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	09/04/2025

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 - 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, interview and record review, the facility failed to ensure the environment remained as free from accidents as possible and that each resident received adequate supervision and assistance to prevent accidents for 1 of 30 residents (Resident #2) reviewed for adequate supervision.The facility failed to provide adequate supervision and put measures in place to prevent residents from eloping. Resident #2 had a history of exit seeking behaviors and wandering from his previous facility and eloped from this facility in 1/7/25. He was found by a good Samaritan in his wheelchair across the street from the facility.This noncompliance was identified as Past Non-Compliance. The IJ began on 1/7/2025 and ended on 1/8/2025. The facility corrected the noncompliance by conducting elopement assessments, updating care plans, providing in-services to staff on elopement, conducting elopement drills, and changing the door code for the secure unit. ---the facility failed to provide adequate supervision and put measures in place to prevent residents from eloping. Resident #2 had a history of exit seeking behaviors and wandering from his previous facility and eloped from this facility in 1/7/25. He was found by a good Samaritan in his wheelchair across the street from the facility. This noncompliance was identified as Past Non-Compliance. The IJ began on 1/7/2025 and ended on 1/8/2025. The facility corrected the noncompliance by conducting elopement assessments, updating care plans, providing in-services to staff on elopement, conducting elopement drills, and changing the door code for the secure unit. Findings include: Record review of Resident #2's face sheet revealed admission date 12/19/24 with diagnoses including encephalopathy (dysfunction of the brain), intracranial injury with loss of consciousness (temporary or permanent loss of awareness or response from a traumatic brain injury), muscle weakness (decreased muscle strength), paranoid schizophrenia (by persistent delusions and hallucinations), recurrent depressive disorders (persistent loss of interest in activities of daily life), cerebral infarction (interruption of blood flow to the brain), anxiety disorder (excessive worry and fear). Record review of Resident #2's admission MDS dated [DATE] revealed adequate hearing, speech, and vision; BIMS score of 10, indicating moderately impaired cognitive skills; limitation in range of motion in upper and lower extremities; moderate assistance required for personal hygiene; maximal assistance required for toileting, showering, and dressing; and occasionally incontinent of bladder and bowel. (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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(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	Record review of Resident #2's baseline care plan dated 12/19/24 revealed resident was an elopement risk, with special concerns to be in secure unit. Record review of Resident#2's admission elopement assessment dated [DATE] with a score of 9 indicated cognitive impairment, history of elopement, history of leaving without informing staff at sister facility. Interventions included secure unit, frequent monitoring, staff aware of wandering behavior. Recommendations included: if resident has exit seeking behaviors, increase supervision and consider electronic device. Record review of Resident #2's elopement assessment dated [DATE] with a score of 15 indicated cognitive impairment, expressions of a desire to go home to his mother's house, history of elopement, wandering aimlessly, with interventions including secured unit, frequent monitoring, use of a check in/out log, recreational activities, music, staff aware of wander risk. Recommendations included if resident has exit seeking behaviors, increase supervision and consider electronic device. Record review of Resident #2's most recent physician orders dated 6/2/25 revealed: may admit to Secured Unit for safety/security due to elopement risk . Record review of Resident #2's care plan dated 1/8/25 revealed: resident eloped from the unit and facility and was down the street at a Dr. office-was brought back to facility/unit without incident. (Resident got the code to the unit and let himself out). Intervention included wander guard bracelet to alert staff, monitor daily, 1/7/25- code to unit door changed, staff in-service to be more observant when residents by the door of the unit; structured activities- toileting, walking inside and outside, reorientation, signs, pictures, memory boxes. Record review of the incident report for Elopement, dated 1/7/25 at 4:44pm, revealed predisposing factors of the event were resident confused, impaired memory, active exit seeker and wanderer. Incident note: 3:00pm: “Good Samaritan called this facility to inform us that there is a resident that was coming from out direction, and he is sitting on his wheelchair with a cap on and is asking to be taken to his mother house. Good Samaritan wheeled patient to safety at the doctor's office across the street from this facility until staff can go verify if the patient is ours. Resident is confused and unable to give statement, staff [NAME] resident back into this facility, skin assessment done, no changes, vitals stable, RP made aware and MD, no new orders, no signs of distress noted. Staff in-service to be more observant when entering lock down unit when residents are sitting near the exit door, secure unit pass code changed, will continue to closely monitor. ” Record review of the 24-hour report dated 1/7/25 to 1/8/25 revealed Resident Summary for Resident #2 including the above Incident Note at 4:44pm, a Social Service Note at 3:30pm, weekly skin assessment at 3:40pm and elopement assessment at 3:44pm, with a score of 15. Record review of the Provider Investigation Report dated 1/8/25 revealed the facility immediate action was staff brought the resident back to the facility, skin assessment was done with no changes, vital signs were stable, RP, MD, Ombudsman, Admin , DON, HHSC notified, in-services with staff on elopement and vigilance when entering the secure unit, pass code to secure unit changed, closely monitoring Resident #2 and all residents, in-services on elopement, elopement drills, rounding every 2 hours. (continued on next page)

