STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 (Resident #1) of 5 residents reviewed for resident rights.- Nurse A did not respond to the Dr.'s text message on 05/01/26 at 10:12 p.m. when she asked him if it looked like Resident #1 had a stroke.-Nurse B failed to report Resident #1's change in condition for approximately 12 hours and 36 minutes beginning on 05/01/26 around 10:12 p.m. NP was notified on 05/02/26 at about 10:48 a.m. and Resident #1 was not transported to the hospital until 05/02/26 at approximately 11:42 a.m.An Immediate Jeopardy (IJ) was identified on 05/09/26. The IJ template was provided to the facility on [DATE] at 1:30 p.m. While the IJ was removed on 05/11/26, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal (POR).This failure could place residents at risk of not receiving appropriate care and required notifications being made when there is a change in their condition.Findings included:Record review of Resident #1's admission Record, dated 05/06/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (lung disease), hemiplegia and hemiparesis (hemiplegia is paralysis of one side of the body, while hemiparesis is weakness on one side) following cerebral infarction (ischemic stroke and requiring targeted rehabilitation for recovery) affecting right dominant side, cognitive communication deficit (occurs when a person struggles to communicate effectively because of impairments in cognitive processes such as attention, memory, and executive function rather than problems with speech or language itself, and dysphagia (difficulty swallowing), oropharyngeal phase (initial, automatic stage of swallowing).Record review of Resident #1's MDS Assessment, dated 02/14/26, revealed a BIMS score of 14, indicating her cognition was intact. Section B, B0600, Speech clarity, was coded as 1 indicating unclear speech - slurred or mumbled words and Section B, B0700, Makes Self Understood, was coded as 1 indicating Resident #1 was usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time.Record review of Resident #1's Care Plan, undated, revealed resident had a communication problem. Interventions for the resident included allowing adequate time to respond, repeating as necessary, requesting clarification from the resident to ensure understanding, asking yes/no questions if appropriate, and using simple, brief, consistent words/cues. Additional interventions included encouraging the resident to continue stating thoughts even if resident is having difficulty and to monitor for/record cofounding problems such as a decline in cognitive status and oral motor function.Record review of Resident #1's Change in Condition Evaluation form, dated 05/02/26 at 11:00 a.m., revealed Nurse C completed the evaluation and noted Resident #1 showed signs of aphasic speech (impaired communication caused by damage to the brain's language centers, affecting speaking, understanding, reading, and writing), was easy to (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	arouse, not able to respond as she normally did, no facial drooping, able to move left arm and leg which was normal, no respiratory distress, NP ordered to send resident to ER for evaluation and treatment.Record review of Resident #1's progress note, dated 05/06/26 at 12:59 p.m., revealed on 05/02/26 at 11:00 a.m., Nurse C entered a SBAR Summary for Providers for a CIC. CIC noted Resident #1's neurological status evaluation as abnormal speech. In addition, the CIC note indicated Nurse C was informed resident was not acting herself, was easy to arouse, not able to respond as she normally did, no facial drooping, able to move left arm and leg which was normal, no respiratory distress, NP notified and ordered to send resident to ER for evaluation and treatment.Record review of Resident #1's progress note, created date 05/06/26 at 18:58 [6:58 p.m.], revealed Nurse A created the note as a late entry. Note reflected an effective date of 05/01/26 at 21:35 [9:35 p.m.] and indicated Resident in bed watching Tv, but not as vocal as normal.Resident started singing and started speaking garbled English. Dr. [name] notified asked if she appeared to have a stroke. Unable to answer informed the on coming nurse, that the resident was not vocal and that Dr. [name] wanted to know if it appears that the resident has had a stroke. Resident viewed again and was singing no distress at the moment. Nurse agreed to monitor the resident and if any changes to notify the Dr.Record review of Resident #1's progress note, dated 05/06/26 at 12:59 p.m., revealed on 05/02/26 at 12:30 p.m., Nurse C entered EMS arrived at facility at 11:42A and placed resident on stretcher and left facility 11:48A.Record review of hospital records, dated 05/02/26 revealed Resident #1 had diagnosis of altered mental status and acute cerebrovascular accident (CVA). She returned to the facility on [DATE].During an interview on 05/07/26 at 8:37 a.m., Nurse B said he worked Friday, 05/01/26 from 10:00 p.m. to 6:00 a.m. He said Nurse A gave him resident updates verbally and told him Resident #1's speech was not clear, and it took her 30 seconds to a minute longer, compared to her regular baseline to respond. He said Nurse A told him he texted the Dr. [name] and was waiting for a response from her. He said Nurse A told him to monitor the resident during his shift. He said he monitored Resident #1 during his shift. He said he monitored her at 10:30 p.m. and resident was asleep and he checked her vital signs. He said at 1:30 a.m. resident was asleep and he touched her arm, she blinked, opened her mouth, and went back to sleep. He said at 3:15 a.m., she was asleep, he touched her arm, she opened eyes and went back to sleep. He said he went to resident's room around 5:00 a.m.