STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675454	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Oaks Nursing & Rehab Center	3625 Green Crest Houston, TX 77082

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on observation, interview, and record review the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs for 2 of 18 residents (Resident #89, Resident #310) who were observed for call light placement. The facility failed to ensure that call light were within reach for Resident #89 and Resident #310. This could place the residents at risk of not receiving the care and services to maintain their highest level of well-being. Findings included: 1. Record review of Resident #89's face sheet captured on 01/16/2025 revealed a [AGE] year-old male originally admitted to the facility on [DATE]. His medical diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right-sided weakness after a stroke), essential hypertension (high blood pressure), Schizophrenia (a serious mental health condition characterized by hallucinations, delusions and unorganized thinking), Bipolar Disorder(a serious mental health condition characterized by extreme mood swings ranging from depression to mania to hypermania), Anxiety Disorder (prolonged anxiousness and worry), acute kidney failure, Depression, and muscle wasting and atrophy (reduced muscle function). Record review of Resident #89's Quarterly MDS (a resident assessment tool) dated 11/20/2024 revealed a BIMS score of 4, indicating severe cognitive impairment in thinking and decision-making. Resident #89 required total assistance for activities of daily living such as toileting, showering or bathing, lower body dressing, and putting on and taking off footwear. Record review of Resident #89's care plan last completed 12/05/2024 revealed the following focus areas: (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Self Care deficit related to Dementia, with interventions including one person assistance with bed mobility, dressing and grooming, and toileting and incontinent care. -Risk for falls secondary to deconditioning and gait/balance problems, with interventions including having the resident's call light within reach and encourage the resident to use it for assistance as needed The resident needs prompt response to all requests for assistance. Observation and interview with Resident #89 on 1/14/2025 at 10:11am, resident was lying in bed with his blanket covering from his legs to his upper torso and did not appear in distress. Resident #89 said that he did not like the temperature in the room and that he wanted the heat turned off but could not locate the call light. The call light wire was observed hanging off Resident #89's bed on his right side not within reach and the button was seen on the floor. Resident #89 said if he had the button, he would call for help. Observation and interview with LVN L on 1/14/2025 10:11am, after being informed about Resident #89's concerns regarding the temperature and call light, LVN L went into Resident #89's room and came out. She said she adjusted the temperature for him. After immediately re-entering Resident #89's room, the call light wire and button were observed in the same location. Interview with the DON on 1/14/2025 at 10:59am, she was informed of Resident #89's concerns regarding the call light and when she went into his room, she picked up the call light and reclipped it to his bed. The DON told Resident #89 to press the button, but he was unable to physically press down on it. The DON said she will switch Resident #89's call light from a button to a press pad so he could more easily press down on it to call for assistance. A later interview with the DON on 1/14/2025 at 1:03pm, she said that a press pad was installed in Resident #89's room and he was able to demonstrate using the press pad for her. Interview with LVN L on 1/14/2025 at 4:26pm, she said that call lights needed to be close to residents so they can call for help. If residents were unable to reach the call light, then they would not get the assistance they needed. Interview with the Administrator on 1/6/2024 at 3:02pm, she said that call lights were supposed to be answered in a timely manner and positioned within reach so residents could get things they need, and if not, they would be unable to get the help they require. 2. Record review of Resident #310's Face Sheet dated 01/14/2025 revealed, that Resident #310's was a [AGE] year-old female who admitted to the facility on [DATE]. Resident's diagnosis included nondisplaced subtrochanteric fracture of left femur (break in upper thigh bone), subsequent encounter for closed fracture with nonunion (not open to the outside, but failed to heel), idiopathic aseptic necrosis of left femur (blood flow to bone disrupted), anemia (low red blood), severe protein-calorie malnutrition (not enough protein for energy), hypertension (high blood pressure), fall, fracture of one rib, right side, subsequent encounter for fracture with routine healing, complete rotator cuff tear or rupture of right shoulder, specified as traumatic, bipolar disorder (shift in moods, energy, and activity level), alcohol abuse with unspecified alcohol-induced disorder, unsteadiness on feet, other lack of coordination, and muscle weakness. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #310's Care Plan undated revealed, that Resident #310 FOCUS: Resident at risk for falls and had an actual fall on 12/23/2024 attempting to self-transfer to wheelchair and slid to the floor 12/20/24. Resident had been noted sitting on floor beside her bed. Resident had an actual fall on 01/16/2025 while attempting to ambulate in response to a biological need. Date Initiated: 12/23/2024 Created on: 12/24/2024 Revision on: 01/16/2025. GOAL: Resident will have no significant injuries related to falls thru next review. Date Initiated: 12/23/2024 Created on: 12/24/2024 Revision on: 01/16/2025 Target Date: 03/17/2025. INTERVENTION: Access for hunger and provide nighttime snacks as desired. Date Initiated: 01/16/2025 Created on: 01/16/2025 Revision on: 01/16/2025. Anticipate resident needs. Date Initiated: 12/23/2024 Created on: 12/24/2024. CALL DONT FALL SIGN placed at bedside. Date Initiated: 12/24/2024 Created on: 12/24/2024 Revision on: 01/16/2025. Encourage resident to use call light for assistance. Date Initiated: 12/23/2024 Created on: 12/24/2024. Fall mat x1 placed at bedside. Date Initiated: 12/30/2024 Created on: 12/30/2024. Therapy to eval and treat as indicated. Date Initiated: 12/24/2024 Created on: 12/24/2024 Revision on: 01/16/2025. Record review of Resident #310's Admission Minimum Data Set (MDS) Assessment, dated 12/23/2024, reflected she had a Brief Interview for Mental Status (BIMS) score of 15 indicating her cognitive status was intact. In an observation/interview on 01/14/2025 at 10:37 a.m., Resident #310 was sitting in a wheelchair at bedside. Resident's call light cord underneath her wheelchair on the floor. Resident stated that she did not feel like she was in control of where she should and wanted to be. She stated that she was at the facility awaiting hip replacement surgery and rehabilitation. She stated that she was not aware of her call light being on the floor and stated she could not reach it. She stated that staff would not answer it anyway as they ignore her. In an observation on 01/14/2025 at 11:02 a.m., Licensed Vocational Nurse (LVN) A entered Resident #310's room and bent down to speak to resident at eye level. In an observation/interview on 01/14/2025 at 11:12 a.m., Resident #310 was observed sitting in her wheelchair bedside with call light cord still underneath the wheelchair on the floor. Resident stated that she asked LVN A for pain medication which she received as she had pain. Resident began crying and this surveyor waved down Certified Nursing Assistant (CNA) A to assist resident. In an observation/interview on 01/14/2025 at 11:16 a.m., CNA A stated that Resident #310 was residing on the hall she was assigned too, but had gone on vacation returning to find the resident had moved to another hall. CNA A asked resident what was wrong, resident told her that staff ignored her and would not answer her call bell. CNA A was informed that Resident #310's call light was on the floor. She stated that she was not working this hall, but that Resident #310 had been on the hall she worked prior to her going on vacation. CNA A immediately picked up the call bell and attached the cord to resident's wheelchair. CNA A stated that it was important for residents to have call bells in reach to ensure that they can call for help when they need assistance. She stated that she would come and check on the resident periodically during her shift. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/14/2025 at 11:41 a.m., LVN A stated when she entered Resident #310's room at 11:12 a.m. resident told her she was in pain and wanted to go smoke. She stated she passed the resident her narcotic medication for pain. She stated when she entered and exited the room, she believed that the resident's call light was attached to her bed. She stated she had not realized the location of the call light was on the floor and had she seen it, would put it within reach of resident and ensured it was in place. She stated that the importance of resident call bells being within reach was to ensure that residents were able to reach out for assistance in case they needed help. In an interview on 01/14/2025 at 11:46 a.m., the Administrator (ADMN) stated she was not aware that Resident #310's call light was not in reach. She stated that she would provide the latest in-services on call-lights. In an interview on 01/14/2025 at 02:47 p.m., the ADMN stated she received notice from LVN A that Resident #310's call light was on the floor. She stated that staff take in-services on an app and once complete, the ADMN would receive notice. She stated that LVN A would be completed an in-service on call lights and completed data would be provided. on your phone via an app. Once completed, a notification would be sent, and she would forward. In an interview on 01/15/2025 at 02:41 p.m., the Director of Nursing (DON) stated that she was not sure the status of Resident #310, but believed she was here to gain weight and increase her health condition for an anticipated hip replacement surgery. She stated that she was not aware that resident's call light was out of reach. She stated the importance for call lights to be in reach was to ensure resident were able to contact staff when they needed assistance. In an interview on 01/16/2025 at 02:57 p.m., the ADM stated that staff were responsible for answering call bells in timely manners, and that call bells were to be within reach of residents at all times so that they were able to call for assistance. She stated that if a resident could not call for assistance, they would not able to get the help they needed to meet needs. In an interview on 01/16/2025 at 03:06 p.m., the DON stated that resident's call bell should be in position of reach at all times. She stated if seen on the floor, the call bells were to be placed within reach and never left on the floor. Record review of In-Service dated 01/14/2025 revealed, LVN A had been in-serviced on call lights. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of policy undated and titled, Call Light Use and Patient Safety. Nursing home residents often require ongoing care to maintain their health. Throughout the day, they may need assistance from nursing staff to stand up, engage in daily activities, or handle medical emergencies. As such, each patient must have a call light system to notify nursing staff if they need help . Placement: Nurse call systems must be accessible within resident rooms. Generally, a call system is required beside the bed and in bathing or toilet facilities. Common areas should also allow access to nurse call systems. The purpose of a call light system is to enable residents to ask for assistance, so they must be placed in all locations where resident may be present. Accessibility: Call lights must also be accessible to all residents, including those with disabilities. If they are placed out of reach on a wall, some patients may be unable to call for help. For patients with limited mobility, a call system must be within reach of their bed and other locations. The nursing home is responsible for setting up each resident's call system to meet their needs . consequences of Call light Neglect: Neglecting call lights can have a devastating impact on a nursing home resident. Whether it means the resident has to wait a long time to be moved or a medical emergency escalates, it is crucial that a staff member can respond to the alert as soon as possible. Record review of policy dated February 2017 and revised date December 2023 titled Statement of Resident Rights revealed, Compliance Guidance: The community should educate, encourage, and honor the rights of those we serve . 