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	06/13/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Purpose: P1 Complaint Investigation Date: 6/2/2026 Intake: 1093120 [3030810] Census: 99 Abbreviations:Admin-AdministratorADL-Activities Daily LivingBIMS-Brief Interview for Mental StatusBOM-Business Office ManagerCNA-Certified Nurse AssistantC/O-Complaints OfCR-Closed RecordCVA-Cerebral Vascular AccidentDME-Durable Medical EquipmentDON- Director of NursingDX-DiagnosisFM-Family MemberHHC-Home Health CareHO-History OfHTN-HypertensionHX-HistoryIDT-Interdisciplinary TeamLTC-Long Term CareLVN - Licensed Vocational NurseMD-Medical DoctorMDS- Minimum Data SetNOMNC-Notice of Medicare Non-CoverageNP-Nurse PractitionerOT-occupational TherapyPCC-Point Click CarePCP-Primary Care PhysicianPRN- Pro Re NataPT-Physical TherapyROM- Range of MotionR/T-Related ToS/S-Signs and SymptomsSW-Social WorkerTrans-TransportationWC-WheelchairBased on record review and interviews, the facility failed to provide and document sufficient preparation and orientation to residents to ensure a safe and orderly transfer or discharge from the facility for 1 of 5 residents (CR #1) reviewed for a safe transfer and discharge.1.The facility failed to arrange a safe and orderly discharge through care planning involving CR #1 and FM #2.2.The facility failed to secure a proper placement for CR #1's discharge from the facility on 5.26.26 , that resulted in CR #1 admitting to a boarding home without skilled services, home health, DME, transportation to dialysis, and communication services.These failures could place residents at risk of emotional distress and not receiving care and services to meet their needs upon discharge.Findings included:Record review of CR #1's undated face sheet revealed he was admitted to the facility on [DATE] and discharged on 05/26/26. CR#1 had diagnoses of Cerebral Infarction (stroke-lack of blood and oxygen to brain), Fracture Of Neck of Right Femur (broken hip), COMPRESSION FRACTURE OF FIRST THORACIC VERTEBRA (break in spine cord), END STAGE RENAL DISEASE (kidney disease), DEPENDENCE ON RENAL DIALYSIS (excess waste is filtered from the blood),TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (body doesn't produce insulin), CONGESTIVE HEART FAILURE (heart muscle too weak to pump blood efficiently), NONRHEUMATIC AORTIC VALVE STENOSIS (narrowing of aortic valve that obstructs blood flow from the heart to the body, REPEATED FALLS, PAROXYSMAL ATRIAL FIBRILLATION (the upper chambers of the heart beat chaotically and rapidly), and HYPERTENSION (high blood pressure).Record review of CR #1's Discharge MDS assessment dated [DATE], revealed a BIMS score of 15, which meant CR#1 has normal thinking and memory (no or very little impairment).Record review of CR #1's Baseline Care Plan, dated 01/30/26, revealed the following:Focus: CR#1 is at risk for falls R/T weakness and lack of coordination, h/o falls preadmit. Date Initiated: 01/31/2026Revision on: 04/16/2026Goal: CR#1 Will be free of minor injury through the review date. Date Initiated: 01/31/2026; Revision on: 02/04/2026Target Date: 04/30/2026Interventions: The residents need a safe environment: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls, personal items within reach. Date Initiated: 02/04/2026Focus: CR#1 is at risk for impairment to skin integrity r/t decreased mobility and (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinence. Date Initiated: 02/04/2026Revision on: 02/04/2026Goal: CR#1 will be free from injury through the review date. Date Initiated: 02/04/2026. Revision on: 02/04/2026Target Date: 04/30/2026Interventions: Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Date Initiated: 02/04/2026Focus: CR#1 has Hip Fracture r/t Fall, post Right Hip Hemiarthroplasty. Date Initiated: 02/04/2026. Revision on: 02/04/2026Goal: CR#1 will remain free of complications related to hip fracture, such as contracture formation, embolism andimmobility through review date. Date Initiated: 02/04/2026. Revision on: 02/04/2026. Target Date: 04/30/2026Interventions: Evaluate/provide with/observe use of adaptive devices PRN [as needed]: Fracture pan, Gait belt, Abduction pillow, Walker, Wheelchair, Elevated toilet seat. Date Initiated: 02/04/2026. Follow MD orders for weight bearing status. See MD orders and/or PT treatment plan. Date Initiated: 02/04/2026. Modify environment as needed to meet current needs: Non-slip surface for bath/shower, Bed in lowest position with wheels