STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675079	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Allenbrook	4109 Allenbrook Dr Baytown, TX 77521

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 - Actual harm Residents Affected - Some	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** 32677 Based on interview and record review the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent falls for 1 (Resident #1) of six residents reviewed for accidents, hazards, and supervision. The facility interventions did not prevent 18 unwitnessed falls and 16 witnessed falls with multiple injuries and hospitalization . The facility failed to implement the physician order for a use of a helmet to prevent injuries from falls. Facility staff, the NP and the Rehab Director were unaware of this physician order. These failures placed residents who are dependent on staff for activities of daily living, supervision, and bed mobility at risk of not being adequately supervised, no adequate intervention, not putting appropriate devices in place, worsening of existing wounds, decline in quality of care, and experiencing pain. Findings include: Record review of Resident #1's face sheet dated 11/29/23 revealed original admitted to facility was 5/9/23 and was readmitted on [DATE]. Resident was diagnosed with dementia with other behavioral disturbance, Urinary Tract infection, bilateral cataract, fracture of right pubis, osteoporosis (bone disease that develops when bone mineral density and bone mass decreases), intertrochanteric fracture of left femur, mood disorder, history of falling, type 2 diabetes (high blood sugar), insomnia, dysphagia (swallowing difficulty), fracture of unspecified part of neck of right femur, anxiety, lack of coordination, repeated falls, disorientation, abnormalities of gait and mobility and pain in right hip. Record review of Resident #1's Quarterly MDS signed on 11/28/23 revealed the resident was rarely/never understood and had severe cognitive impairment and she was dependent on staff and the helper does all of the effort for toileting hygiene, and putting on/taking off footwear, and sit to stand and tub/shower transfer. Resident #1's bed mobility, transfer, walking, dressing, eating and/or swallowing score was 0 for the number of days restorative programs were performed. Resident #1 was not rated on mobility. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident #1's undated care plan revealed resident was at risk for falls and fractures as evidence by: History of Falls, Cognitive Impairment Interventions: 04/21/2023 - Per MD .it was determined that despite all attempted interventions, due to Resident's overestimation of abilities, noncompliance, and advancement of disease processes, Resident's incidences of falls is unavoidable and anticipate needs, provide prompt assistance. Date Initiated: 11/21/2022. Assure lighting is adequate and areas are free of clutter, Encourage resident to ask for assistance of staff, Encourage socialization and activity attendance as tolerated, Ensure call light is in reach and answer promptly, Therapy to evaluate and treat per orders, Resident #1 was identified again for falls: High risk for increased falls and fractures as evidence by: Confusion, Deconditioning, Unaware of safety needs 10/25/2022 - Hit by door when roommate's spouse tried to open the door . Interventions: 10/25/2022 - Move Resident away from door and move Resident's roommate and roommate's spouse to larger area, fall mat beside bed, bed in lowest position , Anticipate and meet The resident's needs, Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, Follow facility fall protocol, Pt evaluate and treat as ordered or PRN, the resident uses a scoop mattress. Ensure the device is in place as needed. Focus: 8/6/22-I have had an actual fall with no injury r/t Poor Balance, Poor communication/comprehension. 9/14/22- witnessed fall with no injury, transferring self 9/24/22- self report of a fall with bump to back of head 11/4/22- unwitnessed fall with injury returning from bathroom 1/4/2022 unwitnessed fall w/no injury 11/5/22- witnessed fall w no injury 11/17/22 - witnessed fall w no new injury 11/21/22- witnessed fall w injury to head 12/5/22- witnessed fall w skin tear(lost balance while standing unassisted) 2/12/23- witnessed fall w skin tear to elbow 2/27/23-unwitnessed fall w no injury 2/27/23- unwitnessed fall w no injury 3/13/23- witnessed fall w no injury-slid out of w/c 3/15/23- UNWITNESSED slid out of chair no injury 4/27/23- witnessed fall with major injury (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	5/16/23 fall with a skin tear 5/25/23- unwitnessed fall with no injury 7/15/23-witnessed fall with no injury Date Initiated: 10/20/2022 Revision on: 07/17/2023 Interventions: 02/12/2023 - PT to eval/treat; remind to call for assistance; staff to monitor/encourage resident to call for assistance; Tx performed r/t s/t; Resident continues to refuse to wear helmet r/t falls; Resident pushing w/c instead of using w/c to ambulate Date Initiated: 02/14/2023 Revision on: 04/27/2023. 