

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
NAME OF PROVIDER OR SUPPLIER Park Manor of Westchase		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record reviews, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 5 residents (CR #1) reviewed for supervision. The facility failed to provide sufficient supervision to CR#1 on 01/31/2026 at 8:00pm, he was located at approximately 7:00 AM on 02/01/2026, approximately 7 miles from the facility, in the parking lot of a local Emergency Care Center. Upon discovery, CR #1 had sustained a laceration to his right eye, suspected to be from a fall. CR #1 required hospitalization from 02/01/2026 through 02/02/2026. These failures could result in residents not receiving appropriate supervision leading to elopement, injuries, hospitalization, or death. The noncompliance was identified as PNC. The noncompliance began on 01/31/2026 and ended on 02/02/2026. The facility had corrected the noncompliance before the survey began. Record review of CR #1 Facesheet revealed a [AGE] year-old male, was admitted on [DATE] with diagnoses including vascular dementia (block blood flow to your brain) and discharged from the facility on 02/01/2026 to local acute hospital. Record Review of CR #1's MDS dated [DATE] indicated that Resident #1 had a Brief Interview for Mental Status (BIMS), score of 9 out of 15, indicating moderate cognitive impairment. He had no behaviors, including wandering, and required partial/moderate assistance with transfers with ADLs. Record review of CR #1 physician order with order start dated of 01/16/2026 revealed CR #1 may go out on pass with medications. Record review of CR #1's comprehensive care plan initiated on 01/26/2026 did not include a care plan identifying CR #1 as an elopement risk prior to the occurrence of the elopement on discharge on [DATE]. Record reviewed of skilled nursing note dated, 01/28/2026 at 11:24pm noted no exit seeking behavior. Record review of CR #1 MAR revealed that medications were administered 01/31/2026 at 7:19pm. Further review revealed medication administered at 8:18pm by CMA A. Further review revealed no significant missed meds on 01/31/2026, after CR #1 was reported missing Record review of the facility entrance and exit log revealed no record that CR #1 had signed out nor notified staff of departure on 01/31/2026. Record review of CR #1 hospital record revealed in physician notes CR #1 was admitted to the hospital on [DATE] at 8:34am and discharged on 02/02/2026. Further review of record revealed RN from local ED searched patient's name and found a missing person's report from 1/31/2026. History was obtained from nursing facility and Cr #1's family member. Patient was initially placed in nursing home due to his difficulties with ambulation. However, he was able to ambulate with a walker of admission. On presentation to the ED, he was brought in by a local unhoused person who stated that she found him in the parking lot. At time he was cold, was bleeding from his right scalp and had minor lacerations to his bilateral hands. CT head negative for intracranial abnormalities, just showed right periorbital soft tissue swelling related to CR #1 fall/trauma Present on admission. infectious causes. Found to be dehydrated and hypotonic saline was administered. Patient medically optimized for discharge on [DATE]. Record review of facility investigation evidence revealed CR #1 was located at approximately 7:00 AM on 02/01/2026, approximately 7</p> <p>(continued on next page)</p>		

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: 676059
		If continuation sheet Page 1 of 4

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>miles from the facility, in the parking lot of a local Emergency Care Center. Upon discovery, CR #1 had sustained a laceration to his right eye, suspected to be from a fall. CR #1 required hospitalization from 02/01/2026 through 02/02/2026. Further review of the investigation evidence revealed the facility's immediate actions: The facility staff performed an immediate search of hall 200, the patient's room, and the patient's bathroom, followed by all adjacent halls, exits, and communal areas. Once it was noted that the patient was no longer in the facility, the exterior and perimeter of the facility, including the neighboring streets where checked, as well as the closet hospital to the facility. The facility nurse supervisor notified the Administrator and DON that CR #1 had 8:30p. Within 30 mins of identifying that the patient was not in the immediate vicinity, a 911 call was made at 8:59p, and a missing person's report was filed, and an investigator was assigned to the case. The facility provided all necessary information, personal and clinical history, to the initial responding officers, as well as the assigned investigator, and a missing person's bulletin was provided. Facility staff performed a facility wide census and confirmed that all other facility residents were accounted for and safe. CR #1's responsible party, was notified, along with the attending physician. Staff in-services related to the management of a patient elopement were initiated. Verified functioning of all facility doors was evaluated to ensure full operational. The time schedule for the door was verified and noted to be 7p as programmed. Staff searched for CR #1 until after midnight on 02/01/2026. The Administrator remained in contact with local police Investigator and received updates throughout the night on 01/31/2026. Elopement risk assessments for complete for all resident, and care plans were verified by the DON to reflect elopement risk. Interviews on 02/08/2026 at 12:13pm, the receptionist stated that there was front door coverage until 8:00 p.m. and all residents should be in account for by 8:00pm. The receptionist stated that she was required to seek coverage at the front desk if she had to take breaks. She stated that the front desk was not to be left unattended. She stated she was made aware of the CR #1 incident occurrence on 01/31/2026. She stated she had worked the day of the incident and recalled seeing CR #1 on earlier during the day, prior to her shift ending at 5:00pm. She stated she was informed that CR #1 had gone missing around 8:00pm after she had left for the day. She stated that since the incident on 01/31/2026. The facility changed the receptionist's hours (8:00am -8:00pm). She stated that she has been trained in elopement risk and management. She stated if a resident is identified as missing, she would first notify the house supervisor. Interview on 02/08/2026 at 12:36pm CR#1 pervious roommate stated he recalled seeing CR # 1 on 01/31/2026 evening, but he could not recall the time CR #1 left the room. Interview on 02/08/2026 at 12:50pm, Nurse A stated she was present at the facility on 01/31/2026. She stated she was not the primary nurse assigned to CR #1. She stated she was familiar with CR #1 and he did not have history of exit seeking behavior. She recalled seeing the resident sometime after dinner between 5:00pm and 6:00pm, but she did not recall seeing him exit the building. She stated an elopement code was implemented around 8:00 after being notified by other staff (she could not recall names) that CR #1 was missing. She staff all staff begin searching the facility and surrounding area for CR #1, who was not found prior to her shift end. She stated, a resident count was completed and verified no other residents had gone missing. She stated she believed CR #1 may have gone missing when 911 was called by another resident in the same hall (200 Hall). She stated she believe the receptionist shift ended at 5:00 on 01/31/2026 and the 911 call by the resident happened after 7:00pm. She stated the facility had provided training on Elopement Response and she would notify the supervisor when first observed that a resident goes missing. Interview on 02/08/2026 at 1:00pm, the DON stated she was informed of the incident at approximately 8:30pm on 01/31/2026. She stated she was informed that staff had last seen CR #1 at 7:00 p.m.</p> <p>(continued on next page)</p>		

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