

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 04/09/2026
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)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 2 of 12 residents (Resident #6 and #107) reviewed for call light placement. The facility failed to ensure Resident #6's call light was within reach on 04/07/2026, while he was asleep in bed. The facility failed to ensure Resident #107's call light was within reach on 04/07/2026 and 04/08/2026, while he was lying in bed. These failures could place residents at risk of not receiving immediate assistance when needed. Findings include: 1. Record review of Resident #6's face sheet, dated 04/08/2026, reflected, a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #6 had diagnoses which included acute osteomyelitis (serous infection of the bone marrow), right ankle and foot, dementia (decline in mental ability severe enough to interfere with daily life, resulting from brain cell damage), without [NAME] disturbance (cognitive decline-such as memory loss, confusion, and impaired reasoning-without accompanying neuropsychiatric symptoms like aggression, hallucinations, agitation, or severe personality changes), psychotic disturbance (mental health state characterized by a loss of contact with reality), mood disturbance (serious mental health condition characterized by severe, persistent, and abnormal emotional states), and anxiety (overwhelming, feeling of fear, dread, or unease in response to stress or perceived threats), type 2 diabetes mellitus with hyperglycemia (a chronic metabolic condition where the body resists or inadequately uses insulin, leading to sustained high blood glucose levels), acquired absence of left leg below knee, severe protein-calorie malnutrition (a life-threatening, extreme nutritional deficiency), pain in right lower leg, and cognitive communication deficit (an impairment in communication). Record review of Resident #6's Quarterly MDS, dated [DATE], reflected, the resident had a BIMS score of 07, which indicated the resident had severe cognitive impairment. He used a wheelchair for mobility. He required substantial assistance from staff with personal hygiene and lower body dressing. He was always incontinent with bladder and bowel. Record review of Resident #6's care plan reflected the resident had impaired cognitive function/impaired thought processes r/t impaired decision making, dated 06/12/202. The resident had an ADL self-care performance deficit r/t left-below the knee amputation, dated 06/12/2025. The resident had an actual fall r/t cognitive impairment on 06/10/2025 and 11/28/2025. Record review of Resident #6' progress note, dated 03/04/2026 at 02:06 p.m., reflected the resident was discontinued from the falling star program (visual alert safety system designed to identify residents at high risk of falling and prevent injuries) due to resident's last fall on 11/25/2025, but safety precautions were to remain in place. Record review of Resident #6' progress note, dated 03/7/2026 at 10:49 p.m., reflected the resident was to be turned and repositioned every 2 hours and for safety precautions, bed to be in lowest position and call light within reach. Created by RN A. During an observation on 04/07/2026 at 8:30 a.m., revealed Resident #6 was observed sleeping in his bed with the call out of reach laying over a nightstand table, under a pillow, with the call light button draped down the side of the nightstand farthest from the resident. During an interview on 04/07/2026 at 08:33 a.m., LVN A stated she was unaware of how Resident #6's call light had been (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: 676059
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She stated when she completed patient care, the resident's call light was placed within reach and at no time after providing the resident care had she seen the resident's call light out of position. She stated sometimes the resident moved and the call light would be caught up under the bed. She stated the resident's call light not being within reach was not good for the resident if something went wrong and he needed to call for assistance such as falling on the floor. She stated the resident falling on the floor and unable to call for help would leave the resident in a bad way. She stated she received in-service training on call lights every day and received the last training on 04/06/2026. During an interview on 04/08/2026 at 03:17p.m., with the ADM and the DON, the DON stated resident call lights were to be within reach at all times for a resident to call for assistance. She stated a resident could fall at any moment reaching for an item they may need. She stated failure to place a call light within reach could result in a resident experiencing a fall with a fracture. She stated CNAs and nurses were required to round/check on residents every 2-hours and ensure call lights were in place and within reach. The ADM stated the importance of having a resident's call light within reach was to prevent a resident overreaching and having an incident or accident. She stated an adverse effect of not ensuring call lights were within reach were falls with injury and the inability for staff to provide timely care. She stated the facility provided call light positioning, answering, and personal items within reach at bedside in-service training daily, and in the facility's daily morning huddle/meeting. 