STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676356	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of North Houston	303 Hollow Tree Lane Houston, TX 77090

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 13 residents (Resident #2) reviewed for pain. - The Facility failed to ensure Resident #2's pain was assessed and treated prior to wound care treatments causing the resident to cry out when touched or moved. An immediate Jeopardy (IJ) was identified on 03/26/2026. The IJ template was provided to the facility on [DATE] at 5:22 PM. While the Immediacy was removed on 03/30/2026 at 4:54 PM, the facility remained out of compliance scoped at pattern with no actual harm and potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. These failures placed residents at risk of increased or unmanaged pain and actual harm. Findings Include: Record review of Resident #2's admission record dated 3/25/26 reflected Resident #2 was a [AGE] year-old female, who admitted to the facility on [DATE] with a primary diagnosis of unspecified dementia (a decline in mental ability), Hypertension, and Major Depressive Disorder. Record review of Resident #2's admission MDS dated [DATE] revealed a BIMS of 00 which indicated severe cognitive impairment. Resident #2 was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) for the following areas: Roll left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Continued record review revealed Resident #2 was coded in Section M related to Skin Conditions as having 1 unstageable (full thickness wound with unknown depth, as the base of the wound becomes obscured by necrotic or dead tissue) pressure injuries upon admission. Record review of Section V of the MDS related to Resident #2's CAA had no care area triggers for pain and had no care planning decision made for pain. Record review of Resident #2's care plan dated revision on 03/25/26 revealed she had a left heel DTI (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure or shear), Right Heel DTI, Pressure Wound to Sacrum,(large triangle shaped bone located at the base of the lumbar vertebrae) Bruise/discoloration/ open blister to right knee, Left Heel Ulcer Pressure Injury, and Right Bunion DTI. Resident #2 had no care plan for pain Record review of Resident #2's order summary revealed the antibiotic medication Doxycycline Hyclate Oral Tablet 100 MG Give 1 tablet by mouth two times a day for Sacral wound for 7 Days with an active order date of 03/25/2026. Record review of Resident #2's physician order recap summary dated 3/31/26 revealed an active order dated 1/12/26 for Acetaminophen Tablet 500 MG. Give 1 tablet by mouth every 6 hours as needed for Pain Do not exceed 3 gm acetaminophen from any source in 24 hr. period. Record review of Resident #2's physician order recap summary dated 3/31/26 revealed an active order dated 3/16/26 for Wound Care Pressure Injury to Sacrum Unstageable cleanse with (sic)Dakin's and pat dry. Apply (sic)Dakin's soaked wet to moist gauze as primary dressing. Cover with a border gauze as secondary dressing twice daily and prn every night shift and every day shift for wound care. Record review of Resident #2's medication administration record dated March 1, 2026, through March 31, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676356	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026
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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2026, revealed she had not been administered any Acetaminophen for pain since 03/06/2026 although the resident received wound care 2 times a day. Record review of Resident #2's undated wound care report revealed she had a left heel DTI, Right heel DTI, and unstageable sacrum pressure ulcer.During an observation of Resident #2 while wound care was attempted on 03/25/26 at 1:52PM, when asked if Resident #2 had been assessed for pain, Treatment Nurse said yes and then said she would have to check with LVN A. When asked if Resident #2 had been medicated for pain, Treatment Nurse said she would have to check with LVN A. Resident #2 was observed wincing when rolled to her left side for positioning to perform wound care and said, [NAME] Dios Mios (Oh my God), and her eyebrows were furrowed. CNA A and CNA B stopped moving her. CNA A stated, I think it's because she's laying on the wound and CNA A stated it's back here and it usually drains a lot. When surveyor asked CNA A and CNA B how Resident #2 communicated CNA A said she believed Resident #2 spoke Spanish. CNA B said she believed Resident #2 spoke English. The Treatment Nurse said she was new to her role and was unsure which language Resident #2 communicated in and would have to check. When asked how did staff assess or ask her about her pain, CNA A said she was unsure. Surveyor asked if the CNAs smelled an odor to which CNA A replied, yes, it's the wound. CNA A said Resident #2's wounds often drain and stated the drainage on the back of Resident #2's exposed brief was from the wound. CNA B attempted to undo the brief, but Resident #2 continued to wince and began to moan so all care was stopped after surveyor intervention. Surveyor observed a brownish green circular spot through the back of the brief and the foul odor remained. The treatment nurse said the wound had an odor since she started a week ago and