STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675000	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Beechnut	12777 Beechnut St Houston, TX 77072

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (CR #1) reviewed for accidents and supervision, in that:The facility failed to ensure CR #1 did not elope from the facility on 3/21/26. The facility did not realize he had left through a window in room [ROOM NUMBER] and exited the facility through the fence. Resident #1 was found by a staff member in front of a store located approximately 2.5 miles away.The non-compliance was identified as PNC. The Immediate Jeopardy (IJ) began on 03/21/26 and ended on 03/21/26. The facility had corrected the non-compliance before the survey began on 04/15/26. The IJ template was sent to the Administrator on 04/16/26 at 3:18 p.m.This failure could have placed residents with exit-seeking behaviors at risk for injury or death.Findings included:Record review of CR #1's face sheet dated 04/15/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE] and was discharged to a behavioral hospital on 3/24/26. His diagnoses included Alzheimer's disease (a progressive irreversible brain disorder), cognitive communication deficit, aphasia (communication disorder caused by brain damage), and hypertension (when the pressure in the blood vessels is too high).Record review of CR #1's quarterly MDS dated [DATE] revealed a BIMS score of 01 out of 15, indicating significant cognitive impairment. CR #1 was self-ambulated and did not use any assistive device and behavior code indicated 0. Further review of the MDS revealed CR #1 required moderate assistance with supervision with 1 staff assist.Record review of CR #1's Care Plan, initiated on 10/7/25, revealed CR #1 was identified as a high elopement risk/wanderer. Intervention: provide structured activities: toileting, walking inside and outside, reorientation strategies, including signs, picture and memory boxes. Resident resides in the faculty secure unit. The Care Plan was reviewed on 03/22/26 indicated CR #1 had an actual elopement on 03/21/26. Interventions included one-on-one supervision, in-house psychology consultation, and transfer to a more secure unit when available. The Care Plan was revised on 03/23/26.Record review of CR #1's incident report dated 03/21/26 indicated that during dinner time, CR #1 was observed eating. The resident later walked to his room and stood in the hallway by his room door. At approximately 7:00 p.m., CR #1 was not present in his room, bathroom, hallway, or other resident rooms and was not observed anywhere within the facility. Staff searched all rooms and bathrooms; however, the resident was not located.During an interview on 04/15/26 at 10:12 a.m., the ADON stated she was not aware CR #1 had expressed a desire to go home. She stated she saw CR #1 during lunch, and he was eating in the dining room. She stated she was notified by LVN N that CR #1 exited the building through the room [ROOM NUMBER] window into the courtyard and left the facility grounds after removing two fence planks. She said staff were unaware CR #1 had left the facility until approximately 7:00 p.m., when MA A attempted to administer medication to CR #1. She stated CR #1 could have sustained injury or experienced a worse outcome.During an interview on 04/15/26 at 11:31 a.m., the Activity Director stated CR #1 typically came to her office at least once weekly and expressed a desire to leave the facility and return to his home. She said she would call CR #1's RP, and at times the RP stated she was attempting to find placement closer to his home. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Activity Director said she reported CR #1 wanted to go home to the management team during a morning meeting but could not recall the date. She stated she was notified that CR #1 had left the facility and staff were unaware of the time of exit. She stated she located CR #1 in front of a store which was on a busy street, approximately 2.5 miles from the facility about 8:25 p.m. The Activity Director said CR #1 had two shirts, a jacket, and shoes on when she found him and he was eating chips and drinking juice. She said CR #1 could have hurt himself or been run over by a car because the staff did not know when he left the facility.During an interview on 04/15/26 at 12:31 p.m., the Maintenance Director stated he was called to the facility after CR #1 left without staff awareness. He reported CR #1 removed the window from the window panel because he was able to bend the long screws which held the glass, then climbed out through the window to the courtyard. He then removed two fence planks which were old and exited the facility through the opening. He said CR #1 could have sustained injury or worse while he was out in public.During an interview on 04/15/26 at 1:14 p.m., MA A stated she identified CR #1 was not in the building when she went to administer medication at approximately 7:00 p.m. She stated she asked CNA E, who reported seeing CR #1 standing in front of his room approximately 15 minutes earlier. MA A said she reported to LVN N, and they conducted a facility-wide search, and CR #1 was not found within the facility. MA A said LVN N reported the incident to management. She stated none of the staff saw him when he pulled the window out and climbed through it or when he pulled out two planks, which were observed on the ground in the courtyard, and staff assumed he left the facility through the opening in the fence. During an interview on 04/15/26 at 2:53 p.m., the DON stated she saw CR #1 on the day of elopement, and he did not exhibit behaviors indicative of elopement risk. She said she was unaware he had been requesting to go home. She reported she was later notified that CR #1 had eloped, and the staff became aware of his absence at approximately 7:00 p.m. She stated the resident exited from the building after removing the window from the frame in the room across from his room, and he exited the facility grounds through