

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Lawrence Street Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Lawrence Street Tomball, TX 77375	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (CR #1) reviewed for accidents and supervision. The facility failed to ensure CR #1 did not elope from the facility on 11/19/24, after being let out by staff to the patio area to smoke unsupervised. CR #1 was found by the previous Social Worker approximately 30 minutes later by a gas station. The non-compliance was identified as PNC. The IJ began on 11/19/24 and ended on 11/19/24. The facility had corrected the non-compliance before the survey. This failure could place residents at risk of elopement or injury. Findings include: Record review of CR #1's face sheet, dated 10/1/25, revealed an [AGE] year-old male who was admitted to the facility on [DATE] and discharged to a board and care/assisted living/group home on 1/1/25. His diagnosis included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities) without behavioral disturbance, peripheral vascular disease (a circulatory disorder that results from narrowed blood vessels, leading to reduced blood flow, primarily affecting the legs and feet), muscle weakness, and unspecified lack of coordination. Record review of CR #1's annual MDS assessment, dated 10/14/24, revealed a BIMS score of 9 out of 15, which indicated moderate cognitive impairment. He had no wandering behavior during the assessment period. He used a wheelchair and required set up or clean up assistance with some ADL care. He used a wander/elopement alarm daily. Record review of CR #1's Care Plan, closed on 1/23/25, indicated he was an independent smoker. CR #1 was noncompliant with the smoking policy. 11/22/24 - resident will have supervised smoking related to wander guard (date initiated 11/24/22, revised on 1/23/25). CR #1 had confusional episodes related to dementia (initiated 12/6/23 and revised on 1/23/25). Interventions were to monitor for/address environmental factors, recent changes in environment, environmental noise and commotion. CR #1 had impaired cognitive function or impaired thought processes related to diagnosis of dementia/fluctuating BIMS (date initiated 11/24/22 and revised on 1/23/25). Interventions were to ask yes/no questions in order to determine the resident's needs, cue, reorient and supervise as needed (date initiated 11/24/22 and revised on 1/23/25). CR #1 was at risk for elopement risk/wanderer related to impaired safety awareness, history of elopement. The resident had wander guard to the right lower leg (date initiated 4/11/24, revised on 1/23/25). Interventions were to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Wander alert: active wander guard alarm in place on right lower leg, visually check placement of wandering alert device during routine care (date initiated 11/19/24, revised on 1/23/25). Record review of CR #1's Physician Orders revealed orders for: Wander device: check functionality of wander alert device per manufacturer instruction every shift to alert of exit seeking attempts, order date 4/11/24; Wander Device: wander device alarm applied exp 5/10/25, order date 7/1/24. Record review of CR #1's MAR for November 2024 indicated from 11/1/24 - 11/19/24 staff documented yes for Wander Device: Check functionality of wander alert device every shift. A yes was documented from 11/1/24 - 11/17/24 (a.m.) and 11/18/24 - 11/19/24 for wander (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675701
		If continuation sheet Page 1 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Lawrence Street Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Lawrence Street Tomball, TX 77375	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	device: visually check placement of wandering alert device every shift. There was one NA documented on 11/17/24 on the night shift for wander device: visually check placement of wandering alert device every shift. (there was no definition for NA provided on the MAR)Record review of CR #1's Smoking Safety Review, dated 11/4/24, revealed a score of 6, which indicated he was not at risk for smoking-related incidents.Record review of CR #1's Elopement Risk Screener, dated 11/13/24, indicated he was low risk for potential elopement. Interventions included an electronic wander device and homelike environment.Record review of CR #1's IDT note, dated 11/13/24, written by the DON read in part, .Resident has wander guard.Record review of CR #1's Care Conference, dated 11/15/24, revealed a meeting was held on 11/15/24 at 1:00 p.m. regarding CR #1. An RN, Social Worker, Nursing Administration, Family, and Administration attended. The conference indicated CR #1 was found smoking paraphernalia in his room. He was reeducated on the smoking policy. His BIMS was a 9, which indicated moderate cognitive impairment.Record review of CR #1's Psychological Services Progress Note, dated 11/19/24 at 9:04 a.m., indicated CR #1 had a mild cognitive decline. His Mental Status Examination indicated he was oriented to person, place, and time. His speech organization was appropriate, and his judgement was within normal limits.Record review of CR #1's Behavior Note, dated 11/19/24 at 3:45 p.m., and written by previous Social Worker, read in part, .Resident was reported to have eloped from smoking area at back of facility, on foot and left WC behind, around roughly 1500 (3:00 p.m.) to management. Resident was located about 1530 (3:30 p.m.), behind nearby gas station on foot by SW. Resident immediately recognized SW and asked for help back to facility. When SW asked resident about leaving facility, resident reported he left his WC in smoking area because he did not want to push it and left to go get smokes and a