STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676381	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Houston Rehabilitation and Healthcare Center	13428 Bissonnet Houston, TX 77083

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observations, interviews and record review, the facility failed to ensure residents receive services in the facility with reasonable accommodation of resident needs for 1 of 5 residents (Resident #56) reviewed for call lights. The facility failed to ensure Resident #56's call light was within reach. This failure could place residents at risk for a delay in care and services, increased falls, and a decreased quality of life. Findings included: Record review of Resident #56's face sheet dated 01/29/25 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: cerebral infarction (blood flow to the brain is blocked), hypertension (pressure in the blood vessels is always higher than normal), and diabetes mellitus (when body cannot control blood sugar level). Record review of Resident #56's annual MDS assessment dated [DATE] revealed a BIMS score of 09 of 15 which indicated moderately impaired cognition. Further review revealed the resident was dependent on the staff for ADL care and the was incontinent for bowel and bladder. Record review of Resident #56's undated care plan revealed Resident #56 was at risk for falls related to gait imbalance and incontinence. Intervention: be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During an interview on 01/28/25 at 10:16 a.m., Resident #56 said she needed her incontinent brief changed and could not reach the call light. Resident #56 said she asked her roommate to use her call light to call for assistance. During an observation on 01/28/25 at 10:17 a.m., Resident #56's call light was on the floor by the insertion site to the wall. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 01/28/25 at 10:19 a.m., CNA B said Resident #56's call light was on the floor close to the wall. CNA B said Resident #56's call light should always be within reach. CNA B said Resident #56 could fall if she tried to reach for the call light because it was not within reach and could delay care if the resident had an emergency. CNA B said she had in-service and skill check-off on the call light, and during training, she was educated to ensure the call light was within reach for safety and to prevent health emergencies. During an interview on 01/28/25 at 10:27 a.m., CNA C said she was Resident #56's aide and did not know the call light was on the floor, out of Resident #56's reach. CNA C said the call light should always be within reach for Resident #56 to prevent the resident from falling and delayed care during emergencies such as choking. CNA C said she had in-service and skills check off on the call light, and they were educated to make sure the call light was within reach for assistance and safety. During an Interview on 01/28/25 at 1:24 p.m., LVN B said he was the nurse for Resident #56 and did not observe the call light was on the floor. LVN B said Resident #56's call light should be placed in close range so Resident #56 could use it when she needed it. LVN B said Resident # 56 could have a fall if the resident tried to reach the call light, which was out of reach. LVN B said Resident #56 could have had an emergency, and the resident could not reach the call light, which could be detrimental for Resident #56. LVN B said the nurses monitored the aides during rounding, and the nurse managers monitored the nurses when they made random rounds. LVN B said he had in-service, and skills checks in October on call lights. During an interview on 01/29/25 at 3:44 p.m., the DON said CNA C should have placed the call light within reach of Resident #56. The DON said the aides should place the call light within reach for safety (assistance and fall), and if Resident #56 needed help and could not reach the call light, then the need for Resident #56 would not be met. The DON said the charge nurses monitor the aides to ensure the call lights are within reach, and the managers monitor the nurses when they make random rounds and ensure the call light is in place. During an interview on 01/29/25 at 5:24 p.m., the Administrator said CNA C should have placed Resident #56's call light within reach. The Administrator said Resident # 56 would not promptly receive the care she needed. The Administrator said the nurses monitor the aides to ensure they provide care for the resident, and the nurse manager monitors the nurses. During an interview on 01/29/25 at 5:58 p.m., the ADON said the call light should always be within reach of Resident #56. The ADON said, if the call light was not within reach, Resident #56 would wait an extended period before care would be provided for the resident. The ADON said Resident #56 could fall if she tried to reach for the call light, and the facility would not want the resident to fall. The ADON said the nurse monitors the aides while the nurse manager monitors the nurse during rounding and ensures the call light is within reach. The ADON said the nurse had been in-serviced on the call light, and they were told to make sure the call light was within reach to prevent delay in care or any other issues. Record review of the facility call light policy dated 02/23 read in part . the purpose of this policy is to assure the facility is adequately equipped with a call light at each resident bed . policy explanation and compliance guideline #5 . staff will ensure the call light is within reach of resident while in bed .