STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676116	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Westwood	8702 Course Drive Houston, TX 77099

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 1of 6 residents (Resident #1) reviewed for cleanliness and sanitization. - The facility failed to ensure Resident #1 had a clean drinking cup. The noncompliance was identified as past noncompliance (PNC) and began on [DATE] and ended on [DATE]. The facility corrected the noncompliance before the investigation began. These deficient practices could place residents at risk of living in an unsafe, unclean, and unsanitary environment which could lead to a decreased quality of life. The findings include: Review of Resident #1's Face Sheet, dated [DATE], reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] and expired on [DATE]. The resident's diagnosed included but were not limited to anemia (blood lacking healthy cells to carry oxygen throughout the body), intestinal obstruction (blockage causing difficult movement of food and waste), moderate protein-calorie malnutrition (low body weight), urinary tract infection (an infection of the urinary system, which includes the kidneys, ureters, bladder, and urethra), and need for assistance with personal care. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment (a federally mandated assessment tool used to evaluate the health of residents in nursing homes) dated [DATE] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated she had moderately impaired cognition. (The BIMS scoring devise identified delirium and needed supports in patients living in skilled nursing facilities and long-term care facilities). Record review of Resident #1 Comprehensive Care Plan capture date on [DATE] reflected that Resident #1 was to have adequate nutrition and fluid intake throughout the review date: Initiated: [DATE] Target Date: [DATE]. Record review of Resident #1 Comprehensive Care Plan capture date on [DATE] reflected that Resident #1 was at risk for nutritional impairment related to (r/t) moderate protein calorie malnutrition. Date Initiated: [DATE] Revision on: [DATE]. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Westwood		STREET ADDRESS, CITY, STATE, ZIP CODE 8702 Course Drive Houston, TX 77099	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Progress Notes dated [DATE], reflected no notes taken on or about [DATE] related to the facility addressing residue in the resident's cup. In an observation on [DATE] at 01:19 p.m., Family #1 provided photographs taken on [DATE] at 01:14 p.m., of the cup found at bedside of Resident #1. A clear cup with a blue lid and blue writing on the side appeared in the photograph. Towards the middle bottom to the bottom of the cup appeared to be black discoloration resembling a mold and/or dirt like substance. In an interview on [DATE] at 01:17 p.m. Family #1 stated that Family #2 had visited Resident #1 on [DATE] and found just before 01:14 p.m. that the bottom of resident's clear drinking cup was black with residue that resembled mold. She stated that Family #2 feared that the facility was allowing Resident # 1 to drink from an uncleaned cup. She stated that Family #2 told her that she had alerted facility staff of the dirty cup and that the licensed vocational nurse (LVN) A who introduced herself as the charge nurse spoke to her about the residue in the bottom of Resident #1's cup but could not explain the substance within the cup. She stated that LVN A requested to take the cup and replace with a new cup. She stated that Family #2 refused to turn over the cup but accepted a new cup for the resident. She provided pictures of the discolored cup provided to the resident by the facility showing the time and date the pictures were taken. In an interview on [DATE] at 2:25 p.m., with Director of Nursing (DON) and the Administrator (ADM), reflected that they were not aware of the discoloration at the bottom of Resident #1's cup on [DATE]. The DON stated that evening shift was responsible for collecting cups from resident rooms in the evening and replacing them with a new cup. The DON stated she was on vacation the week of [DATE] through [DATE]. The ADM stated that her employment with the facility began on [DATE] and she was not made aware of the incident. The DON stated it had been her expectations that the staff were changing out and cleaning resident's drinking cups every evening. She stated that failure to do so would result in resident's drinking from cups that were dirty or residue that could mold. In an interview on [DATE] at 12:15 p.m., LVN A stated she recalled being informed by certified Nursing Aid (CNA) whose name she could not recall and believed no longer worked for the facility alerted her that Family #2 found that Resident #1 had a dirty cup. She stated that she went to Resident #1's room and was told by Family #2 that resident had been drinking from a cup with mold in it. She stated she observed the cup and what appeared to be mold/dirt at the bottom of the cup. She stated she asked Family #2 for the cup, but Family #2 stated she was keeping the cup. She stated that she got Resident #1 a new cup and filled it was ice and water. She stated that Resident #1 made no complaints about the cup. She stated she spoke to the other staff on duty that day and no one recalled seeing the cup with the dark residue. She stated she then reported the incident to ADON. She stated that maybe the residue in Resident #1's cup was from fresh juice. She stated she had staff check all the resident's cups to ensure that they were all free of residue and found that no other residents' cups were like that. She stated it was her expectations that the evening shift made evening rounds and collected and/or checked to see if cups were dirty and needed cleaning. She stated it was the evening shifts responsibility to pick up every cup, replace with a clean cup and then all dirty cups were taken to the dish room for washing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676116	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Westwood	8702 Course Drive Houston, TX 77099