beer bc he could not find any staff to go for him. Reresident (sic) was transported back to facility and then assessed by team and has been moved to memory care unit.Record review of CR #1's progress note, dated 11/19/24 at 4:10 p.m., written by the DON, read in part, .Resident returned from being off premises and is in no distress. He is alert and oriented to x 3. Resident's mood and affect are appropriate, and he is calm. He has no visible injuries or signs of trauma. Vital signs are stable. Staff will continue monitoring per care plan and ensure ongoing communication with resident about safety protocols.Record review of CR #1's BIMS, dated 11/19/24 at 4:20 p.m., revealed a BIMS score of 15 out of 15 which indicated intact cognition.Record review of CR #1's Outpatient Psychiatry Progress Note, dated 11/25/24, read in part, .Staff report resident leaving facility unplanned exit recent during the smoke break going to store. Resident was brought back assessed no injuries, educated such behaviors are unacceptable due to safety concerns without staff or family member on pass. GDR not attempted contraindicated at this time due these exit seeking behaviors apparently have been going on for some time, will monitor resident closely wander guard in place. mental status examination:. pleasantly confused.alert to person, situation.short term memory: moderately impaired. concentration and judgment: fair. Gait & Station: Unsteady, wheelchair mobility. Fund of knowledge: impaired.In an interview on 10/1/25 at 1:07 p.m. the SLP said on the day of the incident with CR #1 (11/19/24), she put the code in to unlock the door. She let approximately 5 residents out of the building to smoke and returned to her work. She said she questioned where CR #1 was when the other residents came back in the building. She said she saw CR #1's empty wheelchair but did not see him. She said she went outside to look for him and the fence gate was completely open. She said she ran back inside and told staff and started to search for CR #1. She said the previous SW found him at a gas station. The SLP said when she started working at the facility the Rehab Director instructed her if residents requested to go outside to smoke, they were allowed to and no one ever supervised them. She said it was not her responsibility to supervise the residents while smoking and no one said she had to sit outside with them. She said her orientation did not include any information on smoke break times and there was no list of residents who smoked. She said special supervision was provided to residents with wander guards. She said she was not familiar with CR #1 and did not know he had a wander guard. She said the alarm did not sound when the residents went outside to smoke. She said she was unsure if CR #1 was in (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Lawrence Street Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Lawrence Street Tomball, TX 77375	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the group of residents she let out or if he was let out by another CNA who put in the code and walked away. She said the alarm was supposed to sound and she would have been alerted to the wander guard. She said she did not check the perimeter gates before letting the residents out and said the gate lock was broken. She said she never saw CR #1 try to leave the facility before and was unaware of any plans for CR #1 to leave the facility. She said there was no risk to CR #1 smoking unsupervised with a wander guard because he did it multiple times before. She said after the incident occurred the facility provided an in-service on wandering, wander guards, resident rights, and smoke times. She said she was told CR #1 had a wander guard during the in-service. She said the facility implemented newly assigned smoking times where CNAs must supervise the residents. She said the next couple of days after the incident the facility checked to ensure all wander guards worked properly. In an interview on 10/1/25 at 1:54 p.m. the DON said CR #1 eloped from the back of the facility where the smokers were. She said he was in his wheelchair most of the time, the staff did not see him, he had gotten up out of his wheelchair and was walking. She said in a short amount of time he went down the road to the store to buy cigarettes. She said the staff drove around to look for him and saw him at the store then brought him back to the facility. She said CR #1 was forgetful and had cognitive issues but could understand and showed he was safe. She said he was appropriate to smoke alone. She said CR #1 was aware of what he was doing and the facility staff explained to him he could not do that (leave the facility). She said before the incident occurred, they never saw him do anything like that and were not expecting him to leave the building. She said CR #1 was safe and showed he was more cognitive than they thought. She said a long time ago he had a wander guard when he came but was not exit seeking. She said he never left the building but would wander. She said CR #1's family member informed them in the past, he left his personal home overnight and the family could not find him. She said he had a wander guard because he was monitored. She said residents with wander guards had orders in place to check functioning and expiration dates. She said staff should check the alarms with the wander guard to ensure they worked. She said there was a book that listed residents at risk of elopement. She said residents with wander guards never went outside by themselves and there was always someone outside with the residents. She said someone needed to supervise a resident with a wander guard who smoked and would not want residents with a wander guard to go