had some necrotic or dead tissue inside and around the edges that could be the cause of the odor. Surveyor also observed towels located on top of pillows that were used for positioning Resident #2's wounds to her bilateral heels. One of the towels was covered in a brownish red discharge. During the positioning and repositioning of Resident #2 in an attempt to perform wound care, she felt warm to touch. Surveyor touched the leg of Resident #2 with a gloved hand, and the resident appeared to feel warm; both CNAs A and B stated the resident felt warm/hot to the touch. The treatment nurse also felt Resident #2 and stated that the resident felt warm to touch. Surveyor asked treatment nurse if the resident had been medicated for pain and if her temperature or vital signs had been assessed and the treatment nurse stated she did not know, she would have to ask the charge nurse; LVN A. LVN A was called to the bedside by the treatment nurse to ask if Resident #2 had been medicated and she stated there was no indication that the resident had been in pain or needed her vital signs assessed. LVN A stated she would check the resident's temperature since Surveyor and 2 CNAs thought Resident #2 felt warm without ever touching or assessing Resident #2 herself. LVN A took Resident #2's temperature with a contactless forehead scanning thermometer and said aloud, Resident #2's temperature was 98.2 degrees and normal. LVN A said she was unsure if Resident #2 had anything prescribed for pain and would have to check the orders. During an interview with the Administrator and DON on 03/25/2026 at 4:10pm the DON stated the staff are expected to assess for pain whether it is verbal or assessing for grimacing, and there was a pain scale. The DON stated that if there was not an order for pain management for a resident, staff were to call the physician if they were noticing any signs or symptoms of pain. The DON stated when providing wound care, the staff were supposed to assess for pain prior to performing the treatment, throughout the treatment and after the treatment. She stated if a resident were non-verbal, the staff were to use a PAIN AID (A validated, observer-based toll used to measure pain in patients with severe dementia)assessment tool to check for facial expressions and moaning throughout the treatment. She stated the wound care nurse or treatment nurse was responsible for assessing pain prior to wound care. Record review of Resident #2's Physician orders on 03/25/2026 at 5:00PM revealed the resident was sent to the hospital for altered mental status and abnormal labs. During a telephone interview with Wound Care NP on 03/26/2026 at 12:37 pm she stated she spoke with Resident #2's NP yesterday and was informed that Resident #2's wound had a smell. She stated Resident #2 did have an increase in dead tissue and she took some of the tissue out of the sacral wound last week, and the (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physician. In a telephone interview with Resident #2's RP on 3/26/26 at 5:34pm she said they were only told by facility staff that Resident #2 was sent to the hospital because of abnormal labs and no one from the facility mentioned any wound odor or infection and no one at the facility told her about antibiotics being ordered for the wound. Resident #2's RP said she believed staff were at least giving her medications for pain and fever and was shocked when she re-played the electronic monitoring device video in the room to see staff performing or trying to perform wound care without medication. Requested copy of video evidence and did not receive prior to facility exit. Record review of facility policy procedure titled Pain Assessment and Management revealed in part: Assessing Pain 1. Assess the resident at admission and during ongoing assessments to help identify the resident who is experiencing pain or for whom pain may be anticipated during specific procedures, care and treatment.2. Monitor the resident for the presence of pain and the need for further assessment when there is a change of condition. Identifying the Causes of Pain 1. Residents may experience pain from several different causes simultaneously.2. In addition, common procedures such as moving the resident, physical therapies, or wound care can cause the resident pain.3. Review the resident's clinical record to identify conditions or situations that may predispose the resident to pain, including:a. musculoskeletal conditions:(1) degenerative joint disease;(2) rheumatoid arthritis;(3) osteoporosis;(4) fractures; and(5) amputation.b. skin/wound conditions:(1) pressure, venous or arterial ulcers; and(2) surgical incision Defining Goals and Appropriate Interventions 1. The pain management interventions are consistent with the resident's goals for treatment which are defined and documented in the care plan. Pain management interventions reflect the sources, type and severity of pain.2. Pain management interventions shall address the underlying causes of the resident's pain.3. For those situations where the cause of the resident's pain has not been or cannot be determined, current standards of practice for managing pain are followed to help determine appropriate options. This was determined to be an Immediate Jeopardy (IJ) on 03/26/2026. The Administrator was notified on 03/26/2026. The IJ template