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 10:57 a.m., Family #2 stated she had gone to visit Resident #1 on [DATE]. She stated Resident #1 asked her to pour some lemonade in her drinking cup. She stated she began to pour the lemonade in the cup when she noticed some discoloration at the bottom that appeared to be black mold. She stated she asked Resident #1 had she been drinking from the cup and resident replied that she had. She stated she became extremely upset and went to the nurse's station with the cup to explain that resident had been drinking from a dirty cup. She stated there were 3-staff members sitting at the desk whose names she did not obtain and asked how resident's cup had come to be that way. She stated that none of the staff had an explanation but stated that they would send the resident's nurse to her room to address her concerns. She stated that LVN A came to the resident's room and apologized for the dirty cup. She stated LVN A asked for the cup, but she told her she would be keeping the cup. She stated then LVN A left the room and returned with a new cup filled with fresh ice water. She stated that she had never seen stains in the resident's cup prior or after. She stated that the facility never gave an explanation for the black discoloration in Resident #1's cup. In an interview on [DATE] at 10:37 a.m., CNA A stated that she worked [DATE] from 10:00 p.m. to 6:00 p.m. She stated that she began collecting cups from the room at about 10:30 p.m. She stated that she takes the used cup and replaced it was a clean cup. She stated that she could not recall a time when she missed or skipped picking up Resident #1 cup, neither had resident every refused having her cup changed, nor gave resident a cup that was stained. She stated had she seen stains in a cup, she would have returned the cup to the kitchen. She stated had a resident ever refused having their cup taken, she would go back later and make another attempt to collect the cup. She stated the importance of residents receiving a clean cup daily was to ensure they stay healthy, maintain hygiene and avoid contamination and decease. Facility policy titled Food Receiving and Storage revised date of [DATE] reflected: Policy Statement Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation 1. Food Services, or other designated staff, will maintain clean food storage areas at all times. Facility policy titled Resident Rights revised date of [DATE] reflected: Policy Statement Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. Record review of facility in-service dated [DATE] reflected: Hydration Cups, Fresh Ice & Water Pass, Wheelchair Cleaning/Hand Hygiene PPE, Pitcher, and Wheelchair Cleaning. Presenter's ADON A and ADON B. 1. Hydration pitchers are to be collected and swapped with clean cup on 10pm - 6am shift. Take clean cups with fresh ice water with you, swap dirty for clean, take dirty pitchers and place outside of dish room door for cleaning, Every night shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Westwood	8702 Course Drive Houston, TX 77099

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 - Minimal harm or potential for actual harm 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** 44669 Based on the observation, interview, and record review, the facility failed to ensure that the residents environment remains free of accidents hazards as possible, and each resident receives adequate supervision to prevent accidents for 5 (Resident #2, #3, #4, #5, #6) of 5 residents reviewed for accidents and supervision. -The facility failed to ensure that the facility's main door alarmed notifying staff when residents with wander guard's exited (Resident #2). -The facility failed to ensure the facility's main entrance wander guard alarmed when residents with wander guard's exited (Resident's #2, #3, #4,#5 and #6). This failure could place residents at risk of injury from accident and hazards. The noncompliance was identified as past noncompliance (PNC) and began on 08/02/2024 and ended on 08/03/2024. The facility corrected the noncompliance before the investigation began. The findings included: Resident #2 Review of Resident #2's Face Sheet, dated 02/20/2025, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. Resident's diagnosis included but were not limited to cerebral infarction (suffered a stroke), hemiplegia and hemiparesis (paralyzed and mild paralyzed) following cerebral infarction affecting right dominant side, hypertension (high blood pressure), atherosclerotic heart disease of native coronary artery (buildup of plaque in the arteries) without