STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676337	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Houston Heights Nursing and Rehabilitation Center	6920 W T.C. Jester Blvd Houston, TX 77091

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 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure residents were free from verbal abuse for 2 of 9 residents (Resident #2 and Resident #3) reviewed for abuse. - The facility failed to prevent verbal abuse by DON K. On 11/20/24 DON K told Resident #2 she would send him to jail if he did not shut up. - The facility failed to prevent verbal abuse by DON K. On 1/30/25 DON K got in Resident #3's face and yelled at her to shut up. These failures could place all residents in the facility at risk for severe negative psychosocial outcomes which could prevent them from achieving their highest practicable physical, mental, and psychosocial well-being. Findings include: Record review of Resident #2's undated face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included cerebral infarction (stroke), epilepsy (seizures), mild intellectual disabilities, cognitive communication deficit, depression, and unspecified psychosis (psychotic symptoms are present, but not a specific disorder). Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated he had a BIMS score of 5 out of 15 which indicated severely impaired cognition. The MDS revealed CR #2 was taking an antidepressant, and a hypnotic. (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 0600 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident #2's care plan dated 12/11/24, revealed a Focus: [Resident #2] had verbal outburst towards staff (Started: 7/23/24, Edited: 11/20/24). The goal was to not have any outbursts in 90 days. The interventions were to redirect Resident #2 and take the resident to a quiet environment. Focus: Resident received antianxiety medication r/t restlessness and agitation (Started: 5/3/24, Edited: 10/24/24). The goal was to improve or maintain Resident #2's functional status. The interventions included monitoring Resident #2's mood and response to medications, assess his behavioral/mood symptoms to see if they present a danger to self or others and intervene. Focus: Resident was PASARR positive for ID and receiving psych services for behavior (Start: 3/3/24, Edited: 10/24/24). The goal was to follow the PASARR recommendations. The interventions included following the PASARR recommendations, conduct quarterly meetings and follow any additional services the local authority recommends. Focus: Resident was at increased risk for memory difficulties, personality changes, anxiety, and relationship difficulties d/t depression. The goal was to exhibit indicators of depression/anxiety or sad mood less than once a month. Interventions included administering medications, assist the resident with an activities program that was meaningful, and encourage exercise. Focus: The resident enjoyed talking to staff (Start: 2/5/24, Edited: 10/24/24). The goal was to remain engaged in independent and facility activity. Interventions included encouraging Resident #2 to spend time out of his room at public locations. In an observation and interview with Resident #2 on 5/21/25 at 11:09am, Resident #2 was laying on his back in bed. He did not remember the incident with the DON when asked about it. In an interview with CNA H on 5/21/25 at 12:12pm, she said DON K was verbally abusive to Resident #2 frequently. She said DON K did say she was going to call the police and have Resident #2 sent to jail. In an interview with LVN E on 5/21/25 at 12:14pm, he said on 11/20/24 DON K was yelling at Resident #2 and telling him she could call the police and have him arrested. LVN E said Resident #2 was alert, but he did not remember things. He said Resident #2 yelled out frequently, but you have to know how to take care of him, and he knew how to calm him down. LVN E said DON K was rude to all the residents and all staff. In an interview with the ADON on 5/21/25 at 1:39pm, she said she heard DON K said those things (she was going to have him arrested) to the Resident #2, but she did not actually hear it herself. The ADON did agree that DON K was rude to the residents. In an interview with LVN M on 5/23/25 at 11:09am, she said she heard Resident #2 tell DON K one time that he was going to tell his family member about the way DON K was treating him, and DON K told him, Tell your family member, they can't whoop me. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	2. Record review of the provider investigation report submitted to the state by Administrator R dated 2/5/25 revealed in part: .Investigation Summary: On 1/30/25, [LVN M] stated that she had witnessed what she considered to be verbal/mental abuse of a resident by [DON K]. She stated that [Resident #3] was at the nurse's station, and she was yelling and cursing, which she does periodically. [LVN M] stated that [DON K] came out of her office, walked over to [Resident #3] and told her she would call the police if she did not calm down, and that she needs to go to her room, [Resident #3] told [DON K] to get out of my mother fucking face. [DON K] stated to the resident I am in your face, I am in your face in a harsh, belittling manner that was confrontational. In interviewing other staff at/or around the nurse's station at that time, [ADON and LVN O] also stated they heard [DON K] speak harshly, using belittling tone when speaking with [Resident #3] . Record review of Resident #3's undated face sheet revealed a [AGE] year-old female admitted to the facility on [DATE], with the most recent admission being 2/20/25. Her diagnoses included schizoaffective disorder (both psychosis and bipolar/depression), severe dementia with agitation (restlessness, distress, and potentially aggressive behavior), anxiety, schizophrenia (chronic brain disorder that affects thinking, feeling, and behavior), cognitive communication deficit. Record review of Resident #3's Annual MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15 which indicated severe cognitive impairment. Further review of the MDS confirmed she had diagnoses of non-Alzheimer's dementia, anxiety, schizophrenia, and schizoaffective disorder bipolar type. She was taking antidepressants. Record review of Resident #3's care plan dated 1/15/25 revealed a Focus: Resident has behaviors when she starts her menstrual cycle (Initiated: 1/28/25). The goal was that she would be free from behaviors through the review date. Interventions included that staff would redirect the resident and she would be respectful towards staff and others. Focus: Staff reported allegation of verbal abuse (Initiated: 1/31/25). The goal was to be free from verbal abuse. Interventions included monitoring behaviors, following up with psychosocial prn, head to toe assessment, and reporting verbal abuse to HHSC. Focus: Resident enjoys sitting in the