locked, Floors that are even and freefrom spills, clutter, Adequate, glare-free light.Focus: CR#1 has the potential for hypo/hyperglycemia related to Diabetes Mellitus Date Initiated: 02/04/2026. Revision on: 02/04/2026.Goals: CR#1 will have no complications related to diabetes through the review date. Date Initiated: 02/04/2026. Revision on: 02/04/2026. Target Date: 04/30/2026.Interventions: CR#1 will have no complications related to diabetes through the review date. Date Initiated: 02/04/2026. Revision on: 02/04/2026. Target Date: 04/30/2026.Record review of CR#1's order dated 1.30.26 revealed CR#1 is scheduled for dialysis 3 times weekly on Monday, Wednesday and Friday.Record review of Care Conference Summary dated 4/22/2026 revealed, Diagnosis, cognitive, visual, communication, ADL, continent, falls and safety, skin, pain, activities, therapy, and medication issues were all discussed with the resident's representative; however, the resident representative was unavailable. The notes for the dietary plan comments read, the care plan was unable to reach the resident family member. Continue with plan of care and monitor intake.Record review of CR#1's Care Conference Summary dated 5/1/2026 revealed Diagnosis, cognitive, visual, communication, ADL, continent, falls and safety, skin, pain, activities, therapy, and medication issues were all discussed with the resident's representative. Social Services topics discussed with resident were, mood/behavior (comments read, Patient was in good mood and participate.), Discharge potential (comment read, Patient states home with [FM #2]), discharge location, PCP, pharmacy, DME, home health agency upon discharge, dental, optometry, audiology, podiatry care, and psychology/psychiatry.Record review of CR#1's Social Services care summary revealed, care conference completed with patient. Unable to reach [FM #2] for scheduled meeting. Patients were reminded of discharge 5.8.26. Patient states no concerns regarding care at facility. During this conference, the activities, dietary, and therapy were discussed with resident representative.Record review of Initial Social Services History dated 2.23.26 revealed the following:2. FM#2 is the responsible party and contact information listed.III. Communication: 110 . Spanish is CR#1's preferred language. 110b. CR#1 stated he needed an interpreter to communicate with a doctor or health care staff.IV, Discharge planning: 3. Resident need assistance post discharge.Record Review of nursing note written by SW dated 5.26.26 at 1:50pm revealed, Social Worker did make an attempt to contact patient's FM#2 regarding discharging patient into group home. Unable to reach or leave voice note as voicemail is full. Social Worker did send a text message to FM#2 informing of patient's discharge into a group homeRecord review of discharge signed by the physician on 5/26/26 at 2:41pm that stated, ok for resident to discharge home with hhc of choice & to be evaluated for pt/ot/st & skilled nursing as needed. This was on a Physicians Telephone Orders sheet. Record review of CR #1's Discharge Plan of Care dated 5.26.26 at 2:51pm revealed, CR#1 is an Assist of 1 (meaning he needs only one person to assist him in his ADL's).Record Review of the signed Discharge document with an effective date of 5.26.26 signed by the CR#1 with an unreadable date of signature. The document was in English.Record review of Discharge Summary notes written by SW dated 5.26.26 at 3:27pm revealed, Social Worker did speak with patient and FM#2, face to face, regarding discharge and notified patient (continued on next page)

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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	06/13/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have FM#2 to sign the discharge form. The DON stated she was told that the place was a group home not a boarding house. She stated she did not investigate the status of the placement where CR#1 was taken to ensure it was a safe placement. The DON stated the discharge form signed by CR#1 was not documented in nursing notes or anywhere else. The DON stated the adverse effect of an unsafe placement would place a resident somewhere where their needs would not be taken care of it could be potentially dangerous for them.On 6.12.26 at 1:55pm in an interview with Rehab Director, he stated he worked with CR#1 when he arrived in the facility. He stated CR#1 was evaluated on 2/1/26 with both, OT and PT departments. He stated CR#1 