STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676111	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Buckingham	8580 Woodway Drive 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 1 (CR#3) of 6 residents reviewed for comprehensive care plans. The facility failed to ensure that CR #3 had a comprehensive care plan that included all care areas triggered on her assessment. This failure could place all residents at risk of not receiving proper care and services to develop and improve their mental, physical and psychosocial well-being. Record review of CR#3's admission face sheet dated 7/18/2025 revealed she was an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included cancer (a disease in which abnormal cells divide uncontrollably and destroy body tissues), coronary artery disease (buildup of plaque that causes narrowing of the arteries), heart failure (a chronic condition in which the heart doesn't pump blood), hyperlipidemia (high levels of fat in the blood), gastro esophageal reflux disease (a condition where stomach content flows back in the esophagus), protein calorie malnutrition (insufficient intake of both calorie and protein in the diet), anxiety disorder, respiratory failure (occurs when the lungs can't properly exchange gases oxygen and carbon dioxide). Record review of CR #3's admission MDS dated [DATE] revealed she was coded as having a BIMS score of 13 indicating she was cognitively intact and was occasionally incontinent of bladder and continent of bowel. Further record review revealed CR#3 was triggered for incontinence, pressure sore, pain, falls, ADLs and psych meds. Record review of CR#3's physician's order dated 6/6/2025 revealed an order for Sertraline 25 mg by mouth once a day for anxiety. Record review of CR #3's care plan initiated 6/05/2025 and revised on 6/16/2025 revealed it did not address anti-anxiety medication Sertraline. In an interview on 7/31/2025 at 4:00pm with MDS Coordinator A she confirmed the care plan did not address anti-anxiety medication sertraline. She said the program they were currently using was new and they were trying to work with it. She said the MDS was the main tool to guide them to develop an accurate and complete care plan. She said they were working on looking at the care plan as soon as they were admitted . She said because most of the residents were short stay residents, they must address all care areas as soon as possible. She said they were going to try and ensure that all triggered areas were captured on the care plans to ensure residents' care needs were addressed. Record review of the facility policy and procedures dated March 2022, Care Plans, Comprehensive Person-Centered read in part.Policy StatementA comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Policy Interpretation and Implementation1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 6 residents (CR#2) reviewed for services.The facility failed to ensure CR#2 received pressure sore treatment as ordered by the physician. These failures could place residents at risk of worsening of their pressure sores due to not getting the treatment as prescribed by the physician. Record review of CR#2's admission face sheet dated 7/1/2025 revealed an [AGE] year-old female who was admitted to the facility on [DATE] and was discharged on 6/24/2025. Her diagnoses included cellulitis of the right lower limb, cellulitis unspecified (spreading skin infection that affects mostly the lower leg), urinary tract infection (infection in the urinary system), pain (physical discomfort ranging from mild to severe and usually cause by illness or injury), dizziness and giddiness (feeling of lightness or unsteadiness), history of falling, anemia(a condition in which the blood doesn't have sufficient red blood cells), hypothyroidism (a condition where the thyroid gland doesn't produce enough thyroid hormones) and mild protein calorie malnutrition (deficiency or excess of energy, protein, and other nutrients). Record review of CR#2's admission MDS, dated [DATE], revealed CR#2 had a BIMS score of 15, which indicated she was cognitively aware. She was coded as continent of bowel and bladder and had no pressure sores. For ADL's she needed set up only for eating, for toileting and shower she needed partial assistance, oral hygiene, lower body and putting on footwear and personal hygiene the resident needed supervision. Skin condition was coded was coded as high risk for pressure. Record review of CR#2's care plan, dated 6/18/2025, revealed the resident had for therapeutic treatment