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	08/28/2025

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 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 14%, based on 5 errors out of 34 opportunities, which involved 3 of 6 residents (Residents #47, #167 and #76) and 3 of 3 staff observed during medication administration reviewed for medication errors. 1. The facility failed to administer Resident #76's antibiotic, Bactrim (Sulfamethoxzole-trimethopine tablet) and Centrum Silver Gel as ordered by the physician on 8/27/25. 2. The facility failed to administer Resident #167's Pantoprazole before breakfast per the pharmacy label instructions on 8/27/25. 3. The facility failed to administer Resident #47's Rosuvastatin and Ipratropium Bromide nasal solution 0.03% 21 mcg as ordered by physician on 8/27/25. These failures could place residents at risk of inadequate therapeutic outcomes, increased negative side effects, and a decline in health. Findings include: 1. Record review of Resident #47's EHR reflected a male who was admitted to the facility on [DATE] and re-admitted [DATE]. Resident #47 had diagnoses which included pneumonia due to methicillin resistant staphylococcus aureus, personal history of covid-19 , acute respiratory failure, unspecifies whether with hypoxia or hypercapnia, muscle weakness (generalized), unsteadiness on feet, dysphagia, oropharyngeal phase, cognitive communication deficit, type 2 diabetes mellitus without complications, Alzheimer's disease, unspecified, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertensive heart disease without heart failure, insomnia, unspecified, chronic obstructive pulmonary disease, unspecified, osteoarthritis of knee, unspecified, hyperlipidemia, unspecified, gastro-esophageal reflux disease without esophagitis, adult failure to thrive and other muscle spasm.Record review of Resident #47's admission MDS, dated [DATE], reflected a BIMS score of 05, which indicated severe cognitive impairment. Record review of Resident #47's care plan, dated 8/6/25, reflected she required assistance with activities of daily living due to Alzheimer's dementia, decreased physical and functional mobility secondary to weakness and multiple medical comorbidities. Record review of Resident #47's physician's orders reflected an order for Ipratropium Bromide nasal solution 0.03% 21mcg 2 spray to each nostril twice daily and Rosuvastatin 10 mg tab every day. Record review of the facility's medication pass times reflected every day medication was scheduled for 9:00AM, and medication was given twice daily at 9:00AM and 5:00PM. Observation on 08/27/25 at 7:45 AM, during medication administration for Resident #47 by RN B revealed RN B prepared medications and administered to Resident #47's by mouth. At 8:23 AM, RN B administered Ipratropium Bromide nasal solution 0.03% 21mcg 1 spray to each nostril and did not administer Rosuvastatin 10 mg by mouth. In an interview with RN B on 8/27/25 at 8:27 AM, RN B said she would be careful with the nasal spray and for Rosuvastatin 10 mg she would have to call the physician to verify because Rosuvastatin should be given at bedtime. RN B said not administering those medications as ordered by the physician could result in not meeting the therapeutic requirement in the blood. 2. Record review of Resident #76 's EHR reflected a male who was admitted to the facility on [DATE]. Resident #76 had diagnoses which included urinary tract infection, site not specified, proteus (mirabilis) (morganii) as the cause of diseases classified (continued on next page)

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

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	elsewhere, neuromuscular rheumatoid arthritis with rheumatoid factor, unspecified dysfunction of bladder, unspecified, retention of urine, unspecified hypo-osmolality and hyponatremia, muscle weakness (generalized), unsteadiness on feet, other lack of coordination, cognitive communication deficit, dysphagia, oropharyngeal phase, dysphagia following unspecified cerebrovascular disease, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, insomnia due to other mental disorder, unspecified protein-calorie malnutrition, unspecified asthma, uncomplicated, hypertensive heart disease without heart failure, gastro-esophageal reflux disease without esophagitis, other gastritis without bleeding, anal spasm, vitamin d deficiency, unspecified, unspecified