STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676059	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Westchase	11910 Richmond Ave 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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a baseline for each resident that included instructions needed to provide effective and person-centered care for the resident that met professional standards of care within 48 hours of the resident's admission for 1 of 5 residents (Resident # 1) reviewed for care plans. The facility failed to develop a comprehensive care plan which addressed and included measurable objectives and timeframes related to Resident # 1's pressure wound of the left lateral thigh (a position or direction that is away from the midline or middle of the body) thigh which she had since her admission 4/24/2025. This deficient practice could affect any resident and contribute to residents not having their needs met according to their assessment. The findings were: Review of Resident # 1's face sheet, dated 6/5/2025, revealed she was admitted to the facility on [DATE] with diagnoses including: Conversion Disorders with Seizures or Convulsions (functional neurological symptom disorder), Schizophrenia (a chronic brain disorder that affects a person's ability to think, feel, and behave clearly), Bipolar Disorder (a mental illness characterized by extreme shifts in mood, energy, and activity levels, impacting a person's ability to carry out daily tasks), Muscle Wasting and Atrophy (the decrease in size and strength of muscle tissue). (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident # 1's Care Plan initiated on 4/28/2025 revealed there was no indication that Resident # 1 had a pressure wound of the left lateral thigh. This care plan revealed the following: focus-Resident # 1 had a Urinary Tract Infection and was at risk for adverse reactions. The goal was Resident # 1's Urinary Tract Infection would be resolved without complications by the review date. The interventions were to check resident during rounds for incontinence, encourage adequate fluid intake, give antibiotic therapy as ordered, observe/document/report to MD for s/sx of UTI: frequency (how often something occurs or repeats over a specific period of time) , urinary urgency (a sudden, compelling urge to urinate that is difficult), malaise (pain), foul smelling urine, dysuria (painful or burning urination), fever (a temporary increase in body temperature, usually above 100.4°F (38°C), and is often a sign that your body is fighting off an infection), nausea and vomiting (common symptoms that can be caused by a variety of factors, including infections), flank pain (pain in the side of the body, specifically between the lower ribs and the hip), Supra-pubic pain (pain in the lower abdomen above the pubic bone), hematuria (blood in urine), cloudy urine, Altered mental status (a change in a person's level of awareness, thinking, or behavior). Females to wipe and cleanse from front to back. Clean peri area well after bowel movement. Review of Resident #1's MDS assessment, dated 4/28/2025, revealed her BIMS score was 13 of 15 reflecting Resident # 1 was cognitively intact; she required partial assistance with self-care, indoor mobility and functional cognition; substantial/maximal assistance with lower body dress, shower/bathing; partial/moderate assistance with upper body dress, oral hygiene and eating, roll left to right, sit to lying, lying to sitting, sit to stand, chair/bed to chair transfer and walk 10 feet; always incontinent with urinary and bowel. Resident # 1 was at risk of developing pressure ulcers/injuries. Resident # 1 had one or more unhealed pressure ulcers/injuries; 1 stage 4 pressure ulcer present upon admission, and MASD; pressure ulcer/injury care, and applications of ointments/medications. Record review of Resident # 1's , Wound Care Physicians progress notes, dated 4/30/2025, 5/2/2025 and 5/9/2025, revealed Resident # 1 had a wound on her left lateral thigh. Record review of local hospital Physical Exam, dated 4/23/2025 revealed Resident # 1 had a pressure ulcer left buttock (stage III/unstageable-the ulcer is so covered with slough or eschar that the full depth of tissue damage cannot be assessed). Record review of local hospital Physician's Attestation, dated 4/20/2025, revealed Resident # 1 had a large pressure ulcer on left buttock: at least stage III/unstageable. No sign of active infection. Continue local wound care. Will get wound care consult. Turn patient every 2 hours. Record review of Internal Medicine Physician's progress notes, dated 4/26/2025, revealed in part [Resident # 1] had a stage 3 ulcer on left buttock and follow up recent Sepsis (a life-threatening condition that arises when the body's response to an infection spirals out of control, damaging its own tissues and organs)/UTI/Syncope (a temporary loss of consciousness caused by a sudden decrease in blood flow to the brain) and possible seizure (a sudden, temporary change in brain activity that can cause a variety of effects, including muscle spasms, loss of consciousness, and changes in behavior or awareness). Record review of ambulance communication form for Non-Emergency Transports, dated 4/24/2025, revealed that Resident # 1 was transported from a local hospital to the nursing facility. Resident # 1 was bed confined and could not support herself while seated in a wheelchair due to seizures, weakness and unable to ambulate. Resident # 1 had a pressure ulcer. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN A on 6/6/2025 at 11:54 am she stated that she provided care to Resident # 1 two or three days before Resident # 1 was discharged to the local hospital. She stated that Resident # 1 did not have a UTI. She stated that Resident # 1 had a pressure sore on the sacrum area (the region of the lower back, specifically the part of the spine located at the base of the lumbar vertebrae) She stated that she did not know when Resident # 1 developed her pressure ulcer. She stated that she reviewed the care plans for every resident that she provided care to. In an interview with LVN C on 6/6/2025 at 3:56 pm she stated that she provided care to Resident # 1. She stated that Resident # 1 did not have a UTI. She stated that Resident # 1 was admitted with a pressure sore on the left hip. She stated that a wedge was used as a pressure ulcer prevention. She stated that Resident # 1 was also repositioned every two hours. She stated that she did not observe Resident #1's pressure ulcer as the wound care nurse provided care to this ulcer. She stated that she reviewed her resident's care plan. She stated that Resident # 1 was care planned for the pressure ulcer. In an interview with the Wound Care Nurse on 6/6/2025 at 4:19 pm he stated that he provided wound care to Resident # 1. He stated that Resident # 1 was admitted to the nursing facility on 4/24/2025 with a pressure ulcer to the left hip He said that the wound care Physician ordered Santyl on 4/25/2025 and they proceeded with treatment which was once daily. He stated that he put the interventions in place and educated Resident # 1. He stated that Resident # 1's pressure ulcer was located on the left lateral thigh. He stated that the pressure ulcer interventions included positioning pillow and wedges to offload. He stated that Resident # 1's interventions were documented on Resident #1's care plan. He stated that the MDS nurse completed the care plan. In an interview with RN A on 6/6/2025 at 4:48 pm she stated that she was the MDS and Care Plan coordinator. She stated that she completed the MDS for all residents. She stated that she completed the Care Plan for Long Term Care residents. She stated that the Care Plan for SNF residents was completed by another nurse and this nurse was no longer with this nursing facility. RN A stated that she completed the MDS for Resident #1 and the MDS reflected that Resident # 1 had a pressure ulcer. She stated that she did not complete the Care Plan for Resident # 1 and she did not know why Resident # 1 was not care planned for a pressure ulcer. She stated that the wound care nurse also completed the care plan for residents who were receiving wound care. RN A stated that all residents should have an individualized care plan as this would ensure effective and personalized care was provided to the resident. In an interview with the DON on 6/6/2025 at 5:00 pm she stated that Resident # 1 was admitted to the nursing facility for skilled nursing. She stated that Resident # 1 was admitted with a pressure ulcer. She stated that she could not remember where the pressure ulcer was located. She stated that Resident # 1 was seen by the Wound Care Physician the following day after she was admitted . She stated that Resident # 1 had wound care treatment every day. She stated that the Wound Care Physician visited Resident # 1 once a week. She stated that Wound Care or MDS nurse should have completed the care plan for Resident # 1. The DON stated that she did not know why Resident # 1 was not care planned for the pressure ulcer. She stated that Resident # 1 had an UTI prior to her admission to the nursing facility. She stated that Resident #1's UTI was resolved prior to admission. She stated that she did not know why Resident was care planned for a UTI. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Wound Care Nurse on 6/11/2025 at 9:30 a.m., he stated he completed care plans within 21 days of admission and in the care plan he documented the wounds; this was for all residents with wounds. He stated that Resident # 1 did not have a care plan as they had 21 days to complete the care plan, and Resident # 1 was discharged from the facility on the 21st day. He stated that Resident # 1 went to the hospital for abnormal laboratory values. He stated that the day Resident # 1 was hospitalized , Resident # 1 was scheduled to be seen by the wound care Physician, but Resident # 1 went to the hospital before the Wound Care Physician could see her. He stated that Resident # 1 did not acquire any additional wounds while in house. He stated that Resident # 1 did not have a wound vac (a medical device that uses suction to help heal wounds that are slow to close) while at this facility. In an interview with RN B on 6/11/2025 at 12:55 p.m., she stated the wound care nurse did the care plan for wounds. She stated that the care plan should be completed within 20-21 days upon admission. RN B stated that if a Resident was admitted with a wound this would be included in the baseline care plan. She stated that Resident # 1 had one wound on admission, and she did not know how many wounds Resident # 1 had when she was discharged from the facility. RN B denied providing wound care to Resident # 1. In an interview with the Administrator on 6/11/2025 at 2:53 pm, she stated that care plans were completed by the MDS coordinator. She stated that she did not know why Resident # 1 was not care planned for a pressure ulcer. \ Record review of the facility's Care Plans, Comprehensive Person-Centered, policy revised December 2016, revealed in part A comprehensive, person-centered care plan that includes measurable objectives ad timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident 8) The comprehensive, person-centered care plan will a) include measurable objectives and timeframes; b) describe the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental and psychosocial well-being; c) include the resident's stated goals upon admission and desired outcomes; g) incorporate identified problem areas; incorporate risk factors associated with identified problems; 10) identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident and the endpoint of the interdisciplinary process; 12) the comprehensive, person-centered care plan is developed within seven days of the completion of the required comprehensive assessment (MDS).