

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455800	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER The Lev Attown Park		STREET ADDRESS, CITY, STATE, ZIP CODE 8820 Town Park Dr Houston, TX 77036	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669</p> <p>Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 8 residents (Resident #1) reviewed for resident rights.</p> <p>The facility failed to ensure certified nursing assistant (CNA) A knocked on Resident #1's door prior to entering his room.</p> <p>This failure could place residents at risk for diminished quality of life, loss of dignity and loss of self-worth.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 04/10/2024 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses including obstructive and reflux uropathy (urine cannot drain from the urinary track), cellulitis (deep infection caused by bacteria), of unspecified part of limb, chronic embolism and thrombosis of deep veins (blood clots) of lower extremity hypothyroidism (lack of thyroid hormones causing the feeling of cold, pain, skin paleness and sadness), essential hypertension (high blood pressure), essential tremor (shakes), lymphedema (built up of fluid in the body), epilepsy (seizures), pain, ulcer and inflammation (swollen sores), and muscle weakness.</p> <p>Record review of Resident #1's annual (Minimum Data Set) MDS assessment dated [DATE] indicated he had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact.</p> <p>Record review of Resident #1's Care Plan undated indicated Focus: He had cussed out staff and turned over bedside table when upset on occasions. Goals: Resident will have fewer episodes by review date. Date Initiated: 6/11/2021 Revision on: 08/17/2022 Target Date: 04/22/2024. Interventions: Allow choices within individual's decision-making abilities: Date Initiated: 06/11/2021</p> <p>Revision on: 10/24/2022 Certified Nursing Assistant (CNA). Anticipate and meet the resident's needs. Date Initiated: 06/11/2021 Revision on: 10/24/2022 CNA.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 04/10/2024 at 12:49 p.m. while interviewing Resident #1 in resident's room, CNA A opened resident's room door without knocking, walked into the room, and stated, Oh, I did not know anyone was in here, I was making sure that his lunch tray was picked up, looked around the room, exited and closed the door.</p> <p>During an interview on 04/10/2024 at 12:50 p.m., Resident #1 stated that staff enter his room all the time without knocking or introducing themselves.</p> <p>During an interview on 04/10/2024 at 12:54 p.m., CNA A stated that he had worked with the facility since February 2024. He stated that he had been a CNA for many years in another state and was familiar with the responsibilities and duties of a CNA. He stated that he realized that he entered Resident #1's room without knocking and he apologized. He stated he knew to knock before entering a resident's room to give them privacy. He stated he received training during onboarding with the facility that covered resident's rights and just last week on resident rights and abuse, neglect, and exploitation (ANE). He stated that he had come into Resident #1's room to pick up his lunch tray.</p> <p>During an interview on 04/10/2024 at 01:19 p.m., RN A stated that he was CNA A's supervisor. He stated that he had trained CNA A and in-serviced him during onboarding, which covered entering residents' rooms by knocking, introducing oneself and informing the resident what services that staff would be providing. He stated that CNAs were also randomly reminded all the time to knock and announce themselves before entering a resident's room. He stated that CNA A would be written up for failing to knock before entering a resident's room. He stated that CNA A should have made it a practice and he would not have made the mistake.</p> <p>During an interview on 04/11/2024 at 03:35 p.m., the DON stated that all staff were to knock and introduce themselves before entering a resident's room. She stated that residents deserve privacy because the facility was their home, and they need to know who was coming into their space. She stated that CNA A should have knocked before entering Resident #1's room.</p> <p>During an interview on 04/11/2024 at 04:45 p.m., the Administrator stated that there were no exceptions, the staff were to knock before entering resident rooms.</p> <p>During an interview on 04/11/2024 at 04:59 p.m., CNA B stated that they received in-services a couple of weeks ago (exact date and time unknown) on resident rights which included knocking and introducing oneself when entering a resident's room.</p> <p>During an interview on 04/11/2024 at 05:15 p.m., CNA C stated that she had worked at the facility for 2-years. She stated that staff were to knock and announce themselves before entering a resident's room.</p> <p>During an interview on 04/11/2024 at 05:21 p.m., CNA D stated that staff received an in-service on resident rights last week (exact date and time unknown) about knocking before entering a resident's room.</p> <p>Record review of facility's in-service dated 03/08/2024 revealed, Resident rights . you should always knock before entering a resident's room, signed by CNA A 03/08/2024.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility's in-service dated 04/10/2024 revealed, Knock on resident's door before entering and resident rights and dignity. Conducted by Licensed Vocational Nurse (LVN) A and signed by CNA A on 04/10/2024.</p> <p>Record review of facility's Policy copy right date of 2022 revealed Promoting-Maintaining-Resident-Dignity. Compliance Guidelines: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 7. Explain care or procedures to the resident before initiating the activity. 12. Maintain resident privacy. Knock before entering a resident's room.