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	03/06/2026

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to incorporate the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care for 2 of 10 residents (Resident #13 and Resident #28). The facility failed to ensure that PASARR requested therapy services were provided to Resident #13 and Resident #28 in accordance with the PCSP meeting to include Occupational Therapy, Physical Therapy, and Speech Therapy. This failure could result in not receiving the support necessary to maintain stability, function, and safety.Findings included: Record review of Resident #13's undated admission record revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included developmental disorders of speech and language, lack of coordination, muscle wasting and atrophy, swelling, and mass lump right upper limb. Record review of Resident #13's physician orders dated 05/09/2025 revealed Speech Therapy may evaluate and treat as indicated, Physical Therapy may evaluate and treat as indicated, and Occupational Therapy may evaluate and treat as indicated. Record review of Resident #13's PCSP meeting dated 10/31/2025 revealed the following services were requested: Specialized Assessment Occupational Therapy, Specialized Assessment Physical Therapy, Specialized Assessment Speech Therapy, Specialized Occupational Therapy, Specialized Physical Therapy, and Specialized Speech Therapy. Resident #13 did not receive an evaluation for Physical Therapy or receive Physical Therapy services. Record review of Resident #13's Speech Therapy Evaluation & Plan of Treatment dated 11/11/2025-01/09/2026 assessment summary read evaluation completed for habilitative services and patient demonstrated cognitive-communication impairment with deficits in auditory comprehension, verbal expression. Dysarthria (when muscles used for speech are weak or hard to control) affect speech intelligibility. Risk factors read due to documented physical impairments and associated functional deficits; the patient is at risk for further decline in function. Record review of Resident #13's MDS Quarterly assessment dated [DATE] revealed a BIMS score of 03 out of 15 indicating he has severe impairment in cognition. He had no impairment on lower extremity (hip, knee, ankle, foot) and impairment on one side for upper extremity (shoulder, elbow, wrist, hand). Record review of Resident #28's undated admission record revealed [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included cellulitis (spreading skin infection) of the lower right limb, intellectual disabilities, dysphagia (difficulty swallowing), parkinsonism (tremors), cognitive communication deficit (trouble participating in conversations), muscle wasting and atrophy right thigh, muscle wasting and atrophy left thigh, left hand contracture, and schizophrenia. Record review of Resident #28's Physical Therapy Evaluation & Plan of Treatment reflected it was completed 06/07/2024, prior to the most recent request of services according to the PCSP meeting. Record review of Resident #28's physician orders dated 05/23/2025 reflected Occupational Therapy may evaluate and treat as indicated, Physical Therapy may evaluate and treat as indicated, Speech Therapy may evaluate and treat as indicated. Physician order review over the phone dated 07/02/2025 indicated to continue ST treatment 24 times in 8 weeks. Record review of Resident #28's (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Occupational Therapy Evaluation & Plan of Treatment dated 05/28/2025-07/26/2025 recommendations read evaluation assessment summary read patient with decreased tolerance for activities, independence with self-care, and strength of UEs. Risk factors revealed patients have weaknesses and falls. The skilled intervention focus was restoration and compensation. Record review of Resident #28's PCSP meeting on 08/14/2025 revealed the following services were ongoing: Specialized Occupational Therapy, new Physical Therapy, and discontinued Speech Therapy. Record review of Resident #28's MDS Quarterly assessment dated [DATE] revealed a BIMS score of 14 out of 15 indicating intact cognition. He had no impairment on upper extremity (shoulder, elbow, wrist, hand) and impairment on one side (hip, knee, ankle, foot). In an interview with LVN M on 03/03/2026 at 2pm stated a meeting is held with the resident or responsible party, care management team of the facility and [NAME] County Health Center staff to conduct the PCSP meeting to develop the needs of therapy services to the resident through the PASARR program. All recommendations and communications are entered into an electronic system accessible to the parties responsible at both the nursing facility and. LVN stated PT services for Resident # 28 were not sent and Resident #13 refused services. LVN M stated she is unsure who is responsible for ensuring that referrals are sent to therapy for completion of the required assessments. LVN M stated the risk of residents not being assessed for PASARR-related services could result in a decline in their condition. In interview with DOR on 03/03/2026 at 2:53pm stated Resident #13 refuses services and would not participate for ST. Resident #13 is not receiving services because he is non-compliant and it was in the best interest to discharge for ST treatment services. Resident #13 was not evaluated for PT or OT services. Resident #28 was receiving ST and OT, but not PT due to having one leg and the other leg was contracted, making him not a good candidate for the program. If no referral is initiated for the residents to receive an assessment, the evaluations are not completed. The DOR stated the care management team is responsible for ensuring all documentation is put into the appropriate electronic system and accessible to all parties involved. The risk of the residents not being assessed for services through PASARR could cause the residents to decline. In an interview with LVN B on 03/04/2026 at 9:30am stated the nursing facility is not