did not need speech therapy after being screened. He stated CR#1 had no deficits or any cognition or swallowing issues, which is also a part of the speech therapy screen process. The rehab director stated CR#1's during the initial evaluation levels of function for bed mobility, transfer and ambulation CR#1 was maximum assist (totally dependent on staff). The Rehab Director stated upon discharge, CR#1's discharge summary revealed he was supervision to get to bed and would need someone to be there just in case of any issues. He stated CR#1 needed 90% supervision in areas of PT prior to discharge and afterwards he was 100% independent. Rehab Director stated when CR#1's pain was under control; he became transfer supervision with assistance because CR#1 continued to have an unsteady gait. Rehab Director stated there was not much gait training with CR#1 because of the pain in his lower extremities. He stated CR#1's main barrier while in therapy was his knee pain. Rehab Director stated upon discharge All CR#1's transfers were with supervision. Rehab Director stated during OT, CR#1 was Maximum assist with OT on upper and lower body dressing (totally dependent on staff). Rehab Director stated at discharge, CR#1 was independent for personal hygiene, upper body dressing. Rehab Director stated the OT summary upon discharge stated, CR#1 was modified independent (Rehab Director did not know what modified independent meant). Rehab Director stated an example that he believes modified independent meant was if CR#1 was given a shirt from the drawer CR#1 could put it on himself; however, Rehab Director was unsure if CR#1 could get the shirt out of the drawer himself. The Rehab Director stated regarding CR#1's toileting, CR#1 needed supervision on discharge because it would be difficult for CR#1 to wipe himself clean. The Rehab Director stated CR#1's wheelchair mobility status was independent.On 6.13.26 at 4:54pm a follow up interview with SW who stated she received safe discharge training (6.12.26). She stated she completed an audit of all residents currently identified as potential discharges to ensure: The discharge location can safely meet the resident's medical, nursing, functional, psychosocial, communication, and supervision needs. At time all the discharges met the needs of the residents. She stated appropriate documentation supports the discharge decision has been documented in PCC [electronic medical record] along with doctors' order for discharge. Conversation was and will be conducted with residents, responsible parties, physicians and IDT [interdisciplinary team] team . Tto ensure required notices (NOMNC) and notify last day of coverage, via care plan meetings, in person, phone calls and document in PCC. The Social Worker contacted all residents (15) discharged within the previous 30 days and verified that the discharge location remains appropriate and that no concerns regarding safety or unmet needs existed. This will be completed by end of day 6/13/2026. Stated the discharge checklist in-service training has been implemented in each area started with SW, then she sends her completed section then she emails to the entire team and then the final copy goes to the Administrator. She stated effective communication with the team, advocating, and documentation in PCC. Ensuring IDT team is also documenting.On 6.13.26 follow up interview at 5:08pm with DON who stated she received training (6.12.26) on the requirements for safe and appropriate discharge planning, which includes the checklist completed starting with social worker. She stated that the Resident rights related to discharge and transfer, assessment of medical, functional, psychosocial, communication, and supervision needs are met before discharge. She stated the documentation requirements would be IDT documentation, and PCC. She stated the last documentation is the licensed nurse who will document the resident leaving the facility. The DON stated the social worker will complete notification requirements for residents and (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible parties and verification that the receiving location can meet the resident's identified needs.Any staff member absent from education will receive training prior to participating in discharge planning activities. The Systemic changes are the mandatory Discharge Readiness Checklist to be completed prior to every discharge. The checklist requires verification and sign-off by her, Administrator, Socia