STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675543	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Janisch Health Care Center	617 W Janisch St Houston, TX 77018

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675543	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Janisch Health Care Center	617 W Janisch St Houston, TX 77018

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to protect the resident's right to be free from abuse, neglect, and exploitation for 1 of 5 Halls (400 Hall) 22 of 22 residents (CR #44, Resident #2, Resident #3, Resident #4, Resident #6, Resident #11, Resident #18, Resident #20, Resident #25, Resident #28, Resident #36, Resident #38, Resident #39, Resident #43, Resident #47, Resident #48, Resident #54, Resident #56, Resident #58, Resident #60, Resident #61, Resident #66) reviewed for neglect.- On [DATE] the facility failed to timely extinguish the fire when CR #44 was engulfed in flames and failed to assess and render aid to CR #44 after the fire was extinguished. The resident expired in the facility immediately after the fire.- The facility failed to take action for over 6 months when it knew after activation of the fire system, control access doors locked and prevented staff from entering to provide services to residents in the 400 Hall without the use of a code. During a fire on [DATE], while CR #44 was engulfed in flames, staff could not access the 400 Hall to provide aide to CR #44, Resident #2, Resident #3, Resident #4, Resident #6, Resident #11, Resident #18, Resident #20, Resident #25, Resident #28, Resident #36, Resident #38, Resident #39, Resident #43, Resident #47, Resident #48, Resident #54, Resident #56, Resident #58, Resident #60, Resident #61 and Resident #66 for 3 minutes when the doors closed and locked with only CNA F on the hall.- The facility failed to ensure staff knew the unlocking mechanisms for controlled access doors in the facility that could prevent them from providing services to residents during emergency circumstances like fires. An Immediate Jeopardy was identified on [DATE]. The IJ template was provided to the Administrator and DON on [DATE] at 05:00 PM. While the immediacy was removed on [DATE], at 04:54 PM, the facility remained out of compliance at a severity level of no actual harm, with a potential for more than minimal harm that was not an immediate jeopardy, and at a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of potential smoke inhalation, fire-related burns, debilitating injuries and death. Findings included Observation of the facility time stamped security footage of the front hall dated [DATE] revealed, at 01:16 AM staff at the nursing station looked around with the doors open to the 400 Hall. At 01:17 AM staff in a blue top and black pants (CNA D) walked into the 400 Hall and shortly after 2 staff one in all black (CNA P) and one in blue walked toward the 400 Hall when CNA D runs out from the 400 Hall and to the nursing station. The staff in blue moved out of frame towards the 500/600 Hall, while CNA P walked into the 400 Hall and CNA D entered the med room located behind the nursing station, grabbed the fire extinguisher and walked into the 400 Hall. The staff in blue and 1 other staff walk into the 400 Hall behind her with the staff in blue holding the door. At 01:18 AM staff in a pink jacket (LVN I) comes out of the 400 Hall and walked in a fast pace out of frame towards the [DATE] Hall and the staff in the blue is seen at the front door looking into the 400 Hall with her hands over her mouth as a resident (Resident #4) walked out pushing her wheelchair. As Resident #4 came out of the 400 Hall the door is seen to hit her and the staff in blue held the door open and then entered the 400 hall. CNA D runs out of the 400 Hall followed by 1 other staff and was seen on the phone as the other staff moved out of frame by the 500/600 Hall. At this time Resident 4 was alone, standing while holding her wheelchair immediately in front of the 400 Hall, when CNA P walked out followed by the staff in blue. CNA P walked back into the 400 Hall and out again and the doors to the 400 Hall slowly closed behind her at 01:18:52 AM. At 01:19 AM, the staff realized the door was closed, banged on the door and attempted were seen entering a code at a keypad. At this time, LVN I entered codes at the door to the 400 Hall with 2 other staff, CNA D was on the phone at the nursing station with the staff in blue, and CNA P runs out the door with another staff. Resident #4 sat in her wheelchair in the front hall and received no assessments