1. To all care necessary for them to have the highest possible level of health. 2. To safe, decent, and clean conditions . 4. To be treated with courtesy, consideration, and respect.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32422 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 5 residents (Resident #6 and Resident #55) reviewed. -The facility failed to ensure that Resident #6's status of anticoagulants was a focus area in the resident's comprehensive care plan and no intervention was in place. -The facility failed to ensure that Resident #6's status of oxygen was a focus area in the resident's comprehensive care plan and no intervention was in place. -The facility failed to ensure Resident #55's status of oxygen was a focus area in the resident's comprehensive care plan. These deficient practices could affect residents by contributing to inadequate care. The findings included: Record review of Resident #6's facility Admission Record dated 1/16/25 revealed that Resident #6 was a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. Resident #6's diagnoses included multiple sclerosis (MS is a chronic disease that damages the central nervous system. It is an autoimmune disease, meaning the immune system attacks healthy cells, including the protective sheath around nerve fibers) and acute respiratory failure with hypoxia (a medical condition where the lungs are unable to adequately exchange oxygen, resulting in low blood oxygen levels). Record review of Resident #6's Quarterly MDS dated [DATE] revealed Resident #6 had a BIM score of 2 out of 15 indicating severe impairment cognitively. Resident #6 was dependent with ADLs requiring substantial/maximum assistance. Record review of section N-Medications revealed Resident #6 received anticoagulants. Record review of Section O (special treatments, procedures, and programs), reflected the areas for oxygen therapy were blacked out. Record review or Resident #6's care plan printed date 1/15/25 revealed there were no care plans to address anticoagulants or oxygen. Record review of the care plan history report dated 1/15/25 for Resident #6 revealed the following: Description, Oxygen Therapy r/t my disease processes related to heart failure. Revision date 1/15/25 signed by the Regional RN. Record review of Resident #6's physician order summary report for January 2025 revealed a physician order for oxygen at 2-3 liters per nasal cannula (N/C) as needed for s/s of SOB/Comfort as needed for shortness of breath (SOB) with a start date of 9/20/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's physician order summary report for January 2025 revealed a physician order for Apixaban Oral Tablet 2.5 MG. Give 1 tablet by mouth two times a day for anticoagulants related to heart failure, unspecified with a start date of 8/26/24, hold date from 10/7/24 to 10/10/24. Record review of Resident #55's Admission Record dated 1/15/2025 revealed a [AGE] year-old female originally admitted on [DATE] with a re-admitted [DATE]. Her medical diagnoses included pneumonitis (inflammation of the lungs), sepsis (the immune system reacting to an infection which could lead to organ failure), hypothyroidism (low levels of the hormone thyroid which regulates the body's functions like the metabolism), Bipolar Disorder, Traumatic Brain Injury, Epilepsy (seizures), Type 2 Diabetes Mellitus, cognitive communication deficit, and vascular dementia (a type of dementia caused by brain damage from impaired blood flow). Record review of Resident #55's care plan last captured on 01/15/2025 at 9:40am revealed there was no focus area for oxygen. Resident #55 had a focus area of hypertension secondary to frontal lobectomy/craniotomy with an initiated date of 06/21/2019 and had interventions including notifying the MD as needed with any signs or symptoms of malignant hypertension including difficulty breathing. Record review of Resident #55's Physician Orders last captured 1/15/2025 at 9:38am revealed she was ordered and started on 01/02/2025 for Continuous Oxygen at 2-3 Liters per N/C every shift. Record review of Resident #55's January TAR revealed she had orders for Continuous Oxygen at 2-3 Liters per N/C every shift, with a start date of 1/2/2025 at 6:00pm and a discontinued date of 1/15/2025 at 12:06pm. Resident #55's oxygen saturation levels were within normal range. Record review of Resident #55's hospital records dated 12/26/2024 revealed she was admitted for Pneumonia and Acute hypoxic respiratory failure (lungs cannot release enough oxygen into the bloodstream and can cause shortness of breath and dizziness). Resident #55 was admitted to the hospital for respiratory distress on 12/22/2024. She was placed on oxygen and was weaned off to 2 L as of 12/26/2024. The records had special instructions for Resident #55 to have O2 NC on DC. Observations of Resident #55 on 1/14/2025 at unknown time revealed she was sleeping with oxygen. She did not appear to be in distress. Later observation on at 11:35am, revealed Resident #55 was sitting in the hallway near the entrance across from the nurse's station without an oxygen mask or tank. She appeared well-groomed, and was sitting up with no discomfort. Resident #55 did not respond to questions. During an interview on 1/15/25 at 8:59 AM, The care plans were given to the surveyor on 1/15/2025 to address Resident #6 for anticoagulants and oxygen. the DON confirmed that Resident # 6 was on anticoagulants and oxygen. she said she did not look at the date of the care plans, that she just printed the care plans. An interview on 1/15/25 at 3:16 PM with the MDS Coordinator/ RN and the DCR. The MDS Coordinator said they worked as a team to get care plans updated but for Resident #6, she did not do those changes regarding oxygen and anticoagulants. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DON on 1/15/25 at 11:35am, she said she will have to check if Resident #55 required oxygen and will provide an update. Another interview with the DON at 3:37 PM, she said they were already auditing Care plans yesterday and the day before yesterday (1/13/25 and 1/14/25). She said the care plans for anticoagulants and oxygen should have been there if there was an order. The DON said that the facility had 48-hours to update the plan. The DON also said Resident #55 had an order for oxygen and it should have been on the care-plan, but that she talked with the doctor and they put in a new order for oxygen as needed since her oxygen saturation levels have been stable. During an interview with the DON on 1/16/25 at 3:02 PM, she said that Care plans tell us what care to perform for residents. The regular care plan is done by the MDS nurses, and the acute care plan is done by residents' nurses for things like antibiotics. She said that Care plan updates are a team effort, in the mornings they talk about resident care, go over orders from the previous day either for acute or long-term care plans and meetings include the 2 ADONs, 2 MDS nurses and a nurse. During an interview on 1/16/25 at 3:02 PM with the Administrator, she said Care plans were used to match resident needs, they had care plan clinical meetings, they discuss expectations and update the care plans. Record review of the facility policy and procedure entitled Care Plans, dated revised January 2023 read in part . The community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan should be reflective of the identified problem or risk, a measurable outcome objective and appropriate intervention/interventions in relation to the identified problem or risk, outcome objective, and the resident's ability, needs, medical condition, preventative measures. The care plan may also include the expressed preferences. The care plan in conjunction with the plan of care throughout the medical record is developed and or recommended to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . The care plan should be initiated upon admission, continued to be developed during the initial 48-72 hrs., throughout the completion of the admission comprehensive assessment. The care plan should be updated and reviewed at least quarterly thereafter, then annually and with significant changes in conditions as defined in the RAI manual. Additional updates to the care plan may be done as indicated.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 48923 Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision and assistive devices to prevent accidents for 1 of 5 residents (Residents #8) reviewed for accidents. -The facility failed to ensure Resident #8 had two fall mats in his room according to his comprehensive care plan. -The facility failed to ensure Resident #8's Physician Orders for two fall mats with a start date of 1/10/2025 were added as interventions in his comprehensive care-plan. Record review of Resident #8's facility Admission record revealed that Resident #8 was an [AGE] year-old male admitted on [DATE]. Resident #8's diagnoses included: chronic heart failure, vascular dementia (a type of dementia caused by brain damage from impaired blood flow), chronic kidney disease, cardiomegaly (enlarged heart), hyperlipidemia (high fat content in the blood), hypothyroidism (low levels of the hormone thyroid which regulates the body's functions like the metabolism), Type 2 Diabetes Mellitus, malignant neoplasm of prostate (prostate cancer), nutritional deficiency, hypertension (high blood pressure), cognitive communication deficit, and Generalized Anxiety Disorder. Record review of Resident #8's Quarterly MDS dated [DATE] revealed he had a BIMS score of 9, indicating moderate cognitive impairment. Resident #8 was documented using a wheelchair. He required supervision for oral hygiene and upper body dressing and required moderate assistance with toileting, showering, lower body dressing, and personal hygiene. Resident #8 required moderate assistance with transfer in bed and from bed to wheelchair or the toilet. Record review of Resident #8's care plan last reviewed 11/19/2024 revealed he was at risk for falls due to Debility (loss of ability) and weakness, with interventions including anticipating and meeting his needs and keeping his call bell within reach as indicated, bed at appropriate height when unattended, and that he was non-compliant with fall intervention which placed him at high risk for falls and injury. Resident #8's care plan did not include interventions for fall mats. Record review of Resident #8's Physician Orders revealed he had an active order with a start date of 1/10/2025 for Fall mats x2 (two) at bedside for every shift. Record review of Resident #8's fall assessment on 1/5/2025, reflected he had an unwitnessed fall on 4:30pm. It was documented there was no evidence of possible head injury, and Resident #8 was alert, had no pain, had normal vitals and had no concern with his motor functions. The document revealed he had neuro-checks completed for 72 hours post-fall. Record review of Resident #8's nursing progress note dated 1/5/2025 at 5:11 am revealed he was noted lying on the floor at the right side of the bed during routine rounding. He was unable to verbalize how he got to the floor. Resident #8 was alert but not to the situation. Vital signs within normal range, and he was assisted back to bed with no discomfort noted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #8 on 1/14/2025 at 9:39am, revealed he was resting in his bed at its lowest position, with a fall mat on the left side of his bed. Further observation of Resident #8 on 1/16/2024 at 11:35am, revealed he was sleeping in his room and had one fall mat on the left side of his bed. Resident #8 was sleeping during observations and was unable to be interviewed regarding fall mats. Interview with CNA G on 1/16/2025 at 11:34am, she stated that