

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

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Form Approved OMB
No. 0938-0391

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 05/22/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan for each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 8 residents (Resident #67 and Resident #3) reviewed for comprehensive care plans. 1.The facility failed to provide Resident #67 with a comprehensive person-centered care plan to address colostomy. 2.The facility failed to address Resident #3's digoxin and insulin on his care plan.This failure could place residents at risk of not having personalized plans developed to address their specific care needs.Findings included:1. Record review of Resident #67's face sheet, dated May 20, 2026, revealed a [AGE] year-old male, with an admission date of 02/18/2024, with diagnosis including Unspecified Dementia, unspecified severity, with agitation (a decline in mental ability including memory, language, reasoning, and problem solving severe enough to interfere with daily life) and colostomy status (a medical term used to describe a patient who has a surgically created opening in their abdomen (called stoma) that connects a part of the large intestine (colon) to the outside of the body).Record review of Resident #67's Quarterly MDS assessment, dated 03/21/2026, revealed BIMS 03, indicating a severe cognitive impairment status in section C. In Section GG revealed that Resident #67 was triggered as dependent on staff for tub/shower and transfers. In section H revealed that Resident #67 required an ostomy (including urostomy, ileostomy, and colostomy). Record review of Resident #67's May 2025 physician orders, revealed the following orders: Colostomy bag cut to fit QD & PRN with a start date of 01/08/2024, Colostomy Care Q shift & PRN with a start date of 01/08/2024, Colostomy-Empty Bag Q shift, with a start date of 01/08/2024. Record review of Resident #67's undated care plan revealed no focus, goal, or interventions for colostomy. In an observation and interview on 05/20/2026 at 2:25pm with ADON A, she stated the MDS Nurse, ADONs, and DONs were responsible for updating the care plans. She stated the residents should not be care planned for things that they do not have. ADON A reported she could not remember if Resident #67 had a colostomy bag or not. Surveyor and ADON A did an observation of Resident #67's, upon entering the room, ADON A asked Resident #67 if he still had his colostomy bag and he reported he did not,. ADON A did an observation of Resident #67 and observed that he did have a colostomy bag, then Resident #67 replied and stated, oh that's what that is. ADON A stated the resident should have been care planned for it. She stated she was not sure why it was not included in his care plan and reported it may have been an oversight. ADON A stated residents (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: 676116	Facility ID: 676116
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be care planned for orders such as colostomy, insulin, and oxygen; when asked about the risk of it not being care planned, she stated she did not know what the risk was. Record review of Resident #3's undated face sheet revealed an [AGE] year old male who admitted to the facility on [DATE]. He had diagnoses of type 2 diabetes mellitus (body does not produce insulin or resists it), and atrial fibrillation (irregular heart rate).Record review of Resident #3's Quarterly MDS assessment, dated 3/31/26, revealed a BIMS score of 3 out of 15 which indicated severely impaired cognition. Resident #3 was partial/moderate assistance (helper does less than half the effort) for all ADLs. The assessment revealed the resident received insulin injections daily and he was not on an anti-coagulant.Record review of Resident #3's Care Plan, dated 9/2/25, revealed a Focus: Resident #3 was on anticoagulation therapy r/t atrial fibrillation (Initiated 9/16/25 Revised: 9/26/25). The interventions included administering the anti-coagulant as ordered. There was no mention of insulin or digoxin.Record review of Resident #3's Physician Orders on 5/21/26 revealed the following orders from MD D:-Digoxin Oral Tablet 62.5mcg, Give 1 PO QD for afib/heart failure. Ordered 11/7/25.-Humalog Kwikpen Subcutaneous Solution Pen-injector 100u/ml, Inject per sliding scale ac/hs (before meals and at bedtime). Ordered 11/7/25.-Lantus SoloStar Subcutaneous Solution Pen-injector 100u/ml, Inject 12u SQ Q am for DM2. Ordered 3/23/26.