was provided to the facility on [DATE] at 5:22 PM. The following Plan of Removal (POR) submitted by the facility was accepted on 03/27/2026 at 3:00PM. The plan of removal reflected the following: PLAN OF REMOVAL:F 697 Name of Facility: Date: 03/27/2026According to the IJ Template, the facility failed to ensure that pain management was provided for Resident #2. Immediate Action:Resident #2 was discharged on 03/25/2026 at 8:39pm to the hospital after a repeat laboratory test resulted in a critical level of elevated sodium. Resident remains hospitalized at this time. Upon re-admission, Resident #2's treatment orders will be amended to include prior to treatment being completed, resident will be evaluated for pain and medicated if indicated during evaluation. C.N.A A, B, and LVN A, and facility treatment nurse have all received additional 1:1 education specific to all issues identified in the preliminary fact analysis. Nursing leadership, DON and designee(s) immediately conducted facility rounds on all residents to ensure no unreported or undocumented changes in pain levels were present. Additionally, all wound care orders were audited to ensure pain management orders are present as indicated; no issues were found. All residents with wound care orders have corresponding pain management orders. Date of completion:3/27/2026 Nursing leadership, DON and designee(s) completed house wide pain assessments. No new pain was identified; any reported pain was communicated to the charge nurse for medication administration if indicated and follow up assessment was completed to ensure effectiveness. Date of completion: 3/27/2026 Licensed nurses were provided with re-education by the DON and designee(s) on change in condition, pain assessment and management, administering pain medications, pain-clinical protocol which specifically includes-: 4. The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated, for example, wound care, ambulation, or repositioning as well as review of the critical element pathway for pain recognition and management. Date of completion: 3/27/2026 All additional nursing staff were provided with re-education by the DON and designee(s) on recognizing resident change of condition or status to include any changes in resident pain levels as well as proper protocol of reporting of any (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	identified change of condition or status by using the STOP AND WATCH Alert in PCC, point of care documentation and/or communicating directly with their charge nurse. All staff who are not working will be re-educated prior to working next scheduled shift. Date of completion: 3/27/2026 Facility Administrator and Director of Nursing were both educated by the Divisional [NAME] President of Operations on the following: Standards of Care, Pain Management and Quality Oversight. Date of completion: 3/27/2026 Person(s) Responsible: DON/Designee Date: 3/27/2026 Completion: 3/27/2026 Systemic response: Action: All licensed nurses received immediate re-education on the facility protocol for the following: * Change of Condition or Status * Pain Assessment and Management* Administrating Pain Medication * Pain-Clinical Protocol*Use of e-Interact Change in Condition UDA, STOP AND WATCH Alerts All non-licensed nursing staff were re-educated on resident change of condition or status, proper reporting and STOP AND WATCH Alert system. All staff who are not working will be re-educated prior to working next scheduled shift.Comprehensive knowledge of all presented education will be validated by employee completion of Quiz and acknowledgement of the following:*Recognition of changes in condition*Proper notification procedures*Pain Assessment and Management Person(s) Responsible: Don/designee Date: 3/27/2026 Completion: 3/27/2026 Action: Review of the pain assessment and management policy: Facility reviewed and validated the current policy to ensure alignment with regulatory requirements. No changes are required at this time. Person(s) Responsible: Regional Nurse Consultant Date: 3/27/2026 Completion: 3/27/2026 Monitoring Response:Audit:*Daily change in condition/pain assessment audits x 30 days:*DON/designee will review 24-hour summary report and nurse progress notes*DON/designee will ensure all changes are reported to the provider and documented during audit. *DON/designee will review all completed pain assessments daily to ensure completion prior to treatments being administered. *Audit results will be reviewed by IDT/QAPI weekly during Friday morning meetings to ensure compliance. Any identified issues will be addressed and communicated to the provider immediately. Person(s) Responsible: DON/designee Date: 03/27/2026 Completion: 3/27/2026 Ad-Hoc meeting was conducted with medical director on 3/26/2026 via phone regarding immediate jeopardy. The Plan of Removal was confirmed for the IJ by monitoring from 03/26/2026 through 03/30/2026 as follows: Record review on 3/26/2026 at 10:15 am of DON and designee audits of facility rounds on all residents to ensure no unreported or undocumented changes in pain levels were present and none were identified during the rounds per the audit tool and resident medication administration records. Record review on 3/26/26 at 10:55 am of facility wound care order audits with no issues identified per facility documentation. Record