STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675991	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Humble	19424 McKay Dr Humble, TX 77338

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency) in accordance with State law through established procedures for 2 of 6 residents (Residents #39 and #52) reviewed for reporting allegations of abuse, neglect, and exploitation. -The facility failed to report an allegation of abuse of Resident #39 and Resident #52 to the State Agency within the two-hour timeframe. This failure could place residents at risk of abuse and neglect. Findings include: Resident #39 Record review of Resident #39's clinical record dated 2/5/25 revealed a [AGE] year-old female who admitted on [DATE]. Her diagnoses included bipolar disorder (a mental health condition that causes extreme mood swings), major depressive disorder, atherosclerotic heart disease (plaque buildup, or fatty deposits, in your arteries), and NSTEMI myocardial infarction (a type of heart attack that usually happens when your heart's need for oxygen can't be met). Record review of Resident #39's quarterly MDS assessment, dated 11/11/24 revealed a BIMS score of 15 out of 15 which indicated intact cognition. She required assistance from staff with ADL care. Record review of Resident #39's care plan reviewed 12/6/24 revealed she had potential for psychosocial well-being problem. She had a diagnosis of schizoaffective disorder bipolar type. Interventions were to encourage resident to verbalize feelings of perceptions, and fears. She was also a recipient of alleged verbal aggressive behavior from a resident at risk for psychosocial well-being problem dated 2/3/25. Interventions were to allow the resident time to answer questions and to verbalize feelings, perceptions, and fears. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #39's nursing notes dated 2/3/25 at 5:17 p.m. by the Social Worker read in part, This writer and Administrator went to speak with resident in regards to statement made to Surveyor that her roommate is verbally abusing her. This writer asked her what was stated that made her feel verbally abused. She states her RM is Cussing and yelling in the room and she, the RM, states I am the reason her family does not come to see her and that I am the reason [Administrator] will not let her DC from facility. She also asked me why do you look like that why are you in that chair, are you touching my things, are you stealing my stuff. [Resident #39] reports then she had a traumatic childhood and does not need her bringing all that back to her. I did not want state thinking that you were not assisting me. I just wanted to get out of there, she is nonstop on a 10 all the time . Record review of Resident #39 and Resident #26's chart revealed they shared the same room from 1/16/25 - 2/3/25. In an interview on 2/3/25 at 1:03 p.m. Resident #39 said her roommate (Resident #26) was rude and verbally abusive to her. She said Resident #26 yelled at her and started arguments. She said they were not getting along before they moved in together. She said she spoke to the Administrator previously about changing rooms but there were no rooms available. She said she was informed today there was a room available for her to move to. She said she had been roommates with Resident #26 for approximately 1-3 weeks and was physically and mentally exhausted. In an interview on 2/3/25 at 1:14 p.m. the Social Worker said some residents complained about Resident #26 but she did not know Resident #39 felt abused by the her. In an interview on 2/3/25 at 1:17 p.m. the State Surveyor reported to the Administrator that Resident #39 said she felt verbally abused by her roommate, Resident #26. Administrator said this was the first time he heard she felt abused. In an interview on 2/3/25 at 2:22 p.m. the Administrator said they moved Resident #39 to another room and would interview her. In an interview on 2/4/25 at 12:22 p.m. the Administrator said during his interview with Resident #39 (on 2/3/25) she informed him that Resident #26 would cuss and she did not like those words, it reminded her of childhood trauma. He said Resident #39 informed him she might not have used the right words (regarding abuse) and just wanted to be moved as quickly as possible. In an interview on 2/5/25 at 8:15 a.m. Resident #39 said Resident #26 would yell, cuss, and accuse her of theft. She said she was weary and felt abused and threatened by her and thought the Administrator and Social Worker understood that. She said when the Administrator and Social Worker interviewed her (on 2/3/25), they did not ask her if she felt abused. In an interview on 2/5/25 at 9:19 a.m. Resident #26 said she and Resident #39 were roommates for a couple of weeks. She said they did not get along, but she never yelled, cussed, or treated her bad. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/5/25 at 9:28 a.m. the Social Worker said she and the Administrator spoke with Resident #39 (after being informed of the incident on 2/3/25) to obtain her statement and the resident restated verbal abuse. She said Resident #39 informed her that Resident #26 would cuss in the room and asked her if she was touching or stealing her stuff. The Social Worker said Resident #39 mentioned emotional childhood trauma that she did not want brought back. She said when Resident #39 first moved in with Resident #26, Resident #39 requested a room change because they were too much alike. She said the facility tried to move her last week but was unable to (for various reasons). She said Resident #26 had issues with some of the residents at the facility, but no one previously said she was verbally abusive. In an interview on 2/5/25 at 9:43 a.m. the Administrator said when he and the Social Worker talked to Resident #39, she did not state she felt abused and there was no emotional change. He said when the facility followed up with her, she kept saying she was happy to be out of there and thought it was best to report the incident. He said he was first alerted