</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669</p> <p>Based on interviews, and record review, the facility failed to ensure residents were free from abuse for 1 resident (Resident #2) of 8 residents reviewed for abuse.</p> <p>The facility failed to ensure each resident was free from abuse when Resident #2 was physically abused by CNA E on 10/16/2023 during her shift.</p> <p>This failure placed residents at risk of physical harm, emotional distress, mental anguish and death from possible abuse and neglect.</p> <p>The noncompliance was identified as past noncompliance and began on 10/16/2023 and ended on 10/18/2023. The facility corrected the noncompliance before the investigation began.</p> <p>Findings Include:</p> <p>Record review of Resident #2's face sheet dated 04/11/2024 revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including cellulitis (deep infection caused by bacteria), in of right lower limb, cerebral infarction (disrupted blood flow to the brain), type 2 diabetes mellitus (when cells in your muscles, fat, and liver do not respond well to insulin) without complications, atrial fibrillation (irregular heart rate), hyperlipidemia (deposit in blood vessel walls and restricted blood flow), hypertension (high blood pressure), paranoid schizophrenia (brain disorder causing delusion), pain in right ankle and joints of right foot, muscle weakness, lack of coordination, weakness, chronic ischemic heart disease (heart weakening caused by reduced blood flow to heart), morbid (severe) obesity due to excess calories (overweight), intellectual disabilities (limited ability to learn), adjustment disorder with mixed anxiety (restlessness) and depressed mood.</p> <p>Record review of Resident #2's annual MDS assessment dated [DATE] revealed a BIMS score of 09 (suggests moderately impaired). Cognitive skills for daily decision making further revealed, resident can repeat at least three words heard after first attempt, was not accurate when asked about the current month, resident was able to recall prior questions after cueing, able to recall a color with cueing.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's undated Care Plan revealed, Focus: Resident was dependent on staff for meeting intellectual, physical, and social needs related to (r/t) cognitive deficits. Date Initiated: 11/28/2022. Goal: Resident will be escorted to activities 3-5 times weekly by next review date. Date Initiated: 11/28/2022 Revision on: 02/15/2024 Target Date: 05/24/2024. Intervention: Invite the resident to scheduled activities. Focus: Resident has an activity of daily living (ADL) self-care performance deficit r/t activity intolerance, impaired balance date initiated: 11/21/2022 revision on: 03/28/2023. Goal: Resident will improve current level of function in through the review date. Date Initiated: 03/28/2023 Revision on: 02/15/2024, Target Date: 05/24/2024. Intervention: Toilet use: The resident requires extensive assistance by 1 staff for toileting. Date Initiated: 11/21/2022 Revision on: 03/28/2023 Focus: Resident has a communication problem r/t cognitive deficit. Date initiated: 11/21/2022 Revision on: 03/28/2023. Goal: Resident will be able to make basic needs known on a daily basis through the review date. Date Initiated: 11/21/2022 Revision on: 02/15/2024 Target Date: 05/24/2024. Intervention: Anticipate and meet needs. Date Initiated: 11/21/2022. Be conscious of resident position when in groups, activities, dining room to promote proper communication with others. Date Initiated: 11/21/2022. Communication: Allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact, turn off television/radio to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, and use alternative communication tools as needed. Date Initiated: 11/21/2022.</p> <p>During an interview on 04/10/2024 at 12:02 p.m., Resident #2 stated that staff do not always respect her and are rude, but she would not say anything else because every time she had someone was fired. She stated she knows she can report ANE to the Administrator, because she had before, and the Administrator had fired everyone who was not doing their job or not being respectful.</p> <p>During an interview on 04/11/2024 at 03:05 p.m., Resident #2 stated that she remembered something happened one evening in her bathroom with a staff, but she could not remember what or if a nurse made her feel unsafe or if she had been slapped or hit. She stated the next thing she had known that staff was fired. She stated she feels safe and was not worried about ANE.</p> <p>During an interview on 04/11/2024 at 03:17 p.m., LVN A stated that on 10/18/2023 at about 10:15 a.m., she was called to Resident #1's room and resident told her that CNA E had slapped her in the face for pulling the call bell. She stated resident told her that the CNA E told her I am not playing with you, you going to wake everyone up. She stated the resident told her she was upset and had been crying. She stated that the resident was physically assessed finding no injuries or pain, and the resident stated she had no injuries or pain. She stated she immediately reported the incident to the Administrator who completed the incident report, and an investigation was started. The Administrator ultimately terminated CNA E.