2. Record review of Resident #107's face sheet reflected, a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included diabetes mellitus (high blood sugar levels resulting from the body's inability to produce or properly use insulin), repeated falls, mild cognitive impairment (decline in mental abilities).Record review of Resident #107's admission MDS (a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status, used in nursing homes), dated 04/02/2026, reflected a, BIMS (a standardized, mandatory 0-15 point cognitive assessment tool used in long-term care settings to measure mental acuity in residents, scores between 0 and 7 indicate severe cognitive impact, scores between 8 and 12, moderate impairment while scores above 13 show little to no impairment) of 14. He used a walker for mobility. He required substantial assistance from staff with personal hygiene and lower body dressing. He was always incontinent with bowel.Record review of Resident #107's Care Plan, dated 02/05/2025, reflected Problem: The Resident was at high risk for falls related to new environment, unsteady gait and history of falls prior to admission. Goal: The resident will be free of falls. Interventions included: Be sure call light was within reach and encourage to use it for assistance as needed. Respond promptly to all requests for assistance.During an observation and interview on 04/07/26 at 11:31 a.m., reflected, Resident #107 lying in bed, his call light was on the floor, and out of Resident #107's reach. Resident #107 stated he could not reach his call light. During an observation and interview on 04/08/26 at 9:18 a.m., revealed, Resident #107 lying in bed, his call light was on the floor, and out of Resident #107's reach. Resident #107 stated he could not reach his call light.During an interview on 04/08/26 at 9:23 a.m., CNA B stated call lights should be within residents' reach. She stated Resident #107 needed the call light to request assistance when needed. CNA B stated she checked the call lights which included Resident #107's call light at the beginning of her shift and every 2 hours. CNA B stated if call lights were not within the residents' reach, they could fall.During an interview on 04/08/26 at 9:27 a.m., LVN B stated call lights should be within reach of residents. He stated nurses and CNAs should have (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	noticed Resident #107's call light was out of his reach when they went to Resident #107's room and clipped it to his bed. He stated if call lights were not within residents' reach, they could fall. Record review of in-service training, dated 04/08/2026, titled Call Lights reflected . Answer call lights in a timely manner! All staff can answer. Make sure call lights within reach and properly functioning. Signed by multiple facility staff, conducted by LVN D. The in-service included the staff identified to care for Resident #6 and #107. Record review of the facility's, undated, policy titled: Policy: Call System, Residents Policy Statement, reflected, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Policy Interpretation and Implementation 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. 2. Call system communication may be audible or visual. The system may be wired or wireless. Record review of the facility's, undated, policy titled: Policy Answering the Call Light Level I, reflected, Purpose The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines Be sure that the call light is plugged in at all times. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Some residents may not be able to use their call light. Be sure you check these residents frequently.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure within 14-days the facility completed a resident assessment, and electronically transmitted encoded, accurate, and complete MDS data to the CMS System for 2 of 5 closed records (CR #10 and CR #25) reviewed for MDS transmission. The facility failed to ensure CR #10's admission MDS assessment was completed and transmitted within 14 days of CR's entry. The facility failed to ensure CR #25's admission MDS assessment was completed and transmitted within 14 days of CR's admission. These failures could place residents at risk of not having assessments completed and submitted in a timely manner as required. The findings were: Record review of CR #10's face sheet dated 04/09/2026, reflected, a [AGE] year-old male who was admitted to the facility on [DATE], readmitted to the facility on [DATE] and 11/02/2025, and discharged on 11/12/2025. CR #10's diagnoses included acute on chronic combined systolic/diastolic (heart failure) (congestive), end stage renal disease (chronic kidney failure), and dependence on renal dialysis (life-sustaining treatment for kidney failure that removes waste and extra fluid from the blood). Record review on 04/09/2026 at 01:04 p.m. revealed CR #10's entry MDS assessment, dated 10/02/2025, required the completion of the resident's compressive MDS assessment, by 10/16/2026 (14-days from resident's entry/admission). The compressive MDS Assessment was completed on 11/12/2026 was 27-days overdue. During an interview on 04/09/2026 at 1:22 p.m., LVN A stated she was responsible for completing CR #10's comprehensive MDS assessments. She stated the importance of completing a resident's comprehensive assessment was ensure the resident's care plan reflected a clear picture of the resident's care needs to the facility's nursing staff. She stated the importance of completing a resident's discharge MDS assessment was to close the resident's care plan making the plan inactive for staff's awareness the resident was no longer in the facility and for billing to discontinue. She stated she completed CR #10's compressive MDS late because the resident had multiple readmission and discharges during his stay and she could never determine if the resident was going to readmit and stay or discharge and remain out of the facility. She stated she had 14-days from the resident's admission/entry and 14-days from a resident's discharge to complete his comprehensive assessment and/or discharge assessment. She stated when the resident discharged on 11/12/2025, she went to complete his MDS discharge summary, realized she had not completed his comprehensive assessment and completed both the comprehensive and discharge assessments on the same date of 11/12/2025. Record review of CR #25's face sheet, dated 04/08/2026, reflected, an [AGE] year-old female who was admitted to the facility on [DATE], readmitted to the facility on [DATE], and discharged on 11/26/2025. CR #25's diagnoses included hemiplegia and hemiparesis (one-sided body weaknesses caused by brain damage, usually from stroke, trauma, or tumors) following cerebral infarction affecting side (functional deficits on the opposite side of the body from the brain injury due to nerves crossing in the brainstem), spastic hemiplegia affecting right dominant side (a non-progressive neurological condition causing paralysis, muscle stiffness, and reduced function in the right arm and leg), and epilepsy (chronic neurological disorder characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain). Record review on 04/09/2026 at 12:55 p.m., revealed CR #25 had a completed discharge MDS assessment dated [DATE] initiated by the resident's 11/26/2025 discharge with no return, and an incomplete admission MDS record dated 12/03/2025. During an interview on 04/09/2026 at 1:22 p.m., LVN A stated she was responsible for completing CR #25's entry and discharge MDS assessments. She stated on 12/03/2025 she entered an admission record for CR #25 not realizing leaving the 12/03/2025 admission record incomplete started the 14-day requirement for completion and failure to complete. During an interview on 04/09/2026 at 03:30 p.m., the ADM and the DON stated they were not aware of CR #10's untimely admissions and assessments or CR #25's last admission record which showed (continued on next page)		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incomplete. The ADM and the DON stated it was their expectations that the MDS assessment was completed within the required 14-days after entry/admission and discharge for regulation requirements and billing purposes. The ADM stated adverse effects of not completing a MDS assessment timely could result in billing inaccuracies. Record review of the facility policy, dated 2001 and revised 09/2010, titled MDS Completion and Submission Timeframes. Policy Statement reflected, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Policy Interpretation and Implementation 1. The Assessment Coordinator or designee shall be responsible for ensuring that resident assessments are submitted. in accordance with current federal and state guidelines. Discharge Assessment - return not anticipated (Non-Comprehensive), MDS Completion date: discharge date + 14 calendar days. Discharge Assessment - return anticipated (Non-Comprehensive): MDS Completion date: discharge date + 14 calendar days.