11/17/2022 - Remind Resident to call for assist with transfer; mat to remain at bedside; Ensure non-skid socks are in place 11/21/22- sent to ER for eval Date Initiated: 11/21/2022. 11/4/22-Sent to ER to eval & treat Date Initiated: 11/04/2022 Revision on: 04/04/2023. 11/5/22-PT to eval/treat; Remind & encourage Resident to use assistive device Date Initiated: 11/05/2022 Revision on: 04/04/2023. 12/5/22-Helmet Date Initiated: 12/07/2022 Revision on: 04/04/2023. 2/27/23-PT to eval/treat; remind to call for assistance; staff to monitor/encourage resident to call for assistance; Resident continues to refuse to wear helmet r/t falls; Resident continues to push w/c instead of using w/c to ambulate Date Initiated: 02/28/2023 Revision on: 04/27/2023. 3/13/23-PT to eval/treat; Resident continues to refuse to wear helmet r/t falls; Resident continues to push w/c instead of using w/c to ambulate; pharmacy medication review Date Initiated: 03/14/2023 Revision on: 04/27/2023. 3/15/2023 Check me for range of motion; Resident continues to refuse to wear helmet r/t falls; Resident continues to push w/c instead of using w/c to ambulate; Resident being considered for unavoidable falls Date Initiated: 10/20/2022 Revision on: 04/27/2023. 4/27/23- sent to ER for eval (Hip FX). Initiated: 04/27/2023 Revision on: 04/28/2023. 5/16/23- Resident has high incidence of falls and refuses to wear helmet to provide protection for falls. PT to evaluate and treat as indicated, and staff to encourage, remind, and monitor for Resident to call for assistance. Date Initiated: 05/16/2023 Revision on: 11/22/2023. 7/15/23- ensure needed items are in reach Date Initiated: 07/17/2023. 9/14/22- remind to ask for assist with transfers (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Date Initiated: 10/20/2022 Revision on: 10/20/2022. 9/24/22-Neuros and head/skull X-rays ordered; PT to eval/treat; Resident reminded to call for assistance as needed; staff to monitor/encourage resident to call for assistance when completing ADL tasks, Monitor/document /report PRN x 72h to MD for s/sx: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation, Neuro-checks x 72 hrs., Provide activities that promote exercise and strength building where possible. Provide 1:1 activities if bedbound, PT consult for strength and mobility, Focus: 8/3/23-I have had an actual unwitnessed fall with no injury r/t Poor Balance, Unsteady gait 8/20/23- witnessed fall no injury 9/3/23- witnessed fall with no injury 9/3/23- unwitnessed fall with injury-s/t to eyebrow 9/17/23- unwitnessed fall 9/29/23- unwitnessed fall with no injury 10/1/23- fall with no injury 10/10/23- unwitnessed fall with no injury 10/24/23- unwitnessed fall with skin tare and bump to head Date Initiated: 08/03/2023 Revision on: 10/24/2023. Interventions: 10/24/23-PT eval and treat for safety awareness and gait training. Maintain 1/2 siderail and bed lowest position when in bed and x1 mat Date Initiated: 10/24/2023 Revision on: 11/22/2023. 8/3/23- remind to ask for assistance when needing to get up Date Initiated: 08/04/2023. 9/17/23-Continue safety measures such as, low bed, floor mat and dycem in wheelchair. Date Initiated: 09/22/2023 Revision on: 09/22/2023. 9/29/23- continue current safety measures perimeter top to his mattress Date Initiated: 10/03/2023 Revision on: 10/05/2023. 9/3/23-resident educated on the importance of sitting properly in her chair so that she won't fall to the floor and cause injury to self. note resident states prefers to scoot down in her chair. it's comfortable to me. note medi-non slip padding was in use. 9/3/23-Continue safety measures such as, low bed, floor mat and dycem in wheelchair Date Initiated: 09/05/2023 Revision on: 09/22/2023. Check range of motion Date Initiated: 08/03/2023 Revision on: 08/03/2023. Monitor/document /report PRN x 72h to MD for s/sx: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Date Initiated: 08/03/2023 Neuro-checks x's 72 hrs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Date Initiated: 08/03/2023 Revision on: 08/03/2023 PT consult for strength and mobility. Date Initiated: 08/03/2023. Focus: 11/19/23- I have had an actual unwitnessed fall with injury (cut to forehead L) r/t Poor Balance, Unsteady gait, will get up unassisted repeatedly. 