-Lantus SoloStar Subcutaneous Solution Pen-injector 100u/ml, Inject 12u SQ Q am for DM2 Hold if BS <100. Ordered 5/21/26.In an interview on 05/21/2026 at 7:11A.M. with the DON, she stated if the care plan was acute then the DON, ADON, MDS or floor nurse would update the care plan and if it was comprehensive, the MDS Nurse updated it. She stated a care plan should be updated when there was a change. She stated when something was discontinued, they tried to update it as soon as possible. She stated the residents should not be care planned for things they did not have, ex. such as foley, g tube, or trachs. She stated Resident #67 should have been care planned for his colostomy bag because it was something that he currently had. She stated the care plans were for family and goal purposes. The DON stated and reported she could not say there was an actual risk of negative outcome for the resident by it not being care planned because the staff could follow the orders. She stated the care plan should be in place so it will follow through with the residents' total care. She stated Resident #3's insulin should be care planned. She stated if Resident #3 was prescribed Digoxin for his heart, then it should be care planned as well. She stated she did not know why it was not included in the care plan and she stated it may have been overlooked. She stated the risk of those things not being in the care plan was not having the interventions in place for the residents to tell staff what to do if something happened.In an interview on 05/22/2026 at 10:22A.M. with MDS Nurse, she stated she had been employed at the facility since March 2026 and reviewed some of the care plans, but she had not gotten around to review all care plans in their entirety. Record review of the facility policy titled, Resident Assessment, Comprehensive Care Plan, dated 01/20/2021, read in part, Policy .Every resident will have an individualized interdisciplinary plan of care in place. The Care Plan is revised every quarter, significant change of condition, Annual or as the resident condition change on an individualized basis.5. The Interdisciplinary Team will review the healthcare practitioner's notes and orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a Comprehensive Care Plan to meet the residents' immediate care needs including but not limited to: .a. Initial goals based on an admission include GG Section discharge goals. b. Physician orders.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Number of residents sampled: Number of residents cited: The facility failed to ensure physician orders were obtained and care plans were updated to reflect the use of bed rails for 5 of 5 residents reviewed with bed rails. This failure had the potential to result in the inappropriate use of bed rails and increased risk of entrapment, injury, and decline in resident well-being. This failure could place residents at risk for entrapment, injury, restricted movement, and the use of unnecessary physical restraints. Findings included: During observations on 05/19/26 at 10:00am time, bed rails were in use for Resident #1, Resident #3 Resident #5 Resident #7, and Resident #9. Record reviews conducted on 05/20/26 revealed that Residents #1, #3, #5, #7, and #9 had no physician orders authorizing bed rail use and no care plans addressing the use, monitoring, risks, benefits, or clinical necessity of bed rails. During an interview on 05/20/26 at 1:35 p.m., the Administrator stated the facility was a restraint-free facility; however, some residents had bed rails because they were hospice residents. The Administrator further stated that physician orders were required for residents utilizing bed rails. During an interview on 05/21/26 at 9:00 a.m., the Director of Nursing (DON) stated the facility was restraint-free and confirmed that none of the residents identified with bed rails had physician orders or care plans addressing bed rail use. During an interview on 05/21/26 at 9:10 a.m., the Assistant Director of Nursing (ADON) stated she was unaware that physician orders were required for residents using bed rails. During an interview with Resident #1 on 05/19 at 10:10 am she stated that she uses the bedrails to help her move around in her bed. Record review of facility policy on 05/22/26 at 10:00 a.m., titled ,Restraint Management, dated 04/2021 revealed that physician orders must be obtained and care plan updated to reflect appropriate use of siderails.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview and record review the facility failed to ensure the accurate acquiring, dispensing, receiving, and administering of medications for 1 of 1 medication storage rooms, 1 of 8 (100 Hall Nurse Cart) medication carts, and 1 of 1 (Resident #77) residents, reviewed for pharmacy services.-The facility failed to ensure Resident #77's expired Furosemide 20mg was not stored with current medications on the 100 Hall Nurse Cart.-The facility failed to ensure 9 expired wound cultures were not stored with current medications and cultures in the medication storage room. These failures could place residents at risk for not receiving the therapeutic benefit of the medication and/or worsening health concerns. Findings included: Record review of Resident #77's undated face sheet revealed she was a [AGE] year old female who admitted to the facility on [DATE]. She had diagnoses of acute respiratory failure with hypoxia (not enough oxygen in the blood), type 2 diabetes mellitus (body does not produce insulin or resists it), and congestive heart failure (fluid build up due to heart not pumping). Record review of Resident #77's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 7 out of 15 which indicated severely impaired cognition. Resident #77 was partial/moderate assistance (helper does less than half the effort) for all ADLs. The assessment revealed the resident had shortness of breath with exertion (movement), when sitting at rest, and when lying flat. The resident was not taking a diuretic (medication to increase urination) like furosemide. Record review of Resident #77's Care Plan dated 4/5/22 revealed a Focus: Resident #77 had the potential for dehydration/fluid deficit r/t daily diuretic use. Interventions included administering medications as ordered. Focus: Resident #77 had CHF and was at risk for activity intolerance r/t fatigue d/t cardiac insufficiency, and at risk for excess fluid volume r/t cardiac failure. Interventions included administering medications per orders. Record review of Resident #77's Physician Orders from 5/22/26, revealed the following orders from MD D:-Lasix Oral Tablet 20mg, 1 PO Q Mon/Wed/Fri in the AM. Ordered on 8/6/24, discontinued 11/20/24.