Resident #8 had only one fall mat that she was aware of. Interview with RN H on 1/16/2025 at 4:11pm, they said that Resident #8's mat had food spillage on it so the aide took the mat away to be cleaned and it was being air dried and not in his room. He said that the fall mat's purpose was to prevent significant injury and that RN H believed Resident #8's care plan needed to be updated since the fall mat was added when Resident #8 used to be mobile but since he was on Hospice he had a reduction in mobility and being more in bed meant he was not at risk of falls as much. During an interview with the DON on 1/16/25 at 3:02 PM, she said that Care plans tell us what care to perform for residents. The regular care plan is done by the MDS nurses, and the acute care plan is done by residents' nurses for things like antibiotics. She said that Care plan updates are a team effort, in the mornings they talk about resident care, go over orders from the previous day either for acute or long-term care plans and meetings include the 2 ADONs, 2 MDS nurses and a nurse. During an interview on 1/16/25 at 3:02 PM with the Administrator, she said Care plans were used to match resident needs, they had care plan clinical meetings, they discuss expectations and update the care plans. Record review of the facility policy and procedure entitled Care Plans, dated revised January 2023 read in part . The community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan should be reflective of the identified problem or risk, a measurable outcome objective and appropriate intervention/interventions in relation to the identified problem or risk, outcome objective, and the resident's ability, needs, medical condition, preventative measures. The care plan may also include the expressed preferences. The care plan in conjunction with the plan of care throughout the medical record is developed and or recommended to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . The care plan should be initiated upon admission, continued to be developed during the initial 48-72 hrs., throughout the completion of the admission comprehensive assessment. The care plan should be updated and reviewed at least quarterly thereafter, then annually and with significant changes in conditions as defined in the RAI manual. Additional updates to the care plan may be done as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675454	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Oaks Nursing & Rehab Center	3625 Green Crest Houston, TX 77082

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders for 1 (Resident #38) of 8 residents reviewed for infection control. -The NF failed to change Resident #38's midline IV (a Thin flexible tube inserted into a vein in the upper arm) dressing weekly as ordered by the physician on 1/13/25. This failure placed residents at risk for infections and decrease in quality of life. Findings: Record review of Resident #38's face sheet dated 01/16/25 revealed a [AGE] year-old male admitted to the NF on 05/07/24. Resident diagnoses included the following: pulmonary embolism (one or more arteries in the lungs become blocked by a blood clot) , hemiplegia (complete paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the of the body that can affect the arms, legs and facial muscles), Type 2 diabetes mellitus (when the body has trouble controlling blood sugar and using it for energy), pneumonia (infection that inflames air sacs in one or both lungs which may be filled with fluid), and heart failure. Record review of Resident #38's quarterly MDS dated [DATE] revealed that resident had a BIMS score of 15 indicating that resident cognition was intact. Record review of Resident #38's Physician Orders for the month of January 2025 reflected the following order: -Dated 01/13/25 midline dressing change and cap change weekly using sterile technique per protocol one time a day every Monday. -Dated 01/13/25 Ceftriaxone 1 gm (antibiotic) intravenously one time a day for pneumonia for 7 days. Record review of Resident #38's MAR reflected that the NF was administering medication Ceftriaxone as ordered. Record review of Resident #38's care plan initiated 01/15/25 revealed that resident was being care planned for intravenous therapy r/t intravenous access device. The interventions included to change dressing to IV access device site as ordered. Observation on 01/14/25 on Hall 300 at 2:45PM of Resident #38 having a midline to his right upper arm. The date on the dressing was 01/6/25. Interview on 1/14/25 at 2:50PM with LVN G said the midline dressings were supposed to be changed every 24 hours to prevent infections. LVN G said she was Resident #38's nurse but could not say why Resident #38's midline dressing to his upper right arm had not been changed. (continued on next page)

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	675454	A. Building B. Wing	01/16/2025

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/14/25 at 3:00PM with the Infection Control Nurse/ADON F said the midline dressings were supposed to be changed every week to prevent infections. Infection Control Nurse/ADON F said he was responsible for monitoring IV lines for 300 Hall. He said he must have forgotten to check Resident #38's midline dressing to ensure that it was being changed weekly. Interview on 01/14/25 at 3:04PM with the DON said the midline dressings were supposed to be changed every week to prevent an infection. The DON said it was the ADON that ensured the midline dressing was being changed every week. The DON said the ADON assigned to Hall 300 was the Infection Control Nurse. The DON said the NF did not have a policy on IV/midlines. Observation on 01/14/25 at 3:38PM revealed Resident #38's midline dressing to right upper arm being changed by LVN G. Resident's mid-line site was without redness, swelling, or drainage. On 01/16/2025 at 8:15AM the DON was asked for Resident #38's care plan. Record review of the nursing policy regarding Infection Control dated April 2024 reflected in part: .The purpose of surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare associated infections, to guide appropriate interventions, and to prevent further infections .

