infection, and sepsis (a serious condition that occurs when the body has an extreme reaction to an infection). ADON #2 stated nurse LVN A and LVN C should have reported trending high blood sugar to herself, the doctor, and family. ADON #2 stated she does not recall if there were ever any high blood sugar parameters on the chart that needed to be reported to the doctor. In an interview on 3/28/2025 at 9:01 AM with the MD, she reported if she received a call regarding abnormal blood sugars she would act on it depending on the situation. The MD stated she only wants to be called regarding blood sugars below 70 mg/dl and above 400 mg/dl. The MD was asked about a resident who had a blood sugar in the 100 mg/dl range, and then had blood sugars greater than 300 mg/dl for several days. The MD said she would not anticipate any calls from the facility, this is her standard. The MD did not answer questions about nursing standard of care for reporting high blood sugar greater than 300 mg/dl. The MD reported for high blood sugar in a prerenal (a condition in which kidney dysfunction has occurred because of inadequate blood flow to the kidney tissue) resident, she would expect to see the blood sugar to excrete slower. MD reported she does receive verbal or written communication from the dietician regarding recommendations however attends IDT meetings with dietician and management. The MD stated that Resident # 98 was placed on continuous tube feed, was being treated for infection, and had completed antibiotic medication. She said she would anticipate blood sugar rising and only wanted to be notified of sugars below 70 mg/dl and greater than 400 mg/dl. In an interview on 3/28/2025 at 10:05 AM with LVN C. LVN C stated parameters for high and low blood sugars should be on the chart. LVN C stated when the high and low blood sugar parameters are on the chart she will follow them. LVN C stated she would call the MD for blood sugar orders if not on the chart. LVN C stated she should call the doctor if blood sugar was greater than 300 mg/dl. LVN C reported side effects of high blood sugar would be potential damage to organs and adverse effects would be sweating and agitation. LVN C reported if the resident is diabetic and prerenal more issues with the kidneys would be a potential side effect of high blood sugar. LVN C reported she was last in-serviced regarding insulin administration, monitoring, and reporting within the last week and during orientation. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/28/2025 at 10:40 AM with the DON, he stated high and low blood sugar parameters are typically on the chart and the facility needs to call the MD for orders if they are not on the chart. No call documented observed during the record review. The DON stated the MD meets with the IDT and informs the management of high and low blood sugar parameters. The DON then reports the high and low blood sugar parameters to the nurses. The DON did not answer questions regarding when a nurse should call a doctor if an unusual sugar for the resident is found, and there are no high and low blood sugar parameters on the chart. The DON stated the side effects of high blood sugar are thirst and altered mental status. The DON reported if blood sugars are high for several days, calling the MD is dependent on the resident. The DON stated low blood sugar in the elderly population is worse than high blood sugar. The DON reported if a resident has high blood sugar for several days, the resident may be a symptomatic however, it is dependent on their baseline. The DON reported a high blood sugar in a diabetic, who is prerenal could affect their kidneys. The DON reported there was an in-service for insulin monitoring and reporting yesterday and two months ago. The DON's expectations are nurses should report any radical changes in any blood sugars., The DON stated monitoring of blood sugars is being done daily and he would notify the doctor for any increased blood sugar readings. The DON is not sure if any of his nurses reported blood sugars of 300 mg/dl or higher in Resident# 98 in the past few days. In an interview on 3/28/2025 at 11:07 AM, with Dietitian the Dietitian stated she doesn't know if blood sugar parameters are on the chart. The Dietitian reported she looked at the charts monthly for blood sugars to see what the average range was. The Dietitian reported if she changed a supplement or tube feeding, she would monitor and assess during her next visit to see how the resident is being affected. The Dietician relied on nurses to notify her if there's a change in any type of blood sugars and how the resident is tolerating new changes. The Dietitian reported the ADA gives broad range of reporting to doctor for blood sugars, but is not specific to a resident, however, if a resident is completely out of their range she would anticipate changes to be reported to somebody. The Dietitian reported side effects of high blood sugar would be decreased circulation in the small blood vessels and possible damage to liver and kidneys. The Dietitian reported she does look through the chart to understand why critical values might be documented, and if not able to ascertain information in the chart, she would go to the DON. The Dietician stated she remembered changing the tube feeding product for