STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676009	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treemont Health Care Center	2501 Westerland Dr Houston, TX 77063

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 (Resident #55) residents reviewed for intravenous fluids.-The facility failed to ensure Resident #55 's subclavian central line's dry dressing was changed every 5 to 7 days per facility policies and procedures, including orders for monitoring the site. The nurse did not maintain sterile technique while changing subclavian central line dressing on 12/3/25,This deficient practice could place residents at risk of serious harm, injury or death by exposing residents to infections in the blood stream and serious illness.Record review of Resident #55's face sheet dated 12/03/2025 revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. His medical diagnoses included hyperlipidemia(high fat blood), lobar pneumonia (a serious lung infection where one or more entire sections of the lung get inflamed and fill with fluid, pus and dead cells), acute kidney failure, unspecified, essential (primary) hypertension (high blood), septic pulmonary embolism without acute coronary pulmonale (a sudden failure or severe strain on the right side of the heart because of a rapid, major blockage or increased pressure in the lungs, most commonly from a blood clot), and rhabdomyolysis (a condition where damaged muscle tissue breaks down, releasing harmful substances into the bloodstream).Record review of Resident #55's admission MDS assessment, dated 11/30/25, reflected a BIMS score of 13 out of 15, which indicated intact cognition. He required assistance from staff with ADL care.Record review of Resident #55's hospital discharge records dated 11/25/25 revealed Resident #55's midline placement (a catheter placed in a vein used to deliver medications and other treatments quickly to the body) with the last dressing change date of 11/20/25. Further review revealed Resident #55 was ordered meropenem (an antibiotic) 500 mg intravenously every 12 hours for 21 days with a start date of 11/25/2025 and a stop date of 12/16/2025. He had a transfer diagnosis of sepsis ((is a life-threatening medical emergency where the body's over-the -top response to an infection starts damaging its own tissues and organs, leading to potential organ failure and death).Record review of Resident #55's physician's progress notes dated 11/25/25 revealed, change IV dressing on admission, Q(every) week, and PRN one time a day every 7 days with a start date 11/26/25. Record review of Resident #55's December/2025 MAR revealed he was receiving Meropenem - Sodium Chloride Intravenous Sodium Reconstituted 500mg/50ml (Meropenem and Sodium Chloride) Use 33.3 ml/hr intravenously every 12 hours for Sepsis for 21 days 100ml. 0.9% Sodium chloride. Record review of Resident #55's care plan dated 11/28/2025 revealed no instructions for maintenance of the right midline subclavian (type of peripheral venous catheter that is inserted in the upper arm, preferred for residents requiring frequent procedures) double lumen (a catheter which splits into two tubes, with each tube being used to take or give blood products and the other used for medication or IV fluids) to be changed every Sunday and as needed.Observation on 12/3/25 at 10:03 a.m., revealed Resident #55 lying in bed and he had a central line in his right upper chest with a double lumen with the dressings cover dated as 11/20/25. Both dressings and tape were brownish in color. Resident #55 was interview-able, and he said 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
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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing had not changed since his admission to the facility. The ADON was called to Resident #55's bedside to check the central line in his right upper chest dressing. The ADON said the dressing should be changed every Sunday and as needed and she was going to let the nurse know. Further observation on 12/3/25 at 10:09 a.m., revealed LVN C came in Resident #55's room, don clean gloves from her uniform pocket, picked up a central line dressing and opened the sterile dressing package and placed it on the air condition vent by Resident #55's bedside. LVN C doff her gloves, and without washing hands got gloves from her uniform pocket, donned the gloves and tried to remove the old dressing with difficulty. LVN C then pulled scissors from her uniform pocket and cut off the dressing, then picked up the alcohol pad and cleaned around the IV site.Interview with LVN C on 12/3/25 at 2:20 pm regarding the subclavian procedure, LVN C said she should have done the IV change with sterile procedure. She had IV training, but it had been over a year, and the training was somewhere else. LVN C said it her first time working with Resident #55. If she didn't follow the right technique dislodgement, introducing infection could happen. Her gloves and scissors were in her pocket. For the subclavian line, she should have taken the old dressing off with her sterile gloves, then should have cleaned it with the scrubber, made sure it was dry, and made sure the line was secure. She saw the order for dressing change weekly and PRN. Dressing changes were to decrease risk for infection at the site. She said, You could get an embolism and infection. That would not be considered following physician orders. Interview with the DON on 12/3/2025 at 2:54pm, regarding subclavian procedure, she said it was a sterile procedure. The DON said she did checkoffs and did not monitor everyone. The DON said she did PICC and midline training. The DON said the dressing should be done once a week, every seven days. Nurses should ensure residents with a PICC line had physician's orders for it. The PICC line dressings should be changed every 5 to 7 days and that nurses should observe the PICC line site every shift to ensure no redness, drainage, or that the site was not hot to the touch. Record review of the undated facility's Central Venous Catheter Dressing Changes Line policy, revealed in part, .Purpose.The purpose of this procedure is to prevent catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. Follow these guidelines unless otherwise stated in manufacturers' guidelines. Preparation1. Check the State's Nurse Practice Act for LVN/LPNs regarding scope of practice for changing a central venous catheter dressing.2. A physician's order is not needed for this procedure.General GuidelinesApply and maintain sterile dressing on intravenous access devices. Dressings must stay clean, dry, and intact. Explain to the resident that the dressing should not get wet.Change dressings if any suspicion of contamination is suspected.Catheter site care shall allow for the observation and evaluation of the catheter-skin junction and surrounding tissue.After original insertion of CVAD (central line, is a thin, flexible tube inserted into a large vein that leads near the heart), the dressing will consist of gauze and TSM (medication naltrexone to reduce alcohol cravings and consumption). This must be changed within 24 hours.1. Replace with sterile transparent dressing.2. Use gauze under the TSM if there is drainage from the catheter insertion site.Change transparent semi-permeable membrane (TSM) dressings at least every 5-7 days and PRN (when wet, soiled, or not intact).If gauze is used, it must be changed every 2 days.Approved antiseptic solutions for cleaning insertion site area include alcohol, povidone-iodine, chlorhexidine gluconate, and tincture of iodine as single agents or in combination. A formula containing alcohol and >0.5% (less than) chlorhexidine gluconate is preferred.Allow the insertion site to air dry before placing dressing. Do not blow or wave over the site.Removal of old dressing is an aseptic, non-sterile procedure.With a well-healed tunneled central venous access device, consideration may be given to no dressing.