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Focused Care at Allenbrook	4109 Allenbrook Dr Baytown, TX 77521

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(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	Record review of the Incident/Accident report for 12/24 to 9/25 revealed no other elopements since the time of this incident on 1/7/25. Record review of in-services with all staff were as follows: 1/7/25: Resident Elopement, Elopement Policy; 1/8/25: Resident Rounding- Nurses and CNA's to make alternating resident rounds every 2 hours during shift. Observation of resident #2 on 9/3/25 and 9/4/25 revealed he was in the secure unit, with wander guard in place. Interview with ADON on 9/4/25 at 10am revealed the nurses check the wander guards to make sure they are working. She said there are 7 residents who have wander guards, and nurse check them daily to make sure they are working correctly. In a telephone interview with CNA A on 9/4/25 at 11:40am revealed she was working on the secure unit when Resident #2 eloped. She said she was watching residents in the back of the hall in the lounge area, and another aide was showering a resident at that time. She said they do watch out for residents who are close to the door, and do not enter the code if a resident is near the door. She said they do have elopement in-services, and the last one was after this incident with Resident #2. In a telephone interview with CNA B on 9/4/25 at 11:50am revealed she was at work on the secure unit when Resident 32 eloped, she was giving a shower to another resident. She said they have elopement in-services and the most recent was after Resident #2 left the facility. She said the staff on the secure unit always watch that no resident is si near the door when they put the code in to open the door. In a telephone interview with CNA E on 9/4/25 at 12:15pm revealed she works the 6 – 2 shift in the secure unit, so was not working when Resident #2 eloped. She said she used to work on the B Hall, and just started working in the secure unit recently. She said they do have in-services on abuse/neglect and elopement. In an interview with CNA C, in the secure unit, on 9/4/25 at 10am, she said she works the morning shift, so she was not here when Resident #2 eloped. She said they have in-services on elopement, just recently, and also on abuse/neglect. She said they watch to make sure there are no residents by the door when they enter the code to open the door. In an interview with CNA D, in the secure unit, on 9/4/25 at 10:15am, she said she was not working when Resident #2 eloped, and they do have elopement in-services. She said she will re-direct anybody near the door, and make sure the door is completely closed when she leaves the secure unit. In an interview with the Assistant Director of Clinical Operations on 9/4/25 at 11:05 am, she said Resident #2 was new in the facility, and came here from a sister facility, where he had a history of elopement and wandering. In this incident, he was taken to a dentist office across the street and brought back here by staff. He was assessed and had no injuries and was monitored. She said they have elopement drills, and take someone out of the facility, and go through the whole process of elopement investigation and follow-up. She said they have elopement and abuse/neglect in-services. (continued on next page)

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Focused Care at Allenbrook	4109 Allenbrook Dr Baytown, TX 77521

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(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	In an interview with LVN A on 9/4/25 at 10:35am, she said they do have elopement drills, where they practice the entire elopement process. She said the staff will watch for anyone leaving the facility to ensure they are allowed. There is a sign-out book on the table by the door, for anyone to sign if they are leaving the facility In an interview with Director of Environmental Services on 9/4/25 at 4:00pm, she said they do have elopement in-services and elopement drills regularly. In an interview with LVN B on 9/4/25 at 4:05 pm, she said they do have in-services on elopement, including elopement drills every 3 months. The DON was provided the PNC IJ template on 9/3/25 at 5:31 pm. A Plan of Removal was not requested. The non-compliance began on 1/7/25 and ended on 1/8/25. The facility had corrected the non-compliance before the investigation began. The following interventions were implemented prior to surveyor entrance and surveyor confirmed the Past Noncompliance. 1. Resident # 2 was immediately assessed 2. Resident # 2 was placed on 1:1 supervision 3. Resident #2's care plan was updated for elopement risk 4. Facility notified RP, MD, Administrator, DON, Ombudsman, HHSC 5. In-services on elopement, abuse/neglect, including staff and management recognizing and reporting abuse/neglect and elopement. 6. In-services with staff (nurses & CNAs on alternate resident rounding every 2 hours). An ad-Hoc QAPI meeting was held on 1/7/25 with the following addressed: 1. Incident/accidents-elopement reviewed 2. Secure unit code changed 3. Alternating rounds every 2 hours 4. Elopement drill 5. In-services on alternating rounding during shift for CNAs 6. In-services on alternating rounding during shift for nurses. There have been no elopement since this incident. (continued on next page)