Resident# 98 on 3/20/2025 and documented blood sugars could be potentially higher. The Dietician reported the blood sugars could be between 119 mg/dl and 330 mg/dl due to change of feeding over 22 hours. The Dietician stated she communicated with the MD when new orders are placed but would not recommend increase blood sugar monitoring as that would be an MD order. In an interview on 3/28/2025 at 11:23 AM, with LVN A stated there should be high and low blood sugar parameters on charts. LVN A stated she would call the MD if blood sugar was higher than 200 mg/dl, if there are no parameters for high blood sugar. LVN A stated side effects of high blood sugar are confusion, diabetic coma, cold clammy skin , and increased thirst. LVN A stated if high blood sugar persisted, it could affect major organs. LVN A stated a diabetic patient who is pre-renal could have further complications with kidneys. LVN A stated her last in-service regarding insulin monitoring and reporting was yesterday and approximately two months ago. LVN A stated she was not sure why she did not report blood sugars of 300 mg/dl for Resident# 98 to the DON or MD. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Diabetes -Clinical Protocol. Treatment/Management #4. The physician will address complications such as dyslipidemia, coronary artery disease, neuropathy and nephropathy based on individual's overall condition, prognosis, function, and treatment preferences. Monitoring and Follow-Up. #1 The Physician will follow up on any acute episodes associated with significant sustained change in blood sugars or significant deterioration of previous glucose control and document resident status at subsequent visits until the acute situation it is resolved. #4 The physician will order desired parameters for monitoring and reporting information related to blood sugar management. #5 The staff will incorporate such parameters into the Medication Administration Record and Care Plan.

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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** 41392 Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 8 residents (Resident #6) reviewed for pharmacy services. -The facility failed to give Resident #6 medications as ordered by the physician on 3/25/2025. - The facility failed to maintain accurate records of controlled drugs when LVN B signed out a Lorazepam pill but did not administer it. This failure could place residents who receive medications at risk of not receiving the intended therapeutic benefit of the medications. Findings included: Record review of the Admission Record for Resident #6 revealed a [AGE] year-old female admitted to the facility on [DATE] and originally admitted on [DATE]. Her diagnoses included drug induced Parkinsonism (appears like symptom of Parkinson's disease), COPD (chronic obstructive pulmonary disease) (a lung condition caused by damage to the airway), schizophrenia, anxiety, depression, and dementia. Record review of Resident #6's quarterly MDS assessment dated [DATE] revealed a BIMS score of 00 out of 15 indicating severe cognitive impairment. Section E - Behavior of the MDS revealed she had physical and verbal behavioral symptoms directed towards others. She had rejected care and wandering behavior. She required supervision by staff for all ADLs. Further review revealed she was receiving Antipsychotic, Antianxiety and Antidepressant medication. Record review of Resident #6's active physician order summary report dated 03/28/2025 revealed an order for Lorazepam 0.5 mg, give one tablet by mouth three times a day for agitation/anxiety, start date 10/14/2024. Record review of Resident #6's undated care plan revealed: Focus - Resident #6 wanders aimlessly r/t dementia and schizophrenia diagnosis. Resident #6 admitted to the secured/memory unit. Interventions included, monitor for fatigue and weight loss. Focus - Resident #6 had mood problems r/t anxiety, insomnia, and depression. Yells out in hall and sings loudly. Refuses care at times and refuses medications. 11/28/24 - she refused all medications. Interventions included, administer medications as ordered. Monitor for side effects and effectiveness. Focus - Resident had potential for behavior problems r/t diagnosis of schizophrenia, history of refusing care, taking items that don't belong to her and aggressiveness. Interventions included, administer medications as ordered. Focus - Resident #6 uses anti-anxiety medications Lorazepam r/t anxiety disorder. Interventions included: Administer Antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's Medication Administration Report dated 03/28/2025 revealed Lorazepam 0.5 mg tablet ordered to be administered on 03/25/2025 at 8:00 PM was corrected to not given by LVN B. Interview and observation on 3/26/2025 at 6:15 AM of the medication cart in the back hall of the secured unit, revealed a Lorazepam 0.5mg blister pack for Resident #6 contained 34 tablets. The narcotic sign out sheet for Resident #6's Lorazepam 0.5mg tablets revealed on 3/25/2025 at 8:00 PM, LVN B signed out one tablet. The amount remaining was recorded as 33 tablets. LVN B stated the tablet was not popped out and she thought she popped it out before giving meds to Resident #6. She stated the missed dose of Lorazepam could affect the resident's behavior. LVN