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 35% based on 11 errors out of 31 opportunities, which involved 4 of 9 residents (Residents #5, #23, #53 and #55) and 2 of 4 staff (MA A, MA B and LVN C) reviewed for medication errors.1. The facility failed to ensure MA A administered Magnesium Oxide (used as a dietary supplement to address magnesium deficiency and as an antacid to relieve heart burn and indigestion). It was initialed as given on 12/1/2025 to Resident #53.2. The facility failed to ensure MA A administered Arginald Powder (used to support wound healing, particularly for chronic and slow-to-heal wounds). It was initialed as given on 12/1/2025 to Resident #5.3. The facility failed to ensure MA B administered Acyclovir (used to treat and prevent infection caused by the herpes virus, cold sores, shingles and chickenpox) with food and extra fluid. It was initialed as given on 12/2/2025 to Resident #23.4. The facility failed to ensure MA B administered the correct dose Baclofen (used as a muscle relaxant and antispasmodic agent to relieve muscle spasms, cramping, tightness and pain caused by specified neurological condition) to Resident #23 on 12/2/25. 5. The facility failed to ensure MA B administered Carvedilol (used to treat high blood pressure, heart failure and to improve outcomes after a heart attack) with food. The Carvedilol was given on 12/2/2025 to Resident #23.6. The facility failed to ensure MA B administered Trazodone (used to treat major depressive disorder (depression) in adults) 50 mg half tablet and taken shortly after meal or light snack to Resident #23 on 12/2/257. The facility failed to ensure MA B administered Gabapentin (used to treat nerve pain and control partial seizures in individuals with epilepsy) at the right time (8:00PM) to Resident #23 on 12/2/258. The facility failed to ensure MA B administered Donepezil (the generic version used to treat dementia) at the right time (8:00PM) to Resident #23 on 12/2/259. The facility failed to ensure MA B administered Lubricating eyedrops ophthalmic drops, on 12/2/25, and initialed as given to Resident #2310. The facility failed to ensure MA B administered Acetaminophen 325 mg (used to treat pain) on 12/2/25, and initialed as given to Resident #23.11. The facility failed to ensure LVN C administered the correct dose of Pantoprazole (used to treat conditions caused by excess stomach acid) to Resident #55 on 12/3/25.These failures could place residents at risk of inadequate therapeutic outcomes.Record review of Resident #55's face sheet, dated 11/25/25, reflected an [AGE] year-old male. His diagnoses included esophageal reflux disease without esophagitis (Gastric reflux), hyperlipidemia (high fat blood), lobar pneumonia (a serious lung infection where one or more (lobes) of the lungs get inflamed and fill with fluid, pus and dead cells often from bacteria like streptococcus pneumoniae) unspecified organism, acute kidney failure, and essential (primary) hypertension (high blood).Record review of Resident #55's admission MDS assessment, dated 11/30/25, reflected a BIMS score of 13 out of 15, which indicated intact cognition. Record review of Resident #55's Physician's Orders for December 2025, reflected an order for Pantoprazole Sodium Oral Tablet Delayed Release 40 mg (Pantoprazole Sodium). Give 1 by mouth one time a day for GERD order date 11/25/25.Record review of Resident #55's new Physician's Orders for December 2025, reflected an order for Pantoprazole Sodium Intravenous Solution reconstituted/mixed 40 mg (Pantoprazole Sodium). Use 40 mg intravenously two times a day for 10 days in 100ML with a start date of 12/4/25.In an observation on 12/3/25 at 9:59 a.m. revealed LVN C had hung IVSS Pantoprazole Sodium 40 mg vial attached to 100ML of normal saline. Pantoprazole Sodium 40 mg vial was diluted with the normal saline but was not reconstituted back in normal saline. Resident #55 was getting normal saline in the IV without Pantoprazole Sodium 40 mg. Resident #55 was given Pantoprazole Sodium 40 mg tablet by mouth at 6:00 a.m. Pantoprazole Sodium 40 mg IVSS was to started on 12/4/25.Record review MAR dated 12/3/25 reflected Pantoprazole Sodium Oral Tablet Delayed Release 40 mg was given on 12/3/25 at 6:00 a.m. by night nurse.In an interview and observation on 12/03/25 at 9:59 a.m. LVN C was shown the Pantoprazole Sodium 40 mg vial was (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diluted with the normal saline but was not reconstituted back in normal saline. She said Resident #55 was not getting the medication., She then went and reconstituted another Pantoprazole Sodium 40 mg vial IVSS. In an interview on 12/03/25 at 11:09 a.m., with LVN C, she said the first time she administered the Pantoprazole Sodium 40 mg vial, she didn't mix the contents of Pantoprazole Sodium 40 mg in the vial in normal saline back into the bag and Resident #55 was getting only normal saline. If Resident #55 was not receiving the Pantoprazole he could have acid reflux, and the medication was used to treat the resident's GERD. LVN C did not know Resident #55's Pantoprazole Sodium 40 mg vial was to start on 12/4/25 and she was not aware that Resident #55 was administered Pantoprazole Sodium 40 mg on 12/03/2025 at 6:00 a.m.In an interview on 12/3/25 at 1:49 p.m., the DON said for Resident #55 she did not know the justification for Pantoprazole orally and IVSS but it was in his hospital records, and it was changed to IVSS on 12/3/25. Record review of Resident #53's face sheet, dated 12/1/25, reflected a 73 -years-old female who admitted to the facility on [DATE]. Her diagnoses included hypomagnesemia(low magnesium in the blood) obstructive sleep apnea (occurs when the tongue and other throat muscles relax during sleep, causing your airway to temporarily close) nicotine dependence, cigarettes, chronic obstructive pulmonary disease, mild protein-calorie malnutrition, chronic diastolic (congestive) heart failure, type 2 diabetes mellitus with hyperglycemia (high sugar levels in the blood), and hypotension (low blood pressure). Record review of Resident #53's admission MDS assessment, dated 11/30/25, reflected a BIMS score of 13 out of 15, which indicated intact cognition. Record review of Resident #53's Physician's Orders for 11/26/ 2025 reflected an order for Magnesium Oxide 420 mg. Give 1 tablet by mouth one time a day for hypomagnesemia. In an observation on 12/1/24 at 7:04 a.m. revealed MA A prepared Resident #53's medications. MA A did not administer Magnesium Oxide 420 mg with other medications as ordered by the doctor.Record review of Resident #53's MAR dated 12/1/25 reflected Magnesium Oxide 420 mg was initial as given on 12/1/2025. Record review of Resident #5's face sheet, dated 12/1/25, reflected a 74 -years -old male who admitted to the facility on [DATE]. His diagnoses included neuropathy, unspecified, spinal stenosis (narrowing of the curvature of the spine), other retention of urine, constipation, insomnia, anemia, hyperlipidemia (high fat in the blood), unspecified, generalized anxiety disorder, urinary tract infection, unspecified injury of urethra, type 2 diabetes mellitus with hyperglycemia, muscle wasting and atrophy, not elsewhere classified, right shoulder, muscle wasting and atrophy, not elsewhere classified, left shoulder, other lack of coordination, muscle wasting and atrophy, not elsewhere classified, multiple sites.Record review of Resident #5's admission MDS assessment, dated 11/3/25, reflected a BIMS score of 15 out of 15, which indicated intact cognition. Record review of Resident #5's Physician's Orders for 11/26/ 2025 reflected an order for Arginald packet two times a day for nutrient repletion/assist with/wound healing for 60 days. Give 1 packet mixed with water or fruit juice order date was 11/10/25 by mouth one time a day for hypomagnesemia. In an observation on 12/1/24 at 7:40 a.m. revealed MA