11/28/23- fall with injury, propelling self leaning forward and fell , -Intervention: pt transferred to Methodist ER for eval/management s/p fall W/injury per in house MD Record Date Initiated: 11/22/2023. 11/28/23- Sent to ER for evaluation, Check range of motion Date Initiated: 11/20/2023 Revision on: 11/20/2023 Monitor/document /report PRN x 72h to MD for s/sx: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Neuro-checks x 72 hrs., PT consult for strength and mobility, Focus: Resident #1 is an elopement risk/wanderer and is at risk for possible injury r/t impaired safety awareness and diagnosis of dementia. 10/2/22- Has made multiple attempts to go out front door, frequent redirection and when redirected she lashes out at any and all staff within reach, Interventions: Assess for fall risk, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television or books, Provide structured activities: Toileting, walking inside and outside, reorientation strategies, including signs, pictures and memory boxes, Wander guard placed for resident's safety, bracelet will alert staff if and when resident attempts to exit doors of facility. Staff to monitor daily. Record review of Resident #1's Physician Orders dated 11/29/23 revealed: -May have bedside mat for safety date 11/4/22 -May have Helmet to head as needed for safety dated 10/25/2023 -Send pt to [local hospital] ER for Eval s/p fall with injury dated 11/28/2023 -Signal device (Wander guard) in place due to (reason) for safety awareness dated 07/28/2023 Record review of Resident #1's Incidents dated 11/29/23 at 12:28 p.m. with date range 5/1/22 to 11/29/23 revealed: -16 Witnessed Fall Incidents 7/25/22 at 7:30 a.m. Closed fracture of right hip 9/14/22 at 4:24 p.m. 11/4/22 at 2:30 p.m. 11/17/22 at 2:26 p.m. 12/5/22 at 11:30 a.m. 2/12/23 at 9 a.m. 3/13/23 at 10:20 a.m. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	4/27/23 at 9:50 a.m. pain to back of head and left hip 911/Left femur fracture 7/15/23 at 8 p.m. Fracture of right pubis 8/20/23 at 2:02 p.m. 9/3/23 at 3:22 a.m. 9/3/23 at 10:30 a.m. 9/17/23 at 1:50 p.m. 9/29/23 at 6:29 p.m. 10/1/23 at 8 p.m. 11/28/23 at 12:38 p.m. -18 Unwitnessed Fall Incidents 5/16/22 at 1 p.m. 8/6/22 at 11 a.m. 9/24/22 at 2:44 a.m. 11/4/22 at 2:01 a.m. 11/5/22 at 11:28 a.m. 2/27/2 at 11:31 a.m. 2/27/23 at 2:02 p.m. 3/15/23 at 12:30 p.m. 5/16/23 at 5:43 a.m. 5/26/23 at 11:30 a.m. (pain to right knee) 8/3/23 at 12:30 a.m. 8/5/23 at 10:15 p.m. 8/25/23 at 8:30 a.m. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Record review of incidents and accidents did not include Resident #1's unwitnessed falls on 11/19/23 and 11/28/23 where Resident #1 was taken to the hospital, and she did obtain hematoma to head on 11/19/23 and reinjured the same forehead hematoma on 11/28/23. Record review of Resident #1's Nurses notes dated 4/27/23 at 9:59 a.m. revealed Called into locked unit by aides. Resident [Resident #1] was being assessed by opposite nurse and vital signs taken by opposite nurse while walking into unit. Resident [Resident #1] had fell on floor laying flat on back. witnessed by hospitality aide. Resident [Resident #1] had no complaints or pain noted at this time. Some redness noted to back of head no hematoma. Hospitality aide communicated that resident had hit back of head on floor. Assisted resident back into w/c and resident able to maneuver w/c without complications. Record review of Resident #1's SBAR Summary written by LPN A dated 4/27/23 at 10:25 a.m. revealed Situation : The Change In Condition/s reported on this Evaluation are/were: Falls. Resident did have pain, other neurological symptoms, recommendations were to send resident out to hospital for evaluation. Record review of Resident #1's Local Hospital records dated 5/1/23 revealed principal diagnosis: left femur fracture and transferred by ambulance. Resident #1's mental status was disoriented and she was partial weight bearing and skin integrity type was incision on left hip. [AGE] year-old female with Progressive macular hypo melanosis of dementia (skin disorder- non-scaly spots on the trunk), hypothyroidism (abnormally low activity of the thyroid), Diabetes Mellitus, recurrent falls, dementia, right hip fracture s/p intramuscular injection nailing (installing medications into the depth of the muscles) 7/2022, seizure, HTN (hypertension) .presents to ER with left hip pain s/p mechanical fall. Patient with history of dementia .No family at bedside at this time. Per report, Resident #1's family member noted patient unable to move left leg and c/o left hip pain while visiting her at