B stated she would write a medication error report and notify Resident #6's physician of the missed dose. Observation on 3/26/2025 at 7:00 AM, revealed Resident #6 was in the dining room of the secured unit with other residents. She was walking around, visiting with other residents, and talking in her language. In an interview on 3/26/2025 at 2:30 PM, the DON stated the nurse is responsible for the narcotic count and the first step of the day would be to count with the next shift. The DON stated any discrepancy should be noted at that time then they would have to find out why a narcotic was not given by checking the MAR and narcotic book. The DON stated he expected the nurses would notify the DON as soon as possible. He stated that each pill must be given the way the doctor ordered. The DON stated the doctor's orders for Lorazepam 0. 5mg to be given three times a day was not followed at that time and LVN B missed it. The DON stated it could potentially affect Resident #6 negatively, but she slept through the night, so it did not affect her. He stated she had no anxiety, but the nurses still would need to be consistent to protect the resident. In an interview on 3/28/2025 at 10:00 AM, the DON stated that the basics of medication administration for nurses was the 5 rights: right resident, right medication, right dose, right route, and right time. He stated LVN B was probably not paying attention when dispensing the Lorazepam tablet from the blister pack. Record review of the facility's policy for General Guidelines for Medication Administration, revised on 08/2020 read in part: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and medication distribution system to ensure safe administration of medications without unnecessary interruptions 4. At a minimum, the 5 Rights - right resident, right drug, right dose, right route, and right time - should be applied to all medication administrations and reviewed at three steps in the process of preparation: (1) when medication is selected, (2) when the dose is removed from the container, and (3) after the dose is prepared and the medication is put away . Record review of the facility's policy for Controlled Substances, revised on 08/2020, read in part: Medications classified as controlled substances by the Drug Enforcement Administration (DEA) are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with state and federal laws and regulations .Procedures .4. Preparation of the dosage form occurs according to the medication administration policy. 5. Accurate inventory of all controlled medications is maintained at all times .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41392 Based on observation, interview, and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for 2 (Station 1 medication cart for the front hall and secured unit medication cart for the back hall) of 3 medication carts reviewed. The narcotic box in the medication cart for the back hall in the secured unit contained a pill card for Lorazepam 0.5 mg with a piece of tape over a torn protective seal. The narcotic box in the medication cart for station 1 front hall contained a pill card for Tramadol 50 mg and a pill card for Lorazepam 1mg with torn protective seals. The failures could place all residents at risk of not receiving the therapeutic benefit of medications, infection, adverse reactions to medications and drug diversion. Findings included: Interview and observation on 3/26/2025 at 6:15 AM of the medication cart for the back hall in the secured unit revealed it contained a pill card for Lorazepam 0.5mg. There were 7 tablets, and each tablet was individually sealed. The tablet in the 7th compartment had a torn seal that was closed with a piece of tape. LVN B stated it should not have been taped and the tablet should have been wasted instead. She stated she did not know who taped it or why it was taped. LVN B stated it could be the wrong pill and if given to the resident it could have a negative effect. Interview and observation on 3/26/2025 at 12:30 PM of the medication cart for the station 1 front hall revealed it contained 2 narcotic pill cards with torn protective seals. The Lorazepam 0.5mg pill card contained 23 tablets. Pill compartments #8 and #16 contained round, white tablets with torn seals. The Tramadol 50mg pill card contained 24 tablets. Pill compartment #5 contained a white, oblong tablet with a torn seal. LVN A stated the risks of having the torn seals was that the tablets could pop out, get lost and the resident would lose a pill from that stock. LVN A did not have an answer as to why the seals were torn. LVN A stated she would need to waste the tablets with another nurse. In an interview on 3/26/2025 at 2:30 PM, the DON stated the nurses count the narcotics at the end of every shift and the unit managers will check carts at a minimum once a week. He stated the charge nurses check the narcotics daily. The DON stated tape should not be used and expected the nurses to report torn seals immediately to the DON or manager. He stated this was the first time he had ever heard of tape being used. The DON stated once the backing is damaged, the pill could drop out. He stated the cards are factory sealed and it cannot be accounted for if a pill falls out. He stated the seal may prevent it from falling and anything could get inside the compartment if the seal is torn. He stated the residents must be protected from harm of an unknown pill and to avoid any problems the pills should be wasted if the back of the package was compromised. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the narcotic log sheets for the Lorazepam 0.5mg and Tramadol 50mg in the Station 1 medication cart for the front hall revealed the count was correct. Record review of the facility's policy for Controlled Substances, revised on 08/2020, read in part: Medications classified as controlled substances by the Drug Enforcement Administration (DEA) are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with state and federal laws and regulations .Procedures . 3. All controlled substances, Schedule II-V, are stored and maintained in a locked cabinet or compartment .5. Accurate inventory of all controlled medications is maintained at all times .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44669 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: The facility failed to ensure the ice machine was free from personal drink items (bottled water) within the stored ice. These failures could place residents at risk for food borne illness. The findings included: During an observation/interview on 03/25/2025 at 08:43 a.m., of the kitchen's initial tour, 1 of 1 ice machines contained a bottled water buried under the ice. Once identified, the Dietary Manager (DM) used the ice scooper and scooped out an 8oz bottle of water. The DM stated that the bottled water should not have been within the ice. He stated he was not aware of who placed the bottled water within the ice. He stated that the reason items were not to be within the ice was to prevent contaminated. Next to the ice machine was a cart full of various beverages all containing ice for the morning meal. He stated that he would inform maintenance to come empty and clean the ice machine immediately and he would report the occurrence to the Administrator (ADM). He stated there was no place in the kitchen area for staff to store food/beverages. He stated that staff do however have an employee breakroom where they were able to store food and drinks. He stated that he would provide a policy for properly storing food in the kitchen. During an interview on 03/25/2025 at 01:03 p.m., both the DM and the Corporate DM stated that they had performed in-services on keeping the ice machine free from items including personal drinks amongst the ice in the ice machine. The Corporate DM stated that maintenance had empty, cleaned, and sanitized the ice machine and she had informed the ADM that the in-service had been completed. She stated that any staff not on shift would have an in-service upon starting their shifts. The DM stated that negative outcomes of storing items in the ice would be contamination, that could compromise resident's immune systems and risk stomach infections. He stated that the kitchen staff had been informed that they were to store personal food and drink items in the employee breakroom, in lockers in the kitchen area, and if staff needed to keep a drink nearby for hydration, they could keep a drink in the DM's office on his desk. During an interview on 03/28/25 at 05:52 p.m., the ADM stated that it was her expectations that all individuals follow proper storage protocol and keep items whether they be personal or food service items in the proper designated place. She stated failure to follow protocols could result in the ice encountering items (bottled waters), the ice becoming non-usable, and requiring that the entire ice machine contents to be disposed of. She stated therefore that items not come into contact with any of the ice in the ice machine. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of in-service dated 03/25/2025 instructed by the Corporate DM reflected the in-service topic: Ice Machine and Summary of Subject Material Covered: Drinks Should Not Be Put in the Ice Machines. Record review of Policy titled Food: Safe Handling for Foods from Visitor revised dated 05/2017 revealed: Policy Statement Residents will be assisted in properly storing and safely consuming food brought into the facility for residents by visitors. Procedures 1. The facility staff will request that visitors bringing in food, and/or residents that receive food, must notify a member of the nursing or activities departments. 2. The responsible facility staff member will determine whether the food item is for immediate consumption or to be stored for later use. 3. When food items are for immediate consumption the responsible facility staff member will: . 4. When food items are intended for later consumption, the responsible facility staff member will: o Ensure that the food is stored separate or easily distinguishable from the facility food. o Ensure that foods are in a sealed container to prevent cross contamination. o Label foods with the resident name and the current date. o Determine if food items are shelf stable and whether they can be stored in the resident room or stored under refrigeration . Record review of policy titled Food Storage: Dry Food revised dated 05/2017 revealed: Policy Statement All dry goods will be appropriately stored will be appropriately stored in accordance with the Food and Drug Administration (FDA) Food Code .