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	04/09/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 9%, based on 3 errors out of 31 opportunities, which involved 2 of 5 residents (Resident #29 and #114) and 2 of 4 staff (MA C and MA L) reviewed for medication administration.MA C did not offer or apply Lidocaine patches to all areas indicated in the MD order and administered the wrong Iron supplement to Resident #114 on 4/8/26. MA L did not administer the correct dose of Clearlax (used for the relief of occasional constipation) to Resident #29 on 4/8/26.These failures could place residents at risk of ineffective therapeutic outcomes. Findings include:Record review of Resident #114's admission record dated 4/9/26 revealed a [AGE] year-old male who admitted on [DATE]. His diagnoses included displaced fracture of fifth cervical vertebra, central cord syndrome (incomplete spinal cord injury, primarily affecting the upper limbs and resulting from trauma or degenerative changes in the cervical spine), and person injured in motor vehicle accident.Record review of Resident #114's Order Summary Report revealed orders for:Lidocaine patch 5% apply to bilateral hips/knees topically one time a day for pain and remove per schedule, order date 4/1/26.Ferrous Gluconate 324 (37.5 Fe) mg give 1 tablet by mouth one time a day for anemia, order date 4/2/26.An observation on 4/8/26 at 8:37 a.m., during medication pass, revealed MA C prepared Resident #114's medication for administration. She prepared Lidocaine patch 5%, Ferrous sulfate 325 (65 FE) mg, Sevelamer, Carvedilol, Eliquis, Famotidine, Januvia, Lokelma, Nifedipine, Telmisartan, and Vit D3. MA C entered Resident #114's room and administered all medications to Resident #114. She asked Resident #114 where he wanted the Lidocaine patch and he indicated the left knee, MA C applied the Lidocaine patch to the left knee and exited the room. In an interview and observation on 4/8/26 at 8:50 a.m., MA C said Resident #114's iron supplement order was for Ferrous gluconate. She said she was unsure if Ferrous gluconate and Ferrous sulfate were the same medication. During medication pass she compared the eMAR to the medication and noticed it was one strength off and had a different name but did not think anything of it. Observation of the medication cart revealed ferrous gluconate was not on it. She said Ferrous Gluconate iron was used for dialysis patients. MA C said the instructions for the Lidocaine patch were to apply to bilateral hips/knees and said she was unsure what bilateral meant. She said she applied the patch to his left knee and that was where the patient wanted it. She questioned the instructions to the order previously, but the patient wanted the left knee. To ensure medication administration accuracy MA C said she checked the medication and dosage. In an interview on 4/8/26 at 11:54 a.m. Resident #114 said facility staff always placed the Lidocaine patch on his left knee. He said the pain was not as bad on the other side as it was on the left side.In an interview on 4/8/26 at 1:27 p.m. the DON said she expected nursing staff to read the MD order and apply the Lidocaine patch to the hips and knees. She said bilateral indicated two sides. She said Resident #114's order needed to be clarified, and she would expect staff to get clarification from the nurse, who would reach out to the doctor to see where the patches should be placed. She said placing the patch to the left knee only was not following the order. The patient's pain could be at risk of not being properly managed. She said Lidocaine was a localized patch (used to provide temporary relief from pain by delivering the (continued on next page)