review on 3/26/26 at 11:03 am of facility audit of pain management orders with no issues identified per facility documentation. Record review on 3/26/2026 at 11:14 am of facility audit for all residents with wound care orders who had corresponding pain management orders that had been documented as updated or clarified if not in place. Record review on 3/27/26 of DON and ADON audits of facility wide pain assessments Record review on 03/20/26 of Comprehensive knowledge of completion of the following quizzes: Recognition of changes in condition, Proper notification procedures, and Pain Assessment revealed all licensed and non-licensed staff had completed quizzes. During interviews on 03/28/2026, 03/29/26 and 03/30/26 between 7:00AM and 6:00PM with licensed nurses and non-licensed staff (8 LVNs, 3 RNs and 6 MA, and 14 CNA's who worked both 6:00AM-6:00PM shift and 6:00PM-6:00AM shift, staff were all knowledgeable of the step-by-step process for pain management during care and procedures and reporting uncontrolled pain to the provider using the SBAR as a communication tool and for unlicensed staff reporting any changes in condition to the nurses. Treatment Nurse, ADON, and DON said that for verbal residents they can assess pain on a scale of 1-10 and for non-verbal residents they can assess pain using a PAINAD scale for facial expressions. All licensed nurses gave examples of non-verbal signs/symptoms or cues for pain which could be crying, breathing heavy or fast, wincing, and flinching and that they should evaluate for any pain signs or symptoms prior to, during and after a procedure or treatment. All licensed staff at that time said if a resident were exhibiting signs and symptoms of pain, they were to (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stop the treatment or procedure, redo the assessment and check for any other orders for interventions and if interventions were ineffective, they would initiate SBAR for pain and notify the MD and RP for the resident. The Administrator was informed that the immediacy was removed on 03/30/2026 at 4:54PM. The facility remained out of compliance at a scope of pattern at a severity level of no actual harm that was not immediate due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 2 (Residents #3 and #4) of 6 residents reviewed for pharmaceutical services. The facility failed to ensure accurate administering of all drugs and biologicals to meet the needs of Resident #4, whomissed 2 doses of Lidocaine External Patch 4% on 03/25/26 and 03/26/26 resulting in resident being sore, was administered high dosages and low dosages of Tramadol and Resident #4 putting her at risk of overdose, and Resident #3 was administered insulin outside of her parameters which could cause her to go into hyper or hypoglycemia. MA C and LVN G failed to administer Resident #4's Lidocaine External Patch 4 % during the scheduled time. MA C, RN D, RN F, and MA H failed to administer Resident #4's Tramadol HCL 50 MG Oral tablets per physician orders, who received both 50 mg AND 100 mg doses of Tramadol, 1-3 times a day from 3/21/26 through 3/25/26 LVN B failed to administer Resident #3's Rezvoglar Kwik Pen 100 unit/ml solution pen injector insulin within herscheduled parameters on 6 separate dates. This failure could place residents at risk for adverse side effects, illness, and possible hospitalization. Findings included: Record review of Resident #4 face sheet dated 03/12/26 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Parkinson'sDisease with Dyskinesia (involuntary, erratic writhing movements) and pain in right hip. The resident has a BIMS scoreof 2, which indicated severe cognitive impairment. Record review of Resident #2's care plan dated revision on 03/17/26 revealed the resident had pain related to chronic comorbidities. Record review of Resident #4's physician order summary dated March 2026 revealed the following orders for the narcotic pain medication Tramadol: traMADol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug*Give 1 tablet by mouth three times a day for pain. and traMADol HCl Oral Tablet 100 MG (Tramadol HCl) *Controlled Drug* Give 100 mg by mouth three times a day for pain until 03/27/2026.Record review of Resident #4's physician order summary also revealed the following order for topical pain medication: Lidocaine External Patch 4 % (Lidocaine) Apply to right hip topically one time a day for pain. Record review of Resident #4's Controlled Substance Log on 3/25/26 at 1:56pm revealed: Tramadol HCL 50 MG OralTablet Take 1 tablet by mouth 3 times daily (8:00am, 12:00 Noon and 8:00pm) was not administered correctly on 5 different dates; the correct dosage was not administered, there were staff signatures missing and times were missing. Record review of Resident #4's Controlled substance log on 03/25/26 revealed Tramadol HCL 50 MG Oral tablets were not administered as order between 03/22/26-03/25/26. Observation and interview of Resident #4 at 11:34 am on 3/25/26 revealed she was lying in bed and repeatedly rubbing her right hip/thigh in a circular motion. Resident #4 was shaking her legs, in a twitching motion and her eyebrows were furrowed. When asked if she was itchy or sore the resident replied sore. CNA-I said she would tell the nurse. There was no lidocaine patch observed. Record review of Resident #4's medication