or evaluation as staff moved in and out of frame. At 1:21 AM an unknown resident (unknown resident #1) in a wheelchair moved toward the door of the 400 Hall, appeared to enter a code on the keypad and the door opened at 01:21: 53 AM (3 minutes after closing and 5 minutes after staff were alerted of the fire) and CNA P ran to the 400 Hall doors, held it open and smoke is seen coming out at the top the door. At 01:22:09 a resident (unknown resident #2) walked out the door, CNA P, CNA D and another staff enter into the 400 Hall as the staff in blue attempted to push the 2nd door in the double door to the 400 Hall. The door did not open and Resident #4 and unknown resident #1 who opened the door are wheeled out of frame toward the 500/600 Hall. At 01:23 AM CNA D is seen wheeling an unknown resident out the front door while unknown resident #2 is seen walking around the hall as smoke is seen coming out of the 400 Hall. CNA D, CNA P, the staff in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675543	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Janisch Health Care Center	617 W Janisch St Houston, TX 77018

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675543	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Janisch Health Care Center	617 W Janisch St Houston, TX 77018

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 22 of 22 (CR #44, Resident #2, Resident #3, Resident #4, Resident #6, Resident #11, Resident #18, Resident #20, Resident #25, Resident #28, Resident #36, Resident #38, Resident #39, Resident #43, Resident #47, Resident #48, Resident #54, Resident #56, Resident #58, Resident #60, Resident #61, Resident #66) reviewed for neglect. - The Administrator failed to report to the State Survey Agency a fire in the 400 Hall, in which 22 residents (Resident #2, Resident #3, Resident #4, Resident #6, Resident #11, Resident #18, Resident #20, Resident #25, Resident #28, Resident #36, Resident #38, Resident #39, Resident #43, Resident #47, Resident #48, Resident #54, Resident #56, Resident #58, Resident #60, Resident #61, Resident #66) were exposed to smoke and CR #44 expired, to the State Survey Agency within 2 hours. This failure could result in the state agency receiving late notification of alleged incidents of fire, resident injuries and resident deaths. Findings included: Record review of the HHSC TULIP (system to which providers report accidents and incidents) on [DATE] revealed, the facility reported a fire with a fatality on [DATE] at 05:15 AM via through an email. Reporter's Name and Title: [Administrator]; Date/Time the administrator first learned of the incident on [DATE] at 01:31 AM; Date/Time the incident occurred: [DATE], approximately 01:20 AM. This administrator was informed by the Director of Nursing that there was a fire in the facility. It was reported that a CNA saw smoke and identified a resident on fire. The fire was extinguished. The staff immediately contacted 911 and notified the DON and this Administrator. The resident's roommate was removed from the room and surrounding residents were relocated to other rooms in the facility. Upon arrival to the facility, this administrator was informed by a first response officer that the affected resident was pronounced deceased . Assessment Details: The date and time of the assessment: The resident expired Record review of the Intake Investigation Worksheet dated [DATE] revealed, the reporter states that the upper part of the resident was engulfed in flames, along with the upper left part of their bed. the fire was contained and was isolated to the resident (upper half/above the waist) and the bed. additional reporters stated that they spoke with arson investigators and ruled out the usage of cigarettes, smoking, electrical, cellphone, or parts from a lighter as the cause of the fire, at this time it is still unknown how the fire started. Observation of the facility time stamped security footage of the front hall dated [DATE] revealed, at 01:16 AM staff at the nursing station looked around with the doors open to the 400 Hall. At 01:17 AM staff in a blue top and black pants (CNA D) walked into the 400 Hall and shortly after 2 staff one in all black (CNA P) and one in blue walked toward the 400 Hall when CNA D runs out from the 400 Hall and to the nursing station. The staff in blue moved out of frame towards the 500/600 Hall, while CNA P walked into the 400 Hall and CNA D entered the med room located behind the nursing station, grabbed the fire extinguisher and walked into the 400 Hall. The staff in blue and 1 other staff walk into