-Lasix Oral Tablet 20mg, 1 PO QD. Ordered on 2/12/26, discontinued on 2/19/26.-There were no current orders for Lasix. In an observation and interview on 5/22/26 at 9:09am, Resident #77's blister pack of Furosemide (increases urination) 20mg that had expired on 11/12/25 was found on the 100 hall Nurse Cart. LVN K said she checked her cart weekly for expired medications and if a resident received an expired medication they could have a bad reaction or it may not work. In an observation and interview on 5/22/26 at 10:19am, 9 wound cultures were found in the medication storage room that had expired on 4/9/26. LVN K said if the culture was used and it was expired the lab would not accept it or it may not work. In an interview on 5/22/26 at 12:15pm, the DON said she expected staff to check their medication carts daily before each shift. She said the ADON also checked the carts and the medication room weekly. She said if an expired medication was given to a resident it could cause adverse effects or not be effective. Record review of the facility's policy and procedures on Medication Packaging (no date) read in part: Medications are provided in packaging to facilitate accurate administration and accountability of the medication. All packaging meets USP (United States Pharmacopeia) standards. Unit-dose packages have an expiration date (beyond-use date) on them that (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is checked before administering the medication to the resident. Record review of the facility's policy and procedures on Administering Medications (revised April 2019) read in part: Medications are administered in a safe and timely manner, and as prescribed. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview and record review the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 of 1 (Resident #65) residents reviewed for tube feeding. -The facility failed to ensure Resident #65's G-tube was in the correct place before he was administered medications on 5/20/26. This failure could place residents at risk for the medications going into the abdominal cavity, pain, infection, and hospitalization. Findings include: Record review of Resident #65's undated face sheet revealed he was an [AGE] year old male who admitted to the facility on [DATE]. He had diagnoses of diverticulitis (inflammation or infection of pouches) of large intestine, PNA (lung infection), dysphagia (trouble swallowing), type 2 diabetes (body does not produce insulin or resists it), heart failure (heart does not pump effectively, and gastrostomy (tube into stomach for nutrition). Record review of Resident #65's Quarterly MDS assessment, dated 3/4/26, revealed a BIMS score of 99, which indicated it was unable to be performed due to the resident's medical condition. The assessment revealed the resident had severely impaired (never/rarely made decisions) cognitive skills for daily decision making. Resident #65 was dependent (helper does all the work, resident does none of the effort to complete the activity) for all ADLs. The resident was receiving PEG (tube into stomach for nutrition) feeding while a resident and received 51% or more total calories through the tube feeding and 501 cc/day per day through it. The assessment revealed the resident had received daily insulin injections. Record review of Resident #65's Care Plan, dated 8/14/25, revealed a Focus: Resident #65 required tube feeding of Glucerna 1.5 (type of g-tube feed) @ 50ml/hr r/t dysphagia (trouble swallowing). Interventions included keeping the resident's HOB elevated 45 degrees during and 30min after feeding, checking for tube placement and gastric contents/residual volume per facility protocol and record, holding feed if aspirating (going into the lungs). Record review of Resident #65's Physician Orders as of 5/20/26 revealed the following orders from MD J:-Calcium Carbonate Oral Tablet 600mg, 1 via g-tube BID. Ordered 3/6/26.-Famotidine Oral Tablet 20mg, 1 via g-tube QD. Ordered 3/18/26.-Jardiance 25mg Tablet, 1 via g-tube QD. Ordered 4/16/26.