administration record on 3/25/26 at 12:32pm revealed MA-C documented she had administered Resident #4's Lidocaine External Patch 4 % (Lidocaine) Apply to right hip topically one time a day for pain. At 8:00 am on 3/25/26. In an interview/observation on 03/25/26 at 1:18PM with Resident #4 observed lying in bed rubbing her right thigh in a circular motion and continuing to shake her legs in a repetitive twitching motion. When asked if she was in pain, she stated, sore. Resident #4 had a frowned facial expression and there was no lidocaine pain patch on her right hip or thigh. Due to the resident's cognitive ability, Surveyor was unable to complete a full interview. This was the second observation of the resident not wearing the pain patch on 3/25/26. In an interview with MA C on 3/25/26 at 1:36pm MA C said she did not have Resident #4's pain patches on her medication cart at the time Resident #4 was supposed to receive the lidocaine patch, so she signed that she gave it and (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meant to go get the lidocaine patch and return to Resident #4 and apply it, but she forgot. MA C said she would go and tell the nurse in charge and apply the lidocaine patch for Resident #4. MA C said she was not sure if Resident #4 was in pain or if she had been in pain since 8:00am. MA C said she should not have documented that she administered Resident #4's pain patch without actually applying the patch as ordered. In an observation and interview on 3/26/26 at 12:48pm with the DON, Resident #4 was observed lying in bed on her right sideand when DON and LVN G repositioned Resident #4 to her left side, exposing her right hip and thigh, Resident #4 began repeatedly rubbing her right hip and thigh in a circular motion and began shaking her legs. There was no pain patch observed on her right hip/thigh or her left hip/thigh. There were no patches observed in or on the residents' bedding. Record review of Resident #4's medication administration record on 3/26/26 revealed RN D documented she had administered Resident #4's Lidocaine External Patch 4 % (Lidocaine) Apply to right hip topically one time a day for pain. In an interview with RN D and DON on 3/26/26 at 5:05pm RN D said that she did not administer Resident #4's pain patch or any other medication because she was not assigned to Resident #4. RN D said that LVN G had borrowed her computer earlier in the day because his computer needed to be charged and she had not documented medication administration for Resident 4. The DON said she would need to further investigate EMR glitches and said she would have to follow up with LVN G regarding the signed for lidocaine patch. The DON said aloud that perhaps the resident was somehow rubbing the patch off but agreed that Resident #4 had no lidocaine pain patches on as ordered per the 12:48pm observation. Record review of Resident #4's Controlled substance log on 3/25/26 revealed on 03/21/26 at 4:00PM Two Tramadol HCL 50 MG Tablets were administered; there was no signature indicating who administered the narcotic medication. Record review of Resident #4's Controlled substance log on 3/25/26 revealed on 03/22/26 at an illegible time, two Tramadol HCL 50 MG tablets were administered, and 3/22/26 at 3:00PM two Tramadol HCL 50 MG were administered, there were no signatures indicating who administered the medications and there was no third dose as ordered. Record review of Resident #4's Controlled substance log on 3/25/26 revealed on 03/23/26 ADON administered Two Tramadol HCL 50 MG tablets at an unknown time, and on 3/23/26 at 12:00 pm only one Tramadol tablet was administered and on 3/23/26 MA-H administered only one Tramadol HCL 50 MG tablet at 7:54pm Record review of Resident #4's Controlled substance log on 3/25/26 revealed on 03/24/26 MA-C administered two Tramadol HCL 50 MG at 9:37AM, two Tramadol HCL 50 MG at 1:21PM, and then MA-H administered two Tramadol HCL 50 MG at 3:18PM. Indicating Resident #4 received 200 mg of narcotic pain medication within a 2-hour period. Record review of Resident #4's Controlled substance log on 3/25/26 revealed on 03/25/26 MA-C administered two Tramadol HCL 50 MG at 9:09AM and two Tramadol HCL 50 MG at 12:24PM. During an interview on 3/25/26 at 2:45PM with Administrator and DON they said they were unaware of any pain medication issues with Resident #4 and would look into what happened with her lidocaine patch and tramadol. The DON said MA C had been suspended while they further investigated the concerns. Both said residents should receive medication as ordered or else they could continue to have pain. Record review of Resident #3's face sheet on 03/26/26 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side (complete paralysis and weakness on the left non-dominant side), Type 2 Diabetes Mellitus without complications, and Hypertension. The resident has a BIMS score of 04, which indicated severe cognitive impairment. Record review of Resident #3's order summary revealed Rezvoglar KwikPen(a long-acting, medication used to treat diabetes and provides basal insulin [slow-release medication that keeps blood glucose levels consistent particularly betweenmeals and while sleeping] for 24 hours with once daily dosing) 100 UNIT/ML Solution pen-injector Inject 32 unit subcutaneously at bedtime for hypoglycemia. There was no diagnosis documented in Resident #3's diagnoses for hypoglycemia. Record review of Resident #3's MAR/TAR dated March 2026 revealed the following: Rezvoglar Kwik Pen 100 unit/mlsolution pen injector insulin was scheduled to be administered at 8:00 PM, and it was not given according to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676356	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026
