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	06/17/2025

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to have physician orders for the resident's immediate care at time of admission for 1 of 5 residents (Resident #1) reviewed for physician admission orders. The facility failed to provide physician orders for Resident #1 when admitted to the facility with a need for knee immobilizer on 02/18/25. This failure could place the residents at risk of not receiving necessary physician ordered care that could result in worsening conditions or decline in health. Findings included: Record review of Resident #1's face sheet dated 05/24/25 revealed a [AGE] year-old female was admitted on [DATE]. Resident #1 had diagnoses which included: fracture of lower end of left femur (forms the top of left knee joint), hypertension (when the pressure in the blood vessels is too high), and multiple sclerosis (long lasting (chronic) disease of the central nervous system, and paraplegia (inability to move the lower parts of the body). Record review of Resident #1's admission MDS assessment, dated 02/22/25, revealed the BIMS score was 09, which indicated moderately impaired cognition. Further review of the MDS revealed the resident was dependent on staff with all ADL care. Record review of Resident #1's care plan initiated 02/25/25 and revision on 03/27/25 revealed the resident had a non- pressure traumatic wounds to right lower extremities and needs to wear immobilizer to right leg. Intervention: treat as ordered. Record review of Resident #1's June 2025 physician order report for Resident #1 did not reveal the resident had an order for right knee immobilizer. Record review of Resident #1's hospital discharge information dated 02/18/25 read in part . #3 bilateral distal femur fracture. Intervention right knee immobilizer in place . Record review of Resident #1's progress note dated 02/18/25 read in part resident had bilateral femoral fracture and she had right knee immobilizer in place .: Record review of Resident #1's history and physical dated 2/19/25 read in part right knee immobilizer was placed . (continued on next page)

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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record of Resident #1's physician's progress notes dated 04/23/25 read in part . her right distal femoral fracture may open as well, as she has not had her immobilizer in place to the right knee. According to the nursing staff, the immobilizer has been lost. When she first came to the facility the resident had the immobilizer and the DON has been informed . Record review of Resident #1's progress note dated 05/20/25 read in part .IDT met, and it was noted that the resident was unable to obtain a suprapubic catheter after being sent to interventional radiology and urology with no success of receiving the suprapubic catheter. Due to the complication of the resident's anatomy and extensive wounds a new order was obtained for Specialty Hospital for further treatment of wound and an attempt to obtain the best treatment plan. Resident is her own RP and agree with plan of care . During an interview on 05/24/25 at 10:41 a.m., LVN E said Resident #1 had a right knee immobilizer upon admission, and she also replaced the immobilizer after she did the wound care treatment on the right leg. LVN E said Resident #1 had the right knee immobilizer even after the wound on the knee was healed, and when she did her last treatment in March, she did not know when the staff lost the immobilizer. LVN E said she did not see any order for an immobilizer for Resident #1. LVN E said the admitting nurse should have called the physician and clarified the order for the immobilizer and entered it on the PCC, and then it would be transferred to the care plan and TAR. LVN E said Resident #1's fracture could worsen and not heal properly. She stated that the nurse managers monitored the nurses and reviewed the admission packet to ensure all the orders and instructions were transcribed and verified with the physician. LVN E said she was provided in service today (05/24/25) on a clarification order for an immobilizer on admission. During an interview on 05/24/25 at 11:02 a.m., LVN J said Resident #1 had not been in the facility for up to 100 days. LVN J said she did not remember if Resident #1 had an immobilizer on her right leg. She said if Resident #1 did not have an order for an immobilizer, the nurse would not know to apply the immobilizer, and the fracture could worsen. LVN J said the nurse managers should have reviewed the admission paperwork and ensured all orders and recommendations were verified with the physician and entered into the PCC. LVN J said she was provided in service today (05/24/25) on a clarification order for an immobilizer on admission. During an interview on 05/24/25 at 11:18 a.m., the DON said she was unaware Resident #1 had a right knee immobilizer when Resident #1 was admitted to the facility, and she had not seen any immobilizer on the resident's right knee. The DON said to give her time to research the immobilizer because she was not working when Resident #1 was admitted . The DON said the IDT team made the decision to send the resident to the hospital for surgical placement of the Foley catheter because the staff could not insert the foley. The DON Resident #1 was sent to an outside radiologist and urologist and they were not able to insert the foley catheter. The DON said the IDT made the decision to send her to the hospital for aggressive wound care and surgical insertion of foley catheter. During an interview on 05/24/25 at 11:36 a.m., Resident #1's Physician said the resident was discharged from the hospital to the facility with an immobilizer on her right knee, and the staff should have followed up with the order from the hospital. The Physician said she could not remember if the nurse had clarified the immobilizer order with her or the NP. The Physician said Resident #1 should have worn the immobilizer because she had a right femoral fracture. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/24/25 at 2:05 p.m., CNA B said she was not sure if Resident #1 had an immobilizer because she could not remember seeing the immobilizer on the resident. CNA B said if Resident #1 had a fracture and she did not wear the immobilizer, the fracture may not heal well. CNA B said the nurses were responsible for applying the immobilizer to the resident. CNA B said she had in service on resident immobilizer (05/24/25). She said the DON told her to make sure the resident had the immobilizer on and, if it was not in place, to tell the nurse. During an interview on 05/24/25 at 2:15 p.m., CNA H said she thought she saw an immobilizer on Resident #1's leg but was unsure because Resident #1 was moved to another hall. CNA H said the nurse was responsible for applying the immobilizer. CNA H said she had in-service today and was told to tell the nurse that if a resident with an immobilizer were off, the aide would have to notify the nurse. During an interview on 5/24/25 at 2:32 p.m., the Wound Care nurse said she started doing Resident #1's wound treatment on March 5, 2025, until Resident #1 was discharged . The Wound Care did not see any immobilizer on Resident #1 right knee. The Wound Care Nurse said she did not know Resident #1 should have worn an immobilizer on her right knee, and there was no order for the immobilizer. The Wound Care nurse said Resident #1's fracture could worsen if not stabilized. She stated that the admitting nurse and the nurse manager should have ensured that Resident #1's discharge orders and instructions from the hospital were verified and transcribed. She said if the resident did not have an order, then the nurse would not know to apply the immobilizer. During an interview on 05/24/25 at 7:29 p.m., the DON said she was unaware Resident #1 was supposed to wear an immobilizer. The DON said none of the staff told her Resident #1 had an immobilizer on admission, and there was no order. The DON said the clinical should be reviewed and communicated to the doctor upon admission. She stated the admitting nurses should have clarified the discharge medication order and any other equipment, such as an immobilizer, with the physician when Resident #1 was admitted to the facility, and she had the immobilizer on. The DON said the immobilizer was put in place to prevent the fracture from moving and help the healing process. She said without the immobilizer the fracture could heal deformed. The DON said the nurse management team followed up the next day to ensure all the medications and equipment Resident #1 needed for resident care were verified and ordered. During an interview on 05/24/25 at 7:50 p.m., the ADON said the admitting nurse should have reviewed Resident #1 admission paperwork, and the nurse managers would review the paperwork the same day if the resident were admitted early in the day. Then, ADON said that if the resident were admitted later, ADON would review the admission paperwork the next day. She stated another ADON was supposed to review the discharge records, but they worked as a team because they went to the conference hall and reviewed the admission paperwork. She said she could not remember if she reviewed the paperwork with the team. The ADON said she was unaware Resident #1 had an immobilizer when the resident was admitted . She said if the resident should have an immobilizer and she did not, then it could cause more harm to the fracture. She stated that the ADON and DON monitored the nurses and reviewed the admitting paperwork. She said the manager team greets the new residents and introduces themselves, but they do not do skin assessment, and if the immobilizer was under the cover, they would not see it. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/25/25 at 1:24 p.m., Resident #1 was lying on her back on the hospital bed, and she did not have an immobilizer on her right knee. Resident #1 said she was admitted to the facility with an immobilizer, and after a while, the staff stopped applying the immobilizer. Resident #1 denied pain and said the fracture happened when she was dropped at her previous facility. During an interview on 05/26/25 at 1:45 p.m., the Charge nurse at the hospital said Resident #1 was seen by an orthopedic surgeon yesterday(05/25/25) but did not write any order for immobilizer or any other treatment at this time During an interview on 06/17/25 at 9:46 a.m., the Administrator said she was not aware Resident #1 had an immobilizer, or she was supposed to wear one. The Administrator said she was unsure what could happen to the fracture if Resident #1 did not wear the immobilizer because she did not even know what the immobilizer would do. Record review of the facility QAPI meeting dated 05/24/25 revealed issue/plan Resident #1's facility failed to review admission clinicals and in return did not obtain right knee immobilizer order. The Administrator, DON, The Medical Director attended QAPI meeting plan was: in-services: ANE, review of new admission/readmissions process to include reviewing Hospital clinicals for: immobilizer/splints/devices and physician orders. When a resident admits with an immobilizer/splint/devices in place nurse is to obtain physician order for immobilizer/splint/devices. Record review of the facility in service revealed the staff were in serviced on 05/24/25 on admissions with immobilizer read in part . which included: admitting nurse received clarification orders for immobilizer: how long should the immobilizer be in place . where should the immobilizer be placed .skin assessment should also be assessed prior to donning and doffing the immobilizer .add to care plan as well as Kardex . Record review of the facility undated policy on daily clinical meeting process read in part . review new admission . in PCC review for completed admission documentation, correct order transcription includes . required admission . are completed and scheduled appropriately .