-Glucerna 1.5 @ 50ml/hr and water 45ml/hr x 22hr, every shift. Ordered 3/5/26. In an observation on 5/20/26 at 10:00am, LVN O did not check Resident #65's g-tube placement and then gave the following medications:-Jardiance 25mg 1 via g-tube-Calcium with Vitamin D 600mcg/10mcg 1 via g-tube-Famotidine 20mg 1 via g-tube In an interview on 5/20/26 at 10:10am, LVN O said to check for placement (ensuring the g-tube is in the right place) on a g-tube, the facility checks the resident's residual (pulling back on a syringe to see how much comes back). He said he did not check for placement because he had checked placement earlier in the morning. LVN O agreed that placement should be checked before each time anything was put in the g-tube because if the residual was not checked and it was too high, the resident could choke. In an interview on 5/20/26 at 12:17pm, the DON said the protocol for checking placement on a g-tube was to check residual each time, before anything is given through the PEG tube. She said checking for placement was to prevent (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident from being too full and aspirating. Record review of the facility's policy and procedures on Enteral Tube Medication Administration (effective 9/2018) read in part: Medications will be administered in a safe and effective manner. The guidelines in this policy detail how to administer medication with an enteral tube. Nursing policies developed by the facility may supersede the procedures outlined in this policy. With gloves on, check for proper tube placement in accordance with facility policy. Check gastric content for residual feeding. Return residual volumes to the stomach. Report any residual above 100ml.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids 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 administer parenteral fluids consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 resident (Resident #41) sampled for parenteral fluids.-The facility failed to ensure Resident #41's PICC line was clean before an IV line was attached to it on 5/20/26.-The facility failed to ensure Resident #41 received all of his ordered antibiotic on 5/20/26.These failures could place residents at risk for infection and risk for not receiving the full therapeutic benefits of the antibiotic.Findings included:Record review of Resident #41's undated face sheet revealed he was a [AGE] year old male who admitted to the facility on [DATE]. He had diagnoses of osteomyelitis of his left ankle and foot (bone infection), infection following surgical site incision, cellulitis of left lower limb (skin infection of left lower leg), type 2 diabetes mellitus (body does not produce insulin or resists it), necrotizing fasciitis (severe infection that destroys soft tissue), and ESBL resistance (drug resistant bacteria).Record review of Resident #41's admission MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, which indicated normal cognition. The resident was independent with all ADLs. Resident was receiving IV antibiotics.Record review of Resident #41's Care Plan dated 4/6/26 revealed a Focus: Resident #41 was on antibiotic therapy Cefepime 1g IV x 14d. Interventions included administering the antibiotics as ordered. Focus: Resident #41 had a PICC (deep line that ends near the heart) line to his LUA. Interventions included treating the site using sterile technique.Record review of Resident #41's Physician Orders as of 5/20/26 revealed the following orders from MD D:-Monitor PICC line for s/s of infection every shift. Ordered 4/3/26.-PICC line dressing and cap change weekly using sterile technique per protocol, one time a day every Thursday. Ordered 4/6/26.-Cefepime HCl Injection Solution Reconstituted (mixed together) 1gm, 1gm IV Q6hr for ESBL for 14 days. Ordered 5/7/26.-Normal Saline Flush Solution, Use 10ml IV every shift for ABT therapy, PICC Line-Flush with 10ml NS prior to med administration. Ordered 4/3/26.In an observation and interview on 5/20/26 at 11:38am, LVN O took the cap off of Resident #41's PICC line and wiped it with an alcohol wipe. He then flushed the line with 10ml of NS. LVN O took the NS syringe off the PICC line and left the PICC line dangling with no cap covering the tip, while he set up his IV line, and reconstituted the antibiotic. During this time Resident #41 put his arm down and the tip of the PICC line was against his arm and his side. Once LVN O had reconstituted (mixed) the Cefepime he did not get all of the liquid antibiotic back into the IV bag and left a moderate amount in the vial that would not be delivered. He spiked (put the IV tubing into the IV bag) the IV tubing and primed it (drained the medication through the line). Then he hooked the tubing up to Resident #41's PICC line without cleaning the tip again, after the resident had been rubbing the tip against his shirt the whole time. LVN O said the medication that was left in the vial was just foam and that happened sometimes when medication was reconstituted. He did not think to clean the tip of the PICC line again and did not see the resident rubbing it against his clothes. He said not cleaning the tip could cause infection control issues.In an interview on 5/20/26 at 12:17pm, the DON said the antibiotic vial should be empty and all of it should be in the IV bag to ensure the resident got all of the medication. She also said the tip of the PICC line should have been cleaned before the IV line was attached to prevent any infection.Record review of the facility's policy and procedures on Administration Procedures: Reconstitution of Medications (effective 2/2009) read in part: To provide guidelines for mixing additives into a sterile IV solution.IV certified nurses with proper training and authority may prepare admixtures when: Medication stability requires mixing (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview and record review the facility failed to ensure that the medication error rate was not five percent (5%) or greater. The facility had a medication error rate of 6%, based on 2 errors out of 33 opportunities, which involved 1 of 7 residents (Resident #65) and 1 of 4 staff (LVN O) observed during medication administration reviewed for medication errors.