A prepared Resident #5's medications. MA A did not administer Arginald 1 packet with other medications during medication pass.Record review of Resident #5's MAR dated 12/1/25 reflected Arginald 1 packet was initial as given on 12/1/2025.Attempted interview on 12/3/25 at 11:35 a.m., but MA A did not respond to the telephone call. Record review of Resident #23's face sheet, dated 12/1/25, reflected a 72 -years -old female who admitted to the facility on [DATE] readmitted on [DATE]. His diagnoses included long term (current) drug therapy, muscle wasting and atrophy in right and left thigh, muscle weakness (generalized), insomnia, muscle wasting and atrophy, major depressive disorder, constipation, unspecified, dry eye syndrome of unspecified lacrimal gland duct, other muscle spasm, gastro-esophageal reflux disease without esophagitis Gastric reflux), vitamin deficiency, difficulty in walking, other lack of coordination, personal history of other infectious and parasitic diseases, displaced comminuted fracture of shaft of left tibia (fracture of the lower leg bone), displaced comminuted fracture of shaft of left fibula (fracture of the outer leg bone), other specified disorders of bone density and structure, dysphagia (difficulty swallowing), oropharyngeal phase, other (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abnormalities of gait and mobility, mild protein-calorie malnutrition, acute respiratory distress syndrome, multiple sclerosis (a chronic disease of the and spinal cord where the immune system mistakenly attacks and damages myelin the protective coating of nerve fibers disrupting signals between the brain and body), unspecified dementia (declining brain function(memory , thinking, judgement) severe enough to impact daily life without behavioral disturbance, psychotic disturbance, mood disturbance), and anxiety (a feeling of worry, unease or fear about an upcoming event).Record review of Resident #23's quarterly MDS assessment, dated 11/3/25, reflected a BIMS score of 14 out of 15, which indicated intact cognition. Record review of Resident #23's Physician's Orders for 2/11/2025 reflected orders for: -Acyclovir oral tablet 400mg. Give 1 tablet by mouth two times a day with food and extra fluid. -Baclofen oral tablet 10 mg. Given 3 tablets (30mg) by mouth three times a day for muscle spasm. - Carvedilol oral tablet 3.125mg, give 1 tablet by mouth three times a day for high blood hold if SBP > 110 or DBP>60, give with food. - Trazodone HCL oral tablet 50 mg. Give 0.5mg tablet by mouth two times a day for anxiety and depression, .50 mg half tablet, to take shortly after meal or light snack. - Gabapentin oral Capsule 300 mg. Give 1 Capsule by mouth at bedtime for pain. - Donepezil HCL oral 5 mg. Give 1 tablet by mouth in the evening for unspecified dementia. Give one tablet every evening at the right time. - Lubricating plus eye drops ophthalmic solution 0.5% (Carboxymethyl/cellulose (Ophth) Instill 1 drop in both eyes two times a day for dry eyes. Acetaminophen oral tablet 325 mg. Give 2 tablet by mouth three times a day for pain.In an observation on 12/2/25 at 4:51 p.m. MA B opened the medication cart and picked up Resident #23's medications blister packets and punched the following in the medication cup without reviewing the resident's chart:- Acyclovir oral tablet 400mg with food - Baclofen oral tablet 10 mg was administered to Resident #23, instead of giving Baclofen oral 30mg tablets - Carvedilol oral tablet 3.125mg was given without food - Trazodone HCL oral tablet 50 mg. Resident #23 was not given before a meal or snack. - MA B did not administer Acetaminophen 325mg 2 tablets as ordered by the doctor, initialed as given to Resident #23 on 12/2/25.- MA B did not administer Lubricating plus eye drops ophthalmic solution 0.5% and initialed the med as given to Resident #23 on 12/2/25. - MA B administered Donepezil HCL oral 5 mg not as ordered by the doctor for 8:00 p.m. MA B gave Donepezil oral 5 mg at 4:00 p.m. on 12/2/25.- MA B administered Gabapentin oral Capsule 300 mg not as ordered by the doctor for 8:00 p.m. MA B gave Gabapentin oral Capsule 300 mg at 4:00 p.m. instead of 8:00 p.m. on 12/2/25 Record review of Resident #23's MAR dated 12/2/25 reflected:- Acetaminophen oral tablet 325 mg. Give 2 tablet by mouth three times a day for pain. MA B did not administer Acetaminophen as ordered by the doctor, initialed given at 4:00 p.m. On 12/2/25.- Lubricating plus eye drops ophthalmic solution 0.5% (Carboxymethyl/cellulose (Ophth) Instill 1 drop in both eyes two times a day for dry eyes. MA B did not administer Lubricating plus eye drops ophthalmic solution 0.5% as ordered by the doctor, initialed given at 4:00 p.m. on 12/2/25.-Baclofen oral tablet 10 mg given instead of 3 tablets (30mg) by mouth three times a day for muscle spasm- Donepezil HCL oral 5 mg. Give 1 tablet by mouth in the evening for unspecified dementia. Give one tablet every evening, MA B administered Donepezil HCL oral 5 mg not as ordered by the doctor for 8:00 p.m. MA B gave Donepezil oral 5 mg at 4:00 p.m. on 12/2/25.-Gabapentin oral Capsule 300 mg. Give 1 Capsule by mouth at bedtime for pain. MA B administer Gabapentin oral Capsule 300 mg not as ordered by the doctor for 8:00 p.m. MA B gave Gabapentin oral Capsule 300 mg at 4:00 p.m. on 12/2/25.Interview with MA B on 12/3/25 at 4:07p.m. revealed when asked about Resident #23's medications not being given as ordered by the physician's orders which included, Baclofen 10 mg given instead of 30 mg, Acetaminophen, Lubricating plus eye drops. Trazodone HCL. For Gabapentin, Donepezil not giving at the right time, MA B said it depended on the individual. She said some want it all at once. She said it also depended on the MAR. The individuals might say they're more comfortable taking it at that time. Resident #23 preferred her medication before or during dinner and the other meds at night. The parameters of giving the right time with medications .He said he would tell the charge nurse when the resident wants their given. He brought it to the charge nurse's attention regarding Donepezil (Aricept). He could not remember when (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or who he told regarding the timing. MA B said he did not give Resident23 at the right time. When asked why the medications were not administered and why he punched the blister packets without looking at Resident #23's chart, MA B said if residents didn't get their medications as ordered, it could have a negative effect like imbalance and adverse or toxic effect for the resident. When asked if it could slow down their process of healing, he did not answer the question. In an interview on 12/4/25 at 11:12 a.m., the DON said prior to administering the medication the aide should get clarification from the charge nurse if the order did not appear correct or amount administered did not match the order. The DON said staff had a checkoff for med pass this year.DON said she pop up on their cart from time to time to check med pass. Her expectation was for staff to look at MAR to administer medications. MA can't change time at their convenience but follow physician's orders. If there were any issues with the medication, MA B should have told the charge nurse and they could have followed up with the resident's physician.In an interview on 12/4/25 at 11:12 a.m. the Administrator said she expected nursing staff to give medications timely, correctly, and according to the physician orders.Record review of the facility's Administering Medications policy, undated revealed in part Policy StatementMedications shall be administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so.2. The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions.3. Medications must be administered in accordance with the orders, including any required time frame.4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).5. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns.6. The individual administering medications must verify the resident's identity before giving the resident his/her medications. Methods of identifying the resident include:a. Checking identification band;b. Checking photograph attached to medical record; andc. If necessary, verifying resident identification with other facility personnel.The individual administering the medication must check the label carefully to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen and 5 of 12 residents reviewed for food procurement.-The facility failed to ensure leftover foods were not stored past used by date.-The facility provided food trays containing a hamburger that was at 68 Fahrenheit and spaghetti with meat sauce at 63.2 Fahrenheit and the chef salad was at 63 Fahrenheit.These failures have the potential to place all residents who ate food prepared by the kitchen at risk of food borne illness and disease. Observation of the facility 's kitchen on 12/05/25 between 7:00 am and 8:30 am with the dietary manager revealed the following:-Observed a pan of leftover gravy with used by date 11-26-25.-Observed a pan of leftover Italian gravy with used by date 11-26-25.-Observed a pan of leftover potato casserole with a used by date 11-30-25.Observation on 12/02/2025 at 1:21pm of the three food sample trays brought in conference room, the following temperatures were taken:-Chef Salad temperature 63 degrees Fahrenheit-Hamburger temperature 68 degrees Fahrenheit-Spaghetti with meat sauce 63.2 degrees Fahrenheit The heated bases used to keep food hot under each plate were cold to touch.Interview on 12/01/2025 at 9:00 a.m., with Resident #34, they stated their food was served cold and they ate in their room.Interview on 12/01/2025 at 9:05 a.m., Resident #29 stated their food was served cold and taste unpalatable and they ate in their room.Interview on 12/01/2025 at 9:15 a.m., Resident #38 stated their food was served cold and lack variety and they ate in their room. Interview on 12/01/2025 at 9:30 a.m., Resident #5 stated that food was served cold and they ate in their room. Interview on 12/01/2025 at 12:01pm, Resident #42 and their RP stated food was sometimes 30 to 45 minutes late and was cold sometimes. She said she ate in her room.Confidential group interview conducted on 12/02/2025 at 10:30a.m., residents stated that food was often cold. Interview with the dietary manager on 12/05/25 at 8:40 a.m., revealed that leftover food saved for later had a used by date and to be stored in the refrigerator for 5 days then discarded. Interview on 12/05/25 at 9:40 a.m., the dietary manager stated that he was responsible for training staff regarding labeling and storage requirements ensuring dietary requirements are met.During an interview on 12/02/25 at 2:30p.m., the dietary manager stated his expectation was food should be cooked according to the recipe and be appealing to the residents. The dietary manager stated the cook was responsible for ensuring recipes were followed and the food was served hot and appealing. The dietary manager stated that he was responsible for monitoring the kitchen staff. The dietary manager stated that he monitored by doing spot checks. The dietary manager stated that the effect on residents might not eat food if it did not look appetizing. The dietary manager stated what led to failure was that staff did not check to see if the heated bases were plugged in. He stated that his expectation was for staff to follow policy.Record review of the facility's grievance logs, residents complained about food being cold on 2/18/2025, 8/19/2025 and 11/5/2025. The facility monitored for temperature and range after delivery.Record review of facility policy not dated reflected that food was to be cooked and served according to the recipe that recipe had to be followed and read in part, Hold hot food at 140 F or above. Hold cold food at 41 F or below.Record review of facility's Policy and Procedure Foods dated October 2017 read in part, .Perishable foods must be stored in the refrigerator will be labeled with the use by date. The food service staff will discard any foods past due expiration dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676009	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treemont Health Care Center	2501 Westerland Dr Houston, TX 77063

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with incontinent bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 1 resident (Resident #55) reviewed for incontinent care. -The facility failed to ensure CNA A put on a gown and changed gloves and cleaned Resident #55's scrotum and buttocks before putting on a clean brief during Foley catheter and incontinent care on 12/2/25. This failure could place residents at risk for pain, infection, injury, and hospitalization. Findings included: Record review of Resident #55's face sheet dated 12/03/2025 revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. His medical diagnoses included esophageal reflux disease without esophagitis(Gastric reflux), hyperlipidemia(high fat blood), unspecified, acute embolism and thrombosis (when a blood clot (thrombus) forms and stays put in a blood vessel, blocking flow, while Embolism is when part of that clot breaks off, travels through the bloodstream, and gets struck somewhere else causing a blockage (embolus) of unspecified deep veins of right lower extremity, lobar pneumonia (a serious lung infection where one or more entire sections(lobes) of the lung get inflamed and fill with fluid, pus and dead cells often from bacteria like streptococcus pneumoniae) unspecified organism, acute kidney failure, unspecified, essential (primary) hypertension (high blood), benign prostatic hyperplasia (a common, non-cancerous enlargement of the prostate gland in aging men leading to urinary issues like weak stream, frequent urination urgency, and difficulty emptying the bladder) with lower urinary tract symptoms, septic pulmonary embolism without acute coronary pulmonale (a sudden failure or severe strain on the right side of the heart because of a rapid, major blockage or increased pressure in the lungs, most commonly from a blood clot), rhabdomyolysis (a condition where damaged muscle tissue breaks down, releasing harmful substances into the bloodstream), other lack of coordination, muscle wasting and atrophy in the right and left shoulder, muscle weakness (generalized), unspecified abnormalities of gait and mobility, and unspecified lack of coordination.Record review of Resident #55's admission MDS assessment, dated 11/30/25, reflected a BIMS score of 13 out of 15, which indicated intact cognition. He required assistance from staff with ADL care. Record review of Resident #55 's care plan, dated 11/27/25, reflected, . The resident had an ADL self-care deficit .Interventions.Personal Hygiene and Toilet use- Resident is totally dependent . Resident #55 was also care-planned for a Foley catheter (a sterile tube that is inserted into your bladder to drain urine) and incontinent care, with interventions including following physician orders for catheter insertion, changes and maintenance.Review of Resident #55's Physician's orders from 11/25/2025 through 12/1/2025 reflected orders for the following: Foley Catheter cleansing and perineal hygiene daily and as needed if soiled, using a catheter securing device with a start date of 11/25/2025. Observation on 12/02/25 at 5:04 a.m., during Foley Catheter and incontinent care with Resident #55, revealed CNA A did not [NAME] PPE (gown) and change gloves while cleaning Resident #55's Foley catheter tubing and his penis. CNA A did not clean his scrotum and buttocks and placed a cleaned brief under the resident. In an interview with CNA A on 12/02/25 at 5:41 a.m., she said she did not clean the buttocks because she did not want the dressing on that site to come off and she knew not cleaning the buttocks could cause more skin break and odors. In an interview with CNA A on 12/02/24 at 5:41 p.m., she said she only wears PPE while assisting the nurses with dressing change.Review of the facility's policy titled Subject: Incontinent Care- With or Without Catheter not dated: POLICYIt is the policy of this center to provide incontinent care to residents in a manner which provides privacy, promotes dignity and ensures no cross contamination.MALE1. Follow steps below: . Cleanse the penis shaft with wipe from the top of the shaft towards the rectum, including the scrotum. Using a new wipe with each stroke clean from the upper part of the leg to the hip. Repeat on the other side and then once from hip bone (continued on next page)