</p> <p>During an interview on 04/11/2024 at 03:35 p.m., the DON stated that she was not on shift when it was reported CNA E slapped Resident #2. She stated it happened on the night shift and the resident reported it to certified medical technician (CMT) the next day. She stated it was found that CNA E hit Resident #2 in the face and scared her, making the resident feel unsafe. She stated that CNA E had no previous allegations of ANE against her and no previous disciplinary actions in her employee file. She stated the incident was reported to the resident's family. She stated that the resident had made complaints about likes and dislikes and wanting to discharge home but had not made any similar allegations of that kind in the past. She stated that CNA E was terminated based on the Administrator's investigation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/11/2024 at 04:45 p.m., the Administrator stated that she was the Abuse Coordinator. She stated on 10/18/2023 in the morning from LVN A that Resident #2 had something that she wanted to tell her. She stated she interviewed Resident #2 who told her that CNA E had slapped her in the face while helping her in the bathroom. She stated Resident #2 told her she was crying and waving her hands and the staff tried to stop her from crying and pulling the call bell and slapped her. She stated that she interviewed CNA E and CNA E told her that on 10/23/2023 in the earlier morning, Resident #2 was in the bathroom crying, acting confused and constantly pulling the bathroom call bell. She stated that CNA E told her that the resident had been waving her hands and acting confused and she accidentally hit Resident #2 in the face. She stated CNA E believed that there were active cameras recording her and apologized that the hit was an accident. She stated that CNA E was immediately suspended, and Resident #2's family and physician were contacted. She stated the incident investigation was started, the incident report was completed and called in to the state. She stated that Resident #2 had a history of making false accusations, but never against a staff for abuse. She stated she believed what the resident had told her, and she terminated CNA E. She stated she did not call the police and there were no marks or bruises on the resident's face. She stated that it was her expectation that staff kept their hands off residents.</p> <p>During an interview on 04/11/2024 at 04:59 p.m., CNA B stated the facility provided an in-service on ANE a couple of weeks ago (exact dates and times unknown). She stated if an ANE was reported to her or witnessed she would immediately report to the Administrator.</p> <p>During an interview on 04/11/2024 at 05:15 p.m., CNA C stated that she was provided an in-service on ANE and incontinent care last week 04/01/2024 and 04/04/24. She stated that if she witnessed or ANE was reported to her she would immediately report to the Administrator.</p> <p>During an interview on 04/12/2024 at 10:03 a.m., CNA E stated that she had worked at the facility about a year. She stated on 10/23/2023 in the middle of the morning she was at the nurse's station when the call bell went off in Resident #2's bathroom. She stated the bell was very loud and she rushed to the resident's room. She stated when she entered the room, the resident's bed was covered in blood and the resident was in the bathroom screaming, also covered in blood from the waist down. She stated that the resident had come on her monthly menstrual cycle. She stated she turned off the call bell and asked the resident what was wrong. She stated that the resident continued to scream and pulled the call bell again and again. She stated that she told the resident not to pull the call bell because it made a very loud sound that would wake everyone up in the facility. She stated then she wiped down the resident's bed and cleaned and changed the resident and helped her get back to bed. She stated that later in the morning before leaving shift, the resident allowed her to change her, and the resident never made mention of what happened or voiced any concerns. She stated, the resident was a lot of personality, and never had any problems voicing her concerns. She stated the next day she was approached by LVN A and surprised that she was being suspended for allegations of abuse. She stated that the resident was not swinging her hands and she did not try to stop the resident's hands nor purposefully or accidentally hit her in the face, and she did not tell the Administrator that she had accidentally hit the resident in the face. She stated that she would never abuse or hit a resident. She stated that the resident and her were friends. She stated that she was then terminated. She stated all the staff would at the facility would say she was a good employee. She stated that she received training all the time on ANE, and she knew not to abuse residents.</p> <p>During an interview on 04/23/2024 at 02:13 p.m., CMT stated she did not recall an incident where Resident #2 reported being slapped by CNA E.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's in-service training dated 10/20/2023 revealed an in-serviced on ANE was conducted by Director of Social Services (DSS) was signed by several of the facility's staff acknowledging the in-service.</p> <p>Record review of CNA E's typed and signed statement dated 10/18/2023 revealed, CNA E rushed to Resident #2's room. Resident sitting on the toilet seat, covered with blood. CNA E asked resident to turn off the light because it was going to wake up everyone and CNA E turned off the light. Resident started crying, CNA E asked why she was crying, what was the problem, did I touch you? CNA stated that she held the resident and told her she was there to help her. CNA E standing at the door, and resident sitting on toilet. CNA E cleaned resident up and resident's bed.</p> <p>Record review of the facility's Staff Disciplinary Action Record against CNA E dated 10/18/2023 revealed, Suspended. List below an account of the actions leading to counseling: including dates, times, and any other supposing information: Administrator received a report that employee hit resident in the face. Employee statement attached that there was no physical contact. This was reported to have occurred on 10/16/2023 at 10 p.m. to 6 a.m. Corrective Action: To be completed by Supervisor. Be specific, include goals and timetables for follow-up. Suspended pending abuse investigation. Signed by Supervisor LVN A and witnessed by Administrator.