-The facility failed to administer Resident #65 the correct medication (Calcium 600mg) and instead gave Calcium with Vitamin D 600mcg/10mcg, on 5/20/26.-The facility failed to administer Resident #65 their Insulin Glargine on 5/20/26. These failures could place residents at risk of not receiving the therapeutic effects of their prescribed medications and possible adverse reactions. Finding include: Record review of Resident #65's undated face sheet revealed he was an [AGE] year old male who admitted to the facility on [DATE]. He had diagnoses of diverticulitis (inflammation or infection of pouches) of large intestine, PNA (lung infection), dysphagia (trouble swallowing), type 2 diabetes (body does not produce insulin or resists it), heart failure (heart does not pump effectively, and gastrostomy (tube into stomach for nutrition). Record review of Resident #65's Quarterly MDS assessment, dated 3/4/26, revealed a BIMS score of 99, which indicated it was unable to be performed due to the resident's medical condition. The assessment revealed the resident had severely impaired (never/rarely made decisions) cognitive skills for daily decision making. Resident #65 was dependent (helper does all the work, resident does none of the effort to complete the activity) for all ADLs. The resident was receiving PEG (tube into stomach for nutrition) feeding while a resident and received 51% or more total calories through the tube feeding and 501 cc/day per day through it. The assessment revealed the resident had received daily insulin injections. Record review of Resident #65's Care Plan, dated 8/14/25, revealed a Focus: Resident #65 was at risk for hyper/hypoglycemia (high or low blood sugar) related to insulin glargine/Jardiance. Interventions included giving diabetes medication as ordered by the doctor and monitoring/documenting for side effects and effectiveness. Record review of Resident #65's Physician Orders as of 5/20/26 revealed the following orders from MD J:-Calcium Carbonate Oral Tablet 600mg, 1 via g-tube BID. Ordered 3/6/26.-Famotidine Oral Tablet 20mg, 1 via g-tube QD. Ordered 3/18/26.-Jardiance 25mg Tablet, 1 via g-tube QD. Ordered 4/16/26.-Insulin Glargine Subcutaneous Solution 100u/ml, 5u SQ QD. Ordered 8/8/25. In an observation on 5/20/26 at 10:00am, LVN O gave Resident #65 the following medications:-Jardiance 25mg 1 via g-tube-Calcium with Vitamin D 600mcg/10mcg 1 via g-tube-Famotidine 20mg 1 via g-tube In an interview on 5/20/26 at 11:34am, LVN O said he held the Insulin Glargine 5u because the resident's blood sugar was less than 100 and it was common knowledge to hold the insulin if the blood sugar was less than 100. He said it was ok to hold the insulin even though there was not a doctor's order to hold it or parameters on the insulin. LVN O said he was going to contact the doctor later to let him know. The nurse said he should not have given the Calcium with Vitamin D and should have asked his supervisor about it. LVN O said giving the wrong medication to a resident could be harmful. In an interview on 5/20/26 at 12:17pm, the DON said LVN O should not have held the insulin unless there was an order to hold it, because staff must follow doctor's orders and cannot practice medicine by taking it upon themselves to not give a medicine. She said the nurse should have clarified the Calcium order if he had questions. (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 05/22/2026
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Otherwise, he should have looked for the right medication that was Calcium by itself and not with the Vitamin D in it. The DON said he gave the wrong medication to the resident and giving the wrong medication could cause adverse effects. Record review of Resident #65's blood sugar results as of 5/20/26 revealed his blood sugar was not taken until 2:17pm and was 117. Record review of the facility's policy and procedures on Administering Medications (revised April 2019) read in part: Medications are administered in a safe and timely manner, and as prescribed. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescriber orders. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. Record review of the facility's policy and procedures on General Guidelines for Medication Administration (effective 9/2018) read in part: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer. At a minimum, the 5 Rights - right resident, right drug, right dose, right route, and right time should be applied to all medication administration and reviewed at three steps in the process of preparation: (1) when medication is selected, (2) when the dose is removed from the container, and (3) after the dose is prepared and the medication is put away. Check #1: Select the medication, check the label, container, and contents for integrity, and compare the medication against the Medication Administration Record (MAR) by reviewing the 5 Rights. Always employ the MAR during medication administration. Prior to the administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. If the label and the MAR are different and the