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	676009	A. Building B. Wing	12/04/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to hip bone Turn the resident over and repeat on the back side.2. Take off gloves, put them into the trash bag with the soiled brief and wipes.Findings included: Record review of Resident #55's face sheet dated 12/03/2025 revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. His medical diagnoses included esophageal reflux disease without esophagitis(Gastric reflux), acute kidney failure, unspecified, essential (primary) hypertension (high blood), benign prostatic hyperplasia (a common, non-cancerous enlargement of the prostate gland in aging men leading to urinary issues like weak stream, frequent urination urgency, and difficulty emptying the bladder) with lower urinary tract symptoms, muscle wasting and atrophy in the right and left shoulder, muscle weakness (generalized), unspecified abnormalities of gait and mobility, and unspecified lack of coordination.Record review of Resident #55's admission MDS assessment, dated 11/30/25, reflected a BIMS score of 13 out of 15, which indicated intact cognition. He required assistance from staff with ADL care. Record review of Resident #55 's care plan, dated 11/27/25, reflected, . The resident had an ADL self-care deficit .Interventions.Personal Hygiene and Toilet use- Resident is totally dependent . Resident #55 was also care-planned for a Foley catheter (a sterile tube that is inserted into your bladder to drain urine) and incontinent care, with interventions including following physician orders for catheter insertion, changes and maintenance.Review of Resident #55's Physician's orders from 11/25/2025 through 12/1/2025 reflected orders for the following: Foley Catheter cleansing and perineal hygiene daily and as needed if soiled, using a catheter securing device with a start date of 11/25/2025. Observation on 12/02/25 at 5:04 a.m., during Foley Catheter and incontinent care with Resident #55, revealed CNA A did not [NAME] PPE (gown) and change gloves while cleaning Resident #55's Foley catheter tubing and his penis. CNA A did not clean his scrotum and buttocks and placed a cleaned brief under the resident. In an interview with CNA A on 12/02/25 at 5:41 a.m., she said she did not clean the buttocks because she did not want the dressing on that site to come off and she knew not cleaning the buttocks could cause more skin break and odors. In an interview with CNA A on 12/02/24 at 5:41 p.m., she said she only wears PPE while assisting the nurses with dressing change.Review of the facility's policy titled Subject: Incontinent Care- With or Without Catheter not dated: POLICYIt is the policy of this center to provide incontinent care to residents in a manner which provides privacy, promotes dignity and ensures no cross contamination.MALE1. Follow steps below: . Cleanse the penis shaft with wipe from the top of the shaft towards the rectum, including the scrotum. Using a new wipe with each stroke clean from the upper part of the leg to the hip. Repeat on the other side and then once from hip bone to hip bone Turn the resident over and repeat on the back side.2. Take off gloves, put them into the trash bag with the soiled brief and wipes.Remove gloves and WASH your hands.

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	676009	A. Building B. Wing	12/04/2025

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needs respiratory care, including tracheotomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of two residents reviewed for tracheotomy care (Resident #32). -The facility failed to ensure LVN B used sterile technique during tracheotomy care and suctioning, did not clean around trach site, and did not remove inner canula to clean for Resident #32. - This failure could place residents with a tracheotomy requiring suctioning at risk for respiratory infections, hospitalizations, and a decline in their quality of life. Record review of Resident #32's face sheet dated 12/2/2025 revealed a [AGE] year-old male resident was admitted to the facility on [DATE]. His medical diagnoses included malignant neoplasm of prostate (Prostate cancer), essential (primary) hypertension (high blood pressure), essential tremor age-related physical debility, dysphagia (difficulty swallowing), other seizures, constipation, unspecified, gastro-esophageal reflux disease without esophagitis (gastric reflux) , tracheostomy status (a surgical procedure where a small hole in the neck directly into the windpipe (trachea) is made to insert a tube to help with breathing or clearing lung mucus), acute respiratory failure with hypoxia (low oxygen), and muscle weakness. Record review of Resident #32's admission MDS assessment dated [DATE] revealed the BIMS assessment was 15 and mental status assessment found he had no short-term and long-term memory/recall ability problems and was cognitively intact. Record review of Resident #32's Care Plan reflected he had ADL self-care deficits and was at risk for further decline in ADL functioning and injury. It also reflected Resident #32 had a tracheostomy and was care-planned for routine equipment maintenance and changes as indicated, following physician orders related to oxygen administration, medication administration, labs, and encouraging residents to keep head of bed elevated. Record review of Resident #32's Physician's Orders reviewed 10/06/2025 revealed the following: -Order date: 10/6/2025 - Tracheostomy Care cuffed flex#6 Cannula daily and as needed for SOB/Prophylaxis.(shortness of breath) every shift, trach Care: Suctioning, every shift Suction tracheostomy tube as needed to clear airway. Document # (number) of Suctions Performed During Assigned Shift. Notify MD(medical doctor) of any abnormalities. Observation on 12/2/2025 at 4:19 p.m. revealed Resident #32 was in bed with audible moist breath sounds and his tracheostomy was covered with a cap. LVN B don clean gloves, and she did not set up a clean field on top of the bedside dresser. She picked up a Tri-flo suction (a type of suction for gentle removal of phlegm) catheter kit packet and placed it on the bed side dresser. LVN B removed her dirty gloves without washing hands, opened the sterile Trach Care Kit, then picked up opened gloves inside the bedside dresser. LVN B grabbed the sterile suction catheter kit tray with the inner canula, and using the same hand she picked up the connecting tubing from the suction machine, connected the suction tubing to the sterile suction catheter, then opened the trach cap. LVN B picked up a drinking cup and poured normal saline in the cup. LVN B suctioned Resident #32's tracheotomy twice and replaced the suction catheter in a packet and placed it the resident's bedside dresser. LVN B did not remove Resident #32's inner cannula to clean or replace it. LVN B did not clean the surrounding trach site. Resident #32's was coughing up a significant amount of phlegm while suctioning, and his oxygen saturation was not checked. In an interview on 12/02/2025 at 4:32 PM, LVN B stated she did not wash her hands during trach care or during suctioning. She stated she should have used sterile technique throughout, and she was recently in-serviced on tracheostomy care but could not recall the date of the in-service. LVN B did not disclose why she failed to use sterile technique. She stated she was working with Resident #32 for the first time during the observed trach care. LVN B stated that not using the sterile technique placed the resident at risk for a respiratory infection. In an interview on 12/04/2025 at 5:00 PM, the DON stated that LVN B had been in-serviced on tracheostomy care. The DON stated that LVN (continued on next page)