the 400 Hall behind her with the staff in blue holding the door. At 01:18 AM staff in a pink jacket (LVN I) comes out of the 400 Hall and walked in a fast pace out of frame towards the [DATE] Hall and the staff in the blue is seen at the front door looking into the 400 Hall with her hands over her mouth as a resident (Resident #4) walked out pushing her wheelchair. As Resident #4 came out of the 400 Hall the door is seen to hit her and the staff in blue held the door open and then entered the 400 hall. CNA D runs out of the 400 Hall followed by 1 other staff and was seen on the phone as the other staff moved out of frame by the 500/600 Hall. At this time Resident 4 was alone, standing while holding her wheelchair immediately in front of the 400 Hall, when CNA P walked out followed by the staff in blue. CNA P walked back into the 400 Hall and out again and the doors to the 400 Hall slowly closed behind her at 01:18:52 AM. At 01:19 AM, the staff realized the door was closed, banged on the door and attempted were seen entering a code at a keypad. At this time, LVN I entered codes at the door to the 400 Hall with 2 other staff, CNA D was on the phone at the nursing station with the staff in blue, and CNA P runs out the door with another staff. Resident #4 sat in her wheelchair in the front hall and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675543	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Janisch Health Care Center	617 W Janisch St Houston, TX 77018

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675543	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Janisch Health Care Center	617 W Janisch St Houston, TX 77018

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to ensure that assessments accurately reflected residents' status for 2 (CR #44 and Resident #28) of 6 residents reviewed for accuracy of assessments. The failed to ensure CR #44's left sided hemiplegia and hemiparesis (paralysis and weakness was documented accurately in her Quarterly MDS dated [DATE] as a functional limitation in range of motion and diagnosis.The facility failed to ensure that Resident #28's behavior of wandering was documented on their quarterly MDS assessment dated [DATE].Findings included:Record review of CR #44's Face Sheet dated [DATE] revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: stroke, diabetes, depression, mild cognitive impairment, high cholesterol, acid reflux. CR #44's left side weakness or paralysis was not documented. The resident expired in the facility on [DATE] at 1:45 AM. Record review of CR #44's Facility Transfer Records dated [DATE] revealed, left side weakness Care Plan: Focus- history of stroke with residual left side weakness and is at risk of future stroke. Focus- requires assistance for ADLs and mobility tasks due to history of stroke with residual left side weakness, generalized weakness, poor endurance/activity tolerance. Record review of CR#44's Quarterly MDS dated [DATE], severe impairment as indicated by a BIMS 06 out of 15, no behaviors, no lower or upper extremity limitations in range of motion, use of a wheelchair, total dependence for most mobility (Sit to lying, Lying to sitting on side of bed, Sit to stand, Chair/bed-to-chair transfer and Toilet transfer. Substantial/maximal assistance to propel herself 50-150 feet with a manual wheelchair. CR #44 was 5 feet 8 inches, and 274 lbs.Record review of CR #44's undated Care Plan revealed, Focus- is a smoker and is at risk for smoking-related injury/incident; interventions: Educate the resident and/or resident representative on the established facility smoking schedule, designated facility smoking location, and procedure and location for storage of smoking materials. Focus- has an ADL self-care performance deficit and requires cues, setup, and/or assistance with ADLs r/t Stroke; Interventions: SIT TO LYING: Resident's usual performance is DEPENDENT /MAXIMAL ASSISTANCE - Helper does more than half effort. Helper lifts or holds trunk or limbs and provides more than half the effort. BED MOBILITY: The resident is totally dependent on (X2) staff for repositioning and turning in bed, as necessary. TRANSFER: The resident requires Mechanical Lift with (X2) staff assistance for transfers. Record review of CR #44's Visual/Bedside Kardex Report dated [DATE] revealed, the resident required: substantial/maximal assistance using a wheelchair; totally dependent for chair/bed to chair transfers; mechanical lift with 2 staff assistance for transfers; total dependence on 2 staff for repositioning and turning in bed as necessary; dependent/maximal