by the State Survey on Monday 2/3/25 about the allegation of abuse. He said generally with any allegation of abuse, if stated they feel they've been abused, they would report it within 2 hours to the State Agency. He said it was a case by case with the resident, and Resident #39 may have used the wrong words. He said they determined it would best to report the incident to the State Agency and reported it this morning 2/5/25, outside of the reporting window. In an interview on 2/5/25 at 10:09 a.m. the DON said she was informed yesterday 2/4/25 by the Social Worker that Resident #39 felt verbally abused by Resident #26. She said verbal abuse was the threat to do harm, cussing at them, and being called out of their name (someone referring to you in a way that is demeaning or disrespectful). She said she conducted in-services with staff on abuse, neglect, resident rights, and customer service. In an interview on 2/5/25 at 2:07 p.m. the Administrator said he was the Abuse Coordinator and was responsible for reporting allegations of abuse which included physical, sexual, and verbal. He said verbal abuse could include degrading, putting someone down, or making fun of them. Record review of facility incident report regarding Resident #39 revealed a received date of 2/5/25 via web application. Resident #52 Record review of Resident #52's quarterly MDS assessment, dated 1/24/25 revealed a [AGE] year-old male who readmitted to the facility on [DATE]. His diagnosis included stroke, end stage renal disease, and Alzheimer's disease. He had a BIMS score of 6 out of 15 which indicated severe cognitive impairment. He required assistance from staff with ADL care. In an interview on 2/3/25 at 9:25 a.m. Resident #52 said last month the shower lady (name unknown) pushed him into the wall. He said his back was hurting. This Surveyor reported it to the Administrator, and he said they would check his arm out. In an interview on 2/5/25 at 9:28 a.m. the Social Worker said she was informed of the situation with Resident #52 yesterday 2/4/25 by the Administrator. She said Resident #52 told her a girl picked him up like a football and slammed him against the wall approximately one year ago. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/5/25 at 9:57 a.m. the Administrator said he was originally made aware of the allegation of abuse of Resident #52 on Monday, 2/3/25. He said he was unable to get details from Resident #52. He said the Social Worker spoke with the resident this morning and stated the incident occurred one year ago. He said Resident #52 was requesting an x-ray of his back. He said he generally reported to the State Agency allegations of abuse within 2 hours and start the investigation. Record review of facility incident report regarding Resident #52 revealed a received date of 2/5/25 via web application. Record review of the facility's Reporting Abuse to Facility Management policy dated 2009 read in part, .It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management . 1. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 2. Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability . Record review of the facility's Resident-to-Resident Altercations policy dated 2016 read in part, .All altercations, including those that may represent resident-to-resident abuse, shall be investigated and reported to the Nursing Supervisor, the Director of Nursing Services and to the Administrator . 11. Report incidents, findings, and corrective measures to appropriate agencies as outlined in our facility's abuse reporting policy .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practices, the comprehensive care plan, and the residents' choices and based on the comprehensive assessment of a resident for 1 of 6 residents (Resident #42) reviewed for quality of care. The facility failed to obtain physician orders for an abrasion that Resident #42 sustained on his left leg after an incident on 2/1/25. This failure could place residents at risk of infections. Findings included: Record review of Resident #42's admission record dated 2/5/25 revealed a [AGE] year-old male who readmitted on [DATE]. Diagnoses included severe protein calorie malnutrition, chronic kidney disease, elevated white blood cell count, hemiplegia (a symptom that involves one-sided paralysis), acute pancreatitis (inflammation of the pancreas), and weakness. Record review of Resident #42's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated intact cognition. He required assistance from staff with ADL care. Record review of Resident #42's care plan dated 1/9/25 revealed he had potential impairment to skin integrity related to muscle weakness. Interventions were to observe skin injury for abnormalities, failure to heal, s/sx of infection, maceration etc. and report to MD. Resident #42 had a skin tear to left lower leg date initiated 2/1/25. Interventions were to treat area as indicated, if skin tear occurs, notify MD, family (date initiated 2/1/25). Record review of Resident #42's nursing note dated 2/1/25 by RN K read in part, .The medication aid informed the nurse that the patient had a scratch to his left lateral calf that was bleeding. The nurse clean [sic] with NS and apply a dry dressing. Record review of Resident #42's incident report dated 2/1/25 by RN K read in part, The CMA informed the nurse that the patient has some blood on his LL leg . The patient stated that he did not know how he did it . The nurse assess the area clean with NS pat dry and applied a dry dressing . No notifications to agencies/people were found on the incident report. Record review of Resident #42's nursing note dated 2/5/25 at 1:32 p.m. by the Wound Care Nurse read in part, .resident noted to have an open area to the lle . NP at facility and made aware. Upon assessment of area new order given to treat using TAO and cover with border gauze QOD and prn. Resident and RP made aware of new open area and tx in place . Record review of Resident #42's MD orders for February 2025 revealed no active, completed, or discontinued orders to