Printed: 11/21/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Concierge	2310 South Eldridge Parkway Houston, TX 77077

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary services to maintain grooming and personal care for 2 (Resident #2 and Resident #1) of 7 residents reviewed for ADL care, in that: - The facility failed to ensure Resident #2 was provided personal grooming (dry patches and flaky skin) by facility staff. - The Facility failed to give Resident #1 his schedule showers on Tuesday, Saturday, and Saturday on a consistent basis. These failures placed resident a risk for skin break down, offensive odors, and decrease in quality of life. Findings: Resident #2 Record review of Resident #2's face sheet dated 03/03/25 revealed a [AGE] year-old male was admitted to the facility on [DATE]. Resident #2 had diagnoses included: human immunodeficiency virus disease (virus that damages the body's immune system.), hypertension (blood pushing against the artery walls is consistently too high) and cerebral infarction (strike that occur when blood floor to the brain is blocked). Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed Resident BIMS was 04 which indicated severely impaired cognition. Resident #2 depended on staff with ADL assistance with one to two staff assistant. Record review of Resident # 2's care plan revision on 03/05/25 revealed Resident #2 had ADL self-care performance deficit related to confusion, and limited mobility. Interventions: bathing: The resident is totally dependent on staff to provide a bath as necessary. Personal hygiene : The resident requires total assistance with personal hygiene care (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: 676066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Concierge		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 South Eldridge Parkway Houston, TX 77077	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's NP's progress note dated 03/03/25 revealed NP saw Resident #2 and did not document any issues on the Resident #1's skin and toenails. During an observation on 03/05/25 at 9:43 a.m., during wound care, it revealed Resident #2 had ashy dry patches and flaky skin from below the knee, but from the ankle to the sole of the feet had more caked-up dry skin. During an interview on 03/05/25 at 10:22 a.m., the Wound care nurse said Resident #1 had ashy, dried skin; some skin was flaking off, and others were caked up from below the knee to the soles of his feet. The wound care nurse said Resident #2 had more dried patches of skin on the top and bottom of his feet and had some flaky skin around the pressure ulcer on both heels. She said Resident #2 had dry, flaky skin that could cause the Resident #2 skin to crack, which could cause an open wound. The Wound care nurse said Resident #2's baseline was dry skin because his skin had been dry and flaky since she started working in the facility. The Wound care nurse said she had not reported Resident #2 dry skin on the legs to the floor nurse or the DON. The Wound care nurse said she had not had any skills check-off or in-service on skin assessment in this facility. The wound care nurse said she did not know who monitored the nurse to ensure the nurse provided care for the resident. The Wound care nurse said the charge nurse monitored the aides during rounding. During an interview on 03/05/24 at 10:45 a.m., LVN V said she was Resident #2's nurse. LVN V said the aides shower Resident #2 and should apply lotion on the resident on shower days and daily. LVN V said none of his aides reported to her that Resident #2 skin was dry. LVN V said she did not notice Resident #2 skin was dry when she worked with her yesterday, and none of the aides from yesterday told her Resident # 2 was dry and flaky. LVN V said she just saw Resident #2's skin; his skin was ashy and dry, and some skin was flaking off from below his knees to his feet. She said if Resident #2's skin was not taken care of, it could cause the skin to crack and open, which could cause skin breakdown. She said the charge nurse monitored the aides, and the nurse managers monitored the nurse during random rounding. During an interview on 03/06/25 at 10:10 a.m., the NP said he was unsure if the facility notified him that Resident #2 skin was dry and flaky. The NP said he suspected Resident #2 had vascular diseases and the skin