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the resident environment remained as free of accident hazards as was possible for 2 of 8 (Resident #21 and Resident #33) resident rooms reviewed for accident hazards. The facility failed to ensure mouthwash, hand sanitizer, lotion, hair products and bath wash were properly stored and not out in the open in Resident #21's room on 04/07/2026, 04/08/2026, and 04/09/2026. The facility failed to ensure mouth wash, lotion and hair products were properly stored and not out in the open in Resident #33's room on 04/07/2026, 04/08/2026, and 04/09/2026. These failures could place residents at risk of injury due to unnecessary access to potentially harmful substances. Findings include: Record review of Resident #21's face sheet dated 04/09/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmission on [DATE]. Resident #1 had diagnoses which included angina pectoris (chest pain or discomfort caused by reduced blood flow and oxygen to the heart muscle), hypertension (high blood pressure, is a chronic condition where blood force against artery walls is consistently too high), hyperlipidemia (high levels of lipids (fats), such as cholesterol and triglycerides, in the blood), insomnia (sleep disorder characterized by difficulty falling sleeping, staying asleep, or waking too early, leading to day time fatigue, irritability, and poor concentration), depression (a serious, common mood disorder causing persistent sadness, loss of interest, and physical symptoms that impair daily life), atherosclerotic heart disease of native coronary artery without angina pectoris (plaque buildup narrows the heart's natural arteries, restricting blood flow without causing chest pain), dementia (aging syndrome causing cognitive decline-memory loss, poor judgment, and communication issues-due to brain damage.), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, generalized anxiety disorder (persistent, excessive, and uncontrollable worry about every day, routine events), and cognitive communication deficit (communication impairment stemming from underlying cognitive issues). Record review of Resident #21's Quarterly MDS (a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status, used in nursing homes), dated 01/20/2026, reflected the resident had a BIMS score of 09 which indicated the resident had severe impaired cognition. Record review of Resident #21's care plan reflected the resident had exhibited an ADL Self Care Performance Deficit, which required assistance with cognitive deficit and dementia disease progression dated 10/16/2025. The resident had a deficit in memory, judgement, decision making and thought process r/t dementia dated 01/21/2025. The resident used antidepressant medication, was at risk for side effects r/t depression dated 01/21/2025. The resident was an elopement risk r/t impairment, and safety awareness dated 02/23/2026, and 04/08/2026 at 02:26 p.m. During an observation and interview on 04/07/2026 at 11:31 a.m., revealed Resident #21 sitting at the bedside with various personal items were observed with Resident #21's name written on them on 3 of 3 dressers: 1-bottle of mouth, 1-container of hand sanitizer, 1-bottle of lotion, 1-bottle of hair product, and 1-bottle of bath wash. During an observation on 04/08/2026 at 12:28 a.m., in Resident #21's room revealed there were various personal items on 3 of 3 dressers: 1-bottle of mouth wash, 7-bottles/containers of lotion, 2-bottles of hair products in and around. During an observation on 04/09/2026 at 01:33 p.m., in Resident #21's room there were various personal items on 3 of 3 dressers: 1-bottle of mouth, 7-bottles/containers of lotion, 2-bottle of hair products. Record review of Resident #21's progress notes dated 01/15/2026 at 02:21 p.m., reflected order for resident to continue on: Mirtazapine Oral Tablet 30 mg (Mirtazapine), administer 1 tablet by mouth at bedtime for depression, created by DON. Record review of Resident #33's face sheet dated 04/09/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmission on [DATE]. Resident #1 had diagnoses which included artificial hip joint (replaces a damaged hip joint (usually (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	due to arthritis or injury) with titanium, ceramic, and high-density plastic components to eliminate pain and restore mobility), type 2 diabetes mellitus without complications (characterized by high blood glucose, without associated chronic organ damage), hypertension (high blood pressure, is a chronic condition where blood force against artery walls is consistently too high), mild cognitive impairment of uncertain or unknown etiology (aging and dementia, characterized by memory or thinking problems that are noticeable to others but do not prevent daily independence), and presence of cardiac pacemaker (a small, surgically implanted medical device that uses electrical impulses to regulate a slow heart rate). Record review of Resident #33's Quarterly MDS, (a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status, used in nursing homes), dated 03/07/2026, reflected the resident had a BIMS score of 15, which indicated the resident had intact cognition. Record review of Resident #33's care plan reflected the resident had behavior problems r/t outstanding bill and offers staff money and was witnessed giving money to other residents dated 01/31/2025. The resident had impaired cognitive function/impaired thought processes r/t cognitive communication deficit dated 01/31/2025. During an observation and interview on 04/07/2026 at 11:31 a.m., Resident #33 was observed sitting at the bedside and stated she had no complaints