hemorrhoids, pain, unspecified, constipation, unspecified, wheezing, essential (primary) hypertension, other specified arthritis, unspecified site, and rheumatoid arthritis. Record review of Resident #76's admission MDS, dated [DATE], reflected a BIMS score of 10, which indicated moderate cognitive impairment. Record review of Resident #76's care plan, dated 8/13/25, reflected she required assistance with activities of daily living due to decreased physical and functional mobility secondary to weakness and multiple medical comorbidities, history of CVA with residual left sided weakness and had an indwelling Foley catheter related to urinary retention secondary to neurogenic bladder with risk for infection and injury. Record review of Resident #76's physician's orders reflected an order of Centrum Silver Gel 1 tablet every day and Bactrim (Sulfamethoxzole-trimethopine tablet) 400-80 mg every day for 2 days the order date was 8/26/25. Record review of the nurse's progress notes, dated 8/26/25 at 11:47 PM, reflected the order of Bactrim Sulfamethoxzole-trimethopine tablet) 400-80 mg was sent to the pharmacy and would follow up. Observation of medication administration on 8/27/25 at 8:40 AM by RN C revealed RN C administered medications and did not administer Bactrim Sulfamethoxzole-trimethopine tablet) 400-80 mg and Centrum Silver Gel 1 tablet. In an interview with RN C on 8/28/25 at 9:48 AM, after checking the medication cart for Centrum Sliver Gel tablet was not available and Bactrim Sulfamethoxzole-trimethopine tablet) 400-80 mg blister packet from the pharmacy was received on 8/28/25 and 1 tablet of Bactrim was punched and RN C said she administered it to Resident #76. RN C said she borrowed Centrum Sliver from another medication cart and Bactrim Sulfamethoxzole-trimethopine tablet) 400-80 mg, she took it from the emergency kit. RN C was asked to show the evidence from the ER Kit that Bactrim Sulfamethoxzole-trimethopine tablet) 400-80 mg was taken, and RN C said she forgot to sign the form in the ER kit. RN C said not signing the form from the ER kit was her fault and she was very sorry, and she knew if Resident #76 did not receive her medication as ordered by the physician, it would result in the resident's decline in health. In an interview with ADON A and ADON B on 8/28/25 at 2:45 PM revealed the ADON's checked the ER kit and Bactrim Sulfamethoxzole-trimethopine tablet) 400-80 mg was not among drugs available in the ER kit and Centrum Sliver Gel should not be taken from another cart. The ADON's said they would start in-services and not signing the ER kit after taking any medications was not acceptable practice. 3. Record review of Resident #167 's EHR reflected a female who was admitted to the facility on [DATE]. Resident #167 had diagnoses which included displaced fracture of lateral malleolus of left fibula, subsequent encounter for closed fracture with routine healing, Hyperlipidemia, unspecified, chronic combined systolic (congestive) and diastolic (congestive) heart failure, gastro-esophageal reflux disease without esophagitis, hypertensive heart disease with heart failure, glaucoma, orthopedic aftercare, unsteadiness on feet, Displaced Cognitive communication deficit, dysphagia, oropharyngeal phase, Muscle wasting and atrophy, not elsewhere classified, right shoulder, Muscle wasting and atrophy, not elsewhere classified, left shoulder, Muscle weakness (generalized), Other abnormalities of gait and mobility, Spinal stenosis, and lumbar region with neurogenic claudication. Record review of Resident #167's admission MDS, dated [DATE], reflected a BIMS score of 15, which indicated intact cognition. Record review of Resident #167's care plan, dated 8/20/25, revealed she required assistance with activities of daily living due to history of fracture, decreased physical and functional mobility secondary to weakness and multiple medical comorbidities.Record review of (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #167's physician's orders reflected an order for Pantoprazole sodium tablet 40mg by mouth on 8/18/25. Observation on 08/27/25 at 9:25 AM, during medication administration revealed LVN A administered Pantoprazole sodium tablet 40mg by mouth before breakfast (medication that reduces the amount of acid your stomach produces). Pantoprazole Sodium 40 mg blister packet documented Take before breakfast. Interview with Resident #167 on 08/27/25 