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(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	Record review of the facility Elopement, effective 11/1/2019, revealed, in part: “a prompt investigation and search will be conducted if a patient/resident is considered missing. Elopement drill will be held quarterly…” Findings include: Record review of Resident #2's face sheet revealed admission date 12/19/24 with diagnoses including encephalopathy (dysfunction of the brain), intracranial injury with loss of consciousness (temporary or permanent loss of awareness or response from a traumatic brain injury), muscle weakness (decreased muscle strength), paranoid schizophrenia (by persistent delusions and hallucinations), recurrent depressive disorders (persistent loss of interest in activities of daily life), cerebral infarction (interruption of blood flow to the brain), anxiety disorder (excessive worry and fear). Record review of Resident #2's admission MDS dated [DATE] revealed adequate hearing, speech, and vision; BIMS score of 10, indicating moderately impaired cognitive skills; limitation in range of motion in upper and lower extremities; moderate assistance required for personal hygiene; maximal assistance required for toileting, showering, and dressing; and occasionally incontinent of bladder and bowel. Record review of Resident #2's baseline care plan dated 12/19/24 revealed resident was an elopement risk, with special concerns to be in secure unit. Record review of Resident#2's admission elopement assessment dated [DATE] with a score of 9 indicated cognitive impairment, history of elopement, history of leaving without informing staff at sister facility. Interventions included secure unit, frequent monitoring, staff aware of wandering behavior. Recommendations included: if resident has exit seeking behaviors, increase supervision and consider electronic device. Record review of Resident #2's elopement assessment dated [DATE] with a score of 15 indicated cognitive impairment, expressions of a desire to go home to his mother's house, history of elopement, wandering aimlessly, with interventions including secured unit, frequent monitoring, use of a check in/out log, recreational activities, music, staff aware of wander risk. Recommendations included if resident has exit seeking behaviors, increase supervision and consider electronic device. Record review of Resident #2's most recent physician orders dated 6/2/25 revealed: may admit to Secured Unit for safety/security due to elopement risk . Record review of Resident #2's care plan dated 1/8/25 revealed: resident eloped from the unit and facility and was down the street at a Dr. office-was brought back to facility/unit without incident. (Resident got the code to the unit and let himself out). Intervention included wander guard bracelet to alert staff, monitor daily, 1/7/25- code to unit door changed, staff in-service to be more observant when residents by the door of the unit; structured activities- toileting, walking inside and outside, reorientation, signs, pictures, memory boxes. (continued on next page)

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(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	In a telephone interview with CNA E on 9/4/25 at 12:15pm revealed she works the 6 – 2 shift in the secure unit, so was not working when Resident #2 eloped. She said she used to work on the B Hall, and just started working in the secure unit recently. She said they do have in-services on abuse/neglect and elopement. In an interview with CNA C, in the secure unit, on 9/4/25 at 10am, she said she works the morning shift, so she was not here when Resident #2 eloped. She said they have in-services on elopement, just recently, and also on abuse/neglect. She said they watch to make sure there are no residents by the door when they enter the code to open the door. In an interview with CNA D, in the secure unit, on 9/4/25 at 10:15am, she said she was not working when Resident #2 eloped, and they do have elopement in-services. She said she will re-direct anybody near the door, and make sure the door is completely closed when she leaves the secure unit. In an interview with the Assistant Director of Clinical Operations on 9/4/25 at 11:05 am, she said Resident #2 was new in the facility, and came here from a sister facility, where he had a history of elopement and wandering. In this incident, he was taken to a dentist office across the street and brought back here by staff. He was assessed and had no injuries and was monitored. She said they have elopement drills, and take someone out of the facility, and go through the whole process of elopement investigation and follow-up. She said they have elopement and abuse/neglect in-services. In an interview with LVN A on 9/4/25 at 10:35am, she said they do have elopement drills, where they practice the entire elopement process. She said the staff will watch for anyone leaving the facility to ensure they are allowed. There is a sign-out book on the table by the door, for anyone to sign if they are leaving the facility In an interview with Director of Environmental Services on 9/4/25 at 4:00pm, she said they do have elopement in-services and elopement drills regularly. In an interview with LVN B on 9/4/25 at 4:05 pm, she said they do have in-services on elopement, including elopement drills every 3 months. The DON was provided the PNC IJ template on 9/3/25 at 5:31 pm. A Plan of Removal was not requested. The non-compliance began on 1/7/25 and ended on 1/8/25. The facility had corrected the non-compliance before the investigation began. The following interventions were implemented prior to surveyor entrance and surveyor confirmed the Past Noncompliance. 1. Resident # 2 was immediately assessed 2. Resident # 2 was placed on 1:1 supervision 3. Resident #2's care plan was updated for elopement risk 4. Facility notified RP, MD, Administrator, DON, Ombudsman, HHSC (continued on next page)

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(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	5. In-services on elopement, abuse/neglect, including staff and management recognizing and reporting abuse/neglect and elopement. 6. In-services with staff (nurses & CNAs on alternate resident rounding every 2 hours). An ad-Hoc QAPI meeting was held on 1/7/25 with the following addressed: 1. Incident/accidents-elopement reviewed 2. Secure unit code changed 3. Alternating rounds every 2 hours 4. Elopement drill 5. In-services on alternating rounding during shift for CNAs 6. In-services on alternating rounding during shift for nurses. There have been no elopement since this incident. Record review of the facility Elopement, effective 11/1/2019, revealed, in part: “a prompt investigation and search will be conducted if a patient/resident is considered missing. Elopement drill will be held quarterly…”