responsible for entering information for PASARR II, it is updated by staff. If the referral for an assessment to be completed is not sent, the responsibility falls on staff as they communicate with therapy. LVN B stated Resident #28 should have received an evaluation assessment because it was requested on his PCSP and Resident #13 refuses services, which is why he is not receiving therapy. The risk of the residents not being assessed for services through PASARR could result in the residents not thriving according to their care plan. In an interview with DON on 03/05/2026 at 8:56am stated the procedure for PASARR level II residents is to have a meeting with to review necessary equipment and therapy service or psychiatric services. She stated that she is unsure of the exact process for submitting the requests online, only that the system is electronic. She was unaware that Resident #13 and Resident #28 had not received the services they were approved for through PASARR. She explained that the MDS/Care Management team is responsible for entering and submitting these requests into the system after each meeting. She further stated that if the requests are not entered, the residents will not receive the services they need and have been approved of, which may prevent them from reaching their full potential. In an interview with ADMN on 03/05/2026 at 9:15am stated for PASARR level II residents, the meeting involves participation from [NAME] County Health Center, and on the facility's side, the MDS nurse is typically involved. She was unsure of the specific form names used during the process. If the resident qualifies for and agrees to the recommended services, the required forms are submitted electronically to document the requested services. She reported that she is not fully familiar with PASARR guidelines but does know there is a required timeframe for completing the meeting and entering the information into the portal. She further stated that if the request is not submitted, the residents may miss opportunities to receive needed services and could experience a decline in their quality of life. In an interview with RN N on 03/05/2026 at 9:34am stated during the PASARR level II audits, the facility (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified missing information that should have been entered into the electronic portal. If information is not submitted, they must re-enter and resubmit it. He explained that the NFSS is completed based on the building and must be entered within 20 days, then finalized within 30 days from the PCSP meeting. He reported that he was informed by the MDS coordinators of these requirements. He stated that the facility does not have a policy for PASARR level II and instead follows the Texas Health and Human Services guidelines. He further explained that the risk of not submitting the required information is significant, as residents may lose access to needed services, which could negatively impact their health and quality of life. He stated that the facility does not have any policy or procedure specific to level II.

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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 observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 8 residents (Resident #1) reviewed for comprehensive care plans. The facility failed to ensure that Resident #1's care plan included interventions for the contractures to the left elbow, left hand, right knee and left knee.The facility failed to ensure Resident #1's care plan included heel protectors for the potential for the development of pressure ulcers and for the non-pressure wound to the left foot.This deficient practice could place residents at risk of not receiving proper care, pain, reduced mobility and decline in health.Findings included:Record review of Resident #1's face sheet dated 03/04/26 revealed a [AGE] year-old admitted to the facility on [DATE] and initially admitted on [DATE]. The diagnoses included Hemiplegia (one sided paralysis or severe loss of strength on one side), Hemiparesis (weakness to one side of body), Diabetic neuropathy (affecting peripheral nerves leading to symptoms like pain and numbness), contracture of the left elbow, contracture of the right knee, contracture of the left hand, contracture of the left knee, muscle wasting and dementia (a general term for a group of symptoms that cause a loss of cognitive functioning).Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 7 out of 15 indicating severely impaired cognition. She had impairment to one side of the upper extremity and to both sides of lower extremity. She was dependent on nursing staff for all ADLs. She was frequently incontinent of urine and always incontinent of bowel. The resident was at risk for pressure ulcers and had pressure reducing device for the bed. Further review revealed she was not receiving any therapy services.Record review of Resident #1's active physician orders as of 03/04/26 revealed an order for a mattress: air pressure reduction every shift, start date on 02/21/25. Further review revealed an order for heel protectors to bilateral feet, daily, start date 11/04/25.Record review of Resident #1's undated care plan revealed Problem - Resident #1 had potential for pressure ulcer development r/t and including limited mobility and contractures. Interventions - did not include heel daily protectors/soft booties to the feet. Further review revealed there was no care plan or interventions for multiple contractures: left elbow, left hand, right and left leg. Observation and interview on 03/04/26 at 5:10 AM during incontinent care for Resident #1 revealed the resident had multiple contractures. Her left elbow was bent close to the chest and left hand was severely contracted at the wrist. The fingers on the left hand were also contracted. Resident #1's right leg and left leg were pulled up towards the chest, bent at the knees with knees touching each other. Resident #1 had a soft boot/heel protector to the left foot. Resident #1 