at 9:30 AM revealed she had her breakfast an hour ago. In an interview with LVN A on 08/27/25 at 9:32 AM, LVN A said Resident #167 was served breakfast around 7:30 AM and sometimes before the breakfast tray was passed to the residents, it will be around 8:00 AM. LVN C was then asked to checked Pantoprazole Sodium blister packet and was shown the instruction on Take before breakfast LVN A said she was very sorry, she would be more careful, she had in-service about medication administration, she knew to give medication at the right time for therapeutic effect. Interview on 8/28/25 at 3:40 PM, ADON A and ADON B said medication should be available, given as ordered by the physician and pharmacy recommendation. Interview with ADON A and ADON B on 8/28/25 at 5:30 PM, ADONs A and B stated it was not acceptable for the medication cart to be left unlocked and nasal sprays should be administered 5 minutes apart for absorption. The ADON's said they would be in-servicing the staff. In an interview on 08/28/25 at 5:44 PM, the Administrator said she expected medications to be administered correctly and according to the MD order. Record review of the facility's Administering Medications policy, dated April 2019, read in part, .Medications shall be administered in a safe and timely manner, and as prescribed . Policy Interpretation and Implementation .3. Medications must be administered in accordance with the orders, 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) .10. The individual administering the medication must check the label THREE (3) times 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable and, in accordance with State and Federal laws, drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for three of four medication carts (Nurse Cart 1B [middle Hall], Nurse Cart 2A Hall, Nurse cart 2B [middle Hall]) reviewed for storage of medications . The facility failed to ensure Nurse Cart 1B (middle Hall), Nurse Cart 2A Hall, Nurse cart 2B (middle Hall) did not have multiple medications opened and undated. This failure could place residents at risk of not receiving the therapeutic benefit of medications, adverse reactions to medications and drug diversion. Findings include: Observation on [DATE] at 9:08 AM, during medication administration, revealed LVN A parked the medication cart in the hallway. LVN A did leave the medication cart unlocked.Interview on [DATE] at 9:22 AM with LVN A, regarding leaving the medication cart unlocked in the hallway, she said she forgot and she was very sorry. LVN A said leaving the medication cart unlocked could result to residents and non-licensed staffs gaining access to the cart. Observation of Nurse Cart 1B on [DATE] at 11:06 AM revealed the following opened and not dated medications:1. 2 Albuterol sulfate Inhalations Aerosol 90 mcg were not dated2. 1 vial of Heparin Sodium injection 50,000(10 mls) was opened and not dated3. Fluticasone Propionate Nasal spray open was not dated4. Ipratropium Bromide 21 mcg (0.03%) nasal spray was opened and not dated 5. 2 bottles Timolol Maleate 0.5% eyedrops were opened and not dated6. 2 Latanoprost 0.005% eyedrops were opened and not dated In an interview on [DATE] at 11:10AM, RN C said while she was not responsible for the failure to label that medication found, nursing staff were expected to check their carts daily for expired and inappropriately labeled medications. He said all multi-dose containers should be labeled with the date they were opened to track their beyond use date. Observation of Nurse Cart 2 A on [DATE] at 11:15 AM revealed the following opened and undated medications: 1. Nystatin Cream USP, 100,000 unit per gram opened and not dated2. Metronidazole Gel USP 1% was opened and not dated3. Lidocaine and Prilocaine cream USP was opened and not dated4. Estradiol Vaginal cream USP 0.01% was opened and not dated5. Nystatin and Triamcinolone Acetonide cream USP -Net weight 60gm6. 2 Fluticasone Propionate Nasal sprays were opened and not dated7. Estradiol Vaginal cream USP 0.01% was opened and not date In an interview with LVN B on [DATE] at 11:20 AM, LVN B stated the above listed medications should be dated after opening. Observation of Nurse Cart 2 B on [DATE] at 11:25 AM revealed the following opened and not dated medications: 1. 2 Fluticasone Propionate Nasal sprays were opened and not dated2. Lidocaine HVL 1% 200mg /20ml (10mg/dl) open not dated, expired [DATE]. Voltaren Arthritis pain Net wt. 50gm was opened and not dated4. Albuterol sulfate Inhalation Aerosol 90 mcg was not dated5. 