</p> <p>Record review of the facility's Staff Disciplinary Action Record against CNA E dated 10/20/2023. Category III, Disciplinary Level: Termination. List below an account of the actions leading to counseling: including dates, times and any other supposing information: Investigated for claim of abuse. Corrective Action: To be completed by Supervisor. Be specific, include goals and timetables for follow-up. Terminated via telephone. Signed by Supervisor LVN B and witnessed by the DON.</p> <p>Record review of Resident #2's Progress Notes dated 10/20/2023 15:45 Behavior Note Text created by LVN C: Resident made remark to CMT on duty stating, you're the one that hit me that night. CMT informed this nurse, facility Administrator and the DON made aware. When this nurse asked resident if CMT on duty hit her resident stated no, it wasn't her. When asked resident why she made that statement resident replied Hell, I don't know! why don't you go get me some more juice! Resident education conducted regarding safety and reporting abuse, resident displayed understanding.</p> <p>Record review of the facility's self-report dated 10/24/2023 revealed, an abuse incident occurred on 10/18/2023 at 3:00 a.m. and learned by facility on 10/18/2023 at 10:15 a.m. that Resident #2 was sitting on toilet covered in blood, CNA E came into the bathroom and turned off the light said you going to wake everyone. Resident started crying and CNA E told the resident she was there to help her, cleaned resident, and assisted residents to bed. Description of allegation: Resident stated that she was in restroom and pulled the call light button. According to resident, CNA E was mad and was yelling at her and hit her in the face on her left cheek. The resident started crying and CNA E told the resident, You know I am just playing with you. Resident reported to administration 2-days later. There was not bruising on resident's face. Provider response: CNA E was called into the office, a statement was taken, employee immediately suspended until investigation was complete. Resident payee, physician notified, and resident interviewed. Record review of the facility's conducted. Investigation Summary: After investigation, employee terminated. Unable to confirm abuse. Provider Action Taken Post-Investigation: Staff in-serviced on abuse and neglect. Signed and dated by Administration on 10/23/2024.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Policy: Abuse, Neglect and Exploitation, undated revealed: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: Staff includes employees, the medical director, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and students from affiliated academic institutions, including therapy, social and activity programs. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Prevention of Abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship.</p> <p>Record review of the facility's Policy Promoting-Maintaining-Resident-Dignity. Compliance Guidelines copy right date of 2022 revealed: Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 5. When interacting with a resident, pay attention to the resident as an individual. 10. Speak respectfully to residents.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669</p> <p>Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 (Resident #3 and Resident #4) of 2 residents reviewed for ADLs.</p> <p>The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Resident #3, who required extensive assistance, was provided with timely incontinence care on 01/01/2024. 2. Resident #4 was provided with timely incontinence care on 01/01/2024. <p>These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #3's face sheet dated 04/11/2024 indicated he was an [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including repeated falls, osteoarthritis (wear down of flexible tissue), protein-calorie malnutrition (underweight), benign prostatic hyperplasia with lower urinary tract symptoms (increased urgency to urinate), difficulty in walking, muscle weakness, dementia (impaired ability to remember, think, or make decisions) severity, without behavioral disturbance, psychotic disturbance (disconnection from reality), mood disturbance, and anxiety (restlessness), acute respiratory failure with hypoxia (not enough oxygen in the tissues in body), osteomyelitis (swelling of bone tissue causing an infection, age-related osteoporosis (loss of bone mass) without current pathological fracture (broken bone caused by a disease), and metabolic encephalopathy (chemical imbalance in the brain that causes confusion),</p> <p>Record review of Resident #3's Care Plan undated indicated Focus: Resident has bowel and bladder incontinence r/t Prostate enlargement Date Initiated: 07/25/2021 Revision on: 07/25/2021. Goals: Resident will remain free from skin breakdown due to</p> <p>incontinence and brief use through the review date. Date Initiated: 07/25/2021 Revision on: 03/06/2024 Target Date: 6/07/2024. Interventions: Clean peri-area with each incontinence episode. Date Initiated: 07/25/2021. Incontinent: Check frequently and as required for incontinence. Focus: Resident has potential for pressure ulcer development Date Initiated: 07/25/2021 Revision on: 07/25/2021. Goal: Resident will have intact skin, free of redness, blisters, or discoloration by/through review date. Date Initiated: 07/25/2021 Revision on: 03/06/2024 Target Date: 06/07/2024. Interventions: Complete a full body check weekly and document Date Initiated: 07/25/2021. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: 07/25/2021. Provide incontinence care after each incontinence episode, or per established toileting plan. Date Initiated: 07/25/2021. Reposition in chair frequently for comfort and pressure reduction. Provide resident/family education as needed. Date Initiated: 07/25/2021. Revision on: 10/05/2022.