STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676434	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Houston Transitional Care	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 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** 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 each resident for 1(Resident #1) of 7 residents . The facility failed to ensure there were complete records for Hydrocodone 10/325 mg (opioid pain medication) for Resident #1from 4/27/26 through 5/10/26. The facility received a documented total of 106 Hydrocodone 10/325 mg tablets for Resident #1. It was also alleged that 20 additional Hydrocodone 10/325 mg tablets were given to the facility on 5/10/26 from Resident #1's home supply, but no facility documentation existed. During April and May 2026, Resident #1 had a documented total of 27 doses of Hydrocodone 10/325 mg tablets administered. The facility was unable to provide narcotic sign out records for Resident #1's Hydrocodone 10/325 mg except for 7 tablets received from Resident #1's home supply. This failure could place residents at risk of not having needed medication available or a lack of pain control. Findings included: Record review of Resident #1's face sheet dated 5/19/26, revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Rheumatoid Arthritis (chronic autoimmune disease that primarily affects the joints causing pain, swelling and stiffness). Resident #1 was discharged on 5/11/2026 for a length of stay of 18 days. Record review of Resident #1's admission MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 14 that indicated cognition was intact. Section N revealed Resident #1 was taking an opioid medication. Section J revealed Resident #1 received as needed pain medication or was offered or declined. Section J pain assessment revealed presence of pain with occasional frequency with rating of 3 on a 0 to 10 scale. Record review of Resident #1's Order Summary Report for order date range of 4/22/26 - 5/31/26 revealed a physician's order for Hydrocodone-Acetaminophen oral tablet 10-325 mg with instructions to give 1 tablet by mouth every 8 hours as needed with start date of 4/25/2026. Record review of Resident #1's progress note dated 4/25/26 at 11:44 a.m. by LVN A revealed pt [family member] gave this nurse a bottle of Norco (Hydrocodone) with 7 pills. Record review of email from Pharmacist B dated 5/20/26 at 3:56 p.m. revealed 40 Hydrocodone 10 mg- 325 mg tablets were delivered on 4/27/26 at 10:03 p.m. and 56 Hydrocodone 10 mg-325 mg tablets were delivered 5/10/26 at 8:30 p.m. Record review of Resident #1's April 2026 MAR revealed documentation that Hydrocodone-Acetaminophen oral tablet 10-325 mg with instructions to administer every 8 hours as needed, were administered on the following dates:* 4/25/26 at 12:30 p.m., *4/26/26 at 11:30 a.m., *4/27/26 at 9:44 a.m., *4/28/26 at 11:00 a.m. and 6:08 p.m., 4/29/26 at 5:13 a.m. and 4:22 p.m. and 4/30/26 at 9:35 a.m. Further review revealed a total of 8 doses documented as being administered during April 2026. Record review of Resident #1's narcotic sheet for date ranges from 4/25/26-4/29/26 for Hydrocodone-APAP 10/325 mg revealed that 7 tablets were provided by the family on 4/25/26 with end count of 0. Doses were signed out as being administered on the following dates:* 4/25/26 at 12:30 p.m., *4/26/26 at 11:30 a.m., *4/27/26 at 9:44 a.m., *4/28/26 at 11:00 a.m., and at 6:07 p.m., *4/29/26 at 5:13 a.m. and at 4:22 p.m. Record review of Resident #1's May 2026 (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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North Houston Transitional Care	9814 Grant Rd Houston, TX 77070

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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 - Few	MAR revealed documentation that Hydrocodone-Acetaminophen oral tablet 10-325 mg with instructions to administer every 8 hours as needed were administered on the following dates:*5/1/26 at 12:22 p.m. and 8:10 p.m.; *5/2/26 at 5:04 a.m. and 2:00 p.m.; *5/3/26 at 5:07 a.m., 2:16 p.m. and 11:00 p.m.; *5/4/26 at 7:56 a.m. 3:58 p.m.; *5/5/26 at 7:26 a.m.; *5/7/26 at midnight, 8:58 a.m. and 3:38 p.m.; *5/8/26 at 12 noon; *5/9/26 at 9:45 a.m. and 5:25 p.m.; *5/10/26 at 9:40 a.m. and 3:54 p.m.; and *5/11/26 at 11:47 a.m. Further review revealed a total of 19 doses documented as being administered in May 2026. Record review of Resident #1's progress noted dated 5/9/26 at 9:45 a.m. written by LVN B revealed [family member] gave resident dose of Norco (Hydrocodone) at 0945 am (9:45AM) for c/o of pain. Awaiting Norco (Hydrocodone) from pharmacy . Record review of Transactions by Patient report dated 5/20/2026 at 2:37 p.m. revealed three doses of Hydrocodone 10-325 mg tablets were obtained from the facility's automated medication dispensing system on the following dates:*5/9/26 at 7:12 p.m., *5/10/26 at 9:15 a.m. and at 3:35 p.m. Further review revealed a total of three tablets obtained. Record review of an email from Resident #1's family member dated 5/10/26 at 8:15 a.m. to the Discharge Planning LVN and DON revealed Resident #1's family member's concern that over the weekend family members were required to provide Resident #1's Hydrocodone because the facility had run out. Record review of an email from Resident #1's family member dated 5/18/26 at 7:40 p.m. addressed to the DON and the Discharge Planning LVN revealed Resident #1's family member's asked when they could pick up the left over Hydrocodone they provided to the facility. Resident #1's family member stated they were informed there was uncertainty about whether the Hydrocodone would arrive on 5/11/26 