5 Fluticasone Propionate Nasal sprays were opened and not dated6. Hydrocortisone cream 1% Net wt 1oz(28.4gm) In an interview on [DATE] at 11:55 AM, LVN D stated she always checked the medication cart whenever she worked and when she opened medication, she would always place an open date on it for therapeutic effectiveness. LVN D stated she would notify the ADON. During an interview on [DATE] at 4:55 PM, regarding medication opened and not dated, the ADON and ADM stated all medication opened should have an open date. ADON's A and B it and follow pharmacist recommendations. The ADON stated the nurses was responsible for ensuring the proper labeling and storage of the medications.Interview with ADON A and ADON B on [DATE] at 5:30 PM, ADON A and ADON B stated it was not acceptable for the medication cart to be left unlocked and nasal sprays should be administered 5 minutes apart for absorption. The ADON's said they would be in-servicing (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the staff. The ADON's said the staff were in-services upon hire and the pharmacy consultant did random in-services with licensed staffs. The stated surveyor requested the facility policy for nasal spray on [DATE] from the ADONs. Record review of the policy reflected it did not address timing administration with 2 different nasal sprays.Record review of the facility's policy on Medication Storage, revised April of 2007, reflected in part: .The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed . Record review of the facility's policy for storage of medications, revised [DATE], read in part: Policy Statement: The facility shall store all drugs and biologicals in a safe, secure and orderly manner. Policy Interpretation and Implementation: 1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received .2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. 3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing Policy Interpretation and Implementation.Medications are administered in accordance with prescriber orders, including any required time frame During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 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 infections for 3 of 3 residents (Resident #119, Resident #182 and Resident #153) reviewed for infection control. 1.The facility failed to ensure C.NA A and LVN E used the required PPE for Resident #119, who was on enhanced barrier precautions while assisting with repositioning in bed, LVN E picked up blanket from the floor and placed on 8/26/25. 2. The facility failed to ensure LVN E used the required PPE for Resident #153 on 8/28/25. 3. The facility failed to ensure C.NA A maintained hand hygiene during incontinent/FC on 8/28/25 for resident #119. 4. The facility failed to ensure CNA A cleansed around the buttocks for Resident #182 on 8/28/2025.These failures could place residents at risk of cross-contamination and development of infection.Findings include: 1. Record review of Resident #119's face sheet reflected the date of admission was 6/30/25. Resident #119 had diagnoses which included history of essential (primary) hypertension (high blood pressure), hypothyroidism (thyroid gland isn't producing enough thyroid hormones), edema, hemiplegia and hemiparesis (weakness to one side of the body) following cerebral infarction affecting left dominant side, hyperlipidemia (high fat in the blood), aphasia (difficulty talking), obstructive and reflux uropathy, peripheral vascular disease, atherosclerosis of native arteries, disruption of wound, unspecified, sequela, cerebral infarction, unspecified, other chronic osteomyelitis, left ankle and foot, chronic diastolic (congestive) heart failure, hypertensive heart disease with heart failure, obstructive sleep apnea (adult) (pediatric), type 2 diabetes mellitus with foot ulcer, acute pulmonary edema, other encephalopathy, unspecified abnormalities of gait and mobility, dependence on renal dialysis, acquired absence of right leg below knee, other abnormalities of gait and mobility, pain in left foot, morbid (severe) obesity due to excess calories, peripheral vascular disease, unspecified, type 2 diabetes mellitus with other skin complications, unsteadiness on feet, cognitive communication deficit, muscle weakness (generalized), osteomyelitis, unspecified, encounter for orthopedic