angina pectoris (chest pain caused by reduced flood flow), insomnia (difficulty sleeping), visual hallucinations, contracture, right knee, history of falling, limitation of activities due to disability, muscle weakness (generalized), muscle wasting and atrophy (decrease in size and/or wasting away of a body part or tissue), pain in joints of right hand, difficulty in walking, other abnormalities of gait and mobility other specified depressive episodes, unspecified dementia, unspecified severity, with agitation, hearing loss, bilateral, traumatic subdural hemorrhage (blood loss) without loss of consciousness, muscle wasting and atrophy, not elsewhere classified, multiple sites, other lack of coordination, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Westwood		STREET ADDRESS, CITY, STATE, ZIP CODE 8702 Course Drive Houston, TX 77099	

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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Comprehensive Care Plan capture date of 02/21/2025 reflected Focus: Resident is an elopement risk/wanderer and is at risk for possible injury r/t impaired safety awareness and diagnosis of dementia. Actual Event 8.2.24 Date Initiated: 08/02/2024 Revision on: 08/03/2024. Goal: Resident's safety will be maintained throughout the review date. Date Initiated: 08/03/2024 Revision on: 09/25/2024 Target Date: 03/03/2025. Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television or books. Date Initiated: 08/02/2024. Provide structured activities: Toileting, walking inside and outside, reorientation strategies, including signs, pictures and memory boxes. Date Initiated: 08/02/2024. Wander guard placed for resident's safety, bracelet will alert staff if and when resident attempts to exit doors of facility. Staff to monitor daily. Date Initiated: 08/02/2024. Record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected that the resident had a BIMS score of 02 out of 15 which indicated he had severely impaired cognition. Section P - Restraints and Alarms: reflected: E0900. Wandering - Presence and Frequency. Behavior not exhibited. P0200. Alarms: Not used. Record review of Resident #2's Annual MDS assessment dated [DATE] reflected that the resident had a BIMS score of 02 out of 15 which indicated he had severely impaired cognition. Section P - Restraints and Alarms: E0900. Wandering - Presence and Frequency. Behavior not exhibited. P0200. Alarms: E. Wander/elopement alarm. Used less than daily. Record review of Resident #2's Physician Orders dated 08/02/2024 at 07:48 p.m., reflected: Signal device (Wander guard) in place for safety awareness. Record review of Resident #2's Physician Orders dated 08/02/2024 at 07:49 p.m., reflected: Resident Order WANDER GUARD CHECK PLACEMENT EVERY SHIFT. WANDER GUARD CHECK PLACEMENT EVERY SHIFT. Record review of Resident #2's Progress Notes dated 08/02/2024 at 09:58 p.m., reflected: Nurse's Note Text: While making rounds about 07:15 p.m. noted resident was not in common area where he was last seen after dinner. Immediately called code for resident search. MDS Nurse, located resident outside facility at 7:22 p.m., MDS Nurse and writer, LVN B assisted resident back. Assessment completed. Vital signs: Blood Pressure 134/72, Pulse 78, Respiratory Rate: 18, Temperature: 97.6, Oxygen Stats: 97. No signs of distress noted. Resident's payee and nurse practitioner notified, referral for psychiatric (psych) consult, Elopement Risk Assessment completed per protocol. Wander guard place to left ankle. Will continue to monitor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Westwood		STREET ADDRESS, CITY, STATE, ZIP CODE 8702 Course Drive Houston, TX 77099	

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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Progress Notes dated 08/16/2024 at 04:51 p.m., reflected: Social Service Note Text: Quarterly Social Service Assessment for resident who continues to present to be alert and oriented with noted memory problems. He continues to require assistance from staff with activities of daily living (ADL) care which he at times is resistant to, and his daughter is aware of his behavior. He has not demonstrated any major changes in his mood/behavior or psychosocial wellbeing. Resident still spends the majority of the day in his room, periodically coming out and propelling his wheelchair around the facility. He interacts with others of his choice. He still has a roommate of which he appears content with. And his family members visit with him when they can and provide much emotional support while being attentive to his personal needs. Resident remains a full code status which will be honored by all staff persons and reviewed quarterly for any changes needing to be made. He continues to receive psych services with psych services. And he receives ancillary services . There are no plans in place for discharge so he will remain in this facility for long term care placement. Social Worker (SW) will continue to visit one to one and encourage appropriate behavior during care. SW will also monitor for any issues which may arise requiring social service assistances. Record review of Resident #2's Progress Notes dated 11/15/2024 02:31 p.m. Social Service Note Text: Quarterly Social Service Assessment for resident who continues to present to be alert and oriented with noted memory problems during