-5:30 a.m. He said resident was awake and he tried to speak with her and felt resident's speech was still not clear and that she was trying to say the words, but her speech was still slurred. He said he asked Resident #1 if she was okay and she said she was fine, but it took her more than a minute to answer the question but said he understood her answer. He said he completed a full body assessment on 05/02/26 at approximately around 5:00 a.m.-5:30 a.m. (documentation could not be located). He said around 6:15 a.m. he gave Nurse C the shift change report and told him Resident #1's speech was slurred, that he could not make out the words, and it look like she had seizure activity. Nurse B said he asked Nurse C to assess the resident and then to call the doctor. He said Nurse C said he would do the assessment and would then call the doctor about resident's speech. He said he then left the facility because his shift was over. He said if resident has a physical change he would ensure treatment and care was provided to Resident #1 when there was a change consistent with professional standards of practice. During an interview on 05/07/26 at 11:31 a.m., the NP said she received a phone call from Nurse C around 10:48 a.m. on 05/02/26 about Resident #1. She said Nurse C told her Resident #1's speech was slurred and that she had a significant change with her speech. She said Resident #1's speech went from 3-4 words, for example, not feeling good, stomach hurts, get the hell out of here, but NP said now Resident #1's words were indiscernible. NP said Resident #1 now not being able to speak leads her to believe she had a stroke, but NP said she had not reviewed the hospital paperwork yet.During a telephone interview on 05/07/26 at 11:49 a.m., the Dr. said Nurse A messaged her on 05/01/26 approximately around 9:40 pm-10:00pm saying Resident #1 denies any pain, not herself, sorry to bother you. She said she messaged him back and asked if Resident #1 had any signs of a stroke, but she said she did not hear back from Nurse A. Dr. said she would have (continued on next page)

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She can put a progress not on the EMAR for the resident if a change was experienced while passing meds. There isn't a form that she would complete if she were to recognize a change from the resident. For a resident with stroke would be face drooping, limbs cannot be held, and slurred speech. The expectation for documentation is to complete immediately, right away. She would also inform the nurse verbally. If she passed the message on she would not document.During an interview on 05/10/26 at 1:01 p.m., Nurse C has been at the facility roughly three years and only on the weekends 16 hours shifts on Saturday and Sunday , identify the change in condition is to look for difference in baseline and the resident may not be walking, overall look, speech has changed, when a resident is no longer at or doing their normal. If the resident is having a condition, speak to the resident, check vitals, began assessing, try to speak to resident, and notice the change as if a resident unable to speak, notify doctor, call 911, received order, notify ADON, and the administrator, completed the change in condition and then complete a transfer out form. The expectation for documentation is to complete what is seen and make it understandable for the next person, documentation should be completed within the live time to paint a picture. Resident safety was to make sure they have a safe environment, call light within reach, proper supervision, and monitoring and keep them out of harm's way. They use the dashboard for every resident they can see the care plan and review any changes, everything is normally downloaded and placed in the Kardex and will show everything that is needed regarding the resident. For dignity and respect this is the resident home and interact with them as a person and not a thing. Pull the curtains, make sure they are covered up, don't talk down to them or belittle them. Signs of stroke, facial drooping, limbs of weakness, the resident will become stiff and cannot move out of the position and change in speech. The physician is notified by text and verbal. If severe, they will contact via telephone. The facility doesn't have a 24-hour report.During an interview on 05/10/26 at 1:26 p.m., CNA B has been at the facility almost two years, works 6:00 a.m.-2:00 p.m. and is assigned to hall 300. A change in condition is identified by the resident is not their normal, getting up, not eating, and she would report it to the nurse. She report to the nurse verbally, and they have an area on the POC where she can chart, and she will complete the report.During an interview on 05/10/26 at 2:05 p.m., CNA C said she works 6:00 a.m.-2:00 p.m., she is PRN and only works the weekends, for change in condition, if she see the patient with a change and they are not the same, she is big on appetite and she will see the change and report it immediately, she would also go into the POC and new change alert and she will document what she saw, and she would stay with the patient and inform the nurse and she would let the nurse know to assess, she cannot touch them until the nurse will see them, she will ensure the resident is safe by constantly monitoring and documenting what they do throughout the shift, with dignity and respect and be polite, she ask them what they want to do, maintain privacy at all times, give them choices, signs of a stroke she would look for face drooping, in a daze, non-responsive, and mouth droopy.During an interview on 05/10/26 at 2:31 p.m., Nurse B has been at the facility about a year and half. A change