the nursing home today. Apparently patient lost her balance twisted her left hip and fell . Reports left hip pain, severe, achy pain with movement since yesterday, no pain at rest. Who had her right hip nailing last year on July low dose with a past medical history .Imaging Procedure lower extremity without contrast left collected 4/27/23 at 2:26 p.m. Clinical history: Fracture femur Impression: 1. Acute comminuted intertrochanteric fracture of the left hip with various angulation. Significant communication of the greater trochanter. Displaced lesser trochanter fragment. The lateral wall of the proximal femoral shaft intact. Record review of Resident #1's SBAR for Change in Condition written by LPN B dated 5/16/23 at 6:43 a.m. revealed: The Change in Condition/s reported on this Evaluation are/were: Falls. Record review revealed no documentation of injury. Record review of Resident #1's progress notes dated 5/26/23 at 11:35 a.m., written by LPN A revealed: Called into locked unit by hospitality aide that resident had fallen. Went into locked unit, found resident in bed. resident was in bed in lowest position with head and knees raised to create a cradled position. assessed resident for any skin alterations, none noted at this moment. resident communicated pain to right knee. assessed legs and no alterations noted. Knee had no swelling or redness to area. Administered PRN Norco and adjusted resident in bed to comfortably eat lunch. Notified MD about situation and no new orders made. Notified family about situation. Plan of care continues. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident #1's local Inpatient Physician Progress note dated 11/8/23 revealed, Chief Complaint Anxiety/agitation, 80 y/o female with past medical history of hypertension (high blood pressure), hyperlipidemia (high cholesterol), hypothyroidism (thyroid gland does not make enough thyroid hormones), presented to the hospital with right hip pain post mechanical fall , computed tomography scan of the pelvis revealed a nondisplaced inferior pubic ramus fracture. Seen and evaluated by ortho, no surgical intervention needed, advised extensive physical therapy in a rehab .transferred to SNF for continuation of skilled services and further rehab. Doing well discussed with nursing has had evaluation with PT and OT tolerating medications routine labs ordered for monitoring and wound care assessment screening is done, reviewed medications to limit falls in facility. Will closely monitor. Record review of Resident #1's Local Hospital Record dated 11/20/23 and date of Admission 11/19/23 revealed physical examination .skin: contusions (bruises) along forehead and face . Record review of Resident #1's Morse Fall Scale dated 11/21/23 at 9:58 p.m. revealed: Resident #1 has fallen before, ambulatory aids were none/bedrest/wheelchair/nurse assist .overestimates or forgets limits . Record review of Resident #1's Nurse notes dated 11/28/23 at 12:03 p.m. written by the ADON revealed, This nurse was called down to C hall by housekeeping staff, noted resident lying on the floor in the hallway on her back with her wheelchair beside her, existing abrasion from previous fall noted bleeding this nurse applied pressure to site, and charge nurse obtained vital signs . and Range of Motion performed without any abnormalities. Per housekeeper resident fell straight forward out of her wheelchair head first to the floor. Resident [Resident #1] stated that her head was hurting, MD notified and 911 called for resident to be taken to hospital for further evaluation. This nurse and charge nurse assisted resident [Resident #1] to her wheelchair then to her room and laid her in bed. Stayed with resident and continued to apply pressure to site, once bleeding stopped 2 steri-strips was applied to site 911 arrived at 12:10 pm. Resident left alert without any sign of distress. Record review of Resident #1's Nurse note dated 11/28/23 at 12:15 p.m. written by the ADON revealed, Notified RP that resident had fell and reopened the abrasion to forehead and that she was sent out 911 for further evaluation. Record review of Resident #1's Local Hospital Record dated 11/28/23 at 12:32 p.m. revealed: Previous Emergency Department Visits: 11/19/23 Fall, 6/15/23 Arm Pain-Superficial bruising of arm, left, initial encounter, 4/27/23 Fall-closed displaced intertrochanteric fracture of left femur, 11/21/22 Wound Assessment- scalp hematoma, 11/21/22 Fall- Hematoma of scalp, 11/4/22 Fall- Fall .7/4/22 Hip pain- closed fracture of right hip, 6/11/22 Pain- intractable pain. Chief Complaint: Fall- patient from [facility], fell approximately 12 p.m. today from wheelchair with laceration to forehead. Per EMS patient had a fall approximately 1 week ago also and hit same spot on head. Emergency Department final diagnosis Fall, initial encounter- contusion of face. Record review of Resident #1's SBAR Summary dated 11/28/23 at 12:55 p.m. written by DON revealed: Situation : The Change In Condition/s reported on this Evaluation are/were: Falls, Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Increased confusion (disorientation) Memory loss (new or worsening), Functional Status Evaluation: Fall, Primary Care Provider recommendations were to send to ER. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Observation and attempted interview on 11/22/23 at 1:40 p.m. with Resident #1 revealed both eyes were purple underneath, with a green bruise under her chin. Observation revealed there was a raised open sore in the middle of her forehead by Resident #1's scalp. Further observation revealed bruises on Resident #1's hands. Resident #1's bed was positioned on the wall by the window and she had a bolster mattress on bed and a fall mat on the other side of the bed on the floor. Observation revealed pillows all around Resident #1's bed and on the side by the floor mat Resident #1 had 2 pillows under the sheet to attempt to bolster resident from falling. Resident #1 was attempted to be interviewed but continued falling back to sleep. Observations did not reveal a helmet or wander guard on Resident #1. In an interview with Resident #1's family member on 11/22/23 at 1:47 p.m. she stated she came to see Resident #1 daily. She stated on Sunday night, 11/19/23 she received a call saying Resident #1 had fallen and no one saw her. The Family member stated the facility called 911 and they just got back at 9pm on 11/21/23. She stated the phone call (Unknown staff) said Resident #1 was at the nurses station in the front and Resident #1 fell and no one saw it. Resident #1's Family member stated on 11/19/23 under Resident #1's left eye was really swollen, black and blue and the right eye popped up after. She stated Resident #1's forehead was still bleeding. The Family member stated the fall was on 11/19/23 at around 12:15 p.m. when she was called. In an interview on 11/22/23 at 2:00 p.m. with LVN C she stated Resident #1 was on B hall and she was passing her meds and the RN supervisor calling her from the Nurse Station and LVN C stated the RN Supervisor saw Resident #1 on the floor lying on her left side. The RN supervisor said she did not see what happened, but she saw Resident #1 on the floor. She stated there was a big bump on Resident #1's head and she was bleeding, and the RN Supervisor let the Doctor know and the family and Resident #1 went by 911 10 min later to the hospital. LVN C stated Resident #1 tried to get up and walk from her chair. In an interview on 11/29/23 at 10:30 a.m. with Resident #1 she shook her head saying she was okay. Observation revealed Resident #1 had bruises under both eyes, a raised bruise on the forehead covered with a white strip bandage. Observation revealed Resident #1 was not wearing a helmet and did not have wander guard. Observation revealed Resident #1 moving her legs up and down exercising. Observation revealed a pillow under the sheet on the side of the bed to keep her from rolling out. Observation revealed low bed. In an interview on 11/29/23 at 10:45 a.m., Resident #1's roommate stated Resident #1 keeps falling and 911 people come to get her. Resident #1's roommate stated the facility never offer Resident #1 a helmet that she ever hears of. She stated Resident #1 never wore a helmet since she has been her roommate for at least 3 months. She stated more recently the facility staff have been keeping Resident #1 on a low bed and it made more sense. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	In an observation and interview on 11/29/23 at 11:00 a.m. with CNA A she stated she assisted Resident #1. CNA A stated Resident #1 was a fall risk and she was going to check on Resident #1 again. CNA A stated Resident #1 was a fall risk and cannot stay still. She stated Resident #1 was in Memory Care because she was always a fall risk and moved a lot. CNA A stated she did not know if Resident #1 had dementia. CNA A stated Resident #1 slides in her wheelchair, so they do not want to put Resident #1 in the wheelchair anymore. CNA A stated Resident #1 leans back and slides off of the wheelchair. She stated the facility had Resident #1 in a low bed. She stated the facility used pillows, and the fall mat for Resident #1. CNA A stated Resident #1 did not have a helmet and observation revealed Resident #1 did not have a helmet on. She stated she