one-to-one visits even with family assistance. He still prefers to spend the majority of the day in his room usually in bed. He does have a roommate who he seems to be satisfied with and he will periodically come out to the television area. He continues to require assistance with ADL care from staff which he accepts on his terms. Resident's family members are aware of his behaviors and visits frequently to encourage acceptance of staff assistance. He is receiving psychotropic medications which are being monitored Psychiatric Services and he is receiving ancillary services as needed or requested. Resident is still a full code status which will be honored by all staff persons and reviewed quarterly for any changes needing to be made. There are no plans in place for discharge from this facility so he will remain here for long term care placement. SW will continue to visit and monitor for any issues which may arise requiring Social Service assistance. Record review of Resident #2's Elopement assessment dated [DATE] at 01:34 p.m., reflected: Reason Quarterly: Reflected that the resident had intermediate confusion, explained by anxiety. Resident did not have a safeguard devise. Record review of Resident #2's Elopement assessment dated [DATE] 10:13 a.m., reflected: Reason: Other. Reflected that the resident had intermediate confusion, explained by depression. Resident did not have a safeguard devise. Intervention: safeguard device placed. SUMMARY/CONCLUSIONS/RECOMMENDATIONS: Wander guard placed, increased monitoring. Record review of Resident #2's Elopement assessment dated [DATE] 10:13 p.m., reflected: Reason: Quarterly. Reflected that the resident had intermediate confusion, explained by dementia. Intervention: safeguard device. Observation and interview attempt on 02/20/2025 at 10:30 a.m., reflected Resident #2 lying in bed under a sheet, bed low to ground. Resident repeated the same word/sound over and over and had not reacted to voice or sound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Westwood		STREET ADDRESS, CITY, STATE, ZIP CODE 8702 Course Drive Houston, TX 77099	

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 - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/20/2025 at 02:25 p.m., with the DON and ADM. DON stated that on 08/02/2025 she would not consider Resident #2 had a full elopement as he had been found immediately in the parking lot by MDS Nurse. She stated that when visitors had exited, Resident #2 followed behind them in his wheelchair out into the parking lot. She stated that MDS Nurse saw him go out the door and she followed after him and brought him back inside. She stated that the resident had a stroke that affected his ability to speak and could not communicate with words his desire to go outside. She stated therefore, he would make hand/arm gestures and grunt which had been his way of voicing he wanted to go outside. She stated that she was aware that the resident enjoyed sunshine. She stated the resident had not had a history of eloping. Interview on 02/20/2025 at 03:09 p.m., MDS Nurse stated on 08/02/2025 around 7:00 p.m. she had seen Resident #2 wheeling out with another resident's family member. She stated she met him and wheeled him back into the facility. She stated that the resident had a speech impairment, and he was not able to explain where he was going. She stated once inside, she handed the resident off to his LVN B which was his nurse. Interview on 02/21/2025 at 12:15 p.m., LVN A, stated that the facility's main door had been malfunctioning in the summer of 2024, she could not recall the exact dates, but that the door had been repaired rather quickly. She stated she was not aware of any elopements. She stated that Resident #2 often hung out around the nurse's station and had been known to venture towards the exit door but had not attempted any elopements that she was aware. Interview on 02/21/2025 at 3:15 p.m., DON stated that on 08/02/2025 Resident #2 had not quite made it to the end of the driveway when MDS Nurse called LVN B telling her that she had located Resident #2. Interview on 02/21/2025 at 03:57 p.m., LVN C stated on 08/02/2024, she was informed by LVN B that Resident #2 was missing. She stated since there was already staffing looking for the resident inside and on around the property that she would began search the neighborhood in her car. She stated that she exited the facility property. She stated she found the resident wheeling himself in his wheelchair out on the street near the Walmart across the street. She stated that the resident was being very aggressive and would not allow her to turn him around or redirect his wheelchair. She stated that she was not the resident's nurse and felt he had not recognized her and why he had been aggressive with her. She stated she called LVN B and informed her where he was located and her, MDS Nurse, and LVN B assisted getting the resident back into the facility. She stated that it was a warm summer day as it was August, but it was not too hot that day and resident was not sweating. She stated at the time she was not aware of any door or alarm malfunctioning's relating to the resident's wander guard. She stated that the resident wore a wander guard, but apparently the door had not recognized his guard when he went out the door. She stated on an unknown date/time she received an in-service provided by the DON on elopements and supervision. She stated that the facility also changed out the resident's wander guard and fixed the door. She stated since that incident, the resident wore two wander guards. She stated the important of supervision and use of wander guards and functioning alarms was to ensure that residents with impairments especially Resident #2 remain safe and secure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Westwood	8702 Course Drive Houston, TX 77099