aftercare following surgical amputation. Record review of Resident's #119's admission MDS assessment, dated 07/07/2025, reflected Resident #119's BIMS score was 04, which indicated the cognition was severely impaired. Resident #119's was incontinence of bowel and continent bladder. Record review of Resident's #119's care plan, dated 7/2/2025, reflected the following:I have ADL self-care performance deficit and totally dependent on staff for all ADLs.I will remain clean, dry, without odor and comfortable every shift on a daily basis, with all needs to be anticipated and met by staff through the next 90 days.Observation on 08/26/25 at 12:00 PM revealed Resident #119 lying in bed croaked and needed help repositioning in bed, Resident#119 had EBP posted, the State Surveyor put resident call light on. C.NA A entered Resident #119's room without PPE and EBP (Enhanced Barrier Precautions) sign was posted outside of the room next to the door. LVN E responded to Resident #119's call light to reposition the resident in bed, without donning PPE, don clean glove. LVN E picked up a blanket from the floor and placed it on the resident. At 12:44 PM, LVN E and C.NA did not wash their hands or use hand sanitizer. C.NA picked up Resident #119's lunch tray to the parked food cart on the hallway. Interview with the C.NA A on 8/28/25 at 12:30 PM revealed the CNA ran inside to the room because the toilet call light was on. The CNA stated the resident doesn't use the toilet. That's why she didn't use the gown. Then saw saw the nurse was already in the resident room. When asked why she didn't gown up with PPE when she repositioned the resident in bed. CNA A had no answer. C.NA A stated EBP was for those residents who had wounds and it's to prevent infection. Interview with LVN E on 8/28/25 at 12:45 PM, LVN E said she did not don PPE before touching/repositioning Resident #19 because she was in hurry, and she saw the restroom call light on. She said she had to administer eye drops to Resident #119 also. 2. Record review of Resident #153's face sheet reflected the date of admission was 5/15/25. Resident #153 had diagnoses which included acute and subacute (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infective endocarditis, Cerebral infarction due to embolism of left middle cerebral artery, Other specified sepsis, Hypo-osmolality and hyponatremia, Metabolic encephalopathy, Bacteremia, Acute respiratory failure with hypoxia, Pneumonia, unspecified organism, Depression, unspecified, Hypotension, unspecified, Overactive bladder, Benign prostatic hyperplasia without lower urinary tract symptoms, Unspecified severe protein-calorie malnutrition, Unspecified lack of coordination, Altered mental status, unspecified, Cognitive communication deficit, Muscle weakness (generalized), Dysphagia, oropharyngeal phase, Dysarthria following cerebral infarction, Dysphagia following cerebral infarction, Pleural effusion, not elsewhere classified, Encounter for attention to gastrostomy, History of falling, Sepsis due to Methicillin resistant Staphylococcus aureus, Anemia, unspecified, Hypothyroidism, unspecified, Type 2 diabetes mellitus without complications, Hyperlipidemia, unspecified, Hypertensive heart disease with heart failure, Atherosclerotic heart disease of native coronary artery without angina pectoris, Unspecified atrial fibrillation and Chronic systolic (congestive) heart failure. Record review of Resident's #153's quarterly MDS assessment, dated 08/22/2025, reflected the Resident #153's BIMS score was 04, which indicated the cognition was severely impaired. Resident #153's was incontinent of bowel and continent bladder. Record review of Resident's #153's care plan, dated 5/17/2025 reflected the following: - requires assistance with activities of daily living due to history of stroke, decreased physical and functional mobility secondary to weakness and multiple medical comorbidities.- I have a feeding tube necessary for nutritional needs related to Stroke. I have difficulty in swallowing due to (d/t) Stroke.