assistance to go from lying to sitting on side of bed; dependent/maximal assistance to roll left and right in bed. Record review of CR #44's Progress Notes revealed the following;- [DATE] 09:30 PM signed by LVN I, At 9:30 PM the CNA and another CNA put resident to bed with the mechanical Lift. Resident CR#44 tolerated well.In an interview on [DATE] at 01:28 PM, LVN C said CR #44 was bed/wheelchair bound, required total assistance with all ADLs, had left sided paralysis but could eat with setup/assistance. She said while the resident was grumpy, sarcastic and refused care there were no issues hoarding or hiding times. CR #44 was compliant with the facility smoking policy and would only smoke in the designated area.During interview on [DATE] at 12:39 PM, CNA L said she usually worked on the #400 hallway which was where CR #44 had resided. CR #44's left arm and leg were paralyzed, she could move her right side perfectly fine but not her left side . CNA L said CR #44 transferred out of bed to a wheelchair by using a Hoyer lift and two-person assistance. In an interview on [DATE] at 12:42 PM., LVN E said CR #44 suffered from paralysis from a previous CNA and had left sided weakness with no movement on her left side. LVN E said CR #44 was a two person assist and was transferred using a Hoyer lift. In an interview on [DATE] at 08:24 PM, the MDS Nurse said she was responsible for completing all facility MDSs. She said the MDA represents the resident's status and is usually a 7 day look back period. She said a resident's functional limitation in range of motion documents how a resident performs their day to day activities. She said failure to have the correct diagnosis or an incorrect MDS placed residents at risk for missed services and an inaccurate plan of care. The MDS said CR #44 had paralysis on one side of her body. After she reviewed the MDS, she said CR #44's MDS was coded incorrectly because it did not document her paralysis as a functional limitation of range of motion. She said she was responsible for completing CR #44's diagnosis, MDS and care plan and the errors were an oversight.Record review of Resident #28's face sheet dated [DATE], revealed the resident was a [AGE] year-old female admitted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675543	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Janisch Health Care Center	617 W Janisch St Houston, TX 77018

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675543	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Janisch Health Care Center	617 W Janisch St Houston, TX 77018

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team for 1(Resident #11) of 6 residents reviewed for care plan.Resident #11's care plan printed 9/30/25 was not revised to reflect removal of a urinary catheter with an order to remove the foley catheter on 8/13/24 and when a pressure ulcer wound resolved with a discontinued order dated 9/1/25. This failure could place residents at risk of not being able to attain or maintain their highest practicable level of physical, mental, and psychosocial well-being. Findings included:Record review of Resident #11's face sheet dated 10/1/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Other Schizophrenia (disorder characterized by hallucinations, delusions, disorganized thinking and difficulty distinguishing reality from imagination).Record review of Resident #11's quarterly MDS dated [DATE] revealed a BIMS score of 9 that indicated moderate cognitive impairment. Section H revealed Resident #11 did not have an indwelling catheter. Section M revealed 1 number of Stage 3 pressure ulcers. Record review of Resident #11's discontinued orders revealed wound care to left lower extremity with end date on 9/1/25 and order to remove Foley catheter on 8/13/24.Record review of Resident #11's August 2025 MAR revealed Remove Foley catheter with documentation on 8/13/25. Record review of Resident #11's Progress Note dated 8/13/25 at 11:37 p.m. revealed Resident #11's Foley catheter was removed at 9:45 p.m. Record review of Resident #11's Weekly Wound Observation dated 8/28/25 revealed Stage 3 pressure ulcer to left distal posterior lower leg that was closed, and wound progress was resolved. Record review of Resident #11's care plan printed 9/30/25 revealed a focus of an indwelling suprapubic catheter and actual impairment to skin integrity from a left lower leg pressure ulcer. Record review of Resident #11's order Summary Report as of 10/1/25 did not reveal any orders regarding a catheter or wound care for left lower leg pressure