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 (Resident #2) of 6 residents reviewed for activities of daily living. -The facility failed to groom Resident #2's face that was observed with long facial hairs on her chin. This failure placed resident at risk for embarrassment, depression, and decrease in quality of life. Findings: Record review of Resident #2's face sheet dated 01/30/25 revealed a [AGE] year-old female admitted to the NF on 04/05/23 with the diagnoses that included the following: hypotension (low blood pressure), muscle weakness, need assistance with personal care, glaucoma (nerve damage of the eye that is usually due to high pressure in the eye that could lead to loss of vision), osteoarthritis (type of arthritis when the flexible, tissue at the end of the bones wears away causing a decrease in movement), and cerebral infarction (blood flow to the brain is interrupted). Record review of Resident #2's MDS significant change dated 12/22/24 reflected a BIMS score of 11 indicating resident had moderate impairment of cognition. Further review revealed of section GG (Functional Abilities) was not coded but in section V-Care Area Assessment (CAA) Summary, resident was triggered for ADLs related to personal care. Record review of Resident #2's Care Plan dated 01/02/25 reflected that resident was being care planned for assistance to perform functional abilities in self-care and mobility AEB by weakness in functional range of motion r/t stroke. The interventions included provide hygiene: partial/moderate assistance. Observation on 01/28/25 at 9:47AM of Resident #2 resting in bed. Observation was made of resident having a moderate amount of thick coarse facial hair growing out of resident's chin covering approximately 80 percent of chin. Interview on 01/28/25 at 9:47AM with Resident #2 said she did not like the hair on her face and wanted it removed. Resident said the staff had not removed the hair off her chin in a while. Interview on 01/30/25 at 2:02PM with CNA A said Resident #2 required extensive assistance with grooming. CNA A said it was important to keep the residents groomed because it was a part of the resident's daily living. CNA A said when residents were not groomed, it placed the resident at risk of not feeling good about themselves. CNA A said just like she and other members of the staff like to look presentable, so did the residents. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/30/25 at 2:20PM with the DON said it was the charge nurses that were responsible for ensuring that the residents were being groomed and presentable and that their needs were being met daily. Interview on 01/30/25 at 2:50PM LVN B said he was Resident #2's nurse. LVN B said he worked the 6AM-6PM shift full time. LVN B said he had been working at the NF all week. LVN B said the charge nurse was responsible in making sure that the residents were being provided care that included grooming that consisted of making sure the residents' hair and clothing were clean, nails trimmed, and resident was free of any offensive odors. LVN B said it was important to keep the residents groomed for their personal pride and overall to allow the resident to feel good about themselves. LVN B said if the resident was not groomed, it placed the resident at risk for health issues one being psychosocial issues which placed the resident at risk for becoming depressed. Record review of the NF policy on Activities of Daily Living revised January 2025 reflected in part: .The facility will .ensure .care and services will be provided for the following activities of daily living: bathing, dressing, grooming, and oral care .The facility will provide care to assist the resident in achieving and maintaining the highest practicable outcome .resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene . Record review of the NF policy on Resident Rights revised January 2025 reflected in part: .The resident has the right to a dignified existence, self-determination, and communication with access to persons and services inside and outside of the facility .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to ensure that a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal pharyngeal ulcers for 1 (Resident #66) of six residents reviewed for gastrostomy feedings in that: -The facility failed to administer Resident #66 gastrostomy feedings at the rate ordered, 50 ml/hr. This failure placed resident at risk for not receiving their required daily nutritional intake placing the resident at risk for weight loss. Findings: Record review of Resident #66's face sheet dated 01/30/25 revealed an [AGE] year-old- female admitted to the NF on 05/23/24. Resident diagnoses included the following: cerebral infarction (decreased blood flow to the brain), dysphagia (difficulty in swallowing), gastrostomy (surgical procedure that creates an opening in the abdominal wall and into the stomach), adult failure to thrive, paraplegia (paralysis that affects all or part of the body), anorexia (eating disorder), and gastro-esophageal reflux disease (stomach contents flow back up into the food pipe; symptoms include heartburn, chest pain, difficulty swallowing, burping, and sore throat) . Record review of Resident #66's quarterly MDS dated [DATE] revealed a BIMS score of 3 indicating resident cognition was severely impaired. Record review of section K (Swallowing/Nutritional Status) reflected that resident had a feeding tube (e.g., nasogastric or abdominal (PEG {surgical procedure that places a feeding tube inside of the stomach}). Record review of Resident #66's care plan dated 12/09/24 revealed that resident was being care planned for a nutritional problem r/t being NPO/enteral feeding with intervention to evaluate and make diet change recommendations PRN. Record review of Resident #66's physician order for the month of January 2025 reflected the following orders: -Dated 12/13/24 NPO -Dated 01/13/25 Every Shift for GT feeding Isosource 1.5 at 50cc/hr. Record review of the NF TF Formula Equivalents Chart reflected the following: -Isosource 1.5 equivalent to Jevity 1.5 cal. Record review of Resident #66's MAR for the month of January 2025 reflected the NF was administering resident Isosource 1.5 at 50cc/hr. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #66's weights for the past 6 months did not reflect any significant weight loss. Observation on 01/28/25 at 9:37AM revealed Resident #66 resting in bed receiving gastrostomy feedings Jevity 1.5 cal at 45ml/hr along with water flush at 30ml/hr. Observation on 01/29/25 at 10:07AM revealed Resident # 66 resting in bed receiving gastrostomy feedings Jevity 1.5 cal at 45ml/hr along with water flush at 30ml/hr. Interview on 01/29/25 at 10:30AM with LVN C said the order for Resident #66's gastrostomy feeding Isosource was at 50ml/hr but she could have Jevity 1.5 because it was interchangeable. LVN C said the feeding Isosource was ordered on 01/13/25 at 50ml/hr. LVN C said the night nurse RN D was the nurse that hung Resident #66's gastrostomy feeding. LVN C said if a resident was not receiving their gastrostomy feedings as ordered, it could make the resident sick. Interview on 01/29/25 at 10:57AM with the DON said after review of Resident #66's physician orders said the resident's gastrostomy feedings should be infusing at 50ml/hr instead of 45ml/hr. The DON said not receiving the correct dosage as ordered, placed the resident at risk of not meeting the resident's nutrition goals. Interview on 01/29/25 at 12:04PM with the Dietician said the last time she assessed Resident # 66 was on 01/24/25. The Dietician said Jevity 1.5 was equivalent to Isosource and that resident feedings were ordered at 50ml/hr. Observation on 01/29/25 at 3:45PM revealed Resident #66's gastrostomy feedings had been changed from 45ml/hr to 50 ml/hr by LVN C. Interview on 01/29/25 at 3:50PM with RN D said she worked at the NF on a PRN basis on the morning shift and sometimes on the night shift. RN D said she was Resident #66's nurse on the night shift on 01/28/25. RN D said on the facility 24-hour report sheet, it showed that Resident #66 was receiving gastrostomy feedings Isosource at 45ml/hr. RN D said because the facility did not have Isososurce, the interchangeable feeding was Jevity 1.5cal. RN D said there were 6 rights when administering medications or providing care for a resident that consisted of the following: (1) Right resident, (2) Right time, (3) Right dose, (4) Right route, (5) Right medication, and (6) Right documentation. RN D said if she had followed these rights, she would have set Resident #66's feedings at 50ml/hr instead of 45 ml/hr. RN D said she went by what was on the 24-hour report sheet instead of looking at Resident #66's physician orders. RN D said she had a busy shift and did not check the physician orders. The facility DON was asked for policy on Gastrostomy feedings on 01/30/25 at 4:30PM. The facility provided a policy on Nutritional and Dietary Supplements revised April 2023 that read in part: .It is the policy of this facility that nutritional and dietary supplements will be used to complement a resident's dietary needs in order to maintain nutritional status and the resident's highest practicable level of well-being .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 1 (Resident #62) of 6 residents observed for oxygen management. -The NF failed to dispose of an undated oxygen humidifier bottle from Resident #62's room that was at the bedside. This failure placed resident at risk for cross contamination, infections, and decrease in quality of life. Findings: Record review of Resident #62's face sheet dated 01/30/25 revealed a [AGE] year-old male admitted to the NF originally on 01/10/23. Resident #62's diagnoses included the following: dementia (impairment of at least two brain functions, such as memory and judgement), Tourette's disorder (a nervous system disorder involving repetitive movements or unwanted sounds), adult failure to thrive, and sepsis (infection in the blood). Record review of Resident #62's quarterly MDS dated [DATE] revealed a BIMS score of 10 indicating that resident cognition was moderately impaired. Further review section O (Special