NAME OF PROVIDER OR SUPPLIER The Heights of North Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 303 Hollow Tree Lane Houston, TX 77090	

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician orderson 6 different days; the insulin was given at 12:23AM, 12:35AM, 1:51AM, 10:39PM, 10:42PM, and 12:46AM. Record review of Resident #3's MAR dated March 2026 revealed LVN B documented administering Rezvoglar KwikPen 100 unit/ml solution pen injector insulin outside of the scheduled parameters between 03/04/26 and 03/17/26 which caused Resident #3's blood sugar to fluctuate up and down for the entire month of March 2026, with her lowest blood sugar result 66mg/dL and her highest blood sugar result was 332mg/dL. Record review of Resident #3's blood sugar log dated March 2026 revealed the following entries: 3/30/2026 12:13 pm 93.0 mg/dL 3/30/2026 07:58 am 91.0 mg/dL 3/29/2026 08:53 pm 309.0 mg/dL 3/29/2026 05:31 pm 101.0 mg/dL 3/29/2026 11:25 am 98.0 mg/dL 3/28/2026 08:10 pm 283.0 mg/dL 3/28/2026 11:59 am 181.0 mg/dL 3/28/2026 07:27 am 97.0 mg/dL 3/27/2026 08:33 pm 169.0 mg/dL 3/27/2026 05:03 pm 220.0 mg/dL 3/27/2026 01:12 pm 250.0 mg/dL 3/27/2026 07:39 am 103.0 mg/dL 3/26/2026 08:33 pm 137.0 mg/dL 3/26/2026 06:05 pm 127.0 mg/dL 3/26/2026 12:45 pm 137.0 mg/dL 3/25/2026 09:55 pm 213.0 mg/dL 3/25/2026 02:06 pm 125.0 mg/dL 3/25/2026 07:20 am91.0 mg/dL 3/24/2026 09:16 pm 332.0 mg/dL 3/24/2026 05:42 pm 135.0 mg/dL 3/23/2026 07:49 pm163.0 mg/dL 3/23/2026 05:52 pm 180.0 mg/dL 3/23/2026 11:58 am 87.0 mg/dL 3/23/2026 11:58 am 87.0 mg/dL 3/22/2026 08:17 pm 253.0 mg/dL 3/22/2026 06:22 pm 178.0 mg/dL 3/22/2026 01:06 pm 135.0 mg/dL 3/22/2026 07:24 am 175.0 mg/dL 3/21/2026 09:11 pm 201.0 mg/dL 3/21/2026 05:50 pm 112.0 mg/dL 3/21/2026 11:04 am 100.0 mg/dL 3/21/2026 07:16 am 98.0 mg/dL 3/20/2026 11:33 pm 288.0 mg/dL 3/20/2026 11:22 am 172.0 mg/dL 3/20/2026 07:35 am 81.0 mg/dL 3/19/2026 07:48 pm 246.0 mg/dL 3/19/2026 04:16 pm 119.0 mg/dL 3/19/2026 11:25 am 136.0 mg/dL 3/19/2026 06:42 am 92.0 mg/dL 3/18/2026 05:56 pm 246.0 mg/dL 3/18/2026 07:58 am 143.0 mg/dL 3/18/2026 12:36 am 170.0 mg/dL 3/17/2026 05:17 pm 143.0 mg/dL 3/17/2026 12:12 pm 163.0 mg/dL 3/17/2026 07:10 am 84.0 mg/dL 3/16/2026 08:11 pm 221.0 mg/dL 3/16/2026 04:21 pm 181.0 mg/dL 3/16/2026 11:24 am 178.0 mg/dL 3/16/2026 07:14 am 68.0 mg/dL 3/15/2026 07:46 pm 309.0 mg/dL 3/15/2026 04:04 pm 211.0 mg/dL 3/15/2026 11:35 am 204.0 mg/dL 3/15/2026 07:27 am 98.0 mg/dL 3/14/2026 08:42 pm 160.0 mg/dL 3/14/2026 04:09 pm 173.0 mg/dL 3/14/2026 11:21 am 215.0 mg/dL 3/14/2026 07:44 am 66.0 mg/dL 3/13/2026 10:42 pm 246.0 mg/dL 3/13/2026 04:58 pm 238.0 mg/dL 3/13/2026 12:00 noon 219.0 mg/dL 3/13/2026 08:11 am 118.0 mg/dL 3/12/2026 09:17 pm 223.0 mg/dL 3/12/2026 04:44 pm 172.0 mg/dL 3/12/2026 11:40 am 166.0 mg/dL 3/12/2026 07:32 am 81.0 mg/dL 3/11/2026 07:46 pm 270.0 mg/dL 3/11/2026 04:44 pm129.0 mg/dL 3/11/2026 11:51 am 122.0 mg/dL 3/11/2026 08:07 am 114.0 mg/dL 3/10/2026 08:06 pm 107.0 mg/dL 3/10/2026 05:53 pm126.0 mg/dL 3/10/2026 12:53 pm 204.0 mg/dL 3/10/2026 08:07 am 118.0 mg/dL 3/9/2026 10:39 pm 288.0 mg/dL 3/9/2026 05:21 pm 238.0 mg/dL 3/9/2026 04:52 pm 157.0 mg/dL 3/9/2026 09:34 am 70.0 mg/dL 3/8/2026 05:09 pm 170.0 mg/dL 3/8/2026 12:35 pm 255.0 mg/dL 3/8/2026 09:00 am 151.0 mg/dL 3/8/2026 12:51 am 273.0 mg/dL 3/7/2026 08:51 pm 194.0 mg/dL 3/7/2026 05:01 pm 189.0 mg/dL 3/7/2026 12:43 pm 175.0 mg/dL 3/7/2026 08:23 am 77.0 mg/dL 3/6/2026 09:07 am 187.0 mg/dL 3/6/2026 05:07 pm 133.0 mg/dL 3/6/2026 11:32 am 120.0 mg/dL 3/6/2026 08:33 am 97.0 mg/dL 3/5/2026 08:13 pm 248.0 mg/dL 3/5/2026 05:56 pm 139.0 mg/dL 3/5/2026 10:20 am 111.0 mg/dL 3/5/2026 12:35 am 199.0 mg/dL 3/4/2026 05:54 pm 106.0 mg/dL 3/4/2026 12:14 pm 167.0 mg/dL 3/4/2026 07:40 am 87.0 mg/dL 3/4/2026 12:23 am241.0 mg/dL 3/3/2026 05:54 pm225.0 mg/dL 3/3/2026 08:00 am 227.0 mg/dL 3/3/2026 04:09 am 153.0 mg/dL 3/2/2026 08:20 pm 153.0 mg/dL 3/2/2026 05:39 am 158.0 mg/dL 3/2/2026 12:40 pm 201.0 mg/dL 3/2/2026 07:37 am 88.0 mg/dL 3/1/2026 08:04 pm 166.0 mg/dL 3/1/2026 4:48 pm 200.0 mg/dL 3/1/2026 11:45 am 232.0 mg/dL 3/1/2026 07:40 am 102.0 mg/dL Record review of Resident #3's MAR dated March 1, 2026 revealed, there were no orders for Resident #3's blood sugar checks. Record review of Resident #3's MAR dated March 1, 2026 -March 31, 2026, revealed on 03/04/26 RN D, a day shift nurse, documented in the resident's progress note that the resident's blood sugar was taken again at 7:40 AM and it was 87. Record review of Resident #3's MAR dated March 1, 2026 -March 31, 2026, revealed on 03/03/26 Resident #3 was scheduled to receive Rezvoglar Kwik Pen 100 unit/ml solution pen injector insulin at 8:00 PM, LVN B, a night shift (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676356	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of North Houston	303 Hollow Tree Lane Houston, TX 77090