ulcer.Record review of Resident #11's Skin Observation dated 10/1/25 revealed no documentation regarding pressure ulcers with only documentation regarding rashes. Record review of Resident #11's care plan printed 10/3/25 no longer had a focus if an indwelling suprapubic catheter or actual impairment to skin integrity from a left lower leg pressure ulcer. This care plan was revised after surveyor intervention. Observation on 9/29/25 at 10:21 a.m. of Resident #11 revealed no visible catheter. During an interview on 9/29/25 at 11:59 a.m., LVN C said she had been the wound care nurse for the last two weeks and would be the wound care nurse for the next two weeks and then there would be someone coming to be the wound care nurse. During an interview on 9/29/25 at 12:27 p.m., LVN E said Resident #11 did not have a suprapubic catheter. During an interview on 9/29/25 at 12:39 p.m., CNA L said Resident #11 did not have a catheter. During an interview on 10/3/25 at 2:22 p.m., LVN F said if a catheter was removed or it a wound resolved then she would relay the message to the wound care nurse or ADON and they would update the care plan. During an interview on 10/3/25 at 2:33 p.m., MDS RN said the DON and ADON was who made changes to the care plan like if a resident's catheter was removed. During an interview on 10/3/25 at 2:41 p.m., DON said the nurse on the unit, herself or the ADON, was responsible for updating care plans like when a Foley catheter was removed. The DON said the wound care nurse, ADON or herself would be responsible for updating the care plan when a wound was resolved. The DON said if the care plan was not revised that it did not directly reflect the care that they were providing to Resident #11. At 3:03 p.m., the DON went to check Resident #11 as the DON said she was still learning the residents and confirmed that Resident #11 did not have a catheter. At 3:05 p.m., the DON said she removed the catheter from Resident #11's care plan. The DON said a wound should come off the resident's care plan when the wound was resolved. During an interview on 10/3/25 at 3:10 p.m., ADON said she completed the baseline care plans for new admissions. ADON said the previous DON preferred to update the care plans and attended the care plan meetings. ADON said the MDS RN was responsible for completing the MDS. During an interview on 10/3/25 at 5:23 p.m., LVN C, who was the current wound care nurse, said she was only responsible for wound care and not updating the resident's care plans. LVN C said probably DON or ADON was responsible for updating the residents' care plans regarding wound care. Record review of facility's policy Comprehensive Care Plans dated 2025 revealed The comprehensive care plans will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675543	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Janisch Health Care Center	617 W Janisch St Houston, TX 77018

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675543	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Janisch Health Care Center	617 W Janisch St Houston, TX 77018

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, based on the comprehensive assessment of a resident, residents received treatment and care and services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 13 of 22 residents (CR #44, Resident #2 Resident #3, Resident #6, Resident #11, Resident #18, Resident #20, Resident #36, Resident #43, Resident #48, Resident #54, Resident #58, and Resident #60) and 1 of 4 Halls (400 Hall) reviewed for quality of care.- Facility staff failed to immediately put out CR #44 when she was engulfed in flames with a fire extinguisher, a non-fire retardant blanket was used that worsened the fire. After the fire was extinguished staff failed to assess and render aide to CR #44. The resident expired in the facility immediately after the fire.- Facility failed to follow the facility fire safety plan when evacuating residents from the 400 hall by leaving Resident #2 Resident #3, Resident #6, Resident #11, Resident #18, Resident #20, Resident #36, Resident #43, Resident #48, Resident #54, Resident #58, and Resident #60 in their rooms during a fire on [DATE] which resulted in prolonged exposure to smoke. An Immediate Jeopardy was identified on [DATE]. The IJ template was provided to the Administrator and DON on [DATE] at 11:20 AM. While the IJ was removed on [DATE], at 04:54 PM, the facility remained out of compliance at a severity level of no actual harm, with a potential for more than minimal harm that was not an immediate jeopardy, and at