off on their own. She said the smoking protocol was the same prior to and after the incident. She said residents would go outside to smoke at posted times and a staff member would stay and monitor. She said she was unsure if a staff member stood near the door the day CR #1 eloped. She said there was never a time when residents smoked unsupervised for safety reasons. She said staff were trained on the smoking protocol. In an interview on 10/1/25 at 2:16 p.m., the DON said at one point CR #1 was on the memory care unit and then transitioned to the long-term care side. She said he had no previous incidents or risk and had not exit-sought in a while. She said she could not remember if the wander guard alarms were working the day he eloped. She said he did not sign himself out of the facility to go to the store but probably could have but not if he had a wander guard on. She said technically there was a reason for the wander guard because at some point he was exit seeking. She said there were changes made after the incident. The facility took the incident to QAPI. She said in-services were conducted with staff on elopement alarms, wander guard monitoring, and smoking policy. She said the facility updated the wander guard book and in-serviced staff on its location. She said they conducted a mock elopement that went well. In a telephone interview on 10/1/25 at 2:26 p.m., the previous Administrator said when she was the Administrator residents were assessed to see if they could smoke independently. She said residents who smoked independently were let out and let back in by staff but could smoke unsupervised. She said if a resident smoked and had a wander guard they would not have passed the smoking assessment to smoke independently to her knowledge. In a telephone interview on 10/1/25 at 2:32 p.m., the Rehab Director said residents with wander guards were supervised outside and did not go out alone. She said the alarm would sound. In an interview on 10/1/25 at 2:56 p.m. the Director of Maintenance said all the facility doors were equipped with (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Lawrence Street Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Lawrence Street Tomball, TX 77375	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	alarms. He said the alarms were working at the time of the incident and were checked once per week. He said the back gate was not part of the wander guard system. He said after the incident with CR #1 the facility installed an alarm on the back gate for awareness. He said after the incident the facility replaced the old short fence with a taller fence. He said the facility also ensured no residents went outside without supervision. In an interview on 10/1/25 at 3:24 p.m., the Administrator said he started working for the facility in October of 2024 and was only there for one month when the incident happened with CR #1. He said CR #1 was out smoking with the residents when therapy staff realized his wheelchair was there, but he was not. He said staff searched for him but did not see him on the premises. He said approximately 30 minutes later CR #1 was spotted coming back from the convenience store. He said CR #1 could not understand why facility staff was so concerned because he just went to get beer and cigarettes. He said CR #1 could hold a conversation and had a wander guard. He said there was no policy in place during the incident that he was aware of that required supervision for residents with wander guards but said he did not want them to get into dangerous areas. He said he was unsure of what training staff had on wander guards prior to the incident and was unsure of any issues with the alarms prior to CR #1's incident. He said the incident was taken to QAPI and there was a policy change. He said when he reviewed the previous smoking policy, he did not recall seeing anything about staff staying outside with the residents but now everyone must be supervised. He said staff were educated that residents who had a wander guard in place needed to be supervised while outside. He said staff were made aware of which residents wore wander guards by the binder at the nursing station and the physical wander guard. He said an alarm was placed on the back gate and the height was increased. He said there would never be a time a resident would be outside by themselves. In a telephone interview on 10/2/25 at 11:44 a.m. CR #1's MD said CR #1 had mild cognitive dysfunction. He said CR #1 wandered off and purchased some items (from the store). He said the resident was quite functional but there was some cognitive decline. He said no one was allowed to just wander off from the facility and it was not routine practice to leave the facility. He said CR #1 might have had a wander guard at that point. He said a wander guard in place meant there was some element of concern and would have to review the chart to see why CR #1 needed the wander guard. He said residents needed to be monitored while smoking and an employee had to be outside with them. In a telephone interview on 10/2/25 at 3:33 p.m., the previous SW said when she found out CR #1 was missing, she went to the local corner store because he had asked her previously to get him something from the store. She said she found CR #1 behind the gas station leaning against a pole trying to catch his breath. She said the gas station was located near the main road. She said CR #1 was with it and knew what he had done but should not have been walking that far. She said he was mentally well enough to go to the store and back. She said he had a wander guard because of how he was at home, so he was an elopement risk. She said that was the first time in 2 years he left the building and never threatened to