hallway people watching (Initiated: 3/6/25). Goal was to attend activities 3 times a week. Interventions included reminding the resident to attend activities and escorting her, and if she exhibits behaviors to redirect her. Focus: Resident has a communication problem r/t alcohol induced dementia (Initiated: 1/28/25). The goal was to be able to make basic needs known. Interventions included monitor/document frustration level and wait 30 seconds before providing resident with word. Allow time to respond, ask yes/no questions, use simple/brief/consistent words/cues. Record review of Resident #3's progress note dated 1/29/25 at 5:35 pm and written by LVN O revealed Resident #3 had behavioral issues with outbursts, was agitated, and screaming at staff and other residents. The MD was notified who gave an order for Ativan (medication for anxiety) 2mg PO Q6hr PRN and a dose was given. Record review of Resident #3's progress note dated 1/30/25 at 8:37 am and written by LVN M revealed the MD ordered a UA for Resident #3. Record review of Resident #3's Lab Results reported 1/30/25 at 9:22pm revealed she had a UTI that was positive for E. Coli (type of bacteria that causes urinary infection). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident #3's progress note dated 1/31/25 at 6:22 am and written by LVN E revealed Resident #3 was ordered an antibiotic for a UTI. In an interview with the ADON on 5/20/25 at 1:15pm she said on 1/30/25 Resident #3 was at the nurse's station and was very upset and yelling when DON K went out to talk to her. The ADON said she was in her office, and she heard DON K say, I'm in your face, I'm in your face. In an interview with CNA F on 5/20/25 at 1:51pm he said on 1/30/25 Resident #3 was at the nurse's station yelling and upset and DON K came out of her office and got in the resident's face and told her to Shut up and stop yelling at her nurse's station. CNA F said DON K was rude to all the residents. In an observation and interview on 5/21/25 at 11:14am Resident #3 was sitting in her wheelchair in the dining room. She did not remember the incident when asked about it. In a telephone interview with LVN M on 5/23/25 at 11:09am she said on 1/30/25 she was in her office when she heard commotion at the nurse's station, so she went out to see what was going on. She said Resident #3 was being belligerent and was saying she was missing her purse. LVN M said she did that sometimes because she had alcohol induced dementia. LVN M saw DON K get in Resident #3's face and tell her, You will not act this way. LVN M said then Resident #3 said, Get out of my motherfucking face and then the DON said, I'm in your face, I'm in your face very confrontational. LVN M said the resident looked shocked that DON K was saying this and in her face. LVN M said DON K was disrespectful to the residents and staff all the time. Record review of DON K's Employee Counseling Report from 2/4/25 filled out by Administrator R read in part: .The decision to terminate employment is based on multiple documented complaints and formal statements regarding unprofessional conduct, including reports of verbal abuse, retaliatory behavior, and intimidation, which have contributed to a hostile work environment. Additionally, there were allegations of verbal abuse toward a patient .the consistency and severity of multiple complaints from different individuals, each detailing similar unprofessional behavior in separate incidents, have led the company to conclude that continued employment is not in alignment with our standards and expectations. In an interview with DON K on 5/21/25 at 1:40pm, she denied any verbal abuse to any residents. She said she told Resident #3 Yes, I'm in your face because I have to talk to you. DON K said she did not raise her voice or use any kind of rude tone and then she went with Resident #3 to her room to calm her down. DON K said with Resident #2, he was having an altercation with another resident across the hall from him and he was holding a butter knife. She said she told him he could go to jail if he threatened someone with a knife. Record review of the incidents and accidents log for that month did not reveal any resident altercations that DON K was speaking of. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	In an interview with Administrator C on 5/22/25 at 1:26pm she said her expectations were that her staff were to maintain professionalism, dignity, and courtesy whenever they took care of the residents. She said there should be no reason their voice should be loud, or they should yell unless they were speaking to a hearing-impaired resident. Administrator C said she did not tolerate scaring residents to get them to do something and the staff would be suspended, reported, and ultimately terminated if she found that happened. Administrator C said if she found out a staff member was abusing a resident they would be suspended, reported, the police would be called, facility guidelines would be followed, and the employee would be terminated if it were true. She said abuse could cause emotional and behavioral concerns with the resident. In an interview with the VP of Operations on 5/22/25 at 1:30pm he said he investigated the incident that was filed against DON K and Resident #3. He said once he and the previous Administrator started interviewing staff about what happened, all the staff started saying how they felt scared, retaliated against, and verbally abused by DON K. He said the findings they found were congruent with the allegations of the investigation, so they terminated DON K. Record review of the facility's policy and procedure on Abuse, Neglect and Exploitation (Implemented: 8/15/22 with no revisions) read in part: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability .The facility will develop and implement written policies and procedures that: Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; Establish policies and procedures to investigate any such allegations; and Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriate of resident property, reporting procedures, and dementia management and resident abuse prevention; and Establish coordination with the QAPI program .Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property .Existing staff will receive annual education through planned in-services and as needed .The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: . The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur . The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation .The facility will have written procedures that include: . Assuring that reporters are free from retaliation or reprisal; Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime. This facility will post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if the employee believes the facility has retaliated against him/her for reporting a suspected crime and how to file such a complaint .