Treatments, Procedures, and Programs) reflected resident not being coded for oxygen therapy. Record review of Resident #62's Physician Order Summary Report for the month of January 2025 did not reflect an order for oxygen. Record review of Resident #62's Care Plan dated 01/22/2025 reflected that resident was being care planned for SOB and respiratory infection with interventions that did not mention oxygen therapy. Observation on 01/28/25 at 10:28AM revealed Resident #62 resting in bed quietly. Further observation was made of an oxygen machine on the left side of resident bed with a humidifier bottle connected to the machine. The humidifier bottle was not dated. Interview on 01/30/25 at 2:25PM with the DON said respiratory equipment such as oxygen tubing and humidifiers were supposed to have a date to show when the last time the equipment had been changed. The DON said the equipment had to be changed out every week for infection control. The DON said the Unit Managers were assigned to halls to make sure this was being done. The DON said LVN E was the unit manager assigned to the hall that Resident #62 was residing on (hall 200). Interview on 01/30/25 at 2:45PM with LVN E said she was the unit manager for Halls 200 &300. LVN E said she was responsible in making sure that respiratory equipment such as oxygen tubing and humidifier bottles were being changed out every week and as needed. LVN E said the equipment was supposed to be dated to signify when the last time the equipment was changed. LVN E said this was done for infection control. LVN E said she monitored the respiratory equipment daily when in use but at no specific time. LVN E said she tried to make rounds on the residents in the morning. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor asked facility DON, Administrator, and Corporate Nurse for their policy on Infection Control 01/29/25 and 01/30/25, policy was not received.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview, and record review , the facility failed to provide pharmaceutical services including procedures that assure accurate acquiring, receiving, dispensing and administering of all drugs to meet the needs of each resident for 1 resident (Resident #43) of 9 residents reviewed for pharmacy services, in that, MA A did not administer Dorzolamide Hydrochloride Ophthalmic solution (eyedrops used to lower pressure inside the eye in people with open angle glaucoma or ocular hypertension) to Resident #43's lower eyelid for it to be absorbed for effectiveness. These failures affected residents and placed them at risk of decline in health status. Findings include: . Record review of Resident #43's face sheet dated 1/30/25 revealed an [AGE] year-old female with an original admitted [DATE] and re-admission 6/10/22. Resident #43 had diagnoses which included: unspecified severe protein-calorie malnutrition, other idiopathic peripheral autonomic neuropathy (occurs when there is damage to the nerves that control automatic body functions), anemia of chronic disease(causes inflammation, which prevents the body from producing enough red blood cells) in other chronic diseases classified elsewhere, major depressive disorder, (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #43's Annual MDS dated [DATE] revealed a BIMS of 15, which indicated the resident was cognitively intact. Record review of Resident #43's current physicians orders revealed an order with a start date of 02/15/23, for Dorzolamide Hydrochloride Ophthalmic solution 2% 1 drop to each eye one time a day. During a medication administration observation on 1/29/25 at 8:53 AM for Resident #43, Resident was lying down on her bed with eye open looking up and instructed MA A not to touch her eyes. MA A instilled Dorzolamide Hydrochloride Ophthalmic solution 2% 1 drop to each eye eye directly Resident #43's eyeball . MA A did not administered eyedrop to Resident #43's lower eyelid Interview with MA A on 1/30/25 at 9:38 AM regarding administering Dorzolamide Hydrochloride Ophthalmic solution 2%, MA A said she always instilled eye drops to Resident #43's eyeball because the resident does not want her to touch her eyes. MA A said she would let the nurse know Resident #43 did not allow her to touch her eyes. MA A said she had training for medication administration about 2 months ago with the ADON who no longer work for the facility. MA A said she had been working in the facility for over 3 years and she knew not administering the resident's eye drop correctly would not be effective and could cause harm to the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/25 at 11:29 AM, with the ADM and DON, the DON stated eye drops should be instilled in the lower eyelid for it absorption and it effectiveness., She said she would have to in-service staff on proper medication administration. She stated the system for monitoring accuracy of medication administration observations was conducted with nursing staff several times per year by the Pharmacy Consultant. DON did not have the log of the Pharmacy Consultant for monitoring staffs. The ADM stated his expectation of staff for accurate medication administration was that guidelines were always followed. He stated a potential negative outcome for failure to properly administer medications, according to physicians' orders would be adverse effects on the resident. Record review of the facility-provided training document for Skilled Services and Medication Pass Competency dated 9/01/24 andreflected it was marked satisfactory and was signed by MA A and the ADON. Record review of the facility policy Administration of Eye Drops or Ointments, Date Implemented: 1/2022 and Reviewed/ Revised:1/2025 reflected. 