would be dry and flaky; even after staff applied lotion, it would not stop the resident skin from being dry and flaky. The NP said he may order lotion for the resident and see if it helps. The NP said if Resident #2's skin continues to be dry and flaky, the area could open and get infected. During an interview on 03/06/25 at 11:41 a.m., the DON said Resident #2 had dry and scaley skin on his legs and feet. The DON said none of the staff told her about Resident #2's dry skin. The DON said she would have told the staff to clean the skin and apply lotion on the skin daily. The DON said the wound care nurse does skin assessment for Resident #2 on Wednesdays, and she should have documented that Resident #2's skin was dry and flaky and notified the floor nurse that Resident #2's skin was dry and flaky. The DON said the nurse manager for the unit monitors the nurses during random rounding while the floor nurse monitors the aides during rounding. She said the nurse had a skills - check upon employment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Concierge		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 South Eldridge Parkway Houston, TX 77077	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/06/25 at 12:46 p.m., CNA R said she had been working in the facility for a month, and Resident #2 skin had been dry and flaky below the knees to his feet. CNA R said she did not tell the nurse or DON because she thought that the dry and flaky skin was normal for Resident #2. CNA R said the floor nurse monitored the aides when she made random rounds. CNA R said when she gave Resident #2 a bed bath on his shower days, she applied the facility lotion on the resident, but it did not relieve the dry skin. She said Resident #2 was dry and flaky, and his skin would break down. During an interview on 03/06/25 at 1:23 p.m., the unit manager said none of the staff told her Resident #2 had dry skin. The unit manager said Resident #2's skin would crack if the aides did not apply lotion on shower days and as needed. The Unit Manager said the floor nurse monitored the aides during rounding throughout the nurse's shift, while the nurse managers monitored the nurses during random rounding. RESIDENT #1 Record review of Resident #1's face sheet dated 03/06/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident diagnoses included: neurogenic bladder (lack of urine control), cerebral aneurysm (a weakness in a blood vessel in the brain that balloons and fills with blood), subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain), epilepsy (seizures), central cord syndrome (spinal cord injury), pain, and weakness. Record review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 9 indicating that resident cognition was moderately impaired. Further review section GG Functional Abilities reflected that resident had limitations in range of motion to upper and lower extremities and was dependent upon staff for showers/bath self. Record review of Resident #1's Comprehensive Care Plan dated 07/01/24 and revised 03/05/25 reflected that resident was being care planned for ADL self-care performance deficit r/t limited mobility. The intervention included transfer: the resident requires total assistance with transfer. Further review of Resident #1's care plan did not reflect resident being care planned for refusing showers. Observation on 03/05/25 at 12:42PM on Sage 2 Unit revealed Resident #1 at the bed side sitting up in wheelchair. Interview on 03/05/25 at 12:42PM with Resident #1 said he was supposed to receive showers on Tuesday, Thursday, and Saturdays. Resident said the last time he had received a shower was on last Thursday (02/27/25) but did not receive his shower on Tuesday 03/04/25. Resident said he received his showers on the evening shift between 4:00PM-6:00PM. Resident said he had not been receiving his showers 3 times a week consistently. Resident said when the staff did not provide him with a shower, they would just say they did not have the time and was busy. Resident said he could not remember the CNA told him that. Interview on 03/06/25 at 2:08PM with RN A for the 6am-2pm shift said when the CNA's provide the resident with a shower, the nurse will sign the shower sheet that it had been done or refused. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Concierge	2310 South Eldridge Parkway Houston, TX 77077

