STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675819	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of South Belt	11902 Resource Pkwy Houston, TX 77089

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed in accordance with state and local laws, to store all drugs and biological in locked compartments under proper temperature controls for medications storage for 1 (Resident #1) of 5 residents reviewed for medication storage. -LVN A left normal saline flushes at Resident #1's bedside. This failure placed residents at risk for infections related to contamination and safety precautions.Findings included: Record review of Resident #1's face sheet dated 12/26/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and 03/06/25. Resident #1's diagnoses included the following: paraplegia (loss of muscle function, movement, or feeling in the lower half of the body), contracture (tightening and stiffening of muscles restricting joint movement) of muscle, multiple sites, chronic respiratory failure, gastrostomy, elevated white blood cell count, gastrostomy (surgical procedure creating an opening into the stomach for long-term enteral{nutrition, fluids, or medication delivered directly into the digestive tract due to someone not being able to take anything by mouth} feeding)and obstructive and reflux uropathy (blockage of urine flow). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 7, indicating that Resident #1's cognition was severely impaired. Section N-Medications revealed that Resident #1 was receiving antibiotics including IV medications (method of delivering fluids, medications, or nutrients directly into the vein). Record review of Resident #1's Comprehensive Care Plan dated 04/19/24 revised 08/12/24 reflected the resident was not care planned for antibiotic IV antibiotic therapy or mid-live IV. Further review reflected resident was care planned for Enhanced Barrier Precaution, and he was at risk for infection r/t wounds and indwelling medical device. An intervention included wearing a gown during high contact care activities. Record review of Resident #1's Physician Order Summary Report for November 2025 reflected the following orders: -Dated 11/19/25 Mid line IV: flush line with 10ml's of NS before and after administration of IV medication every shift for maintenance care/infection prevention of IV therapy. -Dated 11/19/25 Ceftriaxone (antibiotic used to treat wide variety of serious bacterial infections) 1 gm one time a day for 10 days. -Dated 11/21/25 Invanz (Ertapenem-antibiotic used for bacterial infection) 1gm intravenously for 10 days. -Dated 11/28/25 Vancomycin (antibiotic) 1 gm IV one time a day for PNA for 3 days. Record review of Resident #1's MAR for the month of November 2025 reflected that the following orders were being following: -Dated 11/19/25 Mid line IV: flush line with 10ml's of NS before and after administration of IV medication every shift for maintenance care/infection prevention of IV therapy. -Dated 11/19/25 Ceftriaxone (antibiotic used to treat wide variety of serious bacterial infections) 1 gm one time a day for 10 days. -Dated 11/21/25 Invanz (Ertapenem-antibiotic used for bacterial infection) 1gm intravenously for 10 days. -Dated 11/28/25 Vancomycin (antibiotic) 1 gm IV one time a day for PNA for 3 days. Observation on 11/26/25 at 2:09PM revealed Resident #1 was resting in bed quietly. There was a pole on the right side of Resident #1's bed with an empty 100 ml bag hanging on the pole with IV tubing connected to the bag. The bag read Ertapenem 1gm infuse over 1 hour. The bag was dated 11/26/25. Further observation revealed Resident #1 had an IV to his upper right arm. The date on the IV dressing read 11/19/25. There were two- 10 cc normal saline syringes on the right side of Resident #1's bed sitting on the nightstand. One of the syringes was in an unopen plastic wrapper and the other one had been open with 5 cc's of fluids inside of the syringe. Interview on 11/26/25 at 2:16PM with LVN A, after observing the normal saline flushes at Resident #1's bedside, revealed she said normal saline was considered a medication and should not be stored at the bedside. LVN A said this placed Resident #1 at risk for something but did not know what. LVN A said she forgot to remove the normal saline flushes from resident's bedside. Interview on 11/26/25 at 3:05PM the DON said normal saline flushes were considered medication. The DON said it was not okay to leave normal saline flushes at the resident's bedside. The DON did not say when ask what risk it could place the resident for but that the risk was minimal. Record review of the facility's policy on Medication Storage revised April 2007 reflected in part: .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner.Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, 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 disease and infections for 1 (Resident #1) of 5 residents reviewed for infection control. -CNA C failed to thoroughly and properly clean Resident #1 during incontinent care. -CNA C failed to wear full PPE when providing incontinent care for Resident #1 on EBP. This failure placed residents at risk for cross contamination, skin irritation, discomfort, and infections. Findings included: Record review of Resident #1's face sheet dated 12/26/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and 03/06/25. Resident #1's diagnoses included the following: paraplegia (loss of muscle function, movement, or feeling in the lower half of the body), contracture (tightening and stiffening of muscles restricting joint movement) of muscle, multiple sites, chronic respiratory failure, gastrostomy, elevated white blood cell count, gastrostomy (surgical procedure creating an opening into the stomach for long-term enteral{nutrition, fluids, or medication delivered directly into the digestive tract due to someone not being able to take anything by mouth} feeding)and obstructive and reflux uropathy (blockage of urine flow). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 7, indicating that Resident #1's cognition was severely impaired. Section GG-Functional Abilities of the MDS reflected that Resident #1 required substantial/maximal assistance with toileting hygiene. Section H-Bladder & Bowel reflected that Resident #1 was frequently incontinent of urine and bowel. Record review of Resident #1's Comprehensive Care Plan dated 05/30/23 revised 08/12/24 reflected that resident was being care planned for Enhanced Barrier Precautions- at risk for infection r/t wounds and indwelling medical device. The interventions included the following: -Educate staff/resident/family on the proper use of PPE and hand hygiene at point of care. -Wear gloves and gown during high-contact care activities for resident indwelling medical devices, wounds, and colonized or infection within the CDC targeted MDRO. Record review of Resident #1's Comprehensive Care Plan dated 11/08/25 revealed that resident was being care planed for incontinence of urine r/t impaired mobility, contractures and loss of bladder control with an intervention that included the following: check resident during rounds and as required for incontinence.wash, rinse, and dry perineum (area of the body between the thighs, located between the genitals and anus {opening through which feces is exited from the body}) Record review of Resident #1's Physician Order Summary Report for November 2025 reflected the following orders: -Dated 03/06/25 Check GT placement prior to feeding and/or medication administration by aspirating of gastric contents -Dated 11/19/25 Mid line IV (long, thin, soft plastic tube inserted into a vein in the arm where the tip of the device rest in a larger, deeper vein, away from the heart): flush line with 10ml's of NS before and after administration of IV medication every shift for maintenance care/infection prevention of IV therapy. Record review of Resident #1's MAR for month of November 2025 reflected that the facility was following the above physician orders. Observation on 11/26/25 at 2:25PM revealed Resident #1 door had EBP signage instructing staff to place on PPE that consisted of gown and gloves regarding care for resident (s). CNA C entered Resident #1's room to provide incontinent care. Resident #1's brief was incontinent of urine. CNA C washed her hands and placed gloves on only. CNA C proceeded to provide incontinent care for Resident #1. Resident was observed having a gastrotomy tube and an IV line to right upper arm. During incontinent care, CNA C did not clean resident groin or penis instead, CNA C repositioned resident to his left side to clean resident buttocks using disposable wipes. CNA C cleaned Resident #1's buttocks not from front to back but towards resident scrotum (the sac of skin that holds and protects the testicles (two egg shaped structures that rest behind the penis that produce sperm in the male). CNA C placed a clean brief on Resident #1, gathered the soiled materials, left the room to dispose of the soiled materials inside the soiled linen room, and sanitized her hands. Interview on 11/26/25 at 3:00PM with CNA C said she had been working at the facility for 1-month full time on the 6:00AM-2:00PM shift. CNA C said by not wearing a disposable gown when she provided incontinent care for Resident #1, it placed the resident at risk for germs. CNA C said when providing incontinent care for residents, she was supposed to clean the resident from front to back. CNA C said if the resident (s) was not provided correct incontinent care, it would place the resident at risk for germs. CNA C refused to talk further with surveyor and walked away. Interview on 11/26/25 at 3:05PM with the DON revealed she and another nurse were both Infection Preventionists. The DON said the staff should be placing on PPE when proving direct care for all