- Recent wt. loss NPO (Nothing by mouth) on peg-tube feeding.Observation on 08/27/25 at 5:10 PM revealed Resident #153 was lying in bed. RN K was outside preparing Resident #153's medications for Gastrostomy tube administration. RN K entered Resident #153's room with EBP (Enhanced Barrier Precautions) sign was posted outside of the room next to the door. RN K entered the room, performed hand hygiene, and put on gloves, but did not put on a PPE gown. There were supply of PPE observed outside of the room. Interview with RN K on 8/27/25 at 5:45 PM, revealed she did not really understand the importance of EBP, and she was going to ask the DON, but never got around to asking her.3. Record review of Resident #182's face sheet reflected the date of admission was 5/25/25. Resident #182 had diagnoses which included history of Pressure ulcer of sacral region, stage 4, Depression, unspecified, Pressure ulcer of right heel, stage 2, Pressure ulcer of left heel, unstageable essential (primary) hypertension (high blood pressure), hypothyroidism (thyroid gland isn't producing enough thyroid hormones), Vitamin D deficiency, hyperlipidemia (high fat in the blood), Personal history of malignant neoplasm of breast obstructive and reflux uropathy, glaucoma and cerebral infarction. Record review of Resident #182's quarterly MDS assessment, dated 08/19/2025, Section C (Cognitive Patterns) reflected a BIMS score was blank which indicated severe impairment in thinking. Section H (Bladder and Bowel) reflected the resident had an indwelling catheter. Resident #182's functional status revealed he was independent with supervision of staff with bed mobility, transfer and toilet use. Resident #182 had an indwelling Foley catheter. Record review of Resident's #182's care plan, dated 5/26/2025, reflected the following: I have ADL self-care performance deficit and totally dependent on staff for all ADLs and requires assistance with activities of daily living due to decreased physical and functional mobility secondary to weakness and multiple medical comorbidities.I will remain clean, dry, without odor and comfortable every shift on a daily basis, with all needs to be anticipated and met by staff through the next 90 days. Observation on 08/28/25 at 11:35 AM of incontinent and Foley Catheter care done by C.NA A and C.NA B assisting Resident #182 revealed C.NA A picked up a clean brief and placed it on Resident #182's bed. C.NA A changed gloves 4 times and donned cleaned gloves without washing hands and not using hand sanitizer. Resident #182 had large pasty BM and C.NA A did not open the labia to clean and cleaned around buttocks before placing a clean brief and fasten it. Interview with C.NA A on 8/28/25 at 11:40 AM, she stated she thought she cleaned around his buttock, and she knew not cleaning around the buttocks . C.NA A further said she usually wiped around the buttocks at the start and end of incontinent care, but she did not this time. She was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nervous. She knew if she didn't clean a resident well it could cause itchiness, skin break down, urinary tract and odors. C.NA A said she was in-serviced for incontinent care, skilled checked and she received infection control in-services recently. In an interview with ADON A and ADON B on 8/28/25 at 5:15 PM, she stated any resident who had wounds, contact isolation, Gastrostomy tube feeding, or Foley catheter was placed on Enhanced Barrier precautions to help reduce the spread of MDRO's. She stated signage was posted outside to the door, which explained what PPE was to be worn and for what task the PPE was to be worn for. She stated any contact with a resident with a catheter required the use of gown and gloves. She stated the staff received trainings on the use of Enhanced Barrier Precautions and hand washing. Record review of the facility's policy revised, October 2018, on Enhanced Barrier Precautions, reflected the following: Policy Statement: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDRO)Policy Interpretation and Implementation1. Enhanced barrier precautions (EBPs)refer to infection prevention and control interventions designed to reduce the transmission of multi-drug -resistant organisms (MDROs) during high contact resident care activities. 2. Enhanced barrier precautions apply when: a. A resident with an infected or colonized with a CDC -targeted, MDRO but does have a wound or indwelling medical device and does not have secretions or excretions that cannot be covered or contained. Record review of CDC guidelines reflected: https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html: Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning Personal protective equipment upon room entry and properly discarding before exiting the patient room is done to contain pathogens.