from the pharmacy and was asked to bring the medication just in case. Resident #1's family member stated that they were at the facility but had not received a response of when they could pick up the Hydrocodone. Record review of email from Resident #1's family member dated 5/21/26 at 9:56 a.m. to the DON and the Discharge Planning LVN revealed they were currently at the facility and was trying to get an update regarding picking up Resident #1's Hydrocodone and would like to receive the medication. Record review of email from Resident #1's family member dated 5/21/26 at 10:13 a.m. to the DON and the Discharge Planning LVN revealed Resident #1's family member's indicated there was a concern regarding 20 Hydrocodone pills that were provided to the facility and that Resident #1 did not believe that Resident #1 finished the 7 Hydrocodone pills that were documented and expressed concern that the medications appeared to have been misplaced or otherwise unaccounted for. During interview on 5/18/26 at 9:41 a.m., Resident #1's family member said the facility had asked them to bring Resident #1's Hydrocodone from home the previous weekend , 5/9-5/10/26, as the residents prescription had not come into the facility. Resident #1's family member said they had not received the remainder of the Hydrocodone that was provided to the facility since Resident #1 discharged from the facility. Resident #1's family member said they asked me to give them the pills I had and I brought some and I said I could bring more if needed. Resident #1's family member said they had talked to the Director of admission and asked if they could get Resident #1's medications back but had not heard anything yet.Observation on 5/19/26 at 2:20 p.m. of the nurse medication cart (the location where Resident #1's medications was located) did not contain narcotic records for Resident #1. During interview on 5/19/26 at 2:27 p.m., RN A said there was no longer a resident in the room where Resident #1 had resided and they no longer had medications for Resident #1 in the medication cart. RN A said if a home medication was brought then they give it back to the residents when they were discharged . RN A said she had not taken care of Resident #1. During interview on 5/20/26 at 10:44 a.m., LVN C said she remembered in April 2026 that they needed to get a prescription called into the pharmacy for Hydrocodone as Resident #1 had just arrived to the facility. LVN C said one of Resident #1's family members had brought up a few Hydrocodone pills and left them to make sure we had pain medication for Resident #1. LVN C said she could not remember when the Hydrocodone was delivered but thought she remembered it was either delivered at the end of her shift or was to be delivered soon. LVN C said Resident #1 did not go without pain medication during this time. During interview on 5/20/26 at 12:42 p.m., LVN A said she (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thought she remembered there were issues with not having Resident #1's Hydrocodone in stock when she was admitted . LVN A said then towards the end of Resident #1's stay, they did not have a blister pack of the Hydrocodone and had to pull from the facility's automated medication dispensing system. LVN A said she did believe that they had a home pill bottle of Hydrocodone that had been obtained upon admission. During interview on 5/20/26 at 1:02 p.m., the DON said she had not been able to find the narcotic records for Resident #1 as the resident had discharged and that her records were between us and medical records and the DON was still trying to find the records. The DON said they did not have any home medications belonging to Resident #1 and believed Resident #1's family member had picked them up. During interview on 5/20/26 at 1:30 p.m., LVN B said she worked for a staffing agency and 5/9/26 was the only shift she had worked at the facility during May 2026 as of the time of the interview. LVN B said the previous nurse had ordered Hydrocodone for Resident #1 and that she was not staffed at the facility so she would not order medications. LVN B said Resident #1's family member had given Resident #1 Hydrocodone from her home medication. LVN B said the staff nurse had told her that Resident #1's family member had given the Hydrocodone and said she guessed it was not the first time. LVN B said she did not instruct Resident #1's family member to give the Hydrocodone to Resident #1. LVN B said that the staff had instructed her that the Hydrocodone was ordered and it was coming. LVN B said the Hydrocodone was not delivered during her shift.During interview on 5/20/26 at 1:41 p.m., LVN D said he did not remember any information regarding Resident #1 and had worked at the facility three times. Observation on 5/20/26 at 2:23 p.m. of the DON's office and narcotic destruction storage revealed no Hydrocodone 10/325 mg tablets were found for Resident #1. There was a stack of narcotic records from April-May 2026 that showed the narcotic counts as 0 and none of these sheets had Resident #1's name. During interview and record review on 5/20/26 at 2:30 p.m., the DON said the last narcotic destruction was completed in April 2026 and would be completed again next Tuesday 5/26/26. The narcotic destruction binder was observed which showed the last narcotic destruction as being completed on 4/20/26. Review of the narcotic sheets with the DON at 2:23 p.m. revealed none were found for Resident #1. During interview on 5/20/26 at 2:45 p.m., LVN E said on 5/8/26 that Resident #1 was running low on her Hydrocodone and she called the doctor to get a new script. LVN E said there were four Hydrocodone tablets remaining. LVN