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Lev Attown Park		STREET ADDRESS, CITY, STATE, ZIP CODE 8820 Town Park Dr Houston, TX 77036	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #3's annual MDS assessment dated [DATE] indicated he had a BIMS score of 03 which suggested severe cognitive impairment. Cognitive skills for daily decision making further revealed, resident can repeat at least three words heard after first attempt, was not accurate when asked about the current month, resident was not able to recall prior questions after cueing, was not able to recall a color with cueing. Under Section GG Functional Abilities and Goals: revealed that resident required partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. Under section H Bladder and Bowel: revealed Urinary Continence: Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). Bowel Continence: Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement), and with no toileting program was being used.</p> <p>Record review of Resident #4's face sheet dated 04/11/2024 indicated she was an [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses wedge compression fracture (collapsed bone in the front of the spine) of lumbar vertebra (spine bones behind the chest), hypertension (high blood pressure), type 2 diabetes mellitus (cells in your muscles, fat, and liver don't respond well to insulin) without complications, dementia (impaired ability to remember, think, or make decisions) severity, without behavioral disturbance, psychotic disturbance (disconnection from reality), mood disturbance, and anxiety (restlessness), history of falling, muscle weakness, and difficulty in walking.</p> <p>Record review of Resident #4's Care Plan undated revealed Resident #4 had the potential for pressure ulcer development r/t of ulcers, immobility, and incontinence. Date Initiated: 01/10/2020 Revision on: 01/10/2020. Resident was to have intact skin, free of redness, blisters, or discoloration by/through review date. Date Initiated: 01/10/2020 Revision on: 09/12/2023 Target Date: 04/07/2024. Resident was to receive complete a full body check weekly and document Date Initiated: 01/10/2020. Staff to follow facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: 01/10/2020. Provide incontinence care after each incontinence episode, or per established toileting plan Date Initiated: 01/10/2020. Reposition in chair/bed frequently for comfort and pressure reduction.</p> <p>Record review of Resident #4's annual MDS assessment dated [DATE] indicated he had a BIMS score of 03 which suggested severe cognitive impairment. Cognitive skills for daily decision making further revealed, resident can repeat at least three words heard after first attempt, was not accurate when asked about the current month, resident was not able to recall prior questions after cueing, was not able to recall a color with cueing. Under Section GG Functional Abilities and Goals: revealed that resident required partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. Under section H Bladder and Bowel: revealed Urinary Continence: Occasionally incontinent (less than 7 episodes of incontinence). Bowel Continence: Occasionally incontinent (one episode of bowel incontinence), and with no toileting program was being used.</p> <p>Observation on 04/10/2024 at 11:21 a.m., revealed Resident #4 was sitting in a wheelchair in the common area watching television, smiled, and waved.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 04/10/2024 at 11:50 a.m., revealed Resident #3 was lying in bed low to ground, fall mat in place. The resident was receiving oxygen and tube-feeding and fluids at bedside, legs propped up on wedge, asleep, did not response and covered with blankets.</p> <p>During an interview on 04/11/2024 at 09:07 a.m., the Administrator stated on 01/01/2024 she received a call from CNA G when CNA G she came on shift at 10:00 p.m. and informed that Resident #3 and Resident #4 were left soiled. She stated she asked LVN A who was assigned to those residents, to determine which staff had left residents soiled. She stated that LVN A confirmed that CNA F had worked and was assigned to Resident #3 and Resident #4.</p> <p>During an interview on 04/11/2024 at 09:43 a.m., LVN A stated that she was the unit manager on duty on 01/01/2024 and assigned to Resident #3 and Resident #4. She stated on 01/01/2024, the Administrator called and stated that Resident #3 and Resident #4 were left horribly wet and soiled at 9:45 p.m. and that CNA G had to come on shift and clean them up immediately. She stated that CNA G stated it was not just wet it was feces and food on the residents. She stated that she spoke with CNA F who admitted that she missed the two residents but provided no good reason. She stated that CNA F had been terminated for poor work performance. She stated this was not the first time CNA F had failed to perform resident's ADL care. She had left a resident without a shower and left a resident without making sure they had eaten.</p> <p>During an interview on 04/11/2024 at 10:29 a.m., CNA F stated she began her employment in April of 2024 and was terminated in January 2024. She stated she was responsible for taking care of Resident #3 and Resident #4 on 01/01/2024. She stated that she had fallen behind and had not change Resident #3 before leaving shift and had not informed the oncoming shift or charge nurse that Resident #3 had not been changed before leaving shift. She stated that residents were to have been checked and changed every 2-hours and before leaving shift. She stated she had changed the residents during her shift but had not provided a time when the residents were changed. She stated she had issues with getting to residents on time, but she would get there as quickly as possible. She stated that the facility put a lot of responsibility on CNAs and nitpicked her unfairly when it came to completing tasks. She stated she never addressed her concerns with any of her superiors about not getting her tasks completed or being nitpicked at. She had not provided a response why she had not addressed her concerns with her superiors. She stated she received training on ANE, incontinent care, and resident rights during her onboarding process with the facility. She stated the importance of not leaving resident soiled for long periods was to avoid rashes and skin irritations.