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 - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/21/2025 at 04:46 p.m., the DON stated that she was not on shift 08/02/2024 when she received a call from MDS Nurse that Resident #2 had eloped to the parking lot and was being aggressive when MDS Nurse tied redirect him back inside the facility. She stated MDS Nurse called LVN B who came to the parking to assist getting resident back into the facility. She stated the resident's skin was tacked, and his wander guard had still been attached. She stated the surveillance video was reviewed and found that the resident had followed other's out of the building approximately 13-minutes from the time resident left the building until he was located. She stated that the facility's main door had ben malfunctioning off and on duration of a month the resident eloped. She stated that the staff were in-serviced on overall elopements, safety and dehydration, and heat related illness. She stated she also gave them a verbal picture of what could have gone wrong had the resident been outside longer. She stated that the resident was not able to communicate clearly. She stated there had been no other incidents of the resident eloping. She stated it was her expectations that the staff supervise residents by always having visual awareness of them, practically after dinner, having someone at the front during the evening with eyes on the door, and being mindful of residents located in the common area. Interview on 02/21/2025 at 03:57 p.m., LVN C stated on 08/02/2024, she was informed by LVN B that Resident #2 was missing. She stated since there was already staffing looking for the resident inside and on around the property that she would began search the neighborhood in her car. She stated that she exited the facility property. She stated she found the resident wheeling himself in his wheelchair out on the street near the Walmart across the street. She stated that the resident was being very aggressive and would not allow her to turn him around or redirect his wheelchair. She stated that she was not the resident's nurse and felt he had not recognized her and why he had been aggressive with her. She stated she called LVN B and informed her where he was located and her, MDS Nurse, and LVN B assisted getting the resident back into the facility. She stated that it was a warm summer day as it was August, but it was not too hot that day and resident was not sweating. She stated at the time she was not aware of any door or alarm malfunctioning's relating to the resident's wander guard. She stated that the resident wore a wander guard, but apparently the door had not recognized his guard when he went out the door. She stated on an unknown date/time she received an in-service provided by the DON on elopements and supervision. She stated that the facility also changed out the resident's wander guard and fixed the door. She stated since that incident, the resident wore two wander guards. She stated the important of supervision and use of wander guards and functioning alarms was to ensure that residents with impairments especially Resident #2 remain safe and secure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Westwood		STREET ADDRESS, CITY, STATE, ZIP CODE 8702 Course Drive Houston, TX 77099	

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 - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/21/2025 at 04:46 p.m., the DON stated that she was not on schedule she received a call from MDS Nurse who was in the parking lot with Resident #2 who was being aggressive with her and not allow her to redirect him back inside. She stated she told MDS Nurse to call LVN B who was the resident's nurse and familiar with the resident. She stated that MDS Nurse told her, I am trying to call her (LVN B) right now, but he is being very aggressive, he won't let me touch him, he is trying to fight me. She stated that MDS Nurse stated that the resident was refusing to allow her to touch him and was being aggressive. She stated she advice the MDS Nurse to call LVN B who had been someone he had been familiar with. She stated that the resident allowed LVN B to assist him back inside and gave him a cup of coffee as she performed her assessment of him. She stated resident was assessed find his skin in tacked, and his wander guard was still attached. She stated she later looked back and the surveillance video and found that the resident had followed another resident's family out the building. She stated it had been approximately 13-minutes from the time resident left the building until he was located. She stated during that time frame it was a duration of a month or so that the main facility door had been malfunctioning. Maintenance would check it and it would work fine and then other times, the alarm would go off for no reason. She stated after a few complaints, it