leave before. She said he previously resided on the memory care unit for being sexually inappropriate and exit seeking but said she was not sure. She said when he transitioned to the general population they placed a wander guard on him. She said she was unsure if the need for the wander guard was ever re-evaluated. In a continued telephone interview on 10/2/25 at 3:46 p.m., the previous SW said the residents who smoked were supposed to be supervised by nursing staff. She said the speech therapist was not responsible for watching them. She said around the time of the incident the back gate was messed up, the alarm would not sound, and it was easy for CR #1 to get out. She said the rehab door alarm would mess up but eventually the company came out to rewire everything. She said the wander guard would also not go off at times. She said after the incident it was strictly enforced that someone had to supervise the residents while smoking. She said residents with wander guards should also be supervised. In an interview on 10/2/25 at 4:45 p.m., the DON said she could not remember if CR #1 was reassessed to see if the wander guard was still needed prior to the elopement. In an interview on 10/2/25 at 5:16 p.m. the Administrator said if CR #1 had a wander guard in place he was at high risk for elopement and supervision was needed. In an (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Lawrence Street Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Lawrence Street Tomball, TX 77375	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	interview and record review on 10/2/25 at 5:31 p.m. the MDS nurse said on the day of the incident CR #1 had a BIMS score of 15 (cognitively intact). She said the facility could not just take someone off the wander guard but had to monitor. She said the facility was educating CR #1 on the facility processes such as signing out and signing in the facility. She said only cognitively intact residents could sign in and out of the building. She said if the resident had moderate cognitive impairment a staff member could take them to the store. Record review of CR #1's BIMS revealed his cognition was assessed as moderately impaired in the three months prior to his elopement: 7/4/24 (BIMS score 12 out of 15), 9/3/24 (BIMS score 10 out of 15) and 10/14/24 (BIMS score 9 out of 15).Record review of the facility's Smoking Policy and Procedure policy, dated 12/19/17 and signed by CR #1 on 8/5/24, read in part, .Policies: . 2. All smokers will be assessed upon admission and as their cognitive and/or physical status mandates. 3. Residents who have been assessed will only use tobacco products with supervision at the appointed smoking times. Procedure: . 2. A staff member will accompany and supervise all residents during designated smoking times, as staffing levels permit.Record review of the facility's, undated, Resident Alarms policy read in part, .The use of alarms does not eliminate the need for adequate supervision of the resident. Types of alarms include. e. Wander/elopement alarms - includes devices such as bracelets. that alert the staff when the resident nears or exits an area or building.6. Monitoring and modification a. supervision shall be provided to the resident in accordance with the resident's plan of care. b. when alarms are utilized, additional monitoring shall be provided, including but not limited to: i. verifying alarms are used in accordance with the resident's care plan. ii. Verifying alarms are working properly. c. ongoing assessment of the resident shall occur to identify changes in patterns, routines, or medical symptoms of the resident. Interventions shall be modified, as needed, to address any changes. D. Considerations for discontinuation of alarms include, but are not limited to: i. the medical symptoms or risks warranting the use of the alarms are no longer present. li. The risks associated with the use of the alarm outweigh the benefit. lii. Evidence of adverse consequences associated with the use of the alarms. Iv. Resident/family goals and preferences change. It was determined this failure placed CR #1 in an IJ situation from 11/19/24 to 11/19/24. The Administrator was notified and provided with the IJ template on 10/2/25 at 5:12 p.m. The facility took the following action to correct the non-compliance beginning on 11/19/24. Record review of the provider investigation report, signed 11/27/24, read in part, . -The Resident's physician and responsible party were notified of the incident. At approximately 4:00 p.m. the DON performed a full body assessment and noted no injuries or significant changes in condition. SW conducted BIMS 15 (cognitively intact) PHQ -9 score of 0 (no signs of depression). -IDT discussed the incident and determined that updating the smoking protocol was necessary. The Administrator changed smoking times to include a time when sessions would end. The Administrator assigned staff members to be present during each smoking session. The designated smoking times and assigned staff were posted at the nurse's station. -The team reviewed care plans for each resident who smoked. The DON implemented a binder containing a photograph of residents requiring special supervision while smoking. The binder will be kept at the nurse's station. The team determined to place red star stickers on smoking bins to further identify residents requiring special supervision while smoking.-The community initiated training of staff in new processes.-The Administrator suspended smoking sessions until substantial training had been completed .-The Administrator placed (SLP) on suspension until further notice.