or concerns to address and she was Resident #21's roommate who had a diagnosis of dementia. Various personal items were observed on 2 of 2 dressers: 1-bottle of mouth, 7-bottles/containers of lotion, 2-bottle of hair products. During an observation on 04/08/2026 at 12:28 p.m., in Resident #33's room there were various personal items on 2 of 2 dressers: 1-bottle of mouth, 7-bottles/containers of lotion, 2-bottle of hair products in and around in a wicker basket. During an observation on 04/09/2026 at 01:33 p.m., in Resident #33's room there were various personal items on 2 of 2 dressers: 1-bottle of mouth, 7-bottles/containers of lotion, 2-bottle of hair products in a wicker basket. During an interview on 04/08/2026 at 03:17 p.m., with the ADM and the DON, the DON stated the resident's personal items could be kept at bedside when labeled to identify the item belonging to the resident. She stated residents had the right to have their personal care items near them for use. She stated she had not considered but understood the risk of items being left at bedside for residents with altered mental cognitive impairment who may wander into other resident rooms and inadvertently consume those personal care products. She stated the danger of a resident consuming personal care products could place their health at risk. She stated she would address the location personal items should now be kept away to assure wandering residents with impaired cognition would not consume. The ADM deferred to the DON's statement and agreed the risk for having items assessable to wandering residents had not outweighed the residents' right to have personal items visible at the bedside. The ADM stated the facility would put a new procedure in place to ensure resident's personal items were stowed away, yet accessible at their leisure. Record review of in-service training dated 04/08/2026 titled Prevention of incidents and accidents, reflected, During daily room rounds, managers should ensure patients of rooms are free of any hazards at the bedside of our residents. This presents incident/injury. Signed by multiple facility staff, conducted by the ADM.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, and interviews the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety and nutrition services for facility residents.1. The facility failed to ensure food items were properly labeled and dated in the Resident Guest Refreshment Room, located on 400 hall.2. The facility failed to ensure foods were properly sealed in the Resident Guest Refreshment Room, located on 400 hall.3. The facility failed to ensure the Resident Guest Room, on 400 hall did not present with a foul odor. These failures could place residents at risk of foodborne illness and disease.Findings include:On 04/09/26, during observation rounds in the Resident Guest Refreshment Room (a room designated for outside vendors and family members to store food items in a refrigerator or freezer) located on the 400-hall, in the refrigerator, it was noted to have an unsecured, unlabeled and undated white bag inside. The bag was partially opened and inside the bag was a white styrofoam container with what appeared to be food items exposed, which violated the Safety of Foods Brought by Visitors facility policy. Additionally, an unpleasant odor was present in the room at the time of observation.Interview on 04/09/26 at 12:07 PM with CNA A revealed an unpleasant smell in the Refreshment room; however, CNA A was unable to give the smell a description. CNA A stated Maintenance had been working in the area since last year, but the smell continues to be in the room. CNA A stated the room was where the resident's family brought in the food. CNA A stated when the water ran in the sink it appeared to get rid of the smell. CNA A stated while the water was running it disappeared. CNA A stated she would not put her food in the refrigerator because the smell made it a health hazard. Interview on 04/09/26 at 11:45 AM with Maintenance, he stated over a year ago the Refreshment room was checked out by a plumbing company that placed a Sure Seal Drain Trap device (floor drain device used to stop odors & bugs), where the odors were suppressed in the pipes. Maintenance stated he would call the plumbing company to come out again today. Maintenance stated he was also looking at replacing the refrigerator in the room and he himself would not place food in the refrigerator due to the smell in the room.Interview on 04/09/26 at 12:21 PM with the Dietary Mgr, who stated families brought food into the facility for all residents and it was stored in the 400-hall Resident Guest Refreshment Center. The food was accepted by nursing staff and not the Dietary Mgr. She stated all nursing staff are to ensure the food is labeled with resident name and the date the food was brought to the facility prior to accepting it. The Dietary Mgr stated she very seldom went into that room. The Dietary Mgr stated the CNAs were supposed to tell housekeeping, the DON or the Administrator