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/11/2024 at 10:58 a.m., CNA G stated she had [AGE] years of experience as a CNA and worked for the facility about 7-months before she resigned in February 2024. She stated she came on shift on 01/01/2024 at 09:34 p.m. and took over the care of residents that CNA F was responsible for on the previous shift of 2 p.m. to 10 p.m. She stated it was routine when she came on shift to put eyes on each of her residents to see if there were any immediate needs of the resident that needed to be addressed first. She stated that when she went to check on Resident #3 and Resident #4, they were both heavily soiled in urine and feces. She stated that their briefs, clothing, and beddings were completely soiled. She stated that was a clear indication that they had not been changed in several hours and that CNA F had not followed policy and procedure by checking and changing residents before leaving shift and before the next shift took over. She stated when she found the resident in that soiled condition, she took pictures of the residents, cleaned, and changed the residents and their bedding, and sent the pictures to the Administrator along with a text message describing the resident's condition upon her arrival coming on shift. She stated that she had pictures in an old phone that she would forward. She stated that she could not remember which resident was which, but the pictures showed the resident's beds soiled in urine and one of the resident's back covered in food crumbs. She stated that she resigned from the facility because of high staffing turn over, and it being custom for her to find residents heavily soiled when she came on shift. She stated that staff that worked the 10 p.m. to 6 a.m. shift did not receive a lot of training in-services and she could not recall ever being in-serviced on ANE or incontinence care. She stated when she resigned, she wrote the Administrator a 3-page letter voicing all her concerns along with the pictures she took of the soiled and uncleaned residents. She stated the importance of checking and changing resident's every 2-hours was to prevent skin breakdowns.</p> <p>During an interview on 04/11/2024 at 03:35 p.m. the DON stated that she was on leave when Resident #3 and Resident #4 were discovered soiled. She stated that CNA F was responsible for changing the residents during her shift. She stated that LVN C was responsible for overseeing CNA F. She stated CNA F had disciplinary actions taken against her for failure to address care areas on a few occasions and had been given a chance to make corrective actions. She stated that it was not uncommon for staff to run behind or feel overwhelmed during their shift, but it was their responsibility to notify their unit manager on shift for assistance. She stated that CNA F had never voiced concerns with feeling overwhelmed and had been given several opportunities to make corrective actions and this incident caused her employment to be terminated with the facility. She stated that the resident's family was notified of the incident.</p> <p>During an interview on 04/11/2024 at 04:45 p.m., the Administrator stated that she had received a text on 01/01/2024 from CNA G who worked the 10 p.m. to 6 a.m. shift. She stated that CNA G told her she followed shift after CNA F who had left Resident #3 and Resident #4 in unchanged briefs before leaving shift. She stated she had spoken to CNA F on several occasions in-servicing her and reminding her to take care of the residents like they were her own mother and father. She also told the staff that if she felt she could not perform the tasks as such, she could not be a part of the team. She stated that all her staff know that if they need to text her, they can do so at any time and they knew there were no exceptions for leaving shift without completing their duties without informing the unit managers that they had fallen behind.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/11/2024 at 04:59 p.m., CNA B stated the facility provided an in-service on ANE and incontinent care a couple of weeks ago (exact dates and times unknown). She stated that residents were to be checked on and changed if needed every two hours to avoid skin breakdowns. She stated if she found a resident excessively soiled, she would change the resident and report the to the unit manager on shift.</p> <p>During an interview on 04/11/2024 at 05:15 p.m., CNA C stated at shift change there was an overlap of 10-15 minutes where staff consult with each other any concerns to be noted from the previous shift. She stated at that time it should be identified if a resident had not been changed prior to that staff leaving shift. She stated that if she found a resident heavy soiled and was not informed by the previous shifts staff, she would assume that the previous shift neglected to change the resident. She would change the resident and report to the unit manager and/or charge nurse that the previous staff had not completed their rounds before leaving shift. She stated that she was provided an in-service on ANE and incontinent care last week 04/01/2024 and 04/04/2024.