in condition is anything that happens outside of the resident normal, difference in behavior, speaking, moving of the body parts. The first thing he would do the assessment is to head to toe, call the MD, call 911 and following any orders, document the (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the resident not eating or not as active as they were, she would report to the nurse and document the change. Sometimes the doctor will come back and ask how the resident has been doing after the change has been identified. She would document by the POC and new alert. To document the appropriate time is after she is caring for the resident and she will try to complete every two hours. Resident safety is by keep everybody together so she can see them and continue to monitor the residents, make sure nothing is on the floor, don't let the ones in the wheelchair try to get up and walk on their own, keep things within reach. For dignity and respect she ensure maintain privacy during peri care, have a conversation with the resident. Some signs of a stroke would be lip drooping, one side of the limbs weak or the resident not being able to walk, and slurred speech.During an interview on 05/11/26 at 3:47 p.m., CNA G said she had been at the facility for almost two years, she works 2:00 p.m.-10:00 p.m. shift, and she is assigned to hall 300. She would identify a change in condition would be for a resident to not be normal such as a wound. She would report the change by POC using the new alert tab, she would document the change and the resident it is for to what is new or what has changed. The expectation for documentation is to put in POC and should be done immediately. After the change, she monitor the resident, notify the nurse. Stay close to make sure the resident doesn't injure themselves and make sure they are safe. Resident safety would be monitoring, document, nothing on the floor, make sure the path is clear, call light within reach and if they are used to getting up she would try to assist if they don't ask for help. For dignity and respect she speak to the resident, ask questions and tell them the care before starting, and ask them how they feel, and sleep them clean. Some examples of a stroke would be slurred speech, drooping jaw, and confusion.The Administrator was informed the Immediate Jeopardy was removed on 05/11/2026 at 4:55 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 5 residents reviewed for quality of care.-Nurse A noticed a change in Resident #1's speech on 05/01/26 around 9:30 p.m. He sent a text message to the Dr. at 9:37 p.m. and at 10:12 p.m., the Dr. asked if it looked like resident had a stroke, but Nurse A did not follow up with the Dr. The Dr. did not follow up with Nurse A.-Nurse B failed to report Resident #1's change in condition for approximately 12 hours and 36 minutes beginning on 05/01/26 around 10:12 p.m.-It took Resident #1 a total of 13 hours and 30 minutes to receive care for a possible stroke. Nurse A noticed a change in condition on 05/01/26 around 9:30 p.m. and Resident #1 was transferred to the hospital by EMS on 05/02/26 around 11:42 a.m.An Immediate Jeopardy (IJ) was identified on 05/09/26. The IJ template was provided to the facility on [DATE] at 1:30 p.m. While the IJ was removed on 05/11/26, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal (POR).This failure could place residents at risk for a delay in medical treatment, of not receiving necessary medical care, hospitalization, and death.Findings included:Record review of Resident #1's admission Record, dated 05/06/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (lung disease), hemiplegia and hemiparesis (hemiplegia is paralysis of one side of the body, while hemiparesis is weakness on one side) following cerebral infarction (ischemic stroke and requiring targeted rehabilitation for recovery) affecting right dominant side, cognitive communication deficit (occurs when a person struggles to communicate effectively because of impairments in cognitive processes such as attention, memory, and executive function rather than problems with speech or language itself, and dysphagia (difficulty swallowing), oropharyngeal phase (initial, automatic stage of swallowing).Record review of Resident #1's MDS Assessment, dated 02/14/26, revealed a BIMS score of 14, indicating her cognition was intact. Section B, B0600, Speech clarity, was coded as 1 indicating unclear speech - slurred or mumbled words and Section B, B0700, Makes Self Understood, was coded as 1 indicating Resident #1 was usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time.Record review of Resident #1's Care Plan, undated, revealed resident has a communication problem. Interventions for the resident included allowing adequate time to respond, repeating as necessary, requesting clarification from the resident to ensure understanding, asking yes/no questions if appropriate, and using simple, brief, consistent words/cues. Additional interventions included encouraging the resident to continue stating thoughts even if resident is having difficulty and to monitor for/record cofounding problems such as a decline in cognitive status and oral motor function.Record review of Resident #1's Change in Condition Evaluation form, dated 05/02/26 at 11:00 a.m., revealed Nurse C completed the evaluation and noted Resident #1 showed signs of aphasic speech (impaired communication caused by damage to the brain's language centers, affecting speaking, understanding, reading, and writing), was easy to arouse, not able to respond as she normally did, no facial drooping, able to move left arm and leg which was normal, no respiratory distress, NP ordered to send resident to ER for evaluation and