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurse, documented that it was administered on 03/04/2026 at 12:23AM and the resident's blood sugar was recorded as 241 at that time. Record review of Resident #3's MAR dated March 1, 2026 -March 31, 2026, revealed on 03/04/2026 Resident #3 was scheduled to receive Rezvoglar Kwik Pen 100 unit/ml solution pen injector insulin at 8:00PM; LVN B documented that it was administered on 03/05/2026 at 12:35AM; the resident's blood sugar was 199. Resident #3's blood sugar was taken again around 7:30AM and was 111. Record review of Resident #3's MAR dated March 1, 2026 -March 31, 2026, revealed on 03/08/2026 Resident #3 was scheduled to receive Rezvoglar Kwik Pen 100 unit/ml solution pen injector insulin at 8:00PM; LVN B documented that it was administered on 03/09/2026 at 1:51AM; the resident's blood sugar was 273, the resident's blood sugar was taken again at 7:30AM and was 70. Record review of Resident #3's MAR dated March 1, 2026 -March 31, 2026, revealed on 03/09/2026 Resident #3 was scheduled to receive Rezvoglar Kwik Pen 100 unit/ml solution pen injector insulin at 8:00PM; LVN B documented that it was administered on 03/09/2026 at 10:39PM, the resident's blood sugar was 288, the resident's blood sugar was taken again 03/10/26 around 7:30AM and was 118. Record review of Resident #3's MAR dated March 1, 2026 -March 31, 2026, revealed on 03/13/2026 Resident #3 was scheduled to receive Rezvoglar Kwik Pen 100 unit/ml solution pen injector insulin at 8:00PM; LVN B documented that it was administered on 03/13/2026 at 10:42PM, the resident's blood sugar was 246, the resident's blood sugar was taken again on 03/14/26 at 7:30AM and was 66. Record review of Resident #3's MAR dated March 1, 2026 -March 31, 2026, revealed on 03/17/2026 Resident #3 was scheduled to receive Rezvoglar Kwik Pen 100 unit/ml solution pen injector insulin at 8:00PM; LVN B documented that it was administered on 03/18/2026 at 12:36AM, the resident's blood sugar was 170, it was taken again on 03/18/26 at 7:30AM, the resident's blood sugar was 143. Observation of electronic video monitoring from Resident #3's room dated 03/04/2026 revealed LVN B administering Resident #3's Rezvoglar Kwik Pen 100 unit/ml solution pen injector insulin scheduled for 8:00 pm at 12:05 am. Resident #3 was also observed to have a gastrostomy tube in place. There was no diagnosis of Resident #3's gastrostomy status. In an interview with LVN B on 3/26/26 at 7:03pm she said she worked Resident #3's unit and had provided care for Resident #3 including administration of her insulin. LVN B said she had not been late administering Resident #3's insulin and worked the night shift at the facility 6pm-6am. LVN B said bedtime medications are usually given between 7pm and 9 pm and include insulins which could be short acting or long acting. LVN B said she recalled Resident #3's insulins should be given around 8pm or 9pm. LVN B said the parameters for administering medications including insulin were one hour before and one hour after the scheduled time. When asked what a potential risk to a resident could be receiving a medication such as insulin outside of medication administration parameters, she replied, if it were a long-acting insulin, the resident's blood sugar could drop too low within 2-3 hours. LVN B said she was unaware of any issues with Resident #3's blood sugar and she had no reason to administer a medication and go back later to document the administration. In an interview with the DON on 03/28/26 at 10:30AM, she stated her expectations are for medications to be administeredper state guidelines and their facility policy which is to administer the medications according to the Physicians' orders. She stated she reviewed the Controlled Substance log for Resident #4 and noted the concern of the incorrect administration of the dosages however she did not notice that the medication times were incorrect (dosages were administered at 1:21PM and 3:18PM). She stated the risk of the resident's medication being administered that close together could cause the resident to overdose. She stated she had not completed an audit on all of her nurses. She stated she was not aware that residents were receiving insulin outside of their parameters. She stated the risk of residents not receiving insulin as scheduled would be an increase or decrease of their blood sugar and she reported it was very dangerous. She stated she ensures that medications are being administered properly by reviewing the Narcotic logs and making sure that all medications are signed out and administered. Record review of the facility's policy titled Administering Medications revised dated April 2019 revealed: Medications are administered in a safe and timely manner, and as prescribed.4. (continued on next page)

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	676356	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of North Houston	303 Hollow Tree Lane Houston, TX 77090