E said when she called the pharmacy, the pharmacy said they do not deliver on the weekend, and she did not understand because they had gotten deliveries on the weekends. LVN E said she asked if she could pull from the automated medication dispensing system and got the code. LVN E said we finally got a delivery on 5/10/26 of Hydrocodone 10 mg tablets which were over 50 pills and the other blister pack was gone at that time. LVN E said she got the script for the Hydrocodone on 5/9/26 and had pulled Hydrocodone from the automated medication dispensing system on the mornings 5/9/26 and 5/10/26. LVN E said they counted narcotics at shift change with the ongoing and off going nurses. LVN E said she checked the narcotic counts before she gave the medication and signed the out the narcotics and sometimes would go back and check that she signed the medication out. LVN E said she checked the narcotics 2-3 times a shift. LVN E said on the east side of the facility (where Resident #1's room was located) the nurses administered the as needed pain medications. LVN E said she had tried to explain to Resident #1's family that they were never out of her medications, and they were pulling from the automated medication dispensing system and there had to be two nurses and there was not always another nurse available so sometimes they had to wait to administer the medication until there were two nurses available to pull the medication. During interview on 5/20/26 at 3:14 p.m., Pharmacist A said she had been the pharmacist at the facility for five years and did all of the medication destruction including narcotic destruction. Pharmacist A said she also did audits including watching shift to shift narcotic counts or she did the narcotic counts with the nurse if it was not shift change. Pharmacist A said the staff did shift to shift counts of the narcotics as well, so her checks were a double check. Pharmacist A said she had not had any narcotic discrepancies when she did her checks. Pharmacist A said for a narcotic delivery they had a (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff member at the facility who signed for receipt of the medications. Pharmacist A said she had instructed the facility staff about what to do if the narcotic count was off or how they should be recording the narcotics but only did narcotic in-services if there were narcotic discrepancies.During interview on 5/20/26 at 3:35 p.m., Pharmacist B said they delivered a total of 45 tablets of Hydrocodone 10/325 mg for Resident #1 on 4/27/26. Pharmacist B said the second order of Hydrocodone 10/325 mg was delivered on 5/10/26 for a total of 56 tablets. Pharmacist B said she saw a total of three doses of Hydrocodone 10/325 mg tablets that were pulled from the Omnicell (medication dispensing system) from reports. Pharmacist B said a possible effect it could have on residents regarding a narcotic discrepancy was a lack of pain control. During interview on 5/21/26 at 10:14 a.m., Resident #1's family member said she had brought the facility 7 Hydrocodone 10 mg tablets on 5/10/26 and the nurse told her it was not enough since they were not able to get the medication and it was best to bring more. Resident #1's family member said she left the facility and brought back 20 additional Hydrocodone 10 mg tablets that same night. Resident #1's family member said she did not know the name of the nurse she gave the medication to, but she would know the person if she saw a picture. Resident #1's family member said she talked to the ADON and the Discharge Planning LVN today at the facility regarding attempting to obtain Resident #1's Hydrocodone tablets. Resident #1's family member said she was told the facility only had documentation of the seven pills that the facility was given and they were all gone. Resident #1's family member said she told the facility that they should have more as Resident #1 was only getting them every 6 hours. Resident #1's family member said it was after 9 p.m. when she brought the 20 pills back on 5/10/26 and Resident #1 left the faciity on 5/11/26 at 8 p.m. Resident #1's family member said the nurse did not have her sign anything either time she dropped the medications off and they just said they had to get another nurse to count them for the 7 Hydrocodone tablets she dropped off but for the 20 Hydrocodone tablets she dropped off there was nothing and they did not get another nurse to count. Resident #1's family member said she did not see either count of the Hydrocodone tablets that were given to the facility.During interview on 5/21/26 at 10:24 a.m., the ADON said if she was coming in for a shift before she took possession of the medication cart and keys, they did a narcotic count and once everything was counted which included checking the medication name, dosage and count were correct then the off going and ongoing nurse would sign their sections of the narcotic sheet and the ongoing nurse was signing they were taking possession of the medication cart. The ADON said the narcotic counts were done with every shift change. The ADON said when they did the narcotic count they read the medication name, dosage and the left count. The ADON denied any problems with the narcotic counts not being correct or any narcotic medications going missing. The ADON said the nurse for that scheduled shift was the only person who had the keys to the medication cart once they took ownership of the medication cart. The ADON said there were no back up keys for the medication cart. The ADON said the process when there was a delivery of narcotics came in red bags and they open them in front of the delivery person and verify the medication, patient