-The Administrator was informed by Maintenance Director that city fire codes prohibit the gate located in the smoking area from being locked. The Maintenance Director and Administrator inspected the Resident Monitoring Systems and did not find any concerns . -The Community continued to monitor the safety and wellbeing of (CR #1)-No additional incidents were reported.-Nurse Managers continued to review resident care plans and smoking assessment protocols. The community continued to conduct staff training. The community monitored compliance with newly implemented smoking supervision protocols due to reinstatement of smoking sessions.-The Administrator met with (CR #1) to discuss the community's smoking and discharge (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Lawrence Street Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Lawrence Street Tomball, TX 77375	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and out on pass protocols. (CR #1) stated that he was coming back and that he just ran to the store.-The incident was reported to Texas Health and Human Services.-The Medical Director visited (CR #1) and mentioned that the resident's cognition is intact.-The DON conducted Elopement Drill. The drill was conducted without concern.-The Regional Maintenance Director inspected the gate located in the smoking area. He gave reports of plans to replace the gate with more height and add an alarm system. No additional concerns reported.Investigation Summary: The community has conducted a root cause analysis related to the incident. The community has amended the smoking protocol to enhance the identification of residents requiring supervision. The community has updated its smoking schedule and established a supervision rotation to promote compliance. The community has educated staff on elopement prevention and the role the updated smoking protocol will play in prevention. The community conducted an elopement drill that had a positive outcome. The community continues to assess (CR #1's) cognitive and functional levels and consult with healthcare providers and responsible parties to continue to promote the least restrictive environment in accordance with the Resident's care needs. The community has educated (CR #1) and other residents on the purpose of Out on Pass, Transfer and Discharge protocols. The community will continue to monitor the effectiveness of the interventions during its quality assurance meetings.Record review of the facility's Smoking Policy - Residents, Elopements, responding and prevention in-service dated 11/19/24 revealed there were approximately 56 staff signatures. The inservice contained protocol on the smoking policy and managing wandering and elopements. Record review of the facility's Resident Smoking Times effective 11/19/24, revealed times and staff who would supervise residents were listed.Record review of the Logbook Report - Resident Monitoring Systems: Check operation of door monitors and patient wandering system, dated 11/19/24, revealed the alarms were checked monthly by the Maintenance Director.Record review of the facility's Wander guards - policy and procedures in-service, dated 11/20/24, revealed there were approximately 52 signatures. The in-service read in part, .residents with wander guards in place should never leave the building without supervision. WG shall be monitored by all staff and should be reported to mgt if malfunctioning or in case of removal by resident or if it is not secure. The list of residents with WG is located at nurses station in a blue binder. These devices are used to monitor residents who are at risk of wandering or elopement. Failure to comply with this policy could result in serious safety risks for the resident. It is the responsibility of all staff members to prioritize the safety of residents at all times.Record review of the Elopment Drill Documentation Form revealed it was conducted on 11/22/24. The document read, . The drill was very organized and effecient (sic). All residents were accounted for. 13 staff participated in the drill.Record review of the facility's 1:1 Training Smoker Safety Resident Elopement Precaution, dated 12/2/24, read in part, .(SLP) received training on updated elopement prevention and smoking protocol. (SLP) understands that resident with wander guard should always be supervised while in the smoking area or outside the community. (SLP) understands that changes or exceptions to the protocols must come in writing from the Administrator or member of the corporate team. The in-service was signed by SLP.Record review of the Elopement Risk binder located at the nursing station which contained 3 residents and their clinical information in it.In an observation and interview on 10/1/25 at 11:35 am revealed CNA S was outside supervising residents during their smoke break. CNA S said she ensured the residents remained safe while outside smoking.In an observation on 10/1/25 at 11:38 a.m. of the back gate revealed a tall brown fence with a magnetic lock. In an interview on 10/1/25 at 11:43 a.m. RN A said if residents were outside on the back patio there was always a staff member present.In an interview on 10/2/25 at 1:01 p.m., CNA J said she was trained on wander guard procedures. She said the alarm would sound if any resident with a wander guard approached the door. She said there was a list of residents who had wander guards at the nursing station. She said if the alarm was not working, she would immediately report it to the Maintenance Director. She said if there was an elopement she would start a head count, determine who was missing and check for the resident around the building. She said if an alarm sounded, she would stop (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Lawrence Street Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Lawrence Street Tomball, TX 77375	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	