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	08/28/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 3 residents (Resident #182) reviewed for ADL care. The facility failed to ensure C.NA A cleaned Resident #182 properly during incontinent/FC (Foley catheter) care on 8/28/25.This failure could place residents at risk for pain, infection and hospitalization.Finding include: Record review of Resident #182's face sheet reflected, the date of admission was 5/25/25. Resident #182 had diagnoses which included history of Pressure ulcer of sacral region, stage 4, Depression, unspecified, Pressure ulcer of right heel, stage 2, Pressure ulcer of left heel, unstageable essential (primary) hypertension (high blood pressure), hypothyroidism (thyroid gland isn't producing enough thyroid hormones), Vitamin D deficiency, hyperlipidemia (high fat in the blood), Personal history of malignant neoplasm of breast obstructive and reflux uropathy, glaucoma and cerebral infarction . Record review of Resident #182's quarterly MDS assessment, dated 08/19/2025, Section C (Cognitive Patterns) reflected a BIMS score was blank which indicated severe impairment in thinking. Section H (Bladder and Bowel) reflected the resident had an indwelling catheter. Resident #182's functional status revealed he was independent with supervision of staff with bed mobility, transfer and toilet use. Further review reflected Resident#182 had an indwelling Foley catheter. Record review of Resident's #182's care plan, dated 5/24/2025, reflected the following: I have ADL self-care performance deficit and totally dependent on staff for all ADLs and requires assistance with activities of daily living due to decreased physical and functional mobility secondary to weakness and multiple medical comorbidities.I will remain clean, dry, without odor and comfortable every shift on a daily basis, with all needs to be anticipated and met by staff through the next 90 days. Observation on 08/28/25 at 11:35 AM of incontinent and Foley Catheter care done revealed C.NA A and C.NA B assisted Resident #182. Resident #182 had a large pasty BM and C.NA A did open the labia to clean it but did not clean around the buttocks before placing a clean brief and fastened it. Interview with C.NA A on 8/28/25 at 11:40 AM revealed she did not clean around her buttock, and she knew if she didn't clean a resident well it could cause itchiness, skin break down, urinary tract and odors. C.NA A further said she usually wiped around the buttocks at the start and end of incontinent care, but she did not this time, she was nervous. C.NA A said she was in-serviced for incontinent care and skilled check. Interview with the ADON on 8/28/25 at 4:51 PM, the ADON said she and the ADON monitored the CNAs randomly monthly and not performing good incontinent care could result in infection, skin break down and UTI. ADON A and B both said they did rounds with the nurse aides before the CNA got on the floor to work, also watching them hands on and checked them off on hand washing, incontinent/Foley catheter care. Record review of the facility's policy on Perineal Care, revised 6/24/25, reflected:The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.

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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 a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #182) reviewed for incontinent care. 1.The facility failed to ensure CNA A cleaned Resident #182's indwelling Foley catheter properly.2. The facility failed to ensure CNA A followed proper hand hygiene during incontinent care on 8/28/25. 3. The facility failed to ensure CNA A secured Resident #182's Foley catheter. These failures could place residents at risk for pain, infection, injury, and hospitalization. Finding include: Record review of Resident #182's face sheet reflected date of admission was 5/25/25 diagnoses include history of Pressure ulcer of sacral region, stage 4, Depression, unspecified, Pressure ulcer of right heel, stage 2, Pressure ulcer of left heel, unstageable essential (primary) hypertension(high blood pressure), hypothyroidism (thyroid gland isn't producing enough thyroid hormones), Vitamin D deficiency, hyperlipidemia (high fat in the blood), Personal history of malignant neoplasm of breast obstructive and reflux uropathy, glaucoma and cerebral infarction. Record review of Resident #182's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score was blank indicating severe impairment in thinking. Section H (Bladder and Bowel) reflected resident had an indwelling catheter. Resident #182's functional status revealed he was independent with supervision of staff with bed mobility, transfer, and toilet use. Further review revealed Resident#182 had an indwelling Foley catheter. Record Review of Resident's #182's care plan dated 5/24/2025 reflectedI have ADL self-care performance deficit and totally dependent on staff for all ADLs and requires assistance with activities of daily living due to decreased physical and functional mobility secondary to weakness and multiple medical comorbidities.I will remain clean, dry, without odor and comfortable every shift on a daily basis, with all needs to be anticipated and met by staff through the next 90 days. Record review of Resident #182's physician order, dated May 2025, read in part .change Foley catheter with 18-inch catheter and 10cc bulb on the 1st of each month, dated 6/25 . keep catheter from kinks and drainage bag lower than bladder at all times, dated 5/29/25. Observation of incontinent /indwelling Foley catheter on 5/28/25 at 11:35 AM, revealed CNA A and CNA B transferred Resident #182's from her recliner to her bed. C.NA A performed F/C and incontinent care with C.NA B assisting. CNA A did not wash their hands and did not use hand sanitizer. C.NA A, donned clean gloves, undid Resident #182's soiled brief, using the wet wipes, cleaned the resident's groin and the F/C was not secured. The CNA cleaned visible parts of the indwelling catheter, she did not open Resident #182's labia to clean it from the insertion site. Resident #182 had a large BM , CNA A cleaned in -between the buttocks and did not clean around the buttocks, she picked up a clean brief and fastened it on the resident. Interview with C.NA A on 8/28/25 at 11:41AM, she said she was nervous and did not open the labia to clean the indwelling catheter insertion site. C.NA A said not cleaning the indwelling catheter from the insertion site for Resident #182, her hands could cause a UTI , she had in-service on Foley catheter/incontinent care. Interview with C.NA B on 8/28/25 at 11:43 AM, she said C.NA A did not open the labia to clean the F/C as she was supposed to from insertion site which could lead to urinary tract infection. Interview with ADON A and ADON B on 8/28/25 at 4:51 PM, she said she did the initial training and would monitor while on the unit. ADON A and ADON B said they monitored the C.NAs randomly monthly and not performing good incontinent could result in infection and UTI. Record review of the facility's policy for Catheter Care Urinary, date 3/31/2016, reflected: For the female: Use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.