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	676009	A. Building B. Wing	12/04/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B should have used sterile technique during tracheostomy care. The DON stated that not using sterile technique could place the resident at risk for an infection. The DON stated that the facility had their nurses trained by the respiratory therapist. The DON said she would be conducting in-services on tracheostomy care and monitoring the nurses during tracheostomy care. Review of the facility's policy titled Tracheostomy Care revised 3/4/2025, revealed in part, It is the policy of this center to provide Tracheostomy care in accordance with current standards of practice to ensure airway patency, maintain skin integrity and prevent infection. Dry area with additional sterile gauze pads and apply new sterile Tracheostomy dressing27. Change trach ties or Velcro collar if soiled or wet (when possible have another staff available to secure trach during this process to prevent accidental dislodgement)28. Mouth care to maintain moist oral membranes and lips and decrease risk of infection 29. Replace any humidification devices.Miscellaneous1. Aseptic technique must be used / sterile gloves must be worn:a. During dressing changes until the Tracheostomy wound is healed (has granulated)b. During Tracheostomy tube changes (non-disposable and disposable)c. During cleaning and sterilization of non-disposable Tracheostomy tubesd. During endotracheal suctioning2. Gloves must be used on both hands during any manipulation of the Tracheostomy and sterile gloves if aseptic procedure3. Mask and eyewear must be worn if splashes, splattering or spraying of body fluids or blood is likely to occur during procedure4. Tracheostomy tubes should be changed per order of the physician or a minimum of q 30 days.5. Non disposable Tracheostomy tubes will be cleaned and sterilized according to manufacturer's recommendations6. Tracheostomy care will be provided as ordered by the physician and as needed (if new Tracheostomy or infection is present required minimum of every 8 hours)7. Replacement Tracheostomy tube of the appropriate type and size must be available at the bedside or an obturator and curved hemostat in the event of accidental dislodgement or other emergencies.8. Suction machine (in working order) connecting tubing, a supply of size appropriate sterile catheters, flushing solution (sterile water / normal saline) and sterile and non-sterile gloves at the bedside at all times9. Protective masks and eyewear are indicated if resident is coughing, producing aerosolization during suctioning or exposure of mucous membranes of the mouth and nose are likely.10. Supplemental oxygen and Ambu bag with trach adapter must be at the bedside for emergency situations.

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	676009	A. Building B. Wing	12/04/2025

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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** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administration of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #42) of 7 residents reviewed for pharmacy services. -Resident #42's Tylenol was delivered on 12/02/2025 at 9:45a.m. when the physician's order said to administer it at 8:00a.m. The deficient practice could place residents at risk of not receiving the therapeutic effects from their medications as intended by the prescribing physician order.Record review of Resident #42's face sheet dated 12/02/2025, she was an [AGE] year-old female originally admitted on [DATE] with medical diagnoses including dementia (declining brain function related to thinking and judgement that is severe enough to impact daily life without behavioral disturbance, psychotic disturbance, mood disturbance), generalized anxiety disorder (excessive fear and worry), muscle wasting and atrophy of the left and right shoulders, depression (prolonged periods of sadness and hopelessness) and muscle weakness. Record review of Resident #42's MDS dated [DATE], Resident #42 had a BIMS score of 13, indicating high cognitive intactness. Record review of Resident #42's care plan dated 12/02/2025, she was care-planned for ADL self-care performance deficit and is at risk for further decline and injury related to dementia and impaired cognition with interventions including physical therapy and occupation therapy and treatment as per MD orders. Record review of Resident #42's Order Summary report dated 12/02/2025, revealed she had acetaminophen oral tablet to be given 500 milligrams by mouth three times a day for arthritis with an order date of 07/28/2025. Record review of Resident #42's individual order for acetaminophen, it had an order date of 07/28/2025 with scheduled times for 8:00a.m., 1:00p.m., and 5:00p.m. daily.Record review of Resident #42's MAR for December 2025 captured 12/02/2025 at 9:05a.m. revealed Resident #42 was documented as not having been administered Acetaminophen oral tablet 500 milligrams by mouth three times a day for arthritis for 12/02/2025. The MAR listed that Resident #42 was scheduled for pain medications at 8:00a.m., 1:00p.m., and 5:00p.m.Record review of Resident #42's pain assessment effective 12/02/2025 at 8:49p.m., revealed she was coded as hurts a whole lot related to pain or hurting in the last 5 days. Resident #42 was coded as having pain almost constantly and it had made it hard for her to sleep at night over the last 5 days. Resident #42 had chronic pain in the left shoulder. Her pain treatment was a lidocaine patch.Interview with Resident #42 on 12/01/2025 at 12:01pm, she said she did not get her pain medication on time on 12/01/2025 in the morning until 11:00a when she checked her clock and her medication was supposed to be given at 9:00am. Resident #42 said she had pain in her left shoulder and that it had felt better after the medication was administered, but she could not give a pain scale rating. Resident #42 said medication was sometimes delivered late. Interview on 12/02/2025 at 9:23am, Resident #42 said she did not think she got her medications that day.Interview on 12/02/2025 at 9:45am with MA A, she said that medication could be given one hour before and one hour after the order time. MA A said she was still administering medication in the other hall and was almost done, and she was going immediately to Resident #42's hallway. MA A said she had not administered Resident #42's medications on 12/02/2025. When asked if there could be any harm to residents if medication was not administered on time, she said she did not know. In a later attempted interview by phone on 12/04/2025 at 12:30pm, MA A did not return the call.Interview on 12/02/2025 at 5:00pm with the DON, she said she would ensure Resident #42 got her medications on time. On 12/03/2025, the DON said MA A told her that she spent a little long getting other residents' blood pressures which caused a delay in medication administration for Resident #42. The DON said if medications were due at 8:00 a.m ., then they would be able to take them as early as 7:00 a.m. and as late as 9:00 a.m. If the medications were given beyond the time range, residents could be at risk of increased pain. Resident #42 never reported to the DON or staff that she had pain. In a later interview (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676009	A. Building B. Wing	12/04/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 12/04/2025 at 1:49pm, the DON said that staff should follow physician orders for administering medications. Record review of the facility's policy on Administering Medications, undated, revealed in part, Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676009	A. Building B. Wing	12/04/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to send to the attending physician and the facility's medical director and director of nursing medication irregularity the pharmacist identified during review for 1 of 2 resident (Resident #23) reviewed for medication review.