the fence after he pulled out two wooden fence planks. The DON said CR #1 was observed outside his room door 15 minutes before he exited the building without staff knowledge. She said CR #1 would have sustained a serious injury or death when he was out in the community alone.During an interview on 04/15/26 at 3:20 p.m., the Administrator stated staff were unaware CR #1 had left the facility until approximately 7:00 p.m., at which time they notified him, law enforcement, and the medical director and continued to search the facility and surrounding area. He stated the Activity Director located CR #1 in front of a store at approximately 8:20 p.m. and returned him to the facility. He stated the resident exited through a window after he had removed the glass from the frame and left the grounds through an opening created after removing two fence planks. He said he was not aware CR#1 wanted to go back home, and they have not had any resident eloped from the memory care or from the facility snice he started working in this building. The Administrator said CR #1 could have sustained injury or a worse outcome when he was away from the facility unsupervised.During an interview on 04/15/26 at 4:32 p.m., CNA E said she observed CR #1 at approximately 6:45 p.m. standing in front of his room while returning a food cart to the kitchen. She said she became aware of his absence when MA A inquired about CR #1, and a search of the facility was conducted; however, CR #1 was not located. LVN N reported the incident to the Administrator. She stated CR #1 occasionally pushed on exit doors, which other residents in the memory care unit did. She said the aides made rounds every two hours, and if an aide was going to provide care for another resident, the aide would inform the other aides. She said the memory care unit had three aides on any given shift, and the aides made rounds every two hours.During an interview on 04/17/26 at 11:51 a.m., CNA B said she was CR #1's CNA on the day he eloped from the facility. She said she last saw CR #1 around 5:30 p.m. She said CR #1 came to the dining room, took his dinner tray, and went back to his room because he liked to eat in his room. She said she did not see CR #1 again because during dinner she started getting other residents ready for bed, and another aide was seated in the living area and ensured no resident left through the exit door. She said she became aware CR #1 was not in the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	building when MA A asked her about CR #1. They searched for him in the memory care unit and the two units in the facility but did not find him. She then reported to LVN N, and she called the Administrator, DON, and police while they searched the whole facility. CNA B said CR #1 usually stayed in his room and came out mostly during meals. She said CR #1 was later found and brought back to the facility, and LVN N assessed him. She said CR #1 could have been struck by a car or sustained other types of injury.During an interview on 04/17/26 at 11:51 a.m., LVN N said she was the nurse on duty when CR #1 eloped from the building and left the facility grounds. LVN N said she last saw CR #1 standing by his room at 6:45 p.m. and did not know he had left the facility through the window across from his room until MA A told her she could not find CR #1 when she went to his room to administer his medication. LVN N said she reported to the Administrator and the police during and after they searched the whole facility and could not find CR #1. She said he was found in front of a store about 2 miles away by the Activity Director. LVN N said she assessed CR #1 when he was brought back to the facility around 8:30 p.m., and he denied pain and had no injuries. She noted CR #1 was placed on one-to-one monitoring immediately.Record review of the facility policy on elopement, effective date 11/01/2019, read in part .To safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing. Elopement drill will be held quarterly. This was determined to be a Past Non-Compliance Immediate Jeopardy on 04/16/26 The Administrator, and DON were notified. The Administrator was provided with the IJ template on .04/16/26 at 3:18 p.m. The facility took the following actions to correct the non-compliance prior to the investigation. Impromptu QAPI RE: ElopementAdministrator, Maintenance Director, DON, ADON E, ADON O, and Medical Director (via phone) were in attendance. The purpose of the meeting was to review the incident and devise strategies to address the issue.Summary: In answering how he was able to exit the building, the incident was reviewed. He had not exhibited any unusual behaviors and was acting at his baseline. CR #1 had a room with a window that faced an interior courtyard. He had gone to room [ROOM NUMBER] and taken the window out of the frame, bending the stopper screws. He was able to exit the window, which was on ground level. This gave him access to a patio that had a fence on the property line. He pulled boards off the fence and was able to exit the property. He had been observed at mealtime eating. When he was noted to be gone, it was 7:00 p.m., and he had been seen about 15 minutes prior. When he was noted missing, staff began searching the facility and grounds. When he was not found, staff expanded the search to the neighborhood and alerted the police. Staff continued searching and located him at a dollar store at 8:10 p.m. He had water and snacks and returned to the facility with staff without incident. He had not missed any critical medications. He was not in pain and had no injuries.Problem: CR #1 was able to exit the facility. He had been observed within a reasonable amount of time. He was able to use force to open the window and exit.Goal: Ensure windows were secure and that the patio was secure.Interventions:The windows were evaluated by the Maintenance Director and reinforced as appropriate to ensure they could not be opened to allow for exit. room [ROOM NUMBER] was checked several times, and CR #1 