was noted that the door needed to be fixed and the resident received a new wander guard that was attached to his ancle. She stated that the staff were in-serviced on overall elopements, safety and dehydration, and heat related illness. She stated she also gave them a verbal picture of what could have gone wrong had the resident been outside longer. She stated that the resident was not able to communicate clearly. She stated that she was aware that the resident enjoyed going outside for fresh air and she would take him and use time to sit outside and cut his nails. She stated there had been no other incidents of the resident eloping. She stated it was her expectations that the staff supervise residents by always having visual awareness of them, practically after dinner, having someone at the front during the evening with eyes on the door, and being mindful of residents located in the common area. Interview on 02/24/2025 at 11:40 a.m., LVN B stated on 08/02/2024, she was called by a staff member who which she could not recall regrading Resident #2 missing. She stated they began looking for the resident in other rooms on the hall he resided on. She stated then she received a call from MDS Nurse who stated she saw him in the parking lot. She stated that she went out to get the resident, checked his vital signs which were within range and placed in to bed. She stated that the resident had on a wander guard, was not sure what happened that he was able to get out the door without their knowledge. She stated she called DON, there resident's family and physician, and charted notes on the incident. She stated that the resident was not overheated nor sweating when she found him in the parking lot. She stated it was important for residents to be supervised and to ensure their safety and keep them from harm's way. She stated failure could result in injury In an interview on 03/06/2025 at 5:37 PM the Maintenance Director stated he checked the wander guard system daily. The wander guard system had a malfunction around August 2024, but he was not sure how long it had not worked properly. During that time the door only had one keypad. The automatic latch was not working properly so the door would not close, or the alarm sometimes would not sound if a resident went by the door. If the door was already open and a resident was leaving the alarm would not sound off. The system was replaced. This system has two keypads one for the door and one for the wander guard system. Staff notify him if there are any issues with the door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Westwood		STREET ADDRESS, CITY, STATE, ZIP CODE 8702 Course Drive Houston, TX 77099	

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 - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/06/2025 at 5:51 PM CNA D stated staff knows residents are an elopement risk if they have a wander guard on, they can check the kiosk on the wall for their care plan, or the nurse will let the aides know. If a resident is missing staff report this to the nurse and try to search for the resident inside and outside the facility. If the wander guard system is broken, then staff notify the Nurse and Maintenance Director. Staff must monitor door until its back working. In an interview on 03/06/2025 at 5:55 PM CNA E if a resident is missing, they search for the resident throughout the facility. Residents that are an elopement risk have wander guard bracelets. Staff can look on kiosk and see the resident's care plan. Staff will take residents to the door in the morning to determine if the wander guard system is working. She has worked at the facility for 8 years and knows residents behaviors and if they are exit seeking. If the system was not working properly, they notify the Maintenance Director. In interview on 03/06/2025 at 5:59 PM CNA G stated she knows residents that are an elopement risk because they have a wander guard bracelet. Staff can the care plans of the resident. When residents go missing staff perform a search. Staff report any issues to the Maintenance Director. Residents that go to the door are redirected. The door is monitored if it is not working, and residents are redirected when they go toward the door. In an interview on 03/06/2025 at 6:04 PM RN F stated when a resident was missing, she notified the Administrator and DON. The staff check the facility and surrounding areas. She stated if the wander guard system was down the nurses notified the DON, Administrator, and Maintenance Director to get instructions. She stated she completed the elopement risk assessments on residents and monitored their behaviors. The physician were notified, and orders were written for wander guard bracelets. She stated that staff could tell if a resident maybe exit seeking if they constantly went by doors and look out windows. In an interview on 03/06/2025 at 6:09 PM, LVN H stated residents who were an elopement risk had elopement risk assessment and wander guard bracelet. The Maintenance Director tested the wander guard system. If the system was down staff would monitor the door and may put a staff to just monitor the door. He stated he would let the DON know the system was down. In an interview on 03/06/2025 at 6:12 PM ADON A stated the front door malfunctioned in the past, but it was fixed. Staff were unable to keep the door locked. The door would not lock, the alarm would not sound, or the alarm would go off when no one was near the door. When the wander guard system was down the facility had staff monitor the door. In an interview on 03/06/2025 at 6:17 PM LVN B stated when the wander guard system was down, the facility normally had someone in the front of the building watching the door. Resident #3 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Westwood		STREET ADDRESS, CITY, STATE, ZIP CODE 8702 Course Drive Houston, TX 77099	