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #1's shower sheet for the month of February 2025: -02/04/25(Tuesday), -02/08/25 (Saturday) and -02/15/25 (Saturday) reflected that resident did not receive a shower on the following days and RN C was working on these following days: Record Revie of Resident #1's shower sheet for the month March 2025 reflected that resident did not receive a shower on 03/04/24 (Tuesday). Interview on 03/06/25 at 2:12PM with LVN B said she worked the 2PM-10PM shift and that the only place that she was aware of where the CNA document that they had provided a resident with a shower was on the shower sheet. LVN B said the nurse would sign the sheet indicating that the resident received their shower or not. LVN B said she ensured that the resident's was receiving their schedule showers by asking the CNA's and sign her signature in the shower book. LVN B said if the resident was not receiving their schedule showers it placed the resident at risk of feeling uncomfortable and it could compromise their skin integrity. Interview on 03/06/25 at 2:27PM with nurse RN C said he worked at the facility on Sage 2 Unit providing care for residents in rooms 85-96 full time on the evening shift 2PM-10PM shift. RN C said he had been working at the facility for a month and 1 week. RN C said when the CNAs came on duty, he provided them their shower assignment. RN C said he signed the shower sheet indicating if the resident had a shower or refused their shower. RN C said after reviewing the shower sheets for Resident #1, he said Resident #1 sometimes refused his showers because of exhaustion or pain. When RN C was asked whenever resident was in pain or exhausted, did he medicate for the pain or if resident was exhausted, did he allow resident to rest and revisit Resident #1 to provide a shower. RN C did not answer the question asked. Further interview with RN C said when residents were not provided their showers on a consistent basis, it placed the resident at risk for skin ailments such as skin break down, odor, and not feeling good about themselves. RN C said if resident care was not documented, it was considered not done. Record Review of Resident #1's POC reflected no documentation of resident refusing their showers. Interview on 03/06/25 at 3:48PM with the DON said after reviewing Resident #1's POC, the DON said it did not reflect resident refusing his showers. The DON said when a resident was not receiving their showers on a consistent basis, it could place resident at risk for skin breakdown, odors, and cause psychological effects due to the resident not feeling clean or good about themselves. The DON said the facility would have to work on ensuring all residents received their schedule showers on a consistent basis and documenting not only on the shower sheet butt in the POC as well. The DON said the unit nurses were supposed to make sure that the CNA's were giving the residents their schedule showers and the Unit Manager was supposed to be following up to ensure that this was being done. Interview on 03/07/25 at 8:09AM Resident #1 said when he did not receive his showers, it made him feel itchy and unclean because he sweats a lot. Resident #1 said he received his shower on 03/06/25 and that the CNA that provided him the shower was the same CNA that was making up excuses why she could not shower him. Record review of Resident #1's shower sheet revealed the CNA who provided Resident #1's shower was CNA D. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Concierge	2310 South Eldridge Parkway Houston, TX 77077