a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of not receiving care and services needed to meet their needs Findings included Observation of the facility time stamped security footage of the front hall dated [DATE] revealed, at 01:16 AM staff at the nursing station looked around with the doors open to the 400 Hall. At 01:17 AM staff in a blue top and black pants (CNA D) walked into the 400 Hall and shortly after 2 staff one in all black (CNA P) and one in blue walked toward the 400 Hall when CNA D runs out from the 400 Hall and to the nursing station. The staff in blue moved out of frame towards the 500/600 Hall, while CNA P walked into the 400 Hall and CNA D entered the med room located behind the nursing station, grabbed the fire extinguisher and walked into the 400 Hall. The staff in blue and 1 other staff walk into the 400 Hall behind her with the staff in blue holding the door. At 01:18 AM staff in a pink jacket (LVN I) came out of the 400 Hall and walked in a fast pace out of frame towards the [DATE] Hall and the staff in the blue was seen at the front door looking into the 400 Hall with her hands over her mouth as a resident (Resident #4) walked out pushing her wheelchair. As Resident #4 came out of the 400 Hall the door is seen to hit her and the staff in blue held the door open and then entered the 400 hall. CNA D runs out of the 400 Hall followed by 1 other staff and was seen on the phone as the other staff moved out of frame by the 500/600 Hall. At this time Resident 4 was alone, standing while holding her wheelchair immediately in front of the 400 Hall, when CNA P walked out followed by the staff in blue. CNA P walked back into the 400 Hall and out again and the doors to the 400 Hall slowly closed behind her at 01:18:52 AM. At 01:19 AM, the staff realized the door was closed, banged on the door and were observed pressing a keypad. At this time, LVN I entered codes at the door to the 400 Hall with 2 other staff, CNA D was on the phone at the nursing station with the staff in blue, and CNA P ran out the door with another staff. Resident #4 sat in her wheelchair in the front hall and received no assessments or evaluation as staff moved in and out of frame. At 1:21 AM an unknown resident (unknown resident #1) in a wheelchair moved toward the door of the 400 Hall, appeared to enter a code on the keypad and the door opened at 01:21: 53 AM (3 minutes after closing and 5 minutes after staff were alerted of the fire) and CNA P ran to the 400 Hall doors, held it open and smoke was seen coming out at the top the door. At 01:22:09 a resident (unknown resident #2) walked out the door, CNA P, CNA D and another staff enter into the 400 Hall as the staff in blue attempted to push the 2nd door in the double door to the 400 Hall. The door did not open and Resident #4 and unknown resident #1 who opened the door are wheeled out of frame toward the 500/600 Hall. At 01:23 AM CNA D was seen wheeling an unknown resident out the front door while unknown resident #2 is seen walking around the hall as smoke was seen coming out of the 400 Hall. CNA D, CNA P, the staff in blue, LVN I and other staff wheeled other residents out the front door until 01:26 AM when fully geared fire men arrived and entered the 400 Hall. At 01:28 AM the firefighters exit the 400 Hall and return into the hall and at 01:29 AM the EMTs arrive and enter into the 400 Hall. More firefighters arrived, moved in and out of the unit, at 1:33 AM (6 minutes after the fire was identified) an EMT walked out of the 400 Hall, while a fire fighter pushed against the 2nd door to the double doored 400 Hall that remained locked in place during this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675543	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Janisch Health Care Center	617 W Janisch St Houston, TX 77018

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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675543	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Janisch Health Care Center	617 W Janisch St Houston, TX 77018