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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's Face Sheet, dated 02/20/2025, reflected the resident was a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident's diagnosis included but were not limited to other sequelae of cerebral infarction (stroke), metabolic encephalopathy (confusion, memory loss and loss of consciousness), essential (primary) hypertension, cerebral infarction, vascular dementia (impaired blood flow causing memory loss and confusion), severity, without behavioral disturbance, psychotic disturbance (mental disorder), mood disturbance, and anxiety. Review of Resident #3's Quarterly MDS dated [DATE] BIMS of 14 reflected resident had cognition. score of 14 out of 15 which indicated he had intake cognition. Review of Resident #3's Comprehensive Care Plan captured date of 02/21/2025 reflected: FOCUS: Resident had impaired cognitive, unction or impaired thought processes at times r/t Dementia. Date Initiated: 07/22/2021 Revision on: 08/22/2022. GOAL: Resident will be able to communicate basic needs on a daily basis through the review. Date Initiated: 07/22/2021 Revision on: 02/20/2025 Target Date: 05/19/2025 date. INTERVENTIONS: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 08/22/2022. Ask yes/no questions in order to determine the resident's needs. Date Initiated: 07/22/2021. Cue, reorient and supervise as needed. Date Initiated: 07/22/2021 Monitor/document/report as needed any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty RN expressing self, difficulty understanding others, level of consciousness, mental status. Date Initiated: 08/22/2022. Present just one thought, idea, question or command at a time. Resident #4 Review of Resident #4's Face Sheet, dated 02/20/2025, reflected the resident was a [AGE] year-old female who initially admitted to the facility on [DATE]. Resident's diagnosis included but were not limited to hypertension, Alzheimer's disease with early onset, insomnia, major depressive disorder, generalized anxiety disorder, cognitive communication other lack of coordination, and unspecified lack of coordination. Review of Resident #4's Quarterly MDS dated [DATE] reflected resident had a BIMS of 03 reflected resident severely cognition impairment. Review of Resident #4's Comprehensive Care Plan captured date of 02/21/2025 reflected: FOCUS: Resident was at risk for increased falls with Alzheimer's Disease and was a wanderer. Date Initiated: 06/14/2023 Revision on: 06/14/2023. FOCUS: Resident elopement risk/wanderer and at risk for possible injury with impaired safety awareness and diagnosis of dementia. Resident wearing a wander guard for safety. On 05/24/2024 resident with behavior of trying to get out of facility by wandering, had exit seeking behavior, wander guard in place. Date Initiated: 06/14/2023 Revision on: 06/10/2024. FOCUS: at risk for increased falls with Alzheimer's Disease, resident was a wanderer. Date Initiated: 06/14/2023 Revision on: 06/14/2023 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER: Focused Care at Westwood		STREET ADDRESS, CITY, STATE, ZIP CODE: 8702 Course Drive Houston, TX 77099	

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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's Progress Notes Dated 08/07/2024 at 09:05 p.m. reflected: Social Service Note Text: Quarterly Social Service Assessment for Resident #4 who continued to exhibit memory problems related to her Alzheimer's Disease. She continued to be up and dressed daily assisted by staff persons walking around the facility freely. She interacts with others of her choice, oftentimes, offering to help residents by pushing their wheelchairs for them. She continued to receive psychotropic medications which are being monitored by Psychological Services. Resident #4 continues to require redirection when trying to leave the facility to go pick up her grandchildren. Her family members continue to visit regularly to provide emotional support while being attentive to her personal needs. There are no plans for discharge from this facility so she will remain for long term care placement. SW will continue to visit one to one and allow open expression of feelings while monitoring for any issues which may arise requiring Social Service assistance. Observation/Interview on 02/20/2025 at 10:10 a.m., Resident #4 laying on her made bed fully dressed. Resident with or without others. Resident was not able to answer any more questions. Interview on 02/20/2025 at 2:25 p.m., DON stated that Resident #4 had attempted elopement in the past and had been wearing a wander guard. She stated that the resident's sister comes to the facility often to braid her hair resident can been seen looking for her sister thereafter. She stated that ADON had to bring resident back into the facility after an elopement and attempt. She stated at that