treatment.Record review of Resident #1's progress note, dated 05/06/26 at 12:59:54 p.m., revealed on 05/02/26 at 11:00 a.m., Nurse C entered a SBAR Summary for Providers for a CIC. The CIC noted Resident #1's neurological status evaluation as abnormal speech. In addition, CIC note indicated Nurse C was informed resident was not acting herself, was easy to arouse, not able to respond as she normally did, no facial drooping, able to move left arm and leg which was normal, no respiratory distress, NP notified and ordered to send resident to ER for evaluation and treatment.Record review of Resident #1's progress note, created date 05/06/26 at 18:58(6:58 p.m.), revealed note was created (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a change from the resident. For a resident with stroke would be face drooping, limbs cannot be held, and slurred speech. The expectation for documentation is to complete immediately, right away. She would also inform the nurse verbally. If she passed the message on she would not document.During an interview on 05/10/26 at 1:01 p.m., Nurse C has been at the facility roughly three years and only on the weekends 16 hours shifts on Saturday and Sunday , identify the change in condition is to look for difference in baseline and the resident may not be walking, overall look, speech has changed, when a resident is no longer at or doing their normal. If the resident is having a condition, speak to the resident, check vitals, began assessing, try to speak to resident, and notice the change as if a resident unable to speak, notify doctor, call 911, received order, notify ADON, and the administrator, completed the change in condition and then complete a transfer out form. The expectation for documentation is to complete what is seen and make it understandable for the next person, documentation should be completed within the live time to paint a picture. Resident safety was to make sure they have a safe environment, call light within reach, proper supervision, and monitoring and keep them out of harm's way. They use the dashboard for every resident they can see the care plan and review any changes, everything is normally downloaded and placed in the Kardex and will show everything that is needed regarding the resident. For dignity and respect this is the resident home and interact with them as a person and not a thing. Pull the curtains, make sure they are covered up, don't talk down to them or belittle them. Signs of stroke, facial drooping, limbs of weakness, the resident will become stiff and cannot move out of the position and change in speech. The physician is notified by text and verbal. If severe, they will contact via telephone. The facility doesn't have a 24-hour report.During an interview on 05/10/26 at 1:26 p.m., CNA B has been at the facility almost two years, works 6:00 a.m.-2:00 p.m. and is assigned to hall 300. A change in condition is identified by the resident is not their normal, getting up, not eating, and she would report it to the nurse. She report to the nurse verbally, and they have an area on the POC where she can chart, and she will complete the report.During an interview on 05/10/26 at 2:05 p.m., CNA C said she works 6:00 a.m.-2:00 p.m., she is PRN and only works the weekends, for change in condition, if she see the patient with a change and they are not the same, she is big on appetite and she will see the change and report it immediately, she would also go into the POC and new change alert and she will document what she saw, and she would stay with the patient and inform the nurse and she would let the nurse know to assess, she cannot touch them until the nurse will see them, she will ensure the resident is safe by constantly monitoring and documenting what they do throughout the shift, with dignity and respect and be polite, she ask them what they want to do, maintain privacy at all times, give them choices, signs of a stroke she would look for face drooping, in a daze, non-responsive, and mouth droopy.During an interview on 05/10/26 at 2:31 p.m., Nurse B has been at the facility about a year and half. A change in condition is anything that happens outside of the resident normal, difference in behavior, speaking, moving of the body parts. The first thing he would do the assessment is to head to toe, call the MD, call 911 and following any orders, document the change in condition, complete nursing note, notify DON and administrator, the appropriate time to document is in live time and document for understanding and clarity of the next person, for dignity and respect they inform the resident care is proper, treat them as a normal human being, when they need help assist the resident, answer call light. Signs of a stroke, face dropping, speech slurred, checking their body for limpness, checking the resident eyes or changes and pupils. For the incident: he assessed, the nurse told him about the change in condition and he informed him verbally. If nothing is documented, he starts to assess and will check the resident. So far he has only done in services. Stated that he also works 10:00 p.m-6:00 a.m.During an interview on 05/10/26 at 3:00 p.m., the Administrator has been at the facility about 45 days, since being identified, they have educated the staff starting with the aides/nurses on recognizing signs and symptoms of CVA and change in condition, appropriate reporting to the change, documentation of the change. In addition, they been doing rounds that started this morning to ensure staff is aware of the education and knowing what the expectation is, they have (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	completed audits for the past 30 days for all residents to ensure no documentation