name and quantity and compare them with the slip that was delivered with the medication and we keep a copy. The ADON said before the medication went onto the cart the nurse who received the medication checked the information with a second nurse. The ADON said when narcotics were removed from the medication carts they were given to the DON and before the nurse handed off to the DON they verified the medication name and amount correlated to the sign off sheet. The ADON said once that was done the DON took possession and cataloged the medication to be destroyed and put in a locked drawer to be destroyed when the pharmacist came. The ADON said the pharmacist came once a month to do drug destruction. The ADON said the nurses trained with a seasoned nurse who knew what the expectations were which included narcotics. The ADON said they try to do audits of the narcotics every two weeks and made sure the nurses were signing off when they do their drug counts. The ADON said that the nurses let her know if there were any narcotics that needed to be destroyed and let the DON know as she was the only one who had the key for the narcotic destruction. The ADON (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said when nurses accept home narcotic medications they do an initial count and make sure there was an actual order before they take possession of the medication. The ADON said then the nurse would draw up a narcotic sheet with the order amount and name of the patient and a verified amount that they start from and moving forward they used that sheet to count. The ADON said regarding Resident #1 the only thing she knew was there was a bottle of seven Hydrocodone 10/325 pills, if she remembered correctly regarding the amount, that was brought and was counted and utilized that medication while she was here and there was none left. During interview on 5/21/26 at 11:40 a.m., the DON said the oncoming and off going nurses were responsible for counting the narcotics. The DON said the process for counting the narcotics was there were always two nurses, one had the book open and the other had the box open and they go through the name, medication and number to verify what they were counting. The DON said both nurses sign the book and then the off going shift hands the key to the oncoming shift. The DON said the nurses should notify her if there was a discrepancy. The DON denied any problems with the narcotic counts not being correct or any narcotic medications going missing. The DON said the narcotics were stored in the narcotic box in the medication cart under two locks and they should always be locked. The DON said the nurses had access to the keys to the medication cart and they only had access to their own medication cart. The DON said there were extra keys to the medication carts that she kept locked up in the narcotic destruction storage cabinet in her office. The DON said when narcotics were delivered the nurse signed with the delivery person and immediately put in the narcotic lock box and put the sheet in the binder. The DON said nurses were the only staff who received the narcotic deliveries. The DON said when residents were discharged or narcotics were discontinued the nurses should leave the narcotic paper in the book and the narcotic on the cart until they see her and then the nurse gave the medication and associated paper to her and she locked it up and logs it. The DON said she made sure the count was good and counted the medication with the nurse who gave her the narcotic before she locks it up in her office for destruction. The DON said training regarding narcotics included signing out the medications at the same time you click/sign them out in the computer and regarding the residents' pain and occurs during orientation and when required. The DON said staff were taught about narcotic counts with one another, signing out and getting the medications in the building. The DON said if home narcotics were received the nurses should make a sheet and sign it out. The DON said it would be best practice for two nurses to count home narcotic medications when received and those medications also go in the count. The DON said regarding Resident #1, a family member had brought 7 Hydrocodone 10/325 mg tablets and they started a sheet and signed those out. The DON said she did not have any information regarding a second delivery. The DON said the April 2026 sign out sheet that the DON provided to the surveyor for Resident #1 was the only sign out sheet for Hydrocodone that she could find for Resident #1. The DON said the ADON did audits of the narcotics on the medication carts. The DON said if narcotic counts sheets could not be found the effect it could have on the residents was to ensure that we have an adequate supply of the medication and the narcotic sheets was a secondary check.Record review of the facility's policy Controlled Substances with revision date of November 2022 revealed the system of reconciling the receipt, dispensing and disposition of controlled substances included the records of personnel access and usage; declining inventory records; and destruction, waste and return to pharmacy records. Policy also revealed accountability record for discontinued controlled substances are kept with the unused supply until it is destroyed or disposed of as required by applicable law or regulation. Record review of the facility's policy Discarding and Destroying Medications with revision date of October 2014 revealed completed medication disposition records shall be kept on file in the facility for at least two years or as mandated by state law governing the retention and storage of such records.