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	675454	A. Building B. Wing	01/16/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on observations, interview and record review, the facility failed to ensure that residents needing respiratory care is provided such care, consistent with professional standards of practice and the comprehensive person-centereed care plan for 1 of 2 residents (Resident #55) reviewed for oxygen therapy. --The facility failed to ensure Resident #55 had continuous oxygen according to Physician Orders when she was found without her oxygen cannula on 1/15/2025 at 11:35am. This deficient practice could affect residents getting medically required treatment and lead to a decline in health. Findings include: An interview with the DON on 1/15/25 at 11:35am, she said she will have to check if Resident #55 required oxygen and will provide an update. She said the care plans for oxygen should have been there if there was an order. The DON said that the facility had 48-hours to update the plan. The DON also said Resident #55 had an order for oxygen and it should have been on the care-plan, but that she talked with the doctor and they put in a new order for oxygen as needed instead of continuous oxygen since her oxygen saturation levels had been stable. The DON discontinued the order for Resident #55 for continuous oxygen on 2L/min after surveyor intervention. Record review of Resident #55's Admission Record dated 1/15/2025 revealed a [AGE] year-old female originally admitted on [DATE] with a re-admitted [DATE]. Her medical diagnoses included pneumonitis, sepsis , hypothyroidism (low levels of the hormone thyroid which regulates the body's functions like the metabolism), Bipolar Disorder, Traumatic Brain Injury, Epilepsy (seizures), Type 2 Diabetes Mellitus, cognitive communication deficit, and vascular dementia (a type of dementia caused by brain damage from impaired blood flow). Record review of Resident #55's care plan last captured on 01/15/2025 at 9:40am revealed there was no focus area for oxygen. Resident #55 had a focus area of hypertension secondary to frontal lobectomy/craniotomy with an initiated date of 06/21/2019 and had interventions including notifying the MD as needed with any signs or symptoms of malignant hypertension including difficulty breathing. Record review of Resident #55's Physician Orders last captured 1/15/2025 at 9:38am revealed she was ordered and started on 01/02/2025 for Continuous Oxygen at 2-3 Liters per N/C every shift. Record review of Resident #55's January TAR revealed she had orders for Continuous Oxygen at 2-3 Liters per N/C every shift, with a start date of 1/2/2025 at 6:00pm and a discontinued date of 1/15/2025 at 12:06pm. Resident #55's oxygen saturation levels were within normal range. (continued on next page)

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	675454	A. Building B. Wing	01/16/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #55's hospital records dated 12/26/2024 revealed she was admitted for Pneumonia and Acute hypoxic respiratory failure (lungs cannot release enough oxygen into the bloodstream and can cause shortness of breath and dizziness). Resident #55 was admitted to the hospital for respiratory distress on 12/22/2024. She was placed on oxygen and was weaned off to 2 L as of 12/26/2024. The records had special instructions for Resident #55 to have O2 NC on DC . Observations of Resident #55 on 1/14/2025 at 9:39am revealed she was sleeping with oxygen. She did not appear to be in distress. Later observation on 1/15/2025 at 11:35am, revealed Resident #55 was sitting in the hallway near the entrance across from the nurse's station without an oxygen mask or tank . She appeared well-groomed and was sitting up with no discomfort. Resident #55 did not respond to questions. An interview with the DON on 1/15/25 at 11:35am, she said she will have to check if Resident #55 required oxygen and will provide an update. Another interview with the DON at 3:37 PM , she said they were already auditing Care plans yesterday and the day before yesterday (1/13/25 and 1/14/25). She said the care plans for anticoagulants and oxygen should have been there if there was an order. The DON said that the facility had 48-hours to update the plan. The DON also said Resident #55 had an order for oxygen and it should have been on the care-plan, but that she talked with the doctor and they put in a new order for oxygen as needed since her oxygen saturation levels have been stable. The DON discontinued the order after surveyor intervention. The DON said she heard the aide wheeled Resident #50 out of bed but did not place the oxygen on the resident and that she would investigate further. She also said the oxygen was on the resident's Kardex (a shortened version of a resident's care plan that aides can acccess on the electronic medical records) so the aide should have known Resident #50 needed oxygen. Later interview with the DON on 1/16/2025 at 4:11pm, she said that Resident #55's aide told the DON and she took Resident #55's oxygen off to get her changed to head outside her room and forgot to put it back on. The DON was requested to ask the aide to come into the room, the aide did not come in. Record review of the facility's Medication Administration policy implemented March 2019 read in part, Resident medications are administered in an accurate, safe, timely, and sanitary manner .Administer medications as ordered by the physician. Routine medications shall be administered according to the established medication administration schedule for the community.