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the planned menus were followed and prepared according to the weekly menu for 6 of 6 meals reviewed for food and nutrition services.The facility failed to ensure the menu was followed for the lunch and dinner meals on 10/02/25, 10/03/25, and 10/04/25. This failure placed the residents at risk of not receiving meals that are adequate to meet their nutritional needs and a decline in nutritional health status.The findings included:Review of the facility's weekly menu, entitled Senior Living S/S Southern 2024, Week 2, revealed the following menu plan:10/02/25 Lunch: Breaded catfish, potato wedges, creamy cole slaw, wheat bread, and [NAME] hash pie10/02/25 Dinner: Roasted red pepper soup, saltines, French dip sandwich, cottage cheese, and mixed melon salad.10/03/25 Lunch: Fried Chicken, okra, cornbread, brownie mousse bar.10/03/25 Dinner: Cheese Quesadilla, seasoned black beans, southwest slaw, apple slices.10/04/25 Lunch: Baked glazed ham, au gratin potatoes, Key [NAME] vegetable blend, wheat bread, banana cupcake10/04/25 Dinner: Unstuffed peppers, roll, orange wedges.Review of the Menu board posted outside of the dining room on 10/02/25 at 11:28 AM revealed the following:lunch menu for the day: bacon maple fish, potato wedges, coleslaw, pudding.dinner menu: homemade soup, cottage cheese, melon salad, corn bread. Everyday Menu listed Grill Cheese comes with soup and side salad, Hamburgers Basket comes with fries or chips, Sandwich of the day comes with fries, chips, or soup. There was no weekly menu posted. In an observation and interview on 10/02/2025 at 12:40 PM, Resident #53 received a hamburger from the Everyday Menu as requested but no side came with the hamburger. Resident #53 did not know why she did not receive a side with her hamburger. The posted Everyday Menu has comes with fries or chips for the Hamburger Basket, which Resident #53 had ordered.In an interview on 10/03/25 at 9:30 AM Resident #53 reported she was offered broccoli cheese soup and cornbread for dinner the previous evening, 10/02/25. She declined the soup and ate cornbread with milk. She ate in her room and did not see what other residents were offered.In an interview on 10/03/2025 at 10:36 AM with the Dietary Director, she reported they served a vegetable soup with hamburger meat, cornbread, a sandwich, and the cottage cheese and melons for dinner on 10/02/25. She reported that the residents do not like roasted red pepper soup, so it was substituted for a soup with hamburger meat with vegetables because the meat makes it a more substantial meal with the protein. She reported all the changes were approved by the dietitian. They just had a quarterly meeting to review the menus with the dietitian. The menu in her office had red pen marks noting changes for each meal in the month. She said there would be a new menu coming with the changes. When asked for records of dietitian approval for menu changes, she was not able to produce any paperwork or documentation. The Dietary Director reported that the residents do not like the fancy food on the menu such as quesadillas and chicken parmesan. The residents prefer the southern cooking that reminds them of home. She also reported that she was unable to order the desserts listed on the menu due to the cost of the ingredients. The Brownie Mousse Bar was substituted for cake because they could not purchase ingredients like chocolate or purchase pre-prepared deserts like lemon cookies or tiramisu cake and stay within the budget. They make the deserts from scratch to save money. The menus are prepared by a new service provider to this facility. The menus were previously done by another company, but that contract was cancelled recently. They order food from the new vendor as well as getting the menus quarterly. She orders food by determining needs from her changed menu.In an interview on 10/03/25 at 12:22 PM the [NAME] who prepared the dinner on 10/02/25 reported there was not a sandwich served with the soup. The soup was broccoli cheddar. Grilled cheese sandwich was served as alternate meal. There was not a side served with the soup other than cottage cheese with fruit syrup on it. No fruit was served. The [NAME] reported that she cooks whatever the Dietary Director tells her is the meal. The menu is not posted in the kitchen.Review of the Menu board posted outside of the dining room on 10/03/25 at 10:06 AM revealed the following:lunch menu for the day: oven fried chicken, okra/tomato, rice, cornbread, cake with whipped topping.dinner menu: Enchiladas, southwest salad, black beans, apple slices.Review of the Menu board posted outside of the dining room on 10/04/25 at 11:26 AM revealed the following:lunch menu for the day: pork loin, au gratin potatoes, Malibu vegetable blend, rolls, chocolate chip cookies. dinner menu: Unstuffed peppers, green beans, bread, apple slices. In an interview on 10/06/25 at 12:08 PM with the Registered Dietitian for the facility, she revealed the approvals for changes of the weekly menu were made by the Regional Registered Dietitian and she had not approved any menu