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

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

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	04/09/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	local anesthetic directly to the skin. They work by numbing the nerves in a specific area). She said Ferrous sulfate and gluconate were assumed to be different because the names were different. Ferrous sulfate and gluconate are used to treat and prevent iron deficiency anemia and were the same concept, but what the staff administered to Resident #114 was not the correct medication. She said staff should ensure everything matches including the right medication, time, dosage, resident, and route, and to ensure the medication is available on the cart. Iron is a supplement to manage anemia.2. Record review of Resident #29's admission record dated 4/9/26 revealed a [AGE] year-old female who admitted on [DATE]. Her diagnoses included hemiplegia and hemiparesis (hemiplegia is paralysis of one side of the body, while hemiparesis is weakness on one side) following cerebral infarction (stroke) affecting left non-dominant side, depression, and mental disorder.Record review of Resident #29's quarterly MDS assessment dated [DATE] revealed a BIMS score of 7 out of 15 which indicated severe cognitive impairment. She required assistance from staff with ADL care.Record review of Resident #29's Order Summary Report revealed an order for Miralax oral powder 17 gm/scoop (Polyethylene Glycol 3350) give 1 scoop by mouth two times a day for constipation, mix with at least 4 oz of water or juice, order date 8/22/25.In an observation on 4/8/26 at 9:30 a.m. during medication pass revealed MA L prepared Resident #29's morning medication for administration. She prepared Amlodipine, Senna-Plus, Magnesium oxide, and Clearlax (Miralax) PEG 3350. Observation of the Clearlax measuring top had 17 gm inscribed in it along with up arrows that pointed to the top of the white section. MA L filled approximately half of the white section with powder and did not prepare the entire 17 grams. She mixed the powder with water and administered all medications to Resident #29.In an interview on 4/8/26 at 9:34 a.m. MA L said she poured Resident #29's Clearlax powder to the line that was at the halfway point of the white section. She said she knew how much to prepare based on the instructions on the label which indicated 1 scoop. This Surveyor pointed out the 17 gm and up arrows to MA L and she said she had not seen that before. She said she used a different bottle in the past that was labeled differently. She said it was important to administer the full dose so the resident could have a bowel movement. She said she would report to the nurse that Resident #29 only received half of the medication, and also did not consume all the liquid in the cup. In an interview on 4/8/26 at 1:27 p.m. the DON said the Clearlax bottle top should be 17 grams, and the powder should be poured in the top. She said medication aides should follow the instructions on the bottle which informed you where to stop. She said the resident could be at risk of her bowels not being regulated properly if the full dose was not received. In an interview on 4/8/26 at 3:31 p.m. the Administrator said he expected staff to follow the rights of medication administration, try to get it right every time, and for the medication error rate to stay under 5%.Record review of the facility's Administering Medications policy dated December 2012 read in part, .Medications shall be administered in a safe and timely manner, and as prescribed.3. Medications must be administered in accordance with the orders, including any required time frame. 7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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	04/09/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 control, and only permit only authorized personnel to have access to the keys for 2 of 5 residents (Resident #115 and Resident #48) reviewed for storage of medications.The facility failed to keep Resident #115's medication secured. Four plastic eye dropper bottles of Eyes Alive (Carboxymethylcellulose sodium 0.5%) were found on Resident #115's bedside tray table. Resident #115 did not have orders to self-administer.The facility failed to ensure Resident #48's Xiidra eye drops (used to treat the signs and symptoms of dry eye disease) were stored at the proper temperature according to the medication label.The deficient practice could place residents at risk of not receiving the therapeutic benefit of medications, drug diversion, or ingestion of unprescribed medications to residents, staff, and visitors.Findings included:1.Record review of Resident #115's undated face sheet revealed an [AGE] year-old male who admitted into the facility on [DATE]. He had diagnoses of cholangitis (infection and inflammation of the bile ducts which could lead to jaundice), hypertension (high blood pressure) , muscle weakness, kidney failure, and sepsis (infection leading to organ dysfunction).Record review of Resident #115's admission MDS assessment dated [DATE] revealed a BIMS score of 14 out of 15 indicating intact cognition.Record review of Resident #115's active physician orders as of 04/07/2026 revealed the following scheduled medication, Carboxymethylcellulose Sod PF Ophthalmic Solution 0.5%, instill 1 drop in both eyes four times a day for dry eyes. There was no physician order authorizing Resident #115 to self-administer Carboxymethylcellulose Sod PF Ophthalmic Solution 0.5%,Record review of Resident #115's e-MAR dated 04/07/2026 revealed MA C administered Carboxymethylcellulose Sod PF Ophthalmic Solution 0.5%, during the morning and afternoon medication pass.During an observation and interview with Resident #115 on 04/07/2026 at 10am, four plastic eye dropper bottles of Eyes Alive (Carboxymethylcellulose sodium 0.5%) were found at the bedside tray table. Resident #115 stated his family member, and the staff will leave the medication near, so he is able to administer if he needed to. This surveyor asked Resident #115 if he had other mediations stored in the room and he stated in his nightstand. This surveyor asked for permission to review the nightstand, and it was a box of Eyes Alive (Carboxymethylcellulose sodium 0.5%) found in the bottom drawer with twelve additional eye dropper bottles.During an interview with LVN B on 04/07/2026 at 10:08am she stated that the expectation for medication storage is that all medications are kept in the nurse medication cart, medication room, or aide cart. LVN B stated that eye drops are administered by the medication aide when they are nonˆantibiotic, and by a nurse if the medication is an antibiotic. LVN B stated that rounds are conducted every two hours or as needed. She also stated that Resident #115 was not authorized to selfˆadminister medications and that she has not left medications in the resident's room nor observed medications stored in the resident's nightstand. LVN B stated the identified risk of prescribed medications being left accessible includes the potential for another resident to take the medication or for overdose.During an interview with MA C on 04/07/2026 at 10:19am she stated she administered medications in the 300 and 400 halls. She stated she recalled Resident #115 and administered his eye drops, although she was unable to recall specific details at the time of the interview. MA C stated the eye drops are kept on the medication cart and that she has never left the medication in the resident's room. She was unsure whether the resident can selfˆadminister the medication but stated she administers it to him. She denied ever leaving the medication accessible to the resident or stored in the nightstand. MA C further stated that the expectation for medication storage is that medications are kept refrigerated in the medication room or secured in a locked cart and that medications should not be left out due to the risk of another resident (continued on next page)