5. Administration: a. Remove medication cap and place on clean, dry surface (i.e. tissue or paper towel) to prevent contamination. b. Steady hand holding the medication, as needed, on resident's forehead. c. With other hand, pull down lower eyelid to form a pouch of the conjunctival sac, instructing resident to look up. d. For eye drops: squeeze the prescribed number of drops into the conjunctival sac, avoiding placement of the drops directly on the eyeball. e. For eye ointment: squeeze a ribbon of ointment on the edge of the conjunctival sac from the inner to outer canthus.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observations, interviews, and record review the facility failed to ensure that its medication error rate was less than 5 percent. The facility had a medication error rate of 7 % based on 3 errors out of 40 opportunities, which involved 3 of 9 residents (Resident # 13, #43 and Resident #18) reviewed for medication administration. 1. MA A failed to administer Cyanocobalamin (a form of vitamin B12= used to treat and prevent a lack of vitamin B12- may cause anemia (condition in which the red blood cells do not bring enough oxygen to the organs) to Resident # 13 according to physician orders. 2. MA A failed to administer Vitamin D (Cholecalciferol = used for vitamin D deficiency = also used with calcium to maintain bone strength) to Resident #43, according to physician orders. 3. MA A failed to administer Cetirizine Hydrochloride tab (drug use to prevents and treats allergy symptoms, such as red, itchy, eyes, sneezing, a runny or stuffy nose or hives) to Resident #18, according to physician orders. These failures could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health. Findings included: 1. Record review of Resident #13's face sheet dated 1/30/25 revealed a [AGE] year-old female with an admitted [DATE]. Resident #13 had diagnoses which included: intraductal carcinoma (non-invasive early stage breast cancer) in situ of left breast, multiple sclerosis (a chronic disease that affects the central nervous system), type 2 diabetes mellitus (too much glucose then stays in your blood) without complications, acute embolism and thrombosis (Blood clot) of unspecified deep veins of lower extremity, bilateral, other specified peripheral vascular diseases, other vitamin b12 deficiency anemias, malignant neoplasm (most breast cancers are carcinomas, which are tumors that start in the epithelial cells that line organs and tissues throughout the body) of unspecified site of left female breast. Record review of Resident #13's Admission MDS dated [DATE] revealed a BIMS of 15, which indicated the resident was cognitively intact. Record review of Resident #13's current physicians orders revealed an order with a start date of 08/14/24, for B12 1000mg, 1 tablet by mouth one time per day for anemia at 08:00 AM. Record review of Resident #13's medication administration record (MAR) dated 1/1/25 reflected B12 1000mg, 1 tablet by mouth one time per day for anemia at 08:00 AM. MA A initialed as given on 01/29/25. During a medication administration observation on 1/29/25 at 8:27 AM for Resident #13, MA A dispensed one B12 500mg 1 tablet into a medication cup and administered the medication to Resident #13 by mouth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676381	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Houston Rehabilitation and Healthcare Center	13428 Bissonnet Houston, TX 77083

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #43's face sheet dated 1/30/25 revealed an [AGE] year-old female with an original admitted [DATE] and re-admission 6/10/22. Resident #43 had diagnoses which included: unspecified severe protein-calorie malnutrition, other idiopathic peripheral autonomic neuropathy (occurs when there is damage to the nerves that control automatic body functions), anemia (chronic disease causes inflammation, which prevents the body from producing enough red blood cells) in other chronic diseases classified elsewhere, major depressive disorder, (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #43's Annual MDS dated [DATE] revealed a BIMS of 15, which indicated the resident was cognitively intact. Record review of Resident #43's current physicians orders revealed an order with a start date of 02/15/23, for Vitamin D 50 mcg 1 tablet po (Cholecalciferol tablet 50 mg (2000unit) one time a day. During a medication administration observation on 1/29/25 at 8:53 AM for Resident #43, MA A dispensed one Vitamin D 25 mcg1 tablet into a medication cup and administered the medication to Resident #43 by mouth. 