address the skin tear to his left leg prior to 2/5/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 2/3/25 at 9:52 a.m. of Resident #42 revealed there was a white dressing on his left leg dated 2/1/25 signed by P(unknown letter). Resident #42 said he scratched his leg on the door last night. In an interview and observation on 2/3/25 at 12:10 p.m. revealed Resident #42 was in the hallway. There was an open oval shaped scab area on his left leg near the knee. He said he removed the bandage from his left leg after his shower. In an observation on 2/3/25 at approximately 12:45 p.m. revealed there was a dressing on Resident #42's left leg dated 2/3/25 signed by DW that covered the previously observed open area. In an observation and interview on 2/5/25 at 12:56 p.m. of Resident #42's left leg revealed an uncovered scab/wound to his left leg near the knee. The area appeared pink. In an interview on 2/5/25 at 12:57 p.m. LVN W said Resident #42 had a skin tear and the Wound Care Nurse was going to look at it. She said she covered the area on Monday 2/3/25 until the Wound Care Nurse could look at it. In an interview on 2/5/25 at 1:03 p.m. the Wound Care Nurse said she was going to get an order to cover the area on Resident #42's leg. In an interview on 2/5/25 at 1:05 p.m. LVN W said she cleaned the area on Resident #42's left lower leg on Monday 2/3/25 but did not tell the Wound Care Nurse about it because it slipped her mind. She said she normally reported concerns to the Wound Care Nurse. She said she was not aware of the area until the resident asked her for a band-aid to cover it since the Surveyor kept asking about the open area. In an interview on 2/5/25 at 1:12 p.m. Resident #42's NP said he learned of the area on the Resident's leg today 2/5/25. He said the area looked fresh and appeared to be an abrasion. He said he provided orders to clean it with saline and triple antibiotic ointment every other day and to keep an eye on it. He said there was no drainage, but it was important to address because it could become infected. He said the facility normally notified him of areas like this one. In an observation and interview on 2/5/25 at 1:15 p.m. the Wound Care Nurse said she looked at the area on Resident #42's lower left extremity on Monday and it did not look the way it did today. The Wound Care Nurse showed the Surveyor what she saw on Monday which was a tiny circle area near the back of the lower left leg. In an interview on 2/5/25 at 1:25 p.m. LVN W said she saw the round shaped pink area on Resident #42's left lower leg near the knee on Monday 2/3/25 when she cleaned it. In an interview on 2/5/25 at 1:33 p.m. the Unit Manager said she spoke with RN K about Resident #42's incident over the weekend and the information provided was vague. She said she talked with RN K about notifications and said she should have put in an order. She said RN K should have notified the RP, DON, and the MD for an order. She said there was no order in the system. She said she saw the dressing on the resident Monday but did not see the skin underneath. She said she told the wound care nurse to follow up on it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/5/25 at 1:46 p.m. the Shower Tech said she assisted Resident #42 with showers on Monday 2/3/25 and Wednesday 2/5/25. She said he had a pink circular area on his left leg today around 11 a. m. She said on Monday she noticed scratches to his leg. She said she documented the new area on the Kardex. In an interview on 2/5/25 at 1:57 p.m. RN K said Resident #42 sustained a scrape to his left lower calf leg (over the weekend). She said it looked like 3 superficial scratches, about the size of a millimeter and similar to a previously healed scab. She said she patted it dry and put a border dressing on it. She said she dropped the ball and forgot to notify the NP because she got caught up late in the evening and the area was superficial. She said she would normally notify the NP that she cleaned it and put something on it. She said she notified the next shift that he had a scratch. In an interview on 2/5/25 at 2:14 p.m. the DON said on Monday 2/3/25 Resident #42 had a skin tear/abrasion and LVN W dressed it. She said she just learned of it and did not know what it looked like. She said a skin tear was considered an incident and nursing staff should notify the RP, MD/NP of the issue and write an incident report. She said RN K should have received an order for treatment, put it in the system, and carry it out because the area needed to be treated. She said if the incident process was not done the next shift would not know what to do for the skin tear/abrasion. In an interview on 2/5/25 at 2:10 p.m. the Administrator said he expected nursing staff to obtain orders right away for treatment provided and document it in the system. Record review of the facility's Skin Tears - Abrasions and Minor Breaks, care of policy October 2009 read in part, . The purpose of this procedure is to guide the prevention and treatment of abrasions, skin tears, and minor breaks in the skin . 1. Obtain a physician's order as needed . 1. An abrasion is an area on the skin that has been damaged by shearing, scraping, rubbing or trauma. A skin tear is the disruption of epidermis resulting in a lifting or shearing of the skin. 2. If the wound is bleeding, gently apply a compress with pressure over the wound. Reinforce the compress as needed to control any bleeding. 3. If the bleeding persists after efforts to stop it, or an object is embedded into the abrasion, or other medical attention is needed, notify the physician . 1.Notify the responsible family member. Physician notification may be routine (that is, non-immediate) if the abrasion is uncomplicated or not associated with significant trauma . Record review of the facility's Change in a Residents Condition or Status policy dated 2016 read in part, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) . 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): a. accident or incident involving the resident;