was missed, change in conditions, and check if something that was noted that they could have possibly missed and she believes that it. At this time, they are going to be here for the night shift and make sure they understand the education they have received.During an interview on 05/10/26 at 3:18pm, the ADON has been at the facility for one year, they have reeducated staff on reporting change in condition, monitoring change in condition, signs and symptoms for stroke related symptoms, and documentation, they have done rounds with the staff to listen to the nurses to ensure they were doing shift to shift reports, she has done audits of all changes in conditions for the last 30 days to make sure notification was there, they do have 24 hour reports that the nurses should be completing every shift and it should be printed and completed, and she was here this morning before 6:00 a.m. so she could see the exchange of how staff are reporting, she has talked about documentation and the expectation of how it should be done and when, the timeframe that staff have for documenting is as it occurs, stop and watch is used for new alert and the alert will come on the dashboard and they will verbally inform the nurse and she will follow up to see what was done and when/how the resident was assessed. The Regional Nurse and Nurse C were ensuring the in-services were being done.During an interview on 05/11/26 at 3:16 p.m., CNA D works 10:00 p.m.-6:00 a.m., she is assigned to community and MCU, change in condition is identified by seeing the patient that slurred speech, anything that they see is different she will report it to the nurse. If the nurse didn't do anything, they go to the DON. The change is reported by informing the nurse, stay in the room and have someone let the nurse know, and document in POR the new alert option. For resident safety she will keep it low position and make sure they are monitored. Rounds are constant, but no more than 2 hours, they will do it sooner. For dignity and respect, she knock on the door, identify who she is and what they are going to do. She also try to make conversation and make sure they have call light within reach and make sure everything that they may reach for is near. Signs of stroke would be not talk, slurred talk. Expectation for documentation would be documented in the POC, in live time and when they see the change.During an interview on 05/11/26 at 3:23p.m., CNA E works 10:00 p.m.-6:00 a.m., she is assigned to MCU. She would identify a change in condition by when she see something different and will notify the nurse right away. After notifying, the nurse will assess and then she continue to assist with rounding, she will document in POC as soon as it occurs. She report changes just by letting the nurse know and state verbally what she has seen and document. The appropriate time to document is during the shift or closer towards the end of the shift. residents safety is by making sure they have a clear path, wheelchairs are put away properly, beds in low position if necessary. Dignity and respect, always call by their name. for stroke, she will check for face twisted a little bit or if the resident is not able to respond. She look for a lot of things because her mom had a stroke, so she takes it very seriously.During an interview on 05/11/26 at 3:34pm CNA F works in the community but mainly in the secured unit, 2:00 p.m.-10:00 p.m. shift, a change in condition is identified by the resident not eating or not as active as they were, she would report to the nurse and document the change. Sometimes the doctor will come back and ask how the resident has been doing after the change has been identified. She would document by the POC and new alert. To document the appropriate time is after she is caring for the resident and she will try to complete every two hours. Resident safety is by keep everybody together so she can see them and continue to monitor the residents, make sure nothing is on the floor, don't let the ones in the wheelchair try to get up and walk on their own, keep things within reach. For dignity and respect she ensure maintain privacy during peri care, have a conversation with the resident. Some signs of a stroke would be lip drooping, one side of the limbs weak or the resident not being able to walk, and slurred speech.During an interview on 05/11/26 at 3:47 p.m., CNA G has been at the facility for almost two years, works 2:00 p.m.-10:00 p.m. shift, she is assigned to hall 300. She would identify a change in condition would be for a resident to not be normal such as a wound. She would report the change by POC using the new alert tab, she would document the change and the resident it is for to what is new or what has changed. The expectation for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Houston	6534 Stuebner Airline Road Houston, TX 77091

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documentation is to put in POC and should be done immediately. After the change, she monitor the resident, notify the nurse. Stay close to make sure the resident doesn't injure themselves and make sure they are safe. Resident safety would be monitoring, document, nothing on the floor, make sure the path is clear, call light within reach and if they are used to getting up she would try to assist if they don't ask for help. For dignity and respect she speak to the resident, ask questions and tell them the care before starting, and ask them how they feel, and sleep them clean. Some examples of a stroke would be slurred speech, drooping jaw, and confusion.The Administrator was informed the Immediate Jeopardy was removed on 05/11/2026 at 4:55 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.