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	04/09/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taking them.During an interview with the DON on 04/09/2026 at 10:50am she stated that the expectation for medication storage is that all medications are to be kept in the medication cart or medication room. The DON stated that storing medications in a resident's room poses the risk of the resident self^administering medications without authorization.2. Record review of Resident #48's admission record dated 4/9/26 revealed a [AGE] year-old male who readmitted to the facility on [DATE]. His diagnoses included other age-related incipient cataract, bilateral (early-stage lens clouding that may cause subtle vision changes.)Record review of Resident #48's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 out of 15 which indicated moderate cognitive impairment. He required assistance from staff with ADL care.Record review of Resident #48's Order Summary Report revealed an order for Lifitegrast ophthalmic solution 5% (Xiidra) instill 1 drop in both eyes two times a day for dry eyes, order dated 2/5/26.In an observation on 4/9/26 at 10:33 a.m. of the medication room refrigerator with the DON revealed Resident #48's Xiidra eye drops were in the door of the refrigerator. The temperature of the refrigerator was 40 F. Observation of the Xiidra prescription box indicated to store the eye drops at room temperature, between 68 F - 77 F.In an observation and interview on 4/9/26 at 10:35 a.m. the DON reviewed the Xiidra eye drops instruction insert and said the eye drops were to be stored between 68 F - 77 F. She said she was unsure who placed Resident #48's eye drops in the refrigerator. She said the eye drops should not be stored in the refrigerator so the drops will not be cold going into the resident's eye.In an interview on 4/9/26 at 1:50 p.m. the DON said she expected medications to be stored properly, and nursing staff could refer to the pharmacy insert, pharmacy, or verify with a nurse on how to properly store the medication.Record review of facility policy revised December 2012 for Storage of Medications read.Policy Statement The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.Policy Interpretation and Implementation1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers.7. 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.10. Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys.