was brought in to test the window; he could not open it.The windows and fence were to be checked weekly by maintenance to ensure they were secure.CR #1 was placed on one-to-one monitoring.CR #1 was referred to psychological services.CR #1 received an immediate eviction notice.Elopement wandering/leaving the facility training was conducted.Abuse/neglect training was conducted for all staff.CR #1 was placed on one-to-one monitoring.Performance improvement plan with immediate intervention included:Head countResident returned to facility within 90 minutesMedical Director/RP notifiedHead-to-toe assessment completedWandering/elopement evaluation on CR #1Audit on all residents to identify residents at risk for elopementCR #1 was transferred to a Behavioral HospitalMaintenance monitored all windows and fence in the memory care unit daily for 5 days and weekly until the next month and would reassess after the next monthRecord review of the facility paperwork for CR #1 one-to-one revealed it was initiated on 03/21/26 until he was discharged on 03/24/26.Record review of facility hourly head count revealed it was initiated on (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	03/21/26 until 04/16/26.Record review of the facility window and fence check and improvement revealed it was initiated on 03/21/26 and was still ongoing.Record review of the elopement binder dated 03/23/26 for the three halls in the facility revealed it was updated with the residents' picture, BIMS, and elopement assessment, and each book was placed at the nursing station.Record review of the facility in-service 03/21/26, 3/22/26, and 3/23/26 revealed all staff were in-serviced on abuse/neglect and elopement drills in all halls.Record review of the patio check revealed it was initiated on 03/23/26 and was still ongoing.Observation conducted on 04/15/26 at 12:50 p.m. with the Maintenance Director revealed the window in room [ROOM NUMBER] and room [ROOM NUMBER] had been secured with 1-inch metal studs instead of the long screws previously in place prior to CR #1 removing the window from the frame.Observation conducted on 04/15/26 at 12:55 p.m. with the Maintenance Director revealed the fence was old and approximately 20 planks had been replaced with new planks. During an interview on 04/15/26 between 8:30 a.m. through 12:32 p.m., ADON O, ADON M, and the Maintenance Director stated they had been in-serviced on abuse/neglect, and the Administrator was the abuse coordinator. They were able to verbalize four types of abuse/neglect, and that abuse should be reported immediately. They stated they were provided in-service on elopement and drills. They said if a resident was noted missing, the CNA would report to the nurse, who would call the Administrator and the DON, and the Administrator would oversee the search. They stated staff would continue to look for the resident inside and outside the facility, start a head count, and after 15 minutes if the resident was not found, the nurse would call the police, and the search would continue. The Administrator would divide staff into different search parties. They stated after the resident was found, they initiated an elopement drill where the resident would be hidden, and the drill would imitate an actual elopement.During an interview on 04/15/26 at 3:20 p.m., the Administrator stated CR #1 was assessed when he was brought back to the facility and did not have any injury or pain. The Maintenance Director secured the windows and checked all the fences and fixed the open area. The next day, they checked the windows daily for 5 days and conducted weekly checks until the next month, after which they would reassess. The fence was checked weekly until the next month, after which they would reassess. The Administrator stated CR #1 was placed on one-to-one monitoring as soon as he was returned to the facility until he was transferred to a behavioral hospital. The Administrator stated monitoring of the windows, the fence, and areas of the courtyard was put in place to observe areas staff could not see and to secure the windows and fence so it would not be easy for residents to remove them and exit the facility grounds. He stated the elopement drill was completed, and they reassessed all residents on C hall and reassessed residents on A hall and B hall for wander guard. The Administrator stated there was a break in the system when staff were assisting other residents, and they did not observe CR #1 manipulating the window, which had long screws that were easier to bend, and the fence was aged. He stated the corporate nurse conducted the in-service on elopement for him and the DON, and he participated in the elopement drill.During interviews on 04/15/26 between 1:03 p.m. through 1:14 p.m. and 3:16 p.m., CNA C, CNA D, MA A, CNA E, and LVN D, and on 04/16/26 between 2:24 p.m. through 4:15 p.m., [NAME], MA G, MA F, LVN Q, and on 04/17/26 between 9:44 a.m. through 12:37 p.m., CNA B, CNA H, CNA I, CNA G, LVN Q, LVN R, LVN N, LVN K, and LVN W were able to verbalize what they were in-serviced on regarding abuse/neglect, and they were able to verbalize four types of abuse/neglect. They stated the Administrator was the abuse coordinator and that abuse/neglect should be reported immediately. They stated the in-service was provided after CR #1 eloped and was brought back to the facility. They also stated they were provided in-service on elopement and elopement drills after CR #1 was found. They stated when a resident was not present in the facility, the aide would report to the nurse, who would call the Administrator and the DON while staff continued to search both inside and outside the facility grounds and continue head count. The Administrator would take charge of the elopement, and when the resident was found, the facility would initiate an elopement drill which would mimic an actual elopement.During an interview on 04/16/26 at 2:13 p.m., the DON stated all staff were provided (continued on next page)

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