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/07/25 at 8:20AM with the Unit Manager said she was the only unit manager at the facility. The Unit Manager said she was supposed to check the shower sheets but sometimes she missed checking them. The Unit Manager said it was really the Unit Nurses that was supposed to check the resident shower sheets and sign them to ensure residents were receiving their showers three times a week. The Unit Manager said she was the back-up to ensure that it was being done. 03/07/25 at 8:55AM An attempted interview via phone with CNA D, no answer, left a voicemail with a call back number. CNA D did not return the call prior to the exit. Record review of the facility policy on Activities of Daily Living (ADL), Supporting revised March of 2018 reflected in part: .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Concierge		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 South Eldridge Parkway Houston, TX 77077	

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure residents received proper treatment and care to maintain mobility and good foot health for one (Resident #2) of four residents reviewed for food care. Resident #2 was not seen by a podiatrist for long, thick, and deformed toenails. This failure placed residents at risk of not receiving foot care consistent with professional standards of practice. Findings included: Record review of Resident #2's sheet dated 03/03/25 revealed a [AGE] year-old male was admitted to the facility on [DATE]. Resident #2 had diagnoses included: human immunodeficiency virus disease (virus that damages the body's immune system.), hypertension (blood pushing against the artery walls is consistently too high) and cerebral infarction (strike that occur when blood floor to the brain is blocked). Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed Resident BIMS was 04 which indicated severely impaired cognition. Resident #2 depended on staff with ADL assistance with one to two staff assistant. Record review of Resident # 2's care plan revision on 03/05/25 revealed Resident #2 had ADL self-care performance deficit related to confusion, and limited mobility. Interventions: bathing: The resident is totally dependent on staff to provide a bath as necessary. Personal hygiene: The resident requires total assistance with personal hygiene care. Record review of Resident #2's NP's progress note dated 03/03/25 revealed NP saw Resident #2 and did not document any issues on the Resident #1's skin and toenails. Record review of Resident #2's podiatrist report dated 03/05/25 read in part . assessment: Onychomycosis(nail fungus) Callus (thick, hardened layer of soft skin)of foot Atherosclerosis(fatty deposits build up inside of an artery))of native arteries of extremities with intermittent claudication, bilateral legs . Patient complaints of long, painful, thick, toenails . DERMATOLOGICAL EXAM: Skin appear to be dry, wrinkled, flaky, with mild cracks . Toenails are noted to be discolored, dystrophlc(poor or degeneration of muscle or tissue), long, thick, with subungal(beneath toenail) debris and periungal (occurring around toenail) skin redness and irritation on toes 1-5 on the right and left foot. Remaining nails are dystrophic . Mycotlc(caused by a fungus) nails debrlded(removal of damagedor infected tissue,) x 1O with sharp nail nippers Calluses debrided with tissue [NAME] without . During an observation on 03/05/25 at 9:43 a.m. revealed all of Resident #2's toenails were long, calcified, and discolored (Khaki brown). The right second-foot toe was long, curved downward, and touched the skin. The third toenail on the right foot toe was long and pointed upwards, while the other toes on the right foot were long and pointed forward. All the toenails on the left foot were long and pointed forward. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Concierge		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 South Eldridge Parkway Houston, TX 77077	

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/05/25 at 10:35 a.m., the Wound care nurse said some of Resident #2's toenails on both feet were long while some were straight; one was growing upward, and one was coved downward. She said the podiatrist cut the resident's toenails. She said she told the social worker about the residents' toenails for about two weeks, and podiatry comes to the facility once every three months. The Wound care nurse said Resident #2's toenails had been long since she started working (December 19, 2024). The Wound care nurse said Resident #2 could scratch himself with long toenails and could get a fungi infection if the podiatrist and the staff did not provide proper foot care to Resident #2. She said she did not have a skills check on nail care or in-service and did not know who monitored the nurses. During an interview on 03/05/24 at 10:45 a.m., LVN V said she saw Resident #2's toenails were long and discolored, and she had not reported it to the unit manager or SW (social worker). LVN V said if Resident #2 hits his toenails, it could cause injury. LVN V said she had a skills check-off on skin and toenails. LVN V said if the staff did not provide foot care for Resident #2, his toenails could crack, and the resident could get infected. LVN V said Resident #2's toenails had been long since she started working in the facility (November 2024). LVN V did not respond when asked why she did not report to the nurse managers or social worker that Resident #2's toenails were long. During an interview on 03/05/25 at 1:50 p.m., the Podiatrist said the social worker texted around 11:00 a.m. It was the first time the facility informed him about Resident #2's toenails. He said the SW texted him about Resident #2 and asked if he could see him today. She sent Resident #2's face sheet to his office, and his office said they do not accept his insurance, and the SW said the administrator said the facility would pay. The Podiatrist said Resident #2 had long sub-fungal toenails. He said he took care of Resident #2's toenails; they look good now. He said you could read the notes, and he gave the hard copy to the administrator. He said if he had been notified earlier, he would have taken care of Resident #2's nails before now, and maybe he would not have tiny cracks and fungi. During an interview on 03/06/25 at 9:01 a.m., SW said she was unaware Resident #2's toenails were long until yesterday, when the administrator notified her to inform the podiatrist to come yesterday and cut Resident #2's feet. During an interview on 03/06/25 at 9:13 a.m., the Administrator said the wound care nurse told him that Resident #2's toenails were long, and he told the SW to contact the podiatrist on 03/05/25. The Administrator said if Resident #2 had long nails with fungus and if it was not treated promptly, the fungus infection could worsen. He said the unit managers and DON monitored the nurses. The Administrator said the facility offers foot care from a podiatrist as needed because most residents are short-stay. During an interview on 03/06/25 at 10:10 a.m., the NP said he was not aware Resident #2's toenails were long and had fungus. He said if the facility had notified him, he would written a consult for the podiatrist before yesterday (03/05/25). During an interview on 03/07/25 at 7:46 a.m., the DON said none of the nurses or aides told her Resident #2 had long toenails, and if she knew, she would have asked the nurse to get a podiatrist consult before Wednesday (03/05/25). The DON said if the staff and podiatrist had provided foot care for Resident #2 earlier, it would have prevented fungus infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Concierge		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 South Eldridge Parkway Houston, TX 77077	

