

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER North Houston Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 9814 Grant Rd Houston, TX 77070	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls for 2 of 3 residents (Resident #3 and #12) reviewed for pharmacy services. 1. The facility failed to ensure Resident #3 did not have Clotrimazole 1% cream (an antifungal medication) on his nightstand near the bedside. 2. The facility failed to ensure Resident #12 did not have a medication cup filled with unidentified white barrier cream on the bedside tray parallel to the bed. These failures could place residents at risk of accidents and hazards. The findings included: 1. Record review of Resident #3's admission record dated 08/28/2024 revealed an [AGE] year-old male admitted to the facility on [DATE]. His diagnosis included encephalopathy (a disease that affects brain structure or function. It causes altered mental state and confusion), sepsis, and hemiplegia (a symptom that involves one-sided paralysis) and hemiparesis (weakness on one side of the body). Record review of Resident #3's care plan dated 8/27/24 revealed he had cognitive impairment. He exhibited cognitive loss related to impaired decision-making skills, CVA seizure disorder. Record review of Resident #3's Physician Orders for August 2024 revealed there was no order for Clotrimazole 1% cream. Observation on 8/28/24 at 10:40 a.m. in Resident #3's room revealed Resident #3 was lying in a low bed. There was a box that contained clotrimazole cream 1% at his bedside. Resident #3 did not respond to this Surveyor's greeting. This Surveyor asked for staff assistance. CNA D entered the room, removed the cream from the bedside, and said she would give it to the nurse. In an interview on 8/28/24 at 2:35 p.m., CNA D said she would bring any medications found in the residents' room to the nurse and would never leave medication at the bedside because it was not safe for the residents. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/28/24 at 1:13 p.m. the Interim DON said Resident #3's family brought the cream in, and he was not on the medication. She said a facility staff member rounded on his room this morning (8/28/24) and the cream was not there. She said the Clotrimazole cream should not be at the bedside because someone could get to it or use it inappropriately. In an interview on 8/28/24 at 1:47 p.m. the Therapy Tech said she rounded on Resident #3's room this morning (8/28/24) before 9 a.m. and did not see anything on his nightstand. 2. Record review of Resident #12's admission record dated 08/28/2024 revealed a [AGE] year-old male readmitted to the facility on [DATE]. His diagnosis included dementia, metabolic encephalopathy (a disease that affects brain structure or function. It causes altered mental state and confusion), sepsis, and hemiplegia (a symptom that involves one-sided paralysis) and hemiparesis (weakness on one side of the body). Record review of Resident #12's 5-day MDS assessment dated [DATE] revealed a BIMS score of 0 out of 15 which indicated severe cognitive impairment. Record review of Resident #12's care plan revealed he was at risk for skin breakdown related to impaired mobility and incontinence of bowel and bladder. Interventions were to apply barrier cream as indicated, administer medication and treatments as ordered. Record review of Resident #12's physician orders for August 2024 revealed orders for: protective skin barrier ointment after each incontinent episode every shift, order date 8/16/24. Treatments: apply barrier cream, order date 8/16/24. Observation on 8/28/24 at 10:55 a.m. in Resident #12's room revealed Resident #12 was asleep in bed. There was a medication cup filled with white cream on the bedside tray next to the resident's water. The bedside tray was against the resident's wall parallel to the resident's bed. In an interview on 8/28/24 at 11:11 a.m., CNA A entered Resident #12's room with this Surveyor and said the white cream was a barrier cream used for skin prevention to the sacrum. He said he did not know the name of the cream and said the Wound Care Nurse provided the cream for the CNAs. He said after using the cream, he normally placed it in the dresser far away from the patient. In an interview on 8/28/24 at 11:14 a.m. the Wound Care Nurse said the cream used for Resident #12 was Triad Hydrophilic wound dressing with zinc oxide. She said she did not give the CNAs the cream and she applied the cream herself. She said the cream should not be left in the room because of the ingredients. In an interview on 8/28/24 at 1:13 p.m. the Interim DON said if the barrier cream was prescribed for the resident, it should not have been in the room. She said she did not want the resident to eat it, or use it in an unintended manner. She said the nurses, CNAs, and guardian angels were responsible to ensure items (biologicals and medication) were not available in the room. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/28/24 at 3:40 p.m. the ADON said the previous wound care nurse had a habit of giving the CNAs barrier cream. She said the staff were leaving the cream in the resident rooms, so she provided extra training and in-services. She said if staff found cream in the room, they should notify the nurse who could throw it away. She said if the cream was in the room, the resident could eat it or apply it to the wrong location. She said CNAs, nurses, and Angel Rounder staff conducted room rounds and should say something if they saw something. In an interview on 8/28/24 at 3:54 p.m. the Administrator said staff should notify the nurse if they saw anything that was not supposed to be in the residents' rooms. He said the facility conducted Ambassador rounds that checked for physical environment and medications at the bedside. He said the facility also provided education to the residents' family on not leaving medication in the residents' rooms. Record review of the facility's in-service on Rounds, Call lights, and Patient Care dated 7/2/24 conducted by the ADON read in part, .No open containers of barrier cream is to be left at the bedside . Record review of the facility's policy, titled Storage of Medications, revised 11/2020, revealed .The facility stores all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation: 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medication have access to locked mediations .		