regarding the odor of the room. The Dietary Mgr stated she would not recommend food be placed in that area due to the smell. She stated all food should be labeled, dated and have resident name on it when it came to the facility. If food was not labeled and dated it should be thrown out. The Dietary Mgr stated she did not know whose responsibility it was to clean the refrigerator. She stated during the 24-hour meeting there were issues regarding the facility; however, she did not remember a discussion regarding the refreshment center.Interview on 04/09/26 at 12:34 PM, with the ESM, she stated she was responsible for housekeeping, laundry, and the refreshment center room. The ESM stated staff were expected to clean and disinfect the refreshment center room like any other area of the facility. The ESM stated she believed the smell came from the P-trap (area under refrigerator that can maintain sitting water) under the refrigerator. The ESM stated she had not been informed of any smell in the refreshment room by staff. She stated each Friday the refrigerator was supposed to be cleaned out and disinfected. The ESM stated when housekeeping cleaned the refreshment room, they were not allowed to discard food items; however, if there were items in refrigerator, then housekeeping may bring this information to the nursing staff attention. The ESM stated during the 24-hour morning meetings, there wasn't any conversation on the smell of that room.Interview on 04/09/26 at 12:47 PM, the DON stated when the family brought food into the facility the food was placed in the (continued on next page)		

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 04/09/2026
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refrigerator located in the Refreshment Room, which was designated for outside food brought in to residents. She stated the food should always be labeled and dated and the facility had also had a conversation with the family members. The DON stated it was nursing responsibility to ensure the food was labeled and dated with the resident name on it. The DON stated on Friday's housekeeping cleaned out the refrigerator and nursing staff usually discarded food. She stated if the refrigerator was opened and food was in there with no label or date; this should be brought to the nursing attention and those food items should be discarded. The DON stated the adverse effect of food not being labeled or dated could cause residents to have a stomach virus. The DON stated an unpleasant smell in the refreshment room was reported to maintenance and housekeeping. She stated this could also be discussed in the 24-hour meeting. The DON stated she was informed about the smell in the past, but not this week. She stated staff may report the smell while passing in the hall; however, maintenance stated it was due to pipes getting dry, which was addressed by the plumbing company. The DON stated she did not know if a plumber was called out on this issue nor did she know how long the smell had been an issue. The DON stated she could not recall if housekeeping had informed the nursing staff about food not labeled or dated in the refrigerator. The DON stated she had not checked the refrigerator in the refresher room in a while. The DON stated the staff should monitor and put a sign up which indicated the refrigerator would be cleaned on Friday and food left over would be discarded. Interview on 04/09/26 at 1:08 PM with the ADM she stated family was allowed to bring residents' food into the facility. She stated family were informed that when food was brought into the facility it must be labeled with the name of the resident and dated. She stated the nursing staff are aware of the name, date and food labeling protocol too. The ADM stated the food should not be opened or exposed. The ADM stated the adverse effect of the food not being labeled was that it could be given to the wrong residents and could cause illness if not properly maintained. The ADM stated the Refreshment Room refrigerator was cleaned out weekly and food should be discarded by nursing staff, which was the only department authorized to discard food. She stated afterwards housekeeping cleaning the refrigerator and other parts of the room. The ADM stated the smell in the Refreshment room was unpleasant and this had been discussed in the daily morning meeting (usually department managers). She stated she was informed the smell/odor came from the P-Trap (Dryness under sink). The admin stated a plumber came to the facility and evaluated this situation in the past. The admin stated to her knowledge it's not something that was hazardous. Record review of the facility's Safety of Foods Brought By Visitors policy reflected: .4. When the food item is for later consumption, the staff member will ensure the food is in a sealed container, label with resident's name and date received, and stored in refrigeration if needed. All refrigerated home-cooked items will be disposed of if not eaten in three (3) days from the date received.		