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy on foot care dated 2001 MED - PASS, Inc (revised February 2018) read in part .the purpose of this procedure are to clean, trimmed nails, and prevent infection . Record review of the facility policy on foot care dated2001 MED - PASS, Inc (revised October 2022) read in part . residents receive appropriate . care and food health .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Concierge	2310 South Eldridge Parkway Houston, TX 77077

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 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on record review and interview, the facility failed to maintain medical records in accordance with accepted professional standards and practices that were accurately documented for 1 of 5 (Resident #7) residents reviewed for accurate medical records.

-LVN C and LVN D failed to document why Resident #7's Tramadol Hcl Oral Tablet 100 MG for pain every 8 hours was not given on 2/13/2025 at 2:00am and 10:00am.

This failure could place residents at risk of having care provided based on inaccurate monitoring and documentation.

Findings included:

Record review of Resident #7's face sheet, she was a [AGE] year-old female originally admitted on [DATE] and last admitted on [DATE]. Her medical diagnoses included: encephalitis (inflammation of the brain, often due to infection) and encephalomyelitis (inflammation of the brain and spinal cord), dysphagia (difficulty swallowing), and cognitive communication deficit. She passed away on 02/13/2025.

Record review of Resident #7's care plan. she had a focus area for potential for alteration in comfort r/t pain, with interventions including administering pain control medication as ordered, monitor for effectiveness of medication and notify MD (doctor) if ineffective and side effects/adverse reaction from pain med.

Record review of Resident #7's Physician Orders, she had orders for Tramadol HCl Oral Tablet 100 MG, give 1 tablet by mouth three times a day for Pain Every 8 hours with a start date of 02/09/2025.

Record review of Resident #7's progress notes for February 2025, there was no reason documented on 2/13/2025 for why Resident #7 did not receive her Tramadol HCl Oral Tablet 100MG.

Record review of Resident #7's MAR/TAR for February 2025 revealed on 2/13/25 at 2:00 AM a code of 9 and on 02/13/25 at 10:: AM a code of 5 documented for Resident #7's Tramadol Hcl Oral Tablet 100 MG for pain every 8 hours. .5=Hold/See Nurse Notes and 9=Other/See Nurse Notes

Interview with LVN A on 3/6/2025 at 1:00pm, she said that she must have held the medication for Resident #7 on 2/13/2025 at 10:00am due to her nearing passing away and that the doctor had ordered that her medications be administered sublingually (medication placed below the tongue and dissolved) but was unable to locate her notes. She said she normally documented reasons for why medication was not given and telling the resident's NP or Physician.

Interview with the Unit Manager on 3/6/25 at 2:00pm, she said that nurses should be documenting in a resident's progress notes why medication was held so that everyone can know what happened, if medication was spit out or not.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Concierge		STREET ADDRESS, CITY, STATE, ZIP CODE 2310 South Eldridge Parkway Houston, TX 77077	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 3/6/25 at 3:55pm, she said that the nurses should have gotten an order from the physician to put Tramadol on hold or discontinued since Resident #7 had been on Morphine for her pain. If Resident #7 took Tramadol and Morphine at the same time that could have caused drowsiness. Record review of the facility's Administering Medications policy last revised April 2019 reflected in part, Medications are administered in accordance with prescriber orders, including any required time frame. 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 will contact the prescriber to discuss the concerns.