what she was doing and ensure the patients were safe. In an observation on 10/2/25 at 4:45 p.m., with the Maintenance Director and DON revealed the door alarms for halls A, B, and E were functioning and the doors were locked. The alarm would beep if the door bar was pushed. All doors had codes that were required to unlock the door. The code panel was deactivated if a wander guard was in the vicinity. In an interview on 10/2/25 at 4:58 p.m., LVN D said she was trained on elopement protocol, wander guards, and smoking protocols. She said there was a book behind the desk with names and pictures of the wanders with guards. She said the procedure was to search the building and its parameters. She said it was important to be alert and aware of the alarm. She said orders were in place to check wander guards for functioning every shift. She said the new smoking protocol included specified times and staff designated to take residents out. She said the back door was secured at all times and residents were not allowed outside to smoke until specified times and only while supervised.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Lawrence Street Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Lawrence Street Tomball, TX 77375	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal Laws, drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 19 residents (Resident #4) reviewed for drug labeling and storage. The facility failed to ensure Resident #4's medication was not stored on the resident's nightstand. This failure could place residents at risk of adverse reactions and drug diversions. Findings included: Record review of Resident #4's face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE] with a recent re-admit on, 02/01/2025. Resident #4 had diagnoses which included dry eye syndrome, restlessness and agitation, sleep disorder, muscle weakness, asthma, chronic congestive heart failure (a heart is unable to pump enough blood to meet the body's needs), type 2 diabetes, and dementia. Record review of Resident #4's Quarterly MDS, dated on 09/10/2025, revealed a Brief Interview for Mental Status (BIMS) score of 14 of 15, which indicated no impairment. Record review of Resident #4 Medication Administration Record dated for 09/2025 revealed the resident was prescribed the following medications in the morning, Tylenol Oral Tablet 4 mg , amlodipine Besylate Oral Tablet 10 MG, Apixaban Oral Tablet 5 mg, Asboric Acid Oral Tablet, Aspirin Oral Capsule 81 mg, Brumetanide Oral Tablet 2 mg, Cyanocobalamin Oral Tablet 500 mg, DULoxetine HCl Oral Capsule Delayed Release Sprinkle 30 mg, Empagliflozin Oral Tablet 25 MG, Gerrous Sulfate Oral Tablet, Folic Acid Oral Tablet, Isosorbide Mononitrate Oral Tablet 20 mg, Losartan Potassium, Oral Tablet 50 mg, Potassium Chloride ER Oral Tablet Extended Release, Toprol XL Oral Tablet Extended Release 24 hour 25 mg, Azelastine HCl Nasal Solution 0.1%, and cyclosporine Ophthalmic Solution. Observation on 09/30/2025 at 10:58 AM of Resident #4's nightstand revealed a plastic cup with approximately 10 pills, 1 nasal spray, and one eye drop, which were unattended. In an interview with Resident #4 on 09/30/2025 at 11:00 AM, revealed Resident #4 the medications on the nightstand belonged to him. Resident #4 stated the medication tech left them on the nightstand for him to take once he returned to his room and stated it was CMA M who left them on the nightstand. Resident #4 stated CMA M didn't normally leave the medications on his nightstand and the medications were possibly unattended for 10-15 minutes. In an interview with the DON on 09/30/2025 at 11:06 AM, revealed leaving medications unattended could put the resident at risk by mistakenly taking medications that were not prescribed to them, or another resident passing by could access and take the medications. The expectation for the nurse or medication aide was to stand near the resident and be with the resident the entire time to watch the resident take the medication. Once the resident took the medication, the nurse or medication aide must document. Resident #4 was not eligible for self-administered medication. In an interview with CMA M on 09/30/2025 at 11:09 AM, revealed CMA M stated this morning (09/30/2025) she had the medications ready outside of the room, but housekeeping was cleaning the room. CMA M stated she did not pre-pop medications and when she saw the resident going towards his room, she went into the room and sat Resident #4's medication on the nightstand. CMA M stated she knew better to leave medications unattended, but she knew the resident was going to the room so she left them on the nightstand for him to take once he entered the room. CMA M stated the risk for Resident #4's medication being unattended and not monitored is someone else taking the medication, or a possible choking hazard. The expectation for medication pass was to wash hands, take vitals, administer medication, watch the resident take the medication, wash hands, and document. In an interview with ADMN on 09/30/2025 at 2:16pm, the policy for medications is to always be kept safe and always secured. AMDN stated to his knowledge, residents need to be accessed to know if they can be self-administered. The risk of leaving medications in the room is the resident not taking the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675701	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Lawrence Street Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 615 Lawrence Street Tomball, TX 77375	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication. Record review of the facility's, undated, policy titled, Medication Storage revealed, General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.		