time it had been determined the resident had taken off her wander guard. She stated the resident refused to put it back on so the sister came up to the facility the next day to address the resident who then allowed them to place it back on. She stated that they called in the elopement to Health and Human Service and it had been investigation unsubstantiated. Resident #5 Review of Resident #5's Face Sheet, dated 02/20/2025, reflected the resident was an [AGE] year-old male who initially admitted to the facility 09/03/2023 and readmitted on [DATE]. Resident's diagnosis included but were not limited to malignant neoplasm of unspecified part of unspecified bronchus or lung, encephalopathy, insomnia, restlessness and agitation, essential (primary) hypertension, brief psychotic disorder, benign prostatic hyperplasia without lower urinary tract symptoms, presence of cardiac pacemaker, shortness of breath, other lack of coordination, cognitive communication deficit, and other lack of coordination. Review of Resident #5's Annual MDS assessment dated of 08/18/2024 reflected resident had a BIMS score of 03 indicating the resident had severe impaired cognition. Section P - Restraints and Alarms. P0200. Alarms: E. Wander/elopement alarm. Used less than daily. Review of Resident #5's Quarterly MDS assessment dated [DATE] resident had a BIMS score of 02 indicating he had severe impaired cognition. Section P - Restraints and Alarms. P0200. Alarms: E. Wander/elopement alarm. Used less than daily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Westwood	8702 Course Drive Houston, TX 77099

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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #5's Care Plan capture date of 02/21/2025 at 10:06 a.m., reflected that resident was an elopement risk/wanderer and at risk for possible injury with impaired safety awareness and diagnosis of dementia. At higher risk with weekend pass with family, and continuous removal of wander guard device. Date Initiated: 10/24/2023 Revision on: 05/25/2024. GOAL: Will be maintained throughout the review date. Date Initiated: 10/24/2023 Revision on: 06/11/2024 Target Date: 03/22/2025. INTERVENTION: Assess for fall risk. Date Initiated: 10/24/2023 Revision on: 10/24/2023. Distract Resident #3 from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books. Date Initiated: 10/24/2023 Revision on: 10/24/2023. Provide structured activities: Toileting, walking inside and outside, reorientation strategies, including signs, pictures and memory boxes. Date Initiated: 10/24/2023 Revision on: 10/24/2023. Wander guard placed for resident's safety; bracelet will alert staff when resident attempts to exit doors of facility. Staff to monitor daily. Date Initiated: 10/24/202. Revision on: 10/24/2023. Wander guard device disguised and attached onto rollator. Educated family on importance of keeping wander guard in place. Date Initiated: 03/14/2024. Review of Resident #5's Elopement assessment dated [DATE] at 01:47 p.m. The resident was Is the resident cognitively impaired with poor decision-making skills (i.e., intermittent confusion, cognitive deficit or disoriented all the time)? Yes. If yes, explain (no explanation provided). Intervention: Personal safety alarm devices. SUMMARY/CONCLUSIONS/RECOMMENDATIONS: Same as above. Review of Resident #5's Order dated 01/24/2024 at 02:37 p.m., reflected: Order Summary: Wander guard check for placement Description: Wander guard check for placement. every shift. Resident #6 Interview on 02/20/2025 at 02:25 p.m., DON stated that Resident #6 had not been exiting seeking in a long time but could not provide any specific dates/times. She stated that the resident had previously fought to go outside until she was taken out. Observation/interview on 02/20/2025 at 10:21 a.m., Resident #3 stated that Resident #2, #4, #5 and #6 who were all elopement risks with wander guards. He stated in August of 2024, the facility's main entrance door failed to alarm when residents with wander guards went out the door. He stated on 07/16/2024, during the day, Resident #6 left through the back door and the alarm went off. He stated he looked for staff to help and could not find anyone. He stated he opened the door using a shoe to propped open the door went out to assisted Resident #6 back into the facility. He stated at that time a staff whose name he could not recall, helped bring Resident #6 back into the facility. He stated on 08/02/2024, around 05:00 p.m., Resident #2 left the facility through the front door. He stated that the alarm did not go off because the resident did not have on the device that alerts staff when a resident leaves (wander guard). He stated that Resident #2 used his right leg to scoot in his wheelchair about half a mile down the road. He started a passerby whose name or description he could not provide, reported to the facility that Resident #2 was seen. He stated that LVN C left the facility in her vehicle and found the Resident. He stated that the resident was gone about 2-hours. He stated that it was 100 degrees outside on 08/02/2024 when staff found the resident. He stated while having a mock fire drill, Resident #5 walked past all of the staff and out of the front door unnoticed. He stated the alarm did not go off because he was not wearing his wander guard. He stated another (unknown) resident altered s