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

Printed: 03/16/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675671	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace Healthcare Center of Houston	7887 Cambridge St Houston, TX 77054

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. (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

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

Printed: 03/16/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Terrace Healthcare Center of Houston	7887 Cambridge St Houston, TX 77054

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preference for 1 (Resident #1) of 3 residents reviewed for tracheal care. The facility failed to follow physician orders for Resident #1 by not performing the prescribed trach care as ordered. Specifically, the facility did not change the trach aerosol tubing, mask, jet nebulizer bottle, and water trap every Sunday on nights shift or change the trach ties every night shift on 10/11/25, 10/12/25, 10/13/25, 10/18/25, 10/19/25, 10/25/25, 10/26/25, 11/2/25, 11/3/25, 11/4/25, 11/5/25, 11/6/25, 11/7/25, 11/8/25, 11/9/25, 11/16/25, 11/23/25, 11/24/25, and 11/27/25. On 11/28/25, Resident #1 was admitted to the hospital due to brown emesis coming from his mouth and trach and Resident #1 was diagnosed with MRSA. On 12/4/25 at 3:40 p. m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 12/5/25, the facility remained out of compliance at a severity level of no actual harm and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk for delayed treatment, worsening of condition, and hospitalization. Findings included:Record review of Resident#1's face sheet reviewed 12/3/25, revealed a [AGE] year-old man who was admitted to the facility on [DATE]. His admitting diagnoses were lymphoma (cancer originated in lymphatic system) of other extranodal and solid organ sites, immunodeficiency (failure of the immune system to protect the body adequately from infection), dysphagia (difficulty swallowing), encounter for attention to tracheostomy, and bacteremia. Record review of Resident #1's care plan dated 10/23/25, revealed he utilized a feeding tube and tracheostomy. The goal was to not have any complications related to ostomy use and interventions/tasks listed to perform care as needed. Record review of Resident #1's medication orders dated 10/8/25, for trach care revealed staff were to change the trach aerosol tubing (plastic medical tubing used to deliver a fine mist of medicine or moisture (aerosol) into a patient's lungs via a tracheostomy tube), mask, jet nebulizer bottle (device that uses a stream of compressed air or oxygen to convert liquid medication or saline solution into a fine, inhalable mist or aerosol), and water trap (device used in humidification or ventilation circuits to collect condensation (excess water) and prevent it from flowing back into the patient's airway or damaging the equipment) every Sunday on night shift, change trach tie every night shift and prn, and suction trach every shift and prn for increased secretions. An order was in place to change the trach collar (delivers oxygen to the lungs but also provides humidification to prevent dryness and irritation) every night shift every Sunday and as needed but was discontinued on 11/13/25 and no new order was implemented. Record review of Resident #1's TAR for October 2025 2025 d revealed 1. Trach was suctioned every shift as ordered. No additional prn suctions were completed. 2. The trach ties were ordered to be changed daily. Review of the TAR revealed that these orders were not completed on 10/11/25, 10/12/25, 10/13/25, 10/18/25, 10/19/25, 10/25/25, and 10/26/25. 3. the trach aerosol tubing, mask, jet nebulizer bottle, and water trap had no documentation of being changed. Record review of Resident #1's TAR for November 2025 revealed 1. Trach was suctioned every shift as ordered. No additional prn suctions were completed, 2. The trach ties were ordered to be changed daily. Review of the TAR revealed that these orders were not completed on 11/2/25, 11/3/25, 11/4/25, 11/5/25, 11/6/25, 11/7/25, 11/8/25, , 11/9/25, , 11/16/25, , 11/23/25, , 11/24/25, , and 11/27/25. 3. the trach aerosol tubing, mask, jet nebulizer bottle, and water trap had no documentation of being completed. Record review of Resident #1's Respiratory Progress Notes by RT, dated 10/10/25, 10/17/25, 10/22/25, 10/23/25, 11/3/25, 11/7/25, 11/11/25, 11/21/25, and 11/26/25 indicated no distress. Record review of Resident #1's progress note documented by LVN D, dated 11/26/25 at 6:38 a.m., revealed that Resident #1 was sent to the hospital via EMS due to brown/black emesis (vomit) from mouth and trach. Resident #1 transferred via stretcher to hospital without any complications. In an interview on 12/3/25 at 12:02 p.m., LVN A stated she worked at the facility for two years on the 6:00 a.m. to 2:00 p.m. shift. She stated she suctioned Resident #1's trach prn, every shift, and the ties were changed daily and prn. LVN A stated the last time she performed trach care for Resident #1 was on 11/25/25 and she stated there was a slight odor a few weeks in 11/25 before they did a culture and started him on antibiotics. LVN A stated sometimes Resident #1 refused suctioning and he communicated with staff by pointing and shaking his head at commands or questions. LVN A stated, she could not explain why the