3. Record review of Resident #18's face sheet dated 1/30/25 revealed an [AGE] year-old female with an original admitted [DATE] and re-admission 1/9/25 . Resident #18 had diagnoses which included acute respiratory failure with hypoxia (low oxygen in the blood), type 2 diabetes mellitus without complications , other seasonal allergic rhinitis (allergies you experience at certain times of the year due to pollen from glassgrass, weeds and trees) bipolar disorder (a mood disorder that causes extreme mood swings, including periods of mania and depression). Record review of Resident #18's Annual MDS dated [DATE] revealed a BIMS of 13, which indicated the resident was cognitively intact. Record review of Resident #18's current physicians orders revealed an order with a start date of 01/18/23, for Cetirizine Hydrochloride 5mg 1 tablet po one time a day for allergy. During a medication administration observation on 1/29/25 at 10:00 AM for Resident #18, MA A dispensed one Cetirizine Hydrochloride 10 mg 1 tablet into a medication cup and administered the medication to Resident #18 by mouth. Interview with Medication Aide (MA A) on 1/30/25 at 9:58 AM regarding Cetirizine 10mg given to Resident #18 (cetirizine 5mg was ordered), Vitamin D 25 mcg given to Resident #43, (instead of 50 mcg ordered= 20000unit), and Vitamin B12 500mg given to Resident #13 (instead of 50 mcg ordered=1000mg), she said she was nervous and she discussed with the ADON about Cetirizine 10 mg needed to be change to 5mg this morning. MA A said she had training about 2 months ago with the ADON who no longer work for the facility. MA A said she had been working in the facility for over 3 years and she knew not giving residents the correct medication dosage would not be effective and could cause harm to the resident. Interview with (unit manager) LVN ADON on 1/30/25 at 10:06 AM, she said she had been working with the facility for 3 years and she was not aware of any change with Cetirizine HCL, said andthe MA A should talk to the floor nurse for medication changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676381	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Houston Rehabilitation and Healthcare Center	13428 Bissonnet Houston, TX 77083

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 1/30/25 at 10:15 AM regarding her expectation with medication administration, she said the nurses were to follow right medication, check expiration date, removing discharged med , and follow medication rights . DON was asked what would happen when rights dose of medication not given , DON said if the right dose of medication was not given, Residents would not receive the right strength of the medication for its effectiveness. She said she would have to re-educate and discipline the staff and watch nurses pass medications once or twice a month and as needed, for eye drops it should be drop in the conjunctiva sac for absorbed . Interview with the Administrator on 1/30/25 at 2:10 pm, he said his expectation was 100% of medication error free., He said depending on the medication it could have an adverse effect on the resident. Interview with the cooperateCorporate nurse on 1/30/25 at 2:13 PM, she said she would have to conduct more in-services . Record review of the facility-provided training document for Skilled Services and Medication Pass Competency dated 9/01/24 reflected it andwas marked satisfactory and was signed by MA A and the ADON. Record review of facility-provided policy titled Administering Medications, Revised dated 2025, revealed: Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frame. . 10. The individual administering the medications checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 16352 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 (Halls 300 medication carts) of 3 medication carts reviewed for medication storage. - The facility failed to ensure the 300 hall medication carts did not contain nasal spray, topical gels and ointment that were opened labeled with the resident's name and not dated . This failure could place residents at risk of adverse medication reactions and infections . Findings Include: During observation on 01/29/25 at 09:11 AM, the following medications were found in the medication carts for 300 hall with LVN C. There were stickers on the medications to document open date: DilofenacDiclofenac Sodium Topical Gel 1% open not dated Triamcinolone Acetonide USP 0.1% open not dated Nystatin Ointment USP (100,000 usp) open not dated Clobetasol Propionate USP 0.005% 960 gm) x 2 open not dated Voltaren Arthritis pain gel 1 % open not dated Tacrolimus ointment 0.1% open not dated Fluticasone Propionate nasal spray USP -50 mcg open not dated During an interview with LVN C on 1/29/25 at 09:11 AM, he was not aware the gel were not dated when opened and the reason was to track the opening date and normally it is good for 30 days. LVN C said if used more than 30 days the effect of the medication may not be potent. During an interview with DON on 1/29/25 at 10:20 AM DON said the facility did not have any policy regarding labeling medication, when asked why the medication had open date sticker on them, she said the pharmacist place the open date sticker on them and it was just the pharmacy requirement . Interview via telephone on 1/30/25 at 11:30AM, with the facility Pharmacist he said they always place open date on the gels, ointments to help the nurses to know the open date and when to discard the topical gel and ointment.