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	04/09/2026

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 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 did not maintain an infection prevention program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for one of 5 residents (Resident #67) reviewed for infection control.CNA A failed to cleanse the tip of the penis while performing incontinent care for Resident #67.CNA A failed to maintain a sanitary environment by placing packages of used supplies back onto a clean linen cart.Findings included:Record review of Resident #67's face sheet dated 04/08/26 revealed a [AGE] year-old admitted to the facility on [DATE]. His diagnoses included progressive multifocal leukoencephalopathy (a serious viral infection of the brain); other combined immunodeficiencies (a group of inherited disorders of the immune system, leading to increased susceptibility to infections), urinary tract infection; Hemiplegia (one sided paralysis or severe loss of strength on one side); Dysarthria and anarthria (a motor speech disorder characterized by slurred or slow speech); chronic kidney disease; hypertension and muscle weakness.Record review of Resident #67's admission MDS assessment dated [DATE] revealed a BIMS score of 13 out of 15 indicating intact cognition. He was dependent on assistance for toileting hygiene. He required maximal assistance with lower body dressing and showers. He required moderate assistance with upper body dressing and supervision for personal hygiene and oral hygiene. He used a wheelchair for mobility. He was always incontinent of bowel and bladder.Record review of Resident #67's undated care plan last reviewed on 03/13/26 revealed: Focus - Resident #67 had a urinary tract infection, date initiated was 03/10/26. Goal - Resident #67's urinary tract infection will resolve without complications. Interventions included- Resident/caregiver teaching should include good hygiene practices: wipe and cleanse from front to back. Clean peri area well after BM to help prevent bacteria in urinary tract. Focus - Resident #67 had an ADL self-care performance deficit r/t hemiplegia and impaired balance. Interventions included - Toilet use: the resident requires (x1) staff participation to use toilet.Observation and interview on 04/08/26 at 4:45 AM, CNA A and CNA D performed incontinent care for Resident #67. CNA A gathered a clean brief, two packages of disposable wipes, and one box of gloves from the clean cart in the hallway then brought the items and a personal hand sanitizer bottle into Resident #67's room. CNA A and CNA D performed hand hygiene and put on clean gowns and gloves. CNA A placed the supplies including a personal hand sanitizer onto the overbed table. CNA A unfastened Resident #67's brief. With a clean wipe CNA A cleansed the lower abdomen, the left and right groin. With a new cleansing wipe CNA A cleansed from the base of the penis towards the opening of the urethra with one motion. CNA A did not cleanse the opening of the urethra. Resident #67 was able to roll to his right side as CNA D stood by. Resident #67 had a small bowel movement and CNA A cleansed the buttocks and anus using several clean wipes until the skin was clean. CNA A removed the soiled brief and disposed of it in the plastic trash liner. CNA A removed soiled gloves, used hand sanitizer to cleans hands, and put on clean gloves from the box of gloves. CNA A placed the clean brief beneath Resident #67 and then fastened the brief. CNA A and CNA D pulled bed covers over Resident #67. Both CNA's removed the used gowns and gloves then washed their hands at the sink. CNA D removed the trash bag from the room. CNA A took from the room: the 2 packages of disposable wipes, the box of gloves and bottle of hand sanitizer then placed them onto the shelf of the linen cart between clean folded linen. CNA A stated she did not realize that she did not clean the tip of the penis because she was nervous. CNA A stated it was important to clean this area to prevent build up of germs which could cause infection. CNA A stated she did not think it was a problem to bring the package of disposable wipes and box of gloves out of the room and back onto the cart. CNA A later stated she understood the items should not have been placed back onto the clean cart after using them for incontinent care because this would be cross contamination.In an interview on 04/08/26 at 5:30 AM, CNA D stated all resident rooms had packages of cleansing (continued on next page)

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	04/09/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wipes in drawers and gloves were stored in the bathroom. CNA D stated the clean cart should remain clean and would never remove items from the cart, bring them into a resident room, use them on a resident then put them back onto the cart due to infection control issues. CNA D stated doing so would be cross-contaminating dirty items onto a clean linen cart where items were kept and used for all residents. CNA D stated when performing incontinent care for a male resident she would always start by cleaning the tip of the penis for infection control. CNA D stated if the tip of the penis was not cleaned first the risk would be pain, UTI and confusion from the UTI.In an interview on 04/08/26 at 5:35 AM, the DON stated cleansing wipes and gloves should not be returned to the clean cart, they should remain in the resident room due to infection and cross-contamination. The DON stated anything on the packages may infect the next resident for example, a package may be contaminated with stool then used for another resident and this could cause infection for that resident. In an interview on 04/08/26 at 5:45 AM, LVN E stated when cleaning peri area during incontinent care for a male resident, she would start at the tip of penis to prevent spread of bacteria, for infection control practices. LVN E stated the carts in the hallways are for clean supplies only and packages of cleansing wipes, boxes of gloves stay in the room to prevent contamination.In an interview on 04/08/26 at 11:00 AM, the DON stated when performing incontinent care for a male resident she expected that the aides start cleansing the front of the peri area, clean the tip of the penis first and that this was facility policy to do so. The DON stated if the tip of the penis was not cleaned the resident would be at risk of infection, UTI and would probably not feel well because of an infection.Record review of the facility policy for Perineal Care revised on December 2011 read in part: The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.10. For a male resident:.b. Wash perineal area starting with urethra and working outward.(1) Retract foreskin of the uncircumcised male. (2) Wash and rinse urethral area using a circular motion. (3) Continue to wash the perineal area including the penis, scrotum and inner thighs.Record review of the facility Policies and Practices - Infection Control, revised August 2010, read in part: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors.2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility; b. Maintain a safe, sanitary, and comfortable environment.