-The facility failed to act on Pharmacist's recommendation for Resident #23 ?s Baclofen. This failure could place residents at risk of adverse reaction related to taking medications.Record review of Resident #23's face sheet, dated 12/1/25, reflected a 72 -years -old female who admitted to the facility on [DATE] readmitted on [DATE]. His diagnoses included long term (current) drug therapy, muscle wasting and atrophy in right and left thigh, muscle weakness, insomnia, muscle wasting and atrophy, major depressive disorder, constipation, vitamin d deficiency, difficulty in walking, displaced comminuted fracture of shaft of left tibia (fracture of the lower leg bone), displaced comminuted fracture of shaft of left fibula (fracture of the outer leg bone), other specified disorders of bone density and structure, multiple sclerosis (a chronic disease of the and spinal cord where the immune system mistakenly attacks and damages myelin the protective coating of nerve fibers disrupting signals between the brain and body), unspecified dementia (declining brain function related to thinking and judgement that is severe enough to impact daily life without behavioral disturbance, psychotic disturbance, mood disturbance), and anxiety (a feeling of worry, unease or fear about an upcoming event).Record review of Resident #23's quarterly MDS assessment, dated 11/3/25, reflected a BIMS score of 14 out of 15, which indicated intact cognition. Record review of Resident #23's Physician's Orders for 2/11/2025 reflected an order for Baclofen oral tablet 10 mg to be given 3 tablets (30mg) by mouth three times a day for muscle spasm.Record review of Resident #23's MAR dated 12/1/25 reflected that Baclofen oral tablet 10 mg. Give 3 tablets (30mg) by mouth three times a day for muscle spasm.Record review of the pharmacist's review dated 2/16/25 revealed According to Long-term Care Drug Monitoring Regulations, our review of the above Patient's Chart identifies the following as requiring your attention: Baclofen 30mg TID (three times daily). Please evaluate and verify the desire to utilize a muscle relaxer. According to CMS(Center Medicare and Medicaid Service) this medication is considered inappropriate for use. The rational is ?.For the most part, these are poorly tolerated by older individuals, leading to anticholingergic (any substance that blocks a key neurotransmitter that works for a functioning central and peripheral nervous system) side effects, sedation, increased risk of fractures and weakness'.Record review of Resident #23's progress notes, (2/16/25) revealed there was no documentation that the doctor and DON were aware of the pharmacist's review.Interview with the DON on 12/3/25 at 12:30p.m., she said she was not aware of it, she was seeing the pharmacist's recommendation the first time. DON said the ADON who no longer worked for the facility was responsible for notifying the doctor about the recommendation. The DON said not following the recommendation could cause drug over dose and falls.Record review of the facility policy of the undated Medication Regimen Review, revealed, Policy StatementThe Consultant Pharmacist shall review the medication regimen of each resident at least monthly.Policy Interpretation and Implementation.1. The Consultant Pharmacist will perform a medication regimen review (MRR) for every resident in the facility.2. Routine reviews will be done monthly.3. The Consultant Pharmacist will perform a medication regimen review (MRR) for every resident in the facility.4. Routine reviews will be done monthly.5. Reviews for short-stay individuals (those who are expected to stay for 30 days or less) will be done as needed to identify individuals with high-risk medications and those who may be experiencing adverse consequences from their medications.6. Additional reviews for long-stay individuals will be done as indicated or as requested by the Physician and staff to help manage drug regimens and identify and address suspected or confirmed adverse consequences.7. The primary purpose of this review is to help the facility maintain each resident's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Treemont Health Care Center	2501 Westerland Dr Houston, TX 77063

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible.8. As part of the MRR, the Consultant Pharmacist will:3. Evaluate whether any medications in a drug regimen present potentially significant drug-drug or drug-food interactions;4. Determine if the resident is receiving the correct medications as ordered.5. Determine if medications are administered at the prescribed times;6. Determine if medications are administered in the correct dosage and form.7. Be alert to medications with potentially significant medication-related adverse consequences and to actual signs and symptoms that could represent adverse consequences; and8. Identify medication errors, including those related to documentation.7. The Consultant Pharmacist will document his/her findings and recommendations on the monthly drug/medication regimen review report.8. The Consultant Pharmacist will provide a written report to physicians for each resident with an identified irregularity. If the situation is serious enough to represent a risk to a person's life, health, or safety, the Consultant Pharmacist will contact the Physician directly to report the information to the Physician, and will document such contacts. If the Physician does not provide a pertinent response, or the Consultant Pharmacist identifies that no action has been taken, he/she will then contact the Medical Director, or-if the Medical Director is the Physician of Record-the Administrator.9. The Consultant Pharmacist will provide the Director of Nursing Services and Medical Director with a written, signed and dated copy of the report, listing the irregularities found and recommendations for their solutions.10. Copies of drug/medication regimen review reports, including physician responses, will be maintained as part of the permanent medical record.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents were free of significant medication errors for 1 (Resident #23) of 9 residents reviewed for pharmacy services.