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	675454	A. Building B. Wing	01/16/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 (Resident #31) of 5 residents observed for medication administration. -The facility failed to administer Resident #31's medications Furosemide and Gabapentin at the scheduled time set by the NF, 8:00AM. This failure placed residents at risk of unwanted drug interactions and decrease in quality of life. Finding: Record review of Resident #31's face sheet dated 01/16/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident diagnoses included the following: heart disease, dementia (impairment of at least two brain functions that includes memory loss and judgement), peripheral artery disease (a condition in which narrow blood vessels reduce blood flow to the extremities), hypertension (elevated blood pressure), and chronic pain. Record review of Resident #31's quarterly MDS dated [DATE] revealed resident had a BIMS score of 10 indicating that resident cognition was moderately impaired. Record review of Resident #31's Care Plan dated 12/19/2024 revealed that resident was being care planned for diuretic (medication that increases urine production by the kidneys) r/t left leg edema (swelling). The intervention included to administer medication as ordered by physician, monitor for side effects and effectiveness Q shift. Record review of the NF Medication Administration times as follows: -BID (8:00AM and 8:00PM) -TID (8:00AM, 3:00PM, and 8:00PM) Record review of Resident #31's Physician Order Summary Report for the month of January 2025 included the following medications to be administered to resident: -Dated 03/31/22 Furosemide 20mg give 1 tablet by mouth two times a day for lower extremity swelling. -Dated 08/19/2024 Gabapentin capsule 300mg give 1 capsule by mouth three times a day for neuropathy (damaged nerves) related to peripheral artery disease. (continued on next page)

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	675454	A. Building B. Wing	01/16/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #31's MAR for the month of January 2025 included the medications gabapentin and furosemide were scheduled to be administered to resident at 8:00AM. Observation of medication pass on 01/14/2025 at 10:00AM with Medication Aide E revealed she administered the medication gabapentin 300mg 1 capsule and furosemide 20mg 1 tablet by mouth to Resident #31. Interview on 01/15/25 at 3:57 PM with the DON said scheduled medications can be administered an hour before or an hour after its scheduled time. The DON said if this was not done, it was considered a medication error. The DON said the physician or NP should be notified to see if the physician needed to make any changes to the resident's medication. The DON said if the medication aide made an error, the medication aide needs to notify the nurse so that the nurse could call the physician. The DON said this was the NF protocol. The DON said the NF would also have to complete a medication error report. The DON said when a resident's medication is not given as scheduled it could cause the medication to not be as effective. The DON was asked for the NF policies on medication administration, the NF drug pass times regarding BID, TID, etc. Interview on 1/16/25 at 7:53AM with Medication Aide E said she was aware of the NF medication times and that she could administer the medication 1 hour early or 1 hour after the scheduled time. She said the reason she was late administering Resident #31's medications gabapentin and furosemide were due to her being on another hall and got behind. She said it was important to administer the medication at the appointed time to ensure that physician orders were being followed and the effectiveness of the medication. Medication Aide E said she did not notify the nurse of Resident #31's medication furosemide and gabapentin being administered late and the more she thought about it, she should have notified the nurse. Record review of a medication error form for Resident #31 dated 01/15/25 reflected that the NF had assessed resident with no adverse reactions identified and the NP was notified. Further review reflected that the NF had in-served Medication Aide E to inform the charge nurse when a resident's medication was administered late so that the physician could be contacted. Medication Aide E verbalizing understanding. Record review of the NF policy on Medication Administration revised January 2024 reflected in part: .Resident medications are administered in a accurate, safe, timely, and sanitary manner .

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	675454	A. Building B. Wing	01/16/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44669 Based on observation, interview, and record review, the facility failed to follow menus for pureed meals (lunch meal on 01/15/2025) reviewed for menus in that: The facility failed to follow the recipe for pureed diets meals prepared for the lunch meal on 01/15/2025. This failure could place residents who consume food prepared by the facility kitchen at risk of not having their nutritional needs met and/or weight loss. The findings included: In an observation/interview on 01/15/2025 at 11:26 a.m., approximately 24-pieases of 4 ounce (oz) baked tilapia on a tray in the oven. [NAME] removed 7-pieces of tilapia from the tray and placed them into the mechanical blender along with 7 pieces of bread, and broth. The [NAME] stated that she was unsure exactly how many residents required pureed diets. She then asked the interim dietary manager (IDM) who had replied that there were 10-residents eating in the dining room and another 6-residents eating in their rooms. When asked how many pieces of fish the [NAME] had blended for those residents, she stated she added 15-pieces of fish to cover the 16-residents. She stated that 16-pieces of fish would also accommodate for any double portion or second portion requests. When the [NAME] had been informed that only 7-pieces of fish were observed being blended, the [NAME] disagreed stating she had placed 15 or 16-pieces of fish in the blender. In an interview on 01/15/2025 at 11:59 a.m., with the Dietitian and the IDM, the Dietitian stated that the Dietary Manager (DM) was off shift and that IDM was filling in until DM returned. IDM stated that there were 10-residents requiring puree meals and another 6residents requiring puree meals who ate in their rooms. She stated that with 16-residents needing puree meals the total number of fish that should have been prepared for puree should have been 16 plus an add additional 7 extra pieces given a total of 23-pieces of fish. She stated