</p> <p>Record review of the facility's self-report incident dated 01/02/2024 revealed: On 01/01/2024: Description of allegation: Employee failed to perform job duties as assigned. CNA F left Resident #3 and Resident #4 soiled and wet. Beds were wet as well. This was reported to the Administrator. Description of injury: None. Provider response: CNA F was terminated for failure to complete job responsibilities. Investigation Summary: Resident interviews conducted. Employee in-services conducted. Provider Action Taken Post-Investigation: Employee terminated. Signed and dated by Administration on 01/09/2024.</p> <p>Record review of the facility's staffing schedule dated 01/01/2024 revealed LVN B was responsible for supervising CNA F during her shift.</p> <p>Record review of Policy copy right date of 2022 revealed Promoting-Maintaining-Resident-Dignity. Compliance Guidelines:</p> <p>Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 14. Each resident will be provided equal access to quality care regardless of diagnosis, severity of condition or payment source.</p> <p>Record review of the facility's Policy: Abuse, Neglect and Exploitation, undated revealed: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Staff includes employees, the medical director, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program, and students from affiliated academic institutions, including therapy, social and activity programs. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 4 residents (Resident #1) reviewed for accidents and hazards.</p> <p>The facility failed to ensure Resident #1 did not have a working and running electric space heater in his room.</p> <p>This failure could place residents at risk of harm or injury and contribute to avoidable accidents.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet dated 04/10/2024 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses including obstructive and reflux uropathy (urine cannot drain from the urinary track), cellulitis (deep infection caused by bacteria), of unspecified part of limb, chronic embolism and thrombosis of deep veins (blood clots) of lower extremity hypothyroidism (lack of thyroid hormones causing the feeling of cold, pain, skin paleness and sadness), essential hypertension (high blood pressure), essential tremor (shakes), lymphedema (built up of fluid in the body), epilepsy (seizures), pain, ulcer and inflammation (swollen sores), and muscle weakness.</p> <p>Record review of Resident #1's annual MDS assessment dated [DATE] indicated he had a BIMS score of 15 which indicated he was cognitively intact.</p> <p>Record review of Resident #1's Care Plan undated indicated Focus: Resident had heat intolerance. Date Initiated: 06/11/2021.</p> <p>During an observation on 04/10/2024 at 11:36 a.m., Resident #1 was lying in bed partially covered with bare legs and feet exposed. Both right and left feet were hanging off the bed and wrapped in medical gauze and ace bandages. Across from the foot of resident's bed approximately 2.5 feet on the wall sat a running electric space heater. Resident's room contained items on every part of the resident's floor aligning the wall including the bathroom and empty bed containing cardboard boxes with papers and other unknown articles, several plastic lock boxes, in addition to the resident's wheelchair.</p> <p>During an observation on 04/10/2024 at 11:55 a.m., Resident #1 rested in bed with eyes closed, and covered with sheet and blanket. Resident did not appear to have a runny nose.</p> <p>During an observation on 04/10/2024 at 12:46 p.m., Resident #1 was shivering under 3-layers of blankets. Resident's room did not feel uncomfortably cold, felt warmer than the hallway, and warmer than resident rooms on the same hall. The space heater previously observed had been removed from resident's room.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/10/2024 at 11:36 a.m., Resident #1 stated repeatedly that he had been cold. He stated that he had constantly asked the staff to raise the temperature so that his room would be warmer. Resident stated that he purchased the space heater and had been using it a couple of weeks. He stated he knew he was not supposed to have the space heater, and staff had taken previous space heaters he had in the past, but he needed it to keep himself warm.</p> <p>During an interview on 04/10/2024 at 11:42 a.m., LVN A stated that she was not the Resident #1s nurse, she was answering the resident's call light. She stated that she would bring the resident some more blankets and cover him up.</p> <p>During an interview on 04/10/2024 at 12:40 p.m., the Maintenance Director stated he had worked for the facility for [AGE] years. He stated he was familiar with Resident #1 being cold. He stated he often adjusted the temperature to the resident's liking while taken into consideration the other residents on the hall who never complained about the temperature. He stated that the temperature on the resident's hall was 73 degrees. He stated he was the only staff in the building that could control the temperatures on the units as it was locked by code. He stated in the warm or summer months he kept the temperature on the halls between 70-75 degrees and in the colder or winter months between 70-89 degrees. He stated that the resident mainly complained of the temperature at night at bedtime.</p> <p>During an interview on 04/10/2024 at 12:46 p.m., Resident #1 stated that the temperature was always 66 degrees or lower. He stated that old people need more heat than young people.</p> <p>During an interview on 04/10/2024 at 12:54 p.m., CNA H stated that she had known Resident #1 to have space heater in his room for weeks. She stated as soon as the Maintenance Director removed the space heater, the resident would replace the space heater with another.