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication are administered in accordance with prescriber orders, including any required time frame.7. Medication are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to 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 disease and infection for 1 of 4 residents (Resident #2) reviewed for infection control, in that: -CNA J failed to wear PPE for EBP, when she provided incontinent care to Resident #2. These deficient practices could place residents at-risk for infection, sepsis, and hospitalization due to cross contamination. Findings included: Record review of Resident #2's admission record on 03/25/26 reflected a [AGE] year-old female, who admitted to the facility on [DATE] with a primary diagnosis of unspecifiedDementia (a decline in mental ability), Hypertension, and Major Depressive Disorder. The resident did not have a diagnosis for wounds. Record review of Resident #2's admission MDS dated [DATE] revealed a BIMS of 00 which indicated severe cognitive impairment. Resident #2 was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for the following areas: Roll left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Continued record review revealed Resident #2 was coded in Section M related to Skin Conditions as having 1 unstageable pressure injuries upon admission. Record review of Resident #2's care plan dated revision on 03/25/26 revealed she had a left heel DTI, Right Heel DTI, Pressure Wound to Sacrum, Bruise/discoloration/ open blister to right knee, Left Heel Ulcer Pressure Injury, and Right Bunion DTI. The resident was also care planned for Enhanced Barrier Precautions Staff must use gown and gloves during high-contact resident care activities that could possibly result in transfer of MDROs to hands and clothing of staff. Enhanced Barrier precautions are recommended for residents known to be colonized or infected with MDROs as well as those who are not confirmed to have MDRO (e.g. residents with wounds or indwelling medical devices)- this was initiated on 03/15/2026. Record review of Resident #2's Physician Orders revealed the following orders: -Enhanced Barrier Precautions: Staff must use gowns and gloves during high-contact resident care activities that could possibly result in transfer of MDROs to hands and clothing of staff. Enhanced Barrier precautions are recommended for residents known to be colonized or infected with MDROs as well as those who are not confirmed to have MDRO (e.g. residents with wounds or indwelling medical devices)- every shift for Enhanced Barrier Precautions In an observation on 3/12/26 at 2:01PM, Surveyor approached Resident #2's room and knocked on the door (the door was open, Resident #2 resided in B side). The curtain was closed and CNA J stepped out and stated she was doing resident care. CNA J was observed with black scrubs, she did not have on a gown. Surveyor waited outside of the room until CNA J completed incontinent care. There was EBP signage observed outside of the residents room. In an interview on 3/12/26 at 2:06PM with CNA J she stated she was changing Resident #2 when surveyor knocked on the resident's door. She stated there was signage on the resident's door for Enhanced Barrier Precautions which indicated that PPE was needed when providing care. She stated she was not sure if the signage was for Resident #2 or her roommate. She stated she had never worn PPE in the past while providing Resident #2 care and that she had only worn PPE while providing care to the roommate. When asked if Resident #2 had wounds, she stated she was not sure. She stated the risk of not wearing PPE was infection. In an interview on 03/12/26 at 2:41PM with LVN K she stated she was assigned to the hall Resident #2 was on. She stated PPE was required when providing direct care to Resident #2 because she had wounds. She stated CNAs had access to the resident's plan of care in Point click care(the facilities electronic health records system) which indicated if PPE is required for a resident or not. She stated there is also signage outside of the resident's room indicating if PPE was needed. In an interview on 03/12/26 at 4:09PM with the DON she stated her expectations were for PPE to be worn when residents require PPE. She (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the risk of it not being worn was infection. Record review of the facility's policy and procedure on Enhanced Barrier Precautions (Revised 3/2024) read in part: Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug-resistant organisms(MDROs) to residents. 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention toreduce the transmission of multi-drug-resistant organisms (MDROs) to residents.2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact residentcare activities when contact precautions do not otherwise apply.a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposedto before entering the room).b. Personal protective equipment (PPE) is changed before caring for another resident.c. Face protection may be used if there is also a risk of splash or spray.3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:a. dressing;b. bathing/showering;c. transferring;d. providing hygiene;e. changing linens;f. changing briefs or assisting with toileting;g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); andh. wound care (any skin opening requiring a dressing). 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/orindwelling medical devices regardless of MDRO colonization.a. Wounds generally include chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, venous stasisulcers, and unhealed surgical wounds), not shorter-lasting wounds like skin breaks or skin tears.b. Indwelling medical devices include central lines, urinary catheters, feeding tubes and tracheostomies.