that the extra pieces of fish would compensate for double portions. She stated that that the number of portions of meat was always determined by the number of residents eating pureed and then they would refer to the Daily Spreadsheet which was the recipe the followed when preparing pureed meals. In an interview/observation on 01/15/2025 at 12:05 p.m., with the Dietitian and the IDM, the Dietitian was not aware of how many oz of fish each of the residents required for each meal. She stated that she observed roughly 24-pieces of fish on the oven pan cooking in the oven. She stated if [NAME] had removed 15-pieces of fish from the tray to cover the 16-residents, that the cooking tray would have been nearly empty. She stated when [NAME] removed the fish from the oven tray she had not placed a full or near full tray of fish into the blender. She stated once the [NAME] completed blending the fish more than half a tray of fish remained. IDM stated that based on the obserthey needed to make more fish to cover all residents receiving pureed fish with their meal. She was then observed going into the freezer bringing out box of frozen fish. She then pulled out the cooking instructions for pureed food and reviewed. (continued on next page)

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	675454	A. Building B. Wing	01/16/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/15/2025 at 01:20 p.m., IMD stated that the puree fish tasted good, like flavored fish. She stated that she made another batch of fish and that was provided with the test tray. Stated that she tasted the first batch of pureed fish and it also tasted good. She stated that she could not have provided fish from the first mix of pureed fish because they had run out and had to make more pureed fish. She stated that they had enough fish to provide meals for all the residents and it was not required for more fish to have been cooked. She stated that the box of fish that was observed being taking from the freezer was placed back. In an interview on 01/15/2025 at 02:04 p.m., DM stated that she had been off shift due to illness and that the IDM had been filling her role while she was off. She stated that the facility had 16-residents that required puree diets. She stated that she placed the weekly orders for food for the facility. She stated that 1-box of tilapia contained 96-4-oz pieces of fish and more than enough to serve the present censes at the facility. She stated that pureed portions should be created to also accommodate double portions. She stated 16-pureed meals should have 16 to 24 pieces to allow for double portions. She stated [NAME] should have prepared the 96- pieces of fish, 72-pieces should have been plated leaving an overage of 24. She stated that IDM should not have opened and/or cooked any more fish, as 24-extra pieces should have covered all the residents. She stated that her staff were in-serviced as often as 1-time monthly on food preparation and following menus. She stated that importance of residents receiving that required portions was to ensure that the facility provided each resident with their required nutritional values. In an interview on 01/15/2025 at 3:51 p.m., IDM stated that it had been her understanding that [NAME] had not blended the correct amount of fish to compensate for the resident's requiring pureed meals. She stated according to the Daily Spreadsheet which was the corporate menu they followed for portion control it noted that if there were 16-residents to receive pureed fish, and the portions were per piece, each resident should have received at least 1-piece of fish. She stated that [NAME] should have pureed 16-pieces of fish. She stated that [NAME] knew to add 16-pieces, at the least and even make extra. She stated after [NAME] began plating the food, the [NAME] had to puree 10 more pieces of fish, because it had not been enough to plate all 16-residents. She stated the risk of not making enough pureed fish would that resident could lack nutritional value, and not be given what the other residents were given, and that would have been unfair. In an interview at 01/16/2025 at 10:30 a.m., [NAME] stated she had worked for the facility in the kitchen since April 2024. She stated that she had not counted the fish when she began the puree process. She stated that she believed it to have been 6 or 7-pieces of fish she placed in the blender with 6 or 7 pieces of bread and broth to feed the 10-residents eating in the dining room and the residents eating in their rooms. She stated that she should have blended 10-pieces of fish for the residents in the dining room and another 6 for the residents eating in their rooms. She stated that she had to puree another 14 or 15 pieces of fish after she was informed, she had not added enough fish to accommodate all pureed meals. She stated that the DM informed the kitchen staff daily how many pureed meals were needed, and it had also been posted on the wall. She stated she verified that the posting for 01/15/2025 read 16-pureed meals. She stated after a 01/16/2025 in-service given to her by the IDM she learned that each pureed resident needs at least 1-piece of fish each even if she adds thickener and/or bread. She stated it was importance for each resident to be feed the correct portion control and nutritional value. (continued on next page)

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	675454	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/16/2025 at 02:57 p.m., the ADM stated that staff were required to follow food recipes for residents to get proper portions of food to receive their nutritional needs. She stated that the adverse effects would cause residents to lack of nutrition would be the adverse effect of resident not receive proper portions. She stated that the kitchen staff received in-services on the importance of portion control and following recipes. In an interview on 01/16/2025 at 03:06 p.m., the DON stated that kitchen staff were to follow recipes to ensure that residents received meals with nutritional values. She stated that failure could cause residents to lack adequate diet. Record review of policy dated June 24, 2024, 08:14:34 and titled Policy Daily Spreadsheet, Corporate Baked Fish 3-oz, 1. Prepare according to regular recipe 2. Prepare until slurry 3. Process until smooth using 1-oz slurry per portion . 1. Amount of Thickener required may vary relative to liquid content of cooked product. For best results. Alternative Thickener and processing, checking product consistency periodically. 2. Nutritional analysis based on using water in the slurry. If other liquid is used nutritional analysis will vary.