was wondering if they would ever use a helmet with Resident #1. CNA A stated in Resident #1's bed she tried to slide down, but they position Resident #1 at a 30 degree angle in the bed sometimes. CNA A stated Resident #1's family member did not want Resident #1 in the bed, she wanted her to be in the wheelchair. She stated they keep telling Resident #1's family member that if they put her in the wheelchair Resident #1 would keep falling. CNA A stated most of Resident #1's falls have been when she was in the wheelchair. She stated Resident #1 had been on C hall for since August 2023. CNA A stated she talked to the Nurses and the Therapist and they tell her what Resident #1 needed when asked about having access to Resident #1's care plan. CNA A stated Resident #1 was a 1 person assist, but when it comes to keeping her on the wheelchair there has to be 2 people watching Resident #1. Observation with CNA A revealed Resident #1 did not have wander guard. In an interview and record review of Resident #1's Nurse notes on 11/29/23 at 11:37 a.m. with LVN D she stated Resident #1 liked to move herself around in the facility. LVN D stated Resident #1 sometimes tried to get up and she forgot she cannot walk. LVN D stated Resident #1 will say yes but other than that she does not answer your questions. LVN D stated Resident #1 tried to get out of bed herself and she was really active and alert. LVN D stated Resident #1 had fall mats, bed in lowest position, call light in reach, they get Resident #1 up for meals so they can watch her in the dining room. She stated when Resident #1 was out in the community sometimes she got away and tried to get up and there goes the falls. LVN D stated on 11/28/23, Resident #1 fell at around this time when staff were busy checking blood sugars and CNA's were getting residents to the dining room. She stated the facility could not keep an eye on her 24/7. She stated she did not know what could be done unless Resident #1 had one on one supervision. LVN D stated sometimes they did short term one on one when there were things going on with residents. LVN D stated Resident #1's family member came to check on Resident #1 daily in the evenings mostly. LVN D stated Resident #1 had a helmet and Resident #1 takes it off and does not want to wear it. LVN D stated Resident #1 did have a wander guard and was in the memory care unit a couple months ago but they took her out of the secure unit. LVN D stated Resident #1 still had the wander guard on and so if she went to the front door, it would go off. LVN D stated the wander guard was on Resident #1's legs. LVN D stated record review of Resident #1's physician orders say check wander guard placement, but the wander guard was on one of her ankles. In an interview on 11/29/23 at 11:46 a.m. with CNA A she stated Resident #1 did not have any wander guards on. She stated Resident #1 used to have a wander guard but she did not know what they did with it. CNA A stated since she has been working with Resident #1 she had not had a wander guard. She stated since she had been working with Resident #1 she had not had a wander guard or a helmet. CNA A stated she had been working at the facility since July 2023, but not always with Resident #1 but they move the CNA's around. CNA A stated when she had Resident #1 on A hall she had wander guard on her right ankle. CNA A stated she did see that Resident #1 needed a helmet and the wander guard to make the alarm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675079	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Allenbrook	4109 Allenbrook Dr Baytown, TX 77521

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F 0689 Level of Harm - Actual harm Residents Affected - Some	In an interview on 11/29/23 at 11:54 a.m. with the NP she stated Resident #1 was a long-term resident and she has been seeing patients here since February 2023. The NP stated she had dementia. She stated recently Resident #1 had fallen and was confused. The NP stated Resident #1 got in her wheelchair and had a recent fall from the wheelchair, hit her face and had to go to the hospital. The NP stated since Resident #1 has come back from hospital the facility had monitoring in place. She stated Resident #1 had a UTI and was receiving antibiotics for that. The NP stated they are monitoring Resident #1, making sure the bruises go away and they are holding blood thinners right now. She stated there were a few NP's that come to the facility so she does not always see all the residents. The NP stated one of Resident #1's bruises opened when she fell and the nurses need to make rounds, fall mat on the ground, neuro checks every 