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 8 residents (Resident #1) reviewed for accidents and supervision. Resident #1, who ambulated via motorized wheelchair, sustained minimally displaced fractures of the 2nd through 4th metatarsal necks (breaks in the long bones in the foot, specifically the part connecting the bone to the foot's arch) on 03/21/2025 when CNA A failed to turn off the wheelchair while providing care and bumped into the joystick (the mechanism that moves the wheelchair) which caused the wheelchair to propel forward and slam Resident #1's feet into a wall in the shower room. This failure placed residents who ambulate via motorized wheelchair at risk of injury, pain, and anxiety of possible recurrence. Findings include: Record review of Resident #1's face sheet dated 05/21/2025 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with Multiple Sclerosis (a disease in which the immune system eats away at the protective covering of nerves), hemiplegia of the right dominant side (when the left side of the brain has been damaged, resulting in paralysis of the right side of the body), hemiplegia of the left non-dominant side (injury, or damage to the right side of the brain, resulting in paralysis of the left side of the body), contracture of muscles - multiple sites (a permanent shortening of a muscle and surrounding tissues leading to limited range of motion and joint stiffness), contracture of the left hand, bipolar disorder (a mental health condition that causes extreme mood swings), and anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of Resident #1's quarterly MDS dated [DATE] revealed she had a BIMS score of 14 (cognitively intact); Resident #1 ambulated via motorized wheelchair; Resident #1 was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, personal hygiene, and transfers; Resident #1 was frequently incontinent of bladder and always incontinent of bowel; and Resident #1 was prescribed scheduled and PRN pain medication. Record review of Resident #1's care plan revised on 05/07/2025 revealed the following care areas: * Acute fractures of the 2nd through 4th metatarsals of the left foot. Goal included: Resident to remain injury free. Interventions included: Resident will operate her wheelchair correctly. Therapy will inspect the wheelchair. * (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	[Resident #1] has an ADL self-care performance and mobility deficit related to intrinsic and extrinsic factors. Goal included: The resident will maintain current level of function. Interventions included: Bed Mobility - The resident requires assistance from 1-2 staff to turn and reposition in bed. Dressing - The resident is totally dependent in 1-2 staff for dressing. Personal Hygiene/Oral Hygiene - The resident is totally dependent on 1 staff for personal and oral hygiene. * The resident has limited physical mobility related to MS. Goal included: The resident will demonstrate the appropriate use of motorized wheelchair to increase mobility. Interventions included: Locomotion: The resident is able to maneuver/drive her motorized wheelchair. Record review of Resident #1's nursing progress notes for March 2025 revealed: * On 03/21/2025, at 11:27 a.m., RN B wrote, Per Resident and CNA, resident was being repositioned by CNA into her electric wheelchair and CNA bumped into resident's wheelchair causing the wheelchair to move and run into wall. MD notified and order given to have an x-ray done to the left foot. Pain medication given. RP and management notified. * On 03/22/2025, at 7:06 a.m., RN G wrote, Received report from night nurse that resident x-ray of the left foot 3 views was positive for fracture (acute fracture of the 2nd through 4th metatarsals). Order received by night nurse for new order to apply boot and consult podiatrist . * On 03/22/2025, at 1:28 p.m., RN G wrote, Follow-up to fracture of the 2nd through 4th metatarsal, no skin discoloration or swelling noted. Complaint of pain continues, PRN pain medication given. Resident is lying in bed, no distress noted, boot applied to left foot, resident tolerated well. Record review of Resident #1's Radiology Report dated 03/22/2025 revealed, . Significant Findings, Left Foot 3 views . There are minimally displaced fractures of the 2nd through 4th metatarsal necks . Soft tissue swelling is noted . Record review of the facility's document titled, One on One Inservice dated 03/24/2025, at 1:00 p.m. revealed CNA A was educated by an unknown instructor (the signature was illegible) regarding motorized wheelchair safety. The document read in part, Subject: Safety. Return demonstration outcome: Staff able to demonstrate and verbalize how to leave the wheelchair off when a resident is placed in an electric wheelchair until the resident is situated and CNA has completed the ADL with the resident. The document was signed by CNA A and the instructor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation and interview with Resident #1 on 05/21/2025, at 12:05 p.m. revealed she was alert and oriented. She was in her room sitting in her motorized wheelchair. Resident #1 sat in her wheelchair with her legs and feet elevated evenly with her hips. Resident #1 stated she always sat in her wheelchair and ambulated with her legs and feet elevated. She said in March 2025, CNA A placed her in her wheelchair in the large part of the shower room (The shower room was separated into three rooms. There were two smaller rooms with showers and there was a larger room where staff could get the residents dry and dressed, which led to the hallway). She said her motorized wheelchair had a joystick on the right side. She said CNA A leaned over her while standing on the right side, and something in her pocket bumped the joystick and caused the wheelchair to move forward and hit her feet against the wall. She said CNA A was possibly repositioning her or reaching for something, but she could not recall for sure. She said she went to a podiatrist (a medical professional devoted to the treatment of disorders of the foot and ankle), and they put a soft cast on her foot. She said she just recently got the cast off. She said she had the wheelchair for five years and the staff were supposed to turn it off when they provided care. She said she was not sure if the staff ever turned it off or not before, but they do turn if off now (after the incident). In a telephone interview with Resident #1's physician on 05/21/2025, at 2:13 p.m., he stated he was familiar with Resident #1 and recalled when staff notified him about the incident when she broke her toes. He said the facility staff called him for x-ray orders. He said staff told him an aide reached over Resident #1 and accidentally hit the go button on her wheelchair. He said the x-ray of her left foot showed fractures of the 2nd through 4th toes. He said they immobilized Resident #1's toes by taping them together and wrapping them. He said the wrap was not a cast, but it allowed the toes to set while aligned in place. He said he was not aware of the proper etiquette for the motorized wheelchair, so he could not say if the staff were supposed to turn the device off while providing care or not. He said the negative outcome of the incident was that Resident #1 fractured her toes. In a telephone interview with RN B on 05/21/2025, at 2:31 p.m., she stated on 03/21/2025, she observed Resident #1 and CNA A walking towards her after Resident #1's shower. She said Resident #1 and CNA A told her after the shower, CNA A leaned over Resident #1 to reposition her and CNA A bumped the joystick, causing it to go forward and hit the wall. She said she called the doctor and asked for something for Resident #1's pain. She said she did not know if the incident was caused by an error by the CNA or a glitch in the chair. She said she asked Resident #1 to show her how the chair worked (she did not give a date or period of time this happened) and Resident #1 told her to touch the joystick to see how it moved. RN B said when she touched the joystick, the wheelchair moved abruptly. She said the negative outcome of this incident was that Resident #1 was so worked up (emotional) about it and she may feel anxious about the incident happening again whenever she is placed in the wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview with CNA A on 05/21/2025, at 3:05 p.m., she stated she often cared for Resident #1 and placed her in the wheelchair daily. She said the staff were possibly trained related to Resident #1's wheelchair when she initially received the wheelchair, but she (CNA A) was not trained when she started working at the facility in December 2024. She said she previously left the motorized wheelchair on when she cared for Resident #1, but now she turned it off. She said on 03/21/2025, around 10:00 a.m. - 10:30 a.m., after her shower, she placed Resident #1 into her wheelchair with assistance via mechanical lift. She said Resident #1 was already dressed and ready to leave the shower room. She said as she walked away from Resident #1, towards the door, she bumped the joystick, and it got stuck under Resident #1's arm. She said the wheelchair moved forward and her feet ran into the wall. She said Resident #1 said, [CNA A], my feet! CNA A said she turned around and moved Resident #1 away from the wall. She said now, there is a longer joystick on Resident #1's wheelchair. She stated the negative outcome of the incident was that Resident #1 hurt her foot. She said after the incident, she was educated on proper use of the motorized wheelchair. Record review of the facility's policy, titled Incidents and Accidents dated 08/15/2022 revealed, . Definitions: 'Accident' refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. An 'incident' is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization . Policy Explanation: The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care .