had a low air loss scoop type mattress. During incontinent care, when CNA A turned Resident #1 or attempted to move the knees apart to cleanse the peri area, the resident said it hurt. LVN B entered the room to assist CNA A and attempted to assist by moving Resident #1. Resident #1 said her left leg hurt and that sometimes the right leg would hurt because she had arthritis in that leg. LVN B stated Resident #1 will yell out during incontinent care d/t her contractures and the resident will work herself up at times, so it was best to allow her some time to relax and come back later to finish ADL care which LVN B instructed CNA A to do. CNA A stated she places a pillow between her legs to keep her skin from breaking down. In an interview and observation on 3/4/26 at 8:10 AM, the DOR stated Resident #1 was off Therapy services but would be evaluated this week. The DOR stated the reason for therapy was for contracture management and that therapy included splinting for both upper and lower extremities when she was on service. The DOR stated after discharge from Therapy she was transferred to Nursing care, but the facility no longer had a Restorative Program. The DOR stated for her knees there was a special bolster pillow for behind the knees to prevent flexion, which would help (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevent skin breakdown. The DOR stated the special bolster pillow should be in her closet. Observed with the DOR present that the special bolster pillow was in the closet. The DOR stated the special bolster pillow would be put in place by therapy during services. The DOR stated it was also appropriate for nursing staff to use pillows between her legs to help keep contractures from worsening.In a telephone interview on 3/5/26 at 7:00AM, LVN B said she would sometimes place rolled towels for Resident #1's contracted hand to prevent worsening of the contracture and a soft bootie to the left foot to help with contractures to the lower leg. LVN B stated she would find how to address Resident #1's contractures in the resident's chart.In an interview and observation on 3/5/26 at 9:35 AM, CNA C stated she was familiar with Resident #1's care. CNA C stated Resident #1 did have contractures to the left arm and both legs. CNA C stated due to her contractures she would have to turn her a certain way during repositioning otherwise Resident #1's feet would bend and cause pain. CNA C stated she knew Resident #1 needed boots for both feet because it was in the plan of care. CNA C stated Resident #1 had a special bolster pillow for in between the knees. CNA C stated she was aware of how to apply the special bolster pillow because of her experience working with therapy long ago prior to working at the facility. CNA C stated the special pillow was to help prevent pressure sores by reducing skin to skin contact because of her contractures. Resident #1 had the blue bolster pillow in place behind the knees. CNA C stated she did not put the bolster pillow in place and did not know who placed it.In an interview on 3/05/26 at 9:55 AM, LVN D stated Resident #1 cannot move her legs. LVN D stated it was important to address Resident #1's contractures to help prevent contractures from worsening by using pillows. LVN D stated sometimes her legs may separate even a little, which would be important to help keep them from tightening back up and prevent skin breakdown as well.In an interview on 3/06/26 at 8:15 AM, the DOR stated Resident #1 would be in pain with every little movement when he worked with her in the past due to her severe contractures. The DOR stated she did receive pain medication at the time but thought her issues were more to do with anxiety. The DOR stated management of contractures had to do with improving a resident's mobility and if the resident was unable then it would just be for maintaining their abilities to the point where mobility would not get worse. The DOR stated he was the one who placed the blue bolster pillow in place.In an interview on 03/06/26 at 8:50 AM, LVN E and LVN M (who were both MDS nurses) stated the purpose of the care plan was to reflect the residents' care, needs, goals and interventions. LVN E and LVN M stated the care plan was the responsibility of the IDT team which included nursing, dietary, social services and MDS. LVN E and LVN M stated if a resident's contracture was an active issue and documented then it would be care planned. LVN E and LVN M stated the purpose of interventions was to prevent any decline, maintain and meet the residents' needs. LVN E and LVN M stated that nursing staff had access to interventions in the care plan and the information would cross over into the Kardex (essentially a care plan chart or template).In an interview on 03/06/26 at 9:05 AM, the DON stated the purpose of the care plan was to provide a big picture of the residents' care and that it should be resident centered. The DON stated the IDT team was responsible for the accuracy of the care plan. The DON stated nursing tasks would transfer from the care plan to the Kardex, and the expectation would be that CNAs review the Kardex before providing care. The DON stated Resident #1's contractures should have been care planned as well as for all residents with contractures. The DON stated she did not know why Resident #1's contractures were not in the care plan and that the MDS nurses had a different system before she started working at the facility as DON.Record review of the facility's policy for Comprehensive Care Plans dated 10/24/22 read in part: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .to meet a resident's medical, nursing and mental and psychosocial needs.3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being.f. Resident specific interventions that reflect the resident's needs.as indicated.6. The comprehensive care plan will include measurable objectives and timeframes (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the residents' progress. Alternative interventions will be documented, as needed.