regimen related to a primary diagnosis which included: Right Leg Cellulitis. Skilled nursing and rehabilitation services needed to addressed diagnosis management and functional declines for safe transition back to preferred community and had potential risk for falls related to the following factors: muscle weakness, decreased balance, unsteady gait, lack of coordination, impaired mobility and needs assistance with ADLs. Record review of CR#2's physicians order, dated 06/20/2025, revealed the following order for wound care: Wound Care Plan: Cleanse right leg with wound cleanser, pat dry, cover with Xeroform, wrap with kerlix, secure with tape daily and PRN. (Dx: Cellulitis, unspecified. Start date 6/20/2025 -06/24/2025). Record review of CR#2's nurse's notes, dated 06/24/2025, revealed the following documentation: While performing wound care for the patient, this nurse observed that the dressing had not been changed since the 21st. Once the dressing was cut, this nurse observed that the wound appeared reddened, swollen, and warmer than the surrounding skin, but there was no bleeding. The affected foot presented with +2. Record review of CR#2's treatment administration record revealed documentation wound treatment was signed by RN E as being done on 6/21/2025, 6/22/2025 and LVN C as done on 6/23/2025. Record review of an email from the facility, dated 7/2/2025, revealed: Upon review of the TAR of patient CR#2 and clarification conversation with nurse RN E, treatment was provided on 06/22/2025. In an interview on 7/01/2025 at 2:30 PM with LVN B via telephone he said he was the nurse who wrote in CR#2's clinical records on 06/24/2025. He said he was providing wound care treatment to the resident and when he was removing the soiled dressing from CR#2's foot he noticed it was dated 6/21/2025. He said the wound at the time appeared reddened, swollen, and warmer than the surrounding skin, but there was no bleeding. He said he called the NP and described what he saw, and she gave him orders for the resident to be sent to the ER for evaluation. In an interview on 07/01/2025 at 2:40 PM via telephone with RN E, she said she was the nurse who worked on 6/21/2025 and 6/22/2025 and she was the nurse who was responsible for wound care treatment for CR#2. She said she provided wound care treatment for CR#2 on 6/21/2025. She said she also work with CR#2 on 6/22/2025. She said she was supposed to provide treatment to CR#2's foot on 6/22/2025 but she did not provide the treatment, because the resident had family visitors, and she did not get a chance to do the treatment. She said she documented in error on 6/22/2025 that the treatment was done but it was not done. She said when she realized the treatment was not done, she tried to correct the documentation, but she could not make corrections because the system they were currently working with was new and she did not know how to do the corrections. She said when she realized she could not correct the documentation she wrote a note to the DON, slipped it under her office door asking her to correct the documentation for her. In an interview on 7/1/2025 at 2:50 PM with LVN C, she said she worked with CR#2 on 6/23/2025 and she did her wound treatment. She saidCR#2 had cellulitis, and she was sure she did the wound treatment for her

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure services were provided or arranged by the facility, as outlined by the comprehensive care plan that met professional standards of quality for 2 of 6 residents (Residents #1 and Resident#3) reviewed for services. 1. The facility failed to ensure Resident #1 and Resident #3 received pressure sore treatment as ordered by the physician. These failures could place residents at risk of worsening of their pressure sores due to not getting the treatment as prescribed by the physician. 1. Record review of Resident #1's face sheet revealed an [AGE] year-old male originally admitted to the facility on [DATE]. His medical diagnoses included hyperlipidemia (high levels of fat in the blood), muscle weakness (decreased strength in the muscles), anemia (a condition in which the blood doesn't have sufficient red blood cells), pneumonia (inflammation of the air sacs), sepsis due to Escherichia (a serious condition where the body's immune response to an E. coli infection becomes dysregulated), urinary tract infection (is infection in the urinary system), severe protein calorie malnutrition (deficiency or excess of energy, protein, and other nutrients), hypertension (high blood pressure), hemiplegia (muscle weakness or partial paralysis on one side of the body), acute respiratory failure with hypoxia (a condition where the lungs cannot provide enough oxygen to the blood), pressure ulcer of the sacral region stage 4 (a wound that extends through the skin and subcutaneous tissue, exposing muscle, tendon or bone), Chronic osteomyelitis (a rare autoimmune disease that causes bone inflammation of the bone), and shortness of breath (difficulty breathing). Record review of Resident #1 quarterly MDS, dated [DATE], revealed Resident #1 was coded as severely impaired for cognition, was dependent on staff for eating, toileting, oral hygiene, putting on and taking off footwear and personal hygiene. For bowel and bladder, he was coded as having an external catheter and has a colostomy. For skin condition he was coded as high risk for pressure, and he had two stage four pressure sores. Record review of Resident #1's care plan, dated 6/16/2024, revealed the resident has an actual pressure sore, activities of daily living and incontinent care. Record review of the physician's order, dated 12/30/24, for sacral wound documented Cleanse with normal saline, pat wound dry, apply collagen, calcium alginate with sliver once a day. Record review of the treatment administration history revealed no documentation wound care treatment was done on 5/14/2025, 5/16/2025, 5/17/2025, 5/23/2025, 6/2/2025, 6/6/2025, 6/12/2025 and 6/26/2025. These dates were blank on the MARs. Record review of the nurse's progress notes, wound management, revealed no documentation as to why the treatment was not done. No other documentation was presented. Record review revealed Resident#1 was admitted to the facility on [DATE]. Note from older EMR said revealed he was admitted on [DATE] with a wound vac to his sacrum. On 2/19/24 the wound was measured at 12cm x 5.5cm x 3.0cm. According to H&P from 3/18/24, Resident #1 had necrotic sacral decubitus s/p debridement 1/17/24 currently with a wound vac. 7/7/25: It indicated the wound was 6cm x 4.3cm x 0.5cm and was stable. The wound had moderate, serous exudate that had no odor. There was 40% granulation tissue and 30% slough. The resident discharged on 7/12/25 Observation of Resident #1 on 6/27/2025 at 4:30 PM revealed he was in bed. He was alert with confusion and complaining things were crawling all over his body. The resident was on contact isolation for c-diff, infection control precaution was observed. The room was visible clean but smelled horrible due to c-diff. Call light was observed to be within reach. Observation on 7/1/2025 at 11:10 am of Resident #1 wound care by nurse surveyor revealed, Resident #1 sacrum wound about the size of a baseball, with a small amount of slough on the edges. Interview on 6/27/2025 at 6:10 PM, LVN A said Resident #1's wound had gotten better. She said Resident #1 was on isolation for C-diff and not wound infection. She said the resident stayed mostly in bed and when they tried to get him out of bed, he refused. LVN A stated Resident #1 has a pressure sore to his sacral area. In an interview on 7/1/2025 at 11:20am with LVN C she said the nurses have been doing wound care for about a month. She said restorative walks with the wound care MD when he comes on Wednesday. LVN C said the wound has gotten better and they tried to get him out of bed but he refuses. 2. Record review of Resident #3's admission face sheet revealed [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included diabetes mellitus with diabetic neuropathy (high blood sugar with nerve damage), acute cystitis without hematuria (inflammation or infection of bladder), lack of coordination (inability to control and coordinate muscle movements), cerebral infraction (this occurs when blood flow to the brain is blocked), acute respiratory failure with hypoxia (it's a condition when the lungs can't properly exchange causing abnormal levels of carbon dioxide or oxygen in the arteries), cellulitis unspecified

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025