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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 observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 5 residents (Resident #47) reviewed for medication administration. 1. RN B failed ensure she waited 3 to 5 minutes while administering Azelastine Hydrochloride and Ipratropium Bromide, nasal sprays, to Resident #47 on 8/27/25. (Azelastine Hydrochloride [helps relieve sneezing, itching and runny nose] and Ipratropium Bromide [helps open up the airways in your lungs to make breathing earlier]). These failures could place residents at risk of not receiving medications as prescribed, decreased therapeutic effects of the medications, risk for drug diversion, delay in medication administration and worsening of their medical conditions.Findings include:2. Record review of Resident #47 's EHR revealed a male who was admitted to the facility on [DATE] and was re-admitted [DATE]. Resident #47 had diagnoses which included pneumonia due to methicillin resistant staphylococcus aureus, personal history of covid-19, acute respiratory failure, unspecifies whether with hypoxia (low oxygen) or hypercapnia, muscle weakness (generalized), unsteadiness on feet, dysphagia (difficulty swallowing), oropharyngeal phase, cognitive communication deficit, type 2 diabetes mellitus (high glucose level) without complications, Alzheimer's disease, unspecified, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertensive heart disease without heart failure, insomnia, unspecified, chronic obstructive pulmonary disease, unspecified, osteoarthritis of knee, unspecified, hyperlipidemia, unspecified, gastro-esophageal reflux disease without esophagitis, adult failure to thrive, other muscle spasm .Record review of Resident #47's admission MDS, dated [DATE], revealed a BIMS score of 05, which indicated severe cognitive impairment. Record review of Resident #47's care plan, dated 8/6/25, revealed she required assistance with activities of daily living due to Alzheimer's dementia, decreased physical and functional mobility secondary to weakness and multiple medical comorbidities. Observation on 08/27/25 at 7:45 AM, during medication administration, to Resident #47 by RN B revealed RN B prepared other medications and administered them to Resident #47's by mouth. At 8:23 AM, RN B administered Ipratropium Bromide nasal solution 0.03% 21mcg 1 spray to each nostril, and at 8:24 AM, RN B administered Azelastine Hydrochloride nasal solution 0.1% 1 spray to each nostril. In an interview with RN B on 8/27/25 at 8:27 AM, RN B said she should have waited for 5 minutes apart before administering the two nasal sprays, she was very nervous. RN B said not waiting for 5 minutes in-between nasal sprays could result to the medication not being effective. Record review of the facility's policy for administering Medications, dated 4/2019, reflected Policy Statement Medications are administered in a safe and timely manner, and as prescribed.Record review of therapeutic guidelines instructions for using a nasal spray, dated December 2020, reflected: For videos demonstrating correct use of nasal sprays , see the National Asthma Council website (www,nationalasthma.org.au/how-to-videos/using your-nasal-spray)To use a nasal spray effectively and safely, follow these instructions.6. Press to spray and sniff gently at the same time- sniffing hard and make the liquid go straight down the throat.If you are using two different nasal sprays. Wait 10 minutes between sprays.