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	06/16/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 (Resident #1) residents reviewed for respiratory care.-The facility failed to ensure Resident #1 had an order for oxygen before administering oxygen at 3.5 L via nasal cannula from 05/12/26 through 06/16/26.This failure could have placed residents at risk of developing respiratory complications and a decreased quality of care.Findings included:Record review of Resident #1's face sheet dated 06/19/26 revealed she was initially admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. Resident #1 had diagnoses which included dementia (a loss of memory, language, and thinking abilities that were severe enough to interfere with daily life), COPD (lung disease that made it hard to breathe), and chronic respiratory failure (a long-term, ongoing condition where the lungs could not properly exchange oxygen and carbon dioxide).Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 07, indicating moderate cognition. Further review of the MDS did not reveal that the resident was on oxygen.Record review of Resident #1's care plan initiated on 11/06/23 revealed the resident had oxygen therapy related to COPD. Intervention: oxygen setting: O2 at 2-3 L as ordered.Record review of Resident #1's May 2026 order revealed oxygen at 2-3 L/NC continuous R/T COPD was discontinued on 05/11/26.Record review of Resident #1's June 2026 order revealed Resident #1 was readmitted to the facility on [DATE], an order for O2 at 3-4 L via NC continuously to maintain O2 sats greater than 90% every shift for oxygen supplementation was initiated on 06/16/26.Record review of Resident #1's June 2026 order revealed Resident #1 was readmitted to the facility on [DATE] an order for O2 at 2-3 L via NC continuously to maintain O2 sats greater than 90% every shift for oxygen supplementation was initiated 06/16/26.During an observation and interview on 06/16/26 at 10:35 a.m., Resident #1's oxygen setting on the concentrator read 3.5 L, and Resident #1 was on her back in bed with the nasal cannula in her nostrils. Resident #1 said she did not touch or change the setting on the concentrator. She said she was not experiencing any shortness of breath.During an observation and interview on 06/16/26 at 10:37 a.m., RN A said the oxygen was set at 3.5 L and Resident #1 had an order for oxygen at 3 to 4 liters. She then checked Resident #1's order on her computer and said she did not see the order for oxygen and was going to talk to the DON.During an interview on 06/16/26 at 11:55 a.m., RN A said Resident #1 was on oxygen at 3 to 4 liters before she went to the hospital, and the order was discontinued and was not transcribed after Resident #1 returned from the hospital. She said the resident was administered oxygen without an order. RN A said she put back the order for 3 to 4 liters after she talked to the DON at 11:00 a.m. She said the facility protocol was to have a physician order for oxygen administration before oxygen was administered to any resident. She said oxygen could have affected Resident #1 in a negative way when the correct liter flow was not administered because oxygen had effects on the resident's brain. RN A was reviewing Resident #1's order during this interview and said she had just found the discontinued oxygen order, which was 2 to 3 liters, and the setting on the concentrator was 3.5 L, which was higher than the previous order. RN A said (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1 had COPD and when more oxygen was administered, the resident could have suffocated because the resident was not able to exhale carbon dioxide in a timely manner. She said she had just discontinued the order for 3 to 4 liters and entered 2 to 3 liters oxygen now. RN A said she thought the resident's previous order was 3 to 4 liters because the setting on the concentrator was 3.5 liters.During an interview on 06/16/26 at 2:20 p.m., the ADON said RN A should have checked the setting on the concentrator and it should have matched the order. She said Resident #1 was readmitted back to the facility on [DATE] from the hospital. She said the nurses were supposed to fax the orders to the physician when a resident returned from the hospital, and she did not see any order for oxygen. The ADON said the nurse should not have gone off the previous order because it was discontinued when Resident #1 went to the hospital. She said Resident #1 may not have needed oxygen because the resident may have been saturating at 100%. She said Resident #1 had COPD and should not have received oxygen without an order because Resident #1 could have gone into respiratory distress if administered more oxygen than needed. She said the nurse managers followed up the next day after admission or readmission and made sure the resident's orders were entered into the computer correctly. She did not respond when asked if she had checked Resident #1's oxygen order.During a telephone interview on 06/16/26 at 2:37 p.m., the NP said none of the nurses called her for an oxygen order when Resident #1 was readmitted and today. The NP said Resident #1 should not have been on oxygen if there was no order. She said if Resident #1 was given more oxygen than prescribed, the resident would have retained CO2 because Resident #1 had COPD.During an interview on 06/16/26 at 3:47 p.m., the DON said the nurse who admitted Resident #1 should have reviewed Resident #1's medication with the physician when the resident returned from the hospital. She said if the resident returned to the building with oxygen on, the admitting nurse should have notified the physician that the resident had oxygen on but no order, and then the physician would have either given an order for oxygen or discontinued the oxygen. She said the nurse should have completed the resident medication review on the admission day, and the ADON should have checked and ensured Resident #1's orders were transcribed properly and should have noted that there was no order for oxygen while the resident had oxygen on. The DON said there was a problem because there was no proper oxygen administration order for Resident #1 when she returned from the hospital. She said Resident #1 could have had an adverse reaction from not having an order because Resident #1 could have had a nosebleed if she was administered more oxygen than required. She also said Resident #1 had COPD and may have gone into exacerbation when given more oxygen than required.During a telephone interview on 06/16/26 at 4:01 p.m., an attempt was made to reach LVN B, who was the nurse that readmitted Resident #1 back to the facility on [DATE].Requested facility policy on oxygen administration from the administrator and DON, but it was not provided upon exit.