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The Buckingham	8580 Woodway Drive 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 2 of 6 residents (Resident #1, Resident #3) reviewed for clinical records. 1. The facility failed to ensure Resident #1's pressure sore treatment form was accurate and complete with no blanks on the TARs on 6/18/2025, 6/23/2025, 6/25/2025 and 6/26/2025 and MARs on 6/19/2025. 2. The facility failed to ensure Resident #3's pressure sore treatment form was accurate and completed with no blanks on the TARs on 6/17/2025 and 6/20/2025 and on the MARs on 6/20/2025. These failures could place residents at risk of not receiving the care and treatment needed to improve their quality of life due to inaccurate or incomplete documentation. 1. Record review of Resident #1's face sheet revealed an [AGE] year-old male originally admitted to the facility on [DATE]. His medical diagnoses included hyperlipidemia (high levels of fat in the blood), muscle weakness (decreased strength in the muscles), anemia (a condition in which the blood doesn't have sufficient red blood cells), pneumonia (inflammation of the air sacs), sepsis due to Escherichia (a serious condition where the body's immune response to an E. coli infection becomes dysregulated), urinary tract infection (is infection in the urinary system), severe protein calorie malnutrition (deficiency or excess of energy, protein, and other nutrients), hypertension (high blood pressure), hemiplegia (muscle weakness or partial paralysis on one side of the body), acute respiratory failure with hypoxia (a condition where the lungs cannot provide enough oxygen to the blood), pressure ulcer of the sacral region stage 4 (a wound that extends through the skin and subcutaneous tissue, exposing muscle, tendon or bone), Chronic osteomyelitis (a rare autoimmune disease that causes bone inflammation), and shortness of breath (difficulty breathing). Record review of Resident #1's quarterly MDS, dated [DATE], revealed Resident #1 was coded as severely impaired for cognition, was dependent on staff for eating, toileting, oral hygiene, putting on and taking off footwear and personal hygiene. For bowel and bladder, he was coded as having an external catheter and had a colostomy. For skin condition he was coded as high risk for pressure sores and had 2 stage four pressure sores. Record review of Resident #1's care plan, dated 6/16/2024, revealed the resident has an actual pressure sore, total care for activities of daily living and was always incontinent. Record review of Resident #1's physician's order, dated 12/30/24, for sacral wound documented, Cleanse with normal saline, pat wound dry, apply collagen, calcium alginate with silver once a day. Record review of Resident#1's physician's order dated 9/24/2024 revealed the following:1. Atorvastatin tablet 20mg amount to administer 1 tablet orally at bedtime .2 2. Vitamin C (ascorbic acid) 500mg amount to administer 1 tablet orally twice a day. Record review of Resident #1's medication administration record revealed blanks on the MARs for Atorvastatin on 6/19/2025 and Vitamin C on 6/19/20205 at 9:00pm. Record review of the nurse's progress notes, revealed no documentation as to why the medication record was blank. Record review of Resident #1's treatment administration record revealed blanks on the wound care treatment for 6/18/2025, 6/23/2025, 6/25/2025 and 6/26/2025. Further record review of the nurse's progress notes, wound management, revealed no documentation as to why the treatment record was blank. In an interview on 6/27/2025 at 6:10 PM, LVN A said Resident #1's wound had gotten better. She said Resident #1 was on isolation for C-diff and not wound infection. LVN A stated Resident #1 had a pressure sore to his sacral area and it was getting better. In an interview with the DON on 7/01/2025 at 4:30 pm she said wound care doctor comes to the building on Wednesdays, and she was sure treatments were done and they just didn't document. She said they should always document, and she was going to get the documentation. Documentation was later presented for review. 2. Record review of Resident #3's admission face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included diabetes mellitus with diabetic neuropathy (high blood sugar with nerve damage), acute cystitis without hematuria (inflammation or infection of bladder), lack of coordination (inability to control and coordinate muscle movements), cerebral infarction (this occurs when blood flow to the brain is blocked), acute respiratory failure with hypoxia (it's a condition when the lungs can't properly exchange gases causing abnormal levels of carbon dioxide or oxygen in the arteries), cellulitis unspecified (spreading skin infection that affects mostly the lower leg), pressure ulcer (injury to skin and underlying tissues), urinary tract infection (infection in the urinary system), dysphagia (difficulty swallowing), gastro esophageal reflux disease (a condition were the stomach acid flows back in the esophagus), pain (physical discomfort ranging from mild to