</p> <p>During an interview on 04/10/2024 at 12:56 p.m., RN B stated that Resident #1 brought space heaters into the facility all the time. She stated as soon as it was known he had one, it would be immediately removed, and the resident would buy another.</p> <p>During an interview on 04/10/2024 at 01:49 p.m., Maintenance Director stated that he was not aware that Resident #1 had a space heater plugged up and running in his room. He stated he was the resident's ambassador which meant he was responsible for checking on the resident every morning between 8 a.m., 8:30 a.m. and again at 8:45 a.m., to report any concerns or findings about the resident during the facility's daily morning meeting at 9 a.m. He stated had had checked on the resident 04/10/2024 before the morning meeting and there was no heater in the resident's room. He stated that the resident was a hoarder and the resident's room was often cluttered with items. He stated that he had explained to the resident on many occasions of the life safety fire hazard reasons it was not safe to have space heater sin the facility. He stated he had removed space heaters from resident's room in the past. He stated as soon as one space heater was removed; the resident purchased another. He stated he would find out who removed the space heater observed in the resident's room and ensure that it would be removed from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/10/2024 at 4:01 p.m., LVN A stated she had worked for the facility for [AGE] years. She stated that she and RN B moved the space heater out of Resident #1's room when she brought him blankets on 4/10/2024 at 11:42 a.m. She stated she had never seen that space heater in the resident's room before and was not aware of him having heaters in his room. She stated she visited the resident's room on her shifts occasionally. She stated the resident was aware and educated that he was not supposed to have space heaters in his room for safety reasons. She stated when she moved the heater from his room, she did not speak to him about the items being moved. She stated that Social Worker (SW) would speak to the resident about the heater.</p> <p>During an interview on 04/11/2024 at 09:17 a.m., SW stated that she worked for the facility for 6 years. She stated that Resident #1 had a history of hoarding and she had to constantly remind him about keeping his room decluttered and that space heaters are not allowed due to being a fire hazard.</p> <p>During an interview on 04/11/2024 at 03:35 p.m., the DON stated that Resident #1 should not have space heaters in his room due to it being a fire safety issue. She stated before morning meetings and during random rounds, the Maintenance Director checked on resident daily and had reported on occasion that the resident had a space heater in his room. She stated if staff see a space heater in the resident's room, they were to immediately notify the Maintenance Director so it could be removed. She stated she was not aware of resident's complaints of being cold. She stated that resident will be offered more blankets and she will have maintenance check the temperature on the floor. She stated if that does not resolve the resident's cold concerns, he could be offered to move to another room.</p> <p>During an interview on 04/11/2024 at 04:45 p.m., the Administrator stated that the facility has an ambassador program where staff are assigned to specific residents and check on them every morning before the daily morning meeting. She stated that Resident #1 was assigned to the Maintenance Director who checked on the resident in the morning and again in the afternoon. She stated that SW had spoken with the resident about space heaters not being allowed in the facility because it was a fire hazard. She stated that the resident would be offered pajamas and more blankets to address his issues with temperatures. She stated that the resident probably had not had the space heater out when the Maintenance Director had done his ambassador rounds 04/10/2024, then brought the space heater out once the Maintenance Director left. She stated that the resident debated the Maintenance Director on a regular about the temperature in the room and the Maintenance Director often adjusted the temperature to make the resident more comfortable.</p> <p>During an interview on 04/11/2024 at 04:59 p.m., CNA B stated that if she found a space heater in a resident's room, she would unplug it, notify that resident's unit manager, and/or report to the Maintenance Director.</p> <p>During an interview on 04/11/2024 at 05:15 p.m., CNA C stated that if she found a safety hazard item plugged in a resident's room, she would unplug the item, notify the unit's charge nurse and/or follow the chain of command to have it removed. She stated all safety hazards issues were reported to the Maintenance Director.</p> <p>During an interview on 04/11/2024 at 05:21 p.m., CNA D stated that if she found a space heater in a resident's room, she would report to the unit manager and/or charge nurse and allow them to handle it.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455800	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER The Lev Attown Park		STREET ADDRESS, CITY, STATE, ZIP CODE 8820 Town Park Dr Houston, TX 77036	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Physical Environment: Electrical Equipment Policy: Copyright date 2024. Policy: The facility will maintain all mechanical, electrical, and patient care equipment in safe operating condition. Policy Explanation and Compliance Guidelines: 1. The Maintenance Director shall maintain schedules for routine inspection and maintenance of all mechanical, electrical, and patient care equipment. 2. Frequency of inspection and maintenance shall be in accordance with the facility's Electrical Safety policy, current Life Safety Code requirements, and manufacturer recommendations.</p>		