4 hours, make sure she was not agitated and trying to get up. The NP stated Resident #1 should have wander guard but she is not 100% sure. The NP stated she was not aware Resident #1 had orders for a helmet right now because there were a few NP's that see the residents. The NP stated Resident #1 should have the helmet on when out of bed and even when sitting in a chair. In an interview on 11/29/23 at 12:01 p.m. with Hospitality Aide A he stated Resident #1 was a busy body, does not like to stay still, was constantly trying to walk and kept hurting herself. Hospitality Aide A stated Resident #1 stuck to herself. He stated Resident #1 had falls when she was in A Hall in Memory Care also. Hospitality Aide A stated Resident #1 tried to stand and walk. He stated Resident #1 did not have a wander guard that he knew of and she never wore a helmet that he knew of. Hospitality Aide A stated he had been working at the facility for 2 1/2 to 3 years. In an interview on 11/29/22 at 12:05 p.m. with CNA B she stated she remembered helping Resident #1 around the building. CNA B stated Resident #1 did not have a wander guard when she was on A hall in Memory Care. CNA B stated she did not remember if Resident #1 wore a helmet. In an interview and record review on 11/29/23 at 12:19 p.m. with the ADON she stated Resident #1's Clinical record shows that she had 16 witnessed falls and 18 unwitnessed falls at the facility. The ADON stated on November 4, 2022 Resident #1 had an unwitnessed fall and Resident #1's progress notes say that a CNA (unknown name) came to RN (unknown name) at 2 a.m. and said Resident #1 was on the floor. Resident #1 was noted with walker and was laying by bathroom door wearing non skid socks, and the intervention was to go to the ER for evaluation because Resident #1 had a hematoma to the back of the head. The ADON stated the facility had to order the helmet back in December 2022 but Resident #1 kept taking it off. The ADON stated they care planned the helmet and she continued taking the helmet off. The ADON stated the facility care planed that Resident #1 was unavoidable for falls and she just wheels herself around the facility because that was what Resident #1 liked to do. She stated Resident #1 had body strength, a dycem on her wheelchair (non-slip material placed in wheelchair to prevent sliding out), bolster mattress, low bed, floor mats. The ADON stated the facility took Resident #1's wander guard off when they sent her to the hospital. She stated the facility had Resident #1 on one on one when she was having the falls, they asked the family to help with one on ones but they could not do it all the time. The ADON stated if Resident #1 would keep the helmet on that would be good because she keeps hitting her head. She stated the CNA's should know about the helmet. (continued on next page)

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	675079	A. Building B. Wing	12/14/2023

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F 0689 Level of Harm - Actual harm Residents Affected - Some	In an interview on 11/29/23 at 12:43 p.m. with the Rehab Director she stated Resident #1 was on PT and they worked on strengthening her muscles and mobility with transferring and getting in and out the wheelchair. The Rehab Director stated there was a dycem on Resident #1's wheelchair seat and it was a non-slip material to decrease her slipping out the chair. She stated there was also anti-tilt to prevent Resident #1 from titling back and the chair was tilted to prevent her from falling out the wheelchair. The Rehab Director stated she was not aware of the helmet being an intervention. In an interview on 11/29/23 at 12:50 p.m. with the Administrator he stated Resident #1 had a low bed, fall mat, no staffing issues, the ratio was perfect, and Resident #1's supervision was where it needed to be. The Administrator stated they put the wheels on Resident #1's wheelchair so it could not tip over, and they have all the therapeutic devices in place. He stated the facility did not have one on one supervision capability in this facility. In an interview on 11/29/23 at 1:04 p.m. with the DON she stated Resident #1 had falls when she was at home and that was why she came to the facility. The DON stated with Resident #1's dementia advancing she was around the 6th to 7th stage of dementia. The DON stated they were trying to get Resident #1 out of bed daily. The DON stated Resident #1 had a fall on 11/28/23. She stated Resident #1's bed was in the lowest position, and on her bed window frame they have little transparent stuff that spins to help to distract Resident #1. She stated there was a p [TRUNCATED]