

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025
NAME OF PROVIDER OR SUPPLIER Caraday of Houston		STREET ADDRESS, CITY, STATE, ZIP CODE 6534 Stuebner Airline Road Houston, TX 77091	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>49710</p> <p>Based on observation, interview, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 3 medication carts reviewed for medication storage.</p> <p>The facility failed to ensure medications were properly stored and labeled when Resident #4's medications were popped into a pull cup and left unattended.</p> <p>This failure could place residents at risk for drug diversion, lack of drug efficacy, and adverse reactions.</p> <p>Findings include:</p> <p>During an observation on 3/27/25 at 9:32am revealed a medication aide cart with a medication cup labeled Resident #4 (name) with at least 7 pills inside.</p> <p>During an interview on 3/27/25 at 9:37am CMA E stated the resident was taking a shower, and she would have to go back to give her medications.</p> <p>During an interview on 3/27/25 at 10:55am LVN A stated you should never leave any open pills on the cart. You never know what could happen to those pills during that time. They should be destroyed, and you start over.</p> <p>During an interview on 3/27/25 at 11:06am LVN B stated you should stand there and wait for the resident to be done. You should never leave them open medications on the cart. Training for CMAs was done with the pharmacist monthly. Medication administration was a part of their training. Monthly. Will do a one to one with medication aide.</p> <p>During an interview on 3/27/24 at 11:11am the administrator stated staff should follow the protocol. They should not be pre popping medications.</p> <p>(continued on next page)</p>		

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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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/27/24 at 11:11am the regional RN C stated if they knew the resident and medication, they put it in a cup then it should ok. First and last name should be labeled on the cup also timed and dated. If they were destroyed that could be costly to the resident.</p> <p>During an interview on 3/27/24 at 12:55 pm RN D stated medications were to be given on time. Staff should be following the medication rights, right patient, dose, route. Before giving the medication, it should be verified. No premedication popping. If premedication was done, you don't know which medication it was. If there's a blood pressure medication staff need to check before the pressure before giving it. So, based on the vitals it may not allow you to give the medication. This could cause a mix up in medication if staff premedicated and didn't know which one to pull.</p> <p>Record review of the facility provided policy titled, Medication and Preparation Administration revealed the following:</p> <p>Medications should be prepared for only one resident at a time. Facility staff should observe the 6 Rights and verify right resident, right drug, right dose, right route and right time, and right documentation for each medication being administered.</p> <p>Abbreviations:</p> <p>CNA-certified nursing assistant</p> <p>LVN-Licensed vocational nurse</p> <p>RN- registered nurse</p> <p>CMA-certified medication aide</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50744</p> <p>Based on observation, interview and record review the facility failed to maintain an effective pest control program so the facility was free of pest and rodents for 2 of 2 residents reviewed for environment.</p> <p>The facility failed to ensure resident rooms were free of gnats.</p> <p>This failure could place residents at risk of infection, skin irritation, allergies, which could result in unsanitary living conditions and decline in health and well-being.</p> <p>Findings include:</p> <p>In an observation with Resident #404, on 03/26/2025 at 9:57am revealed sightings of gnats on the walls, on pictures, lighting above Resident #404 bed, flying around And on a urinal placed on the floor.</p> <p>In an interview with Resident #404 on 03/26/2025 at 9:57 AM, the resident stated the gnats were horrible and there was a substance that was placed by MAINT, but it wasn't catching the gnats.</p> <p>In an interview with HSK on 03/26/2025 at 10:11 AM, revealed the resident room always had gnats. HSK stated they did not know why there were so many gnats in the room but all they did was clean up behind each resident. HSK stated it may be from the trash always overflowing or food that was left out.</p> <p>In an interview with LVN on 03/26/2025 at 10:13 AM, revealed pest control came last week to spray the facility and Resident #404's room. LVN stated when conducting rounds on the morning of, 03/26/2025, he identified gnats in the room, and they were going to have the room cleaned. LVN stated the risk could cause any resident to be uncomfortable with gnats being present in the room/facility.</p> <p>In an observation with Resident #404 on 03/27/2025 at 10:42 AM, revealed gnats in the room, but not as many as the day before. Gnats were observed on the pictures and Resident #404's urinal placed by the bed.</p> <p>In an interview with Resident #404 on 03/27/2025 at 10:43 AM, revealed the gnats seem to come and go, but the gnats were a lot worse than what was being observed. Resident #404 has been at the facility for one month.</p> <p>In an interview with Resident #5 who shared a room with Resident #404 on 03/27/2025 at 10:46 AM, revealed MAINT came to the room and sprayed to try and minimize the gnats. Resident #5 stated there were still gnats in the room, but he did appreciate the facility for trying to take care of the issue.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with MAINT on 03/27/2025 at 12:04 PM, MAINT stated the gnats came from Resident #404 and the urine being spilled on the floors. MAINT stated Resident #404 wanted to be independent and used the urinal and placed it back on the floor. MAINT stated pest control treated the room and the facility once a month. MAINT stated he treated the room as well, once a week to try and prevent the gnats, but they were always present. MAINT stated he used a log to track every time he needed to treat the room or the facility for gnats.</p> <p>In an interview with the ADMN on 03/27/2025 at 2:54 PM, the ADMN stated pest control had been coming to treat the facility and resident rooms. The ADMN stated they were doing the best they could with the gnats, all while trying to encourage the resident to be independent. The ADMN believed Resident #404's urinal waste on the floor and could contribute to the gnats being uncontrolled.</p> <p>Record review of the facility's Pest Control Policy reflected Bed Bugs, Prevent and Managing Infestations of</p> <p>In record review of the facility's maintenance log, on 03/28/2025, listed the issue/concern for a member of maintenance to follow up. On 03/17/2025, 03/19/2025, 03/21/2025, 03/24/2025, 03/25/2025, gnats were noticed and treated by MAINT for rooms [ROOM NUMBERS]. The risk to any resident with gnats could be their dignity and not feeling good about the facility for their care.</p> <p>In record review of the facility's contract with pest control, on 03/28/2025, reflected the pest control company had been active since 07/01/2023. The contract stated pest specifically not covered to include Flying insects (flies, bees, wasps, and gnats) .Service for NON COVERED PESTS may be provided for a fee on a materials plus labor basis.</p>		