-MA A did not administer Carvedilol (medication used to help your heart by lowering blood pressure) with meals to Resident #23 as ordered by the physician on 12/2/25.This failure could place residents at risk of adverse reaction related to taking medications not ordered by the physician. Findings included:Record review of Resident #23's face sheet, dated 12/1/25, reflected a 72 -years -old female who admitted to the facility on [DATE] readmitted on [DATE]. His diagnoses included long term (current) drug therapy and unspecified dementia (declining brain function(memory , thinking ,judgement) severe enough to impact daily life without behavioral disturbance, psychotic disturbance, mood disturbance.Record review of Resident #23's quarterly MDS assessment, dated 11/3/25, reflected a BIMS score of 14 out of 15, which indicated intact cognition. She required assistance from staff with ADL care. She needed extensive assistance of 1-2 staff for ADLs.Record review of Resident #23's Physician Order Report for 02/11/2025 revealed an order for Carvedilol Oral Tablet 3.125 MG (Carvedilol) Give 1 tablet by mouth three times a day for blood pressure with meals HOLD FOR SBP>10, HR>60.In an observation on 12/2/25 at 4:51 p.m., MA B prepared and administered Carvedilol 3.125 mg tablet 1 tablet from the blister packet which had instructions for the medication as, Take with meal. In interview on 12/2/25 at 4:56p.m., MA B was asked if Resident #23 has had eaten, MA B said, not yet, the diner tray comes at 5:30 p.m. and he did not give Med Pass shake because Resident #23 would gain too much weight. MA B was shown the blister packets of Carvedilol 3.125 mg tablet (that indicated to be given with meals), MA B said, I did not read that, I am very sorry.In an interview on 12/4/25 at 11:12 a.m., the DON said prior to administering the medication aide should get clarification from the nurse if the order did not appear correct. She said the amount administered did not match the order and the order was not clear. DON said staff had a checkoff for med pass this year. We pop up on their cart from time to time to check med pass. Her expectation was for staff to look at MAR to administer medication. The DON said MA B should not change medication times at his or the resident's convenience but to follow physician orders. If there were any issues he should have told the charge nurse and they could have followed up with the physician.In an interview on 12/4/25 at 11:12 a.m. the Administrator said she expected nursing staff to give medications timely, correctly, and according to the physician orders.Record review of the facility's Administering Medications policy, undated read in part Policy Statement.Medications shall be administered in a safe and timely manner, and as prescribed.The individual administering the medication must check the label carefully to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interview and record review, the facility failed to dispose of garbage and refuse properly for 1 of 1 dumpster reviewed for Food and Nutrition Services.-The facility dumpster lids and doors were not secured.This failure could place residents at risk of infection and a decreased home-like environment from pests and rodents. Observation on 12/05/2025 at 8:45 a.m., revealed the facility's dumpster area, which was in the lot behind the dietary department had a commercial -size dumpster 3/4 full of garbage and the door was wide open.In an interview with the dietary food manager on 12/05/2025 at 9:20 a.m., with the dietary food manager, he stated that the dumpster doors must be closed to keep vermin, pests, and insects out of the dumpster from entering the facility. He also stated that he will in service dietary staff, nursing, housekeeping and maintenance that the dumpster door was to be closed for proper sanitation and residents' safety. In an interview with the DON and the Administrator on 12/02/2025 at 5:00p.m., the Administrator said the dumpster should not have been open. The [NAME] said waste could come out of the dumpster and animals could come in and spread the trash and infection around. The Administrator said a risk could be residents going into the dumpster and possibly climbing in there.Record review of facility policy and procedures on waste disposal undated revealed that .food related garbage and rubbish is disposed of in accordance with current laws and regulations. The outside dumpster provided by garbage pickup service will be kept closed and free of surrounding liter.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 1 of 4 residents (Resident #55) and 1 of 3 staffs (CNA A) reviewed for infection control. -The facility failed to ensure CNA A performed hand hygiene including washing hands before wearing gloves before incontinent care and washing hands between glove change during incontinent care on Resident #55.This failure could place residents at risk for spread of infection and cross contamination to residents causing resident illness and/or distress. Record review of Resident #55's face sheet dated 12/03/2025 revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. His medical diagnoses included acute kidney failure, benign prostatic hyperplasia (a common, non-cancerous enlargement of the prostate gland in aging men leading to urinary issues like weak stream, frequent urination urgency, and difficulty emptying the bladder) with lower urinary tract symptoms.Record review of Resident #55's admission MDS assessment, dated 11/30/25, reflected a BIMS score of 13 out of 15, which indicated intact cognition. He required assistance from staff with ADL care. The MDS revealed in section H0300: Urinary continence was coded as always continent. Section H0400: Bowel Incontinence was coded as always incontinent. Record review of Resident #55 's care plan, dated 11/27/25, reflected, . The resident had an ADL self-care deficit .Interventions .Personal hygiene and Toilet use- Resident is totally dependent . Resident #55 was also care-planned for a foley catheter/incontinent care, with interventions including following physician orders for catheter insertion, changes and maintenance.Review of Resident #55's Physician orders from 11/25/2025 through 12/1/2025 reflected orders for the following:-Foley Catheter cleansing and perineal hygiene daily and as needed soiled, using a catheter securing device with a start date of 11/25/2025. During observation rounds on 12/1/25 at 6:45 AM, Resident #55 had an Enhanced Barrier Precaution sign posted on the entered door. Observation on 12/02/25 at 5:04 PM of Resident #55's Foley Catheter and incontinent care with CNA A, CNA A did not don PPE before she picked a cleaned brief and wet wipes and placed the items on Resident #55's bed. She donned clean gloves without washing hands, unfastened the residents soiled brief, and used wet wipes to clean Resident #55's penis, Foley catheter tubing and his groin. She did not cleaned his scrotum and buttocks. CNA A placed a cleaned brief under the resident changed gloves without washing hands and don clean gloves. In an interview with CNA A on 12/02/24 at 5:41 p.m., she said she only wears PPE while assisting the nurses with dressing change. She said she did have in-service about using PPE usage to prevent infection to her and the resident. C.NA A said she forgot to wash her hands. Review of the facility's policy titled Enhanced barrier precautions not dated: .Policy.It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Definitions. Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).Policy Explanation and Compliance Guidelines. 1. Prompt recognition of need: a. All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. B. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions. C. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves.Record review of the facility's Hand Hygiene policy (Revised 6/2019) revealed read in part: .It is the policy of this facility that proper hand hygiene/hand washing technique will be accomplished at all times that handwashing is indicated. Hand Hygiene/Hand washing is the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	most important component for preventing the spread of infection. Procedure: After: After removal of medical/surgical or utility gloves. NOTE: Wash hands at end of procedures where glove changes are not required. For procedures in which change of gloves, e.g., clean gloves to sterile gloves, is indicated follow the specific standard of practice. However, hand washing may not be necessary until completion of the procedure. If glove hands become contaminated as gloves are changed hands can be washed. Contact with a patient's/resident's intact skin (e.g. taking a pulse or blood pressure, performing physical examinations, lifting the patient/resident inn bed .Record review of the Infection Control Program (Revised 2/2022) revealed read in part: .Policy: Evidence-based policies and procedures are the foundation of a facility's infection control and prevention program. Goals: A Decrease in the risk of infections and communicable diseases to residents, employees, volunteers, and visitors .