container has not already been flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit. Record review of the facility's policy and procedures on Preventing and Detecting Adverse Consequences and Medication Errors (effective 8/2020) read in part: Significant medication related problems are assessed, documented, and reported as appropriate to the resident's attending physician, the Quality Assessment and Assurance Committee, the pharmacy, the consultant pharmacist, and the Food and Drug Administration MedWatch Program or USP/ISMP Medication Error Reporting Program (when applicable). The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis in accordance with the policy on Medication Management. Facility staff monitor the resident for possible medication-related adverse consequences, including mental status changes and/or changes in level of consciousness, when the following conditions occur: Medication error, such as wrong or expired medication. In the event of a significant medication-related error or adverse consequence, immediate action is taken, as necessary, to protect the resident's safety and welfare. Significant is defined as: Requiring medication discontinuation or dose modification. Requiring hospitalization or extending a hospitalization. Resulting in disability. Requiring treatment with a prescription medication. Resulting in cognitive deterioration or impairment. Life threatening. Resulting in death. Data regarding medication adverse (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 05/22/2026
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consequences and errors (i.e., total number of incidents, number of Incidents by category/type, trends) will be compiled and presented to the Quality Assessment and Assurance (QM) Committee by the Director of Nursing on a monthly basis. The QAA Committee then conducts a root cause analysis of medication administration errors to determine the source of errors and implement process improvement steps and compares results over time to determine that system improvements are effective in reducing errors.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review the facility failed to ensure residents were free from any significant medication errors for 1 of 7 (Resident #65) residents reviewed for pharmacy services.-The facility failed to administer Resident #65's ordered Insulin Glargine on 5/20/26.This failure could place residents at risk of not receiving the therapeutic benefits of their medication and possible hyperglycemia (high blood sugar).Findings include:Record review of Resident #65's undated face sheet revealed he was an [AGE] year old male who admitted to the facility on [DATE]. He had diagnoses of diverticulitis (inflammation or infection of pouches) of large intestine, PNA (lung infection), dysphagia (trouble swallowing), type 2 diabetes (body does not produce insulin or resists it), heart failure (heart does not pump effectively, and gastrostomy (tube into stomach for nutrition).Record review of Resident #65's Quarterly MDS assessment, dated 3/4/26, revealed a BIMS score of 99, which indicated it was unable to be performed due to the resident's medical condition. The assessment revealed the resident had severely impaired (never/rarely made decisions) cognitive skills for daily decision making. Resident #65 was dependent (helper does all the work, resident does none of the effort to complete the activity) for all ADLs. The resident was receiving PEG (tube into stomach for nutrition) feeding while a resident and received 51% or more total calories through the tube feeding and 501 cc/day per day through it. The assessment revealed the resident had received daily insulin injections.Record review of Resident #65's Care Plan, dated 8/14/25, revealed a Focus: Resident #65 was at risk for hyper/hypoglycemia related to insulin glargine/Jardiance. Interventions included giving diabetes medication as ordered by the doctor and monitoring/documenting for side effects and effectiveness.Record review of Resident #65's Physician Orders as of 5/20/26 revealed the following orders from MD J:-Calcium Carbonate Oral Tablet 600mg, 1 via g-tube BID. Ordered 3/6/26.-Famotidine Oral Tablet 20mg, 1 via g-tube QD. Ordered 3/18/26.-Jardiance 25mg Tablet, 1 via g-tube QD. Ordered 4/16/26.-Insulin Glargine Subcutaneous Solution 100u/ml, 5u SQ QD. Ordered 8/8/25.In an observation on 5/20/26 at 10:00am, LVN O gave Resident #65 the following medications:-Jardiance 25mg 1 via g-tube-Calcium with Vitamin D 600mcg/10mcg 1 via g-tube-Famotidine 20mg 1 via g-tubeIn an interview on 5/20/26 at 11:34am, LVN O said he held the Insulin Glargine 5u because the resident's blood sugar was less than 100 and it was common knowledge to hold the insulin if the blood sugar was less than 100. He said it was ok to hold the insulin even though there was not a doctor's order to hold it or parameters on the insulin. LVN O said he was going to contact the doctor later to let him know. In an interview on 5/20/26 at 12:17pm, the DON said LVN O should not have held the insulin unless there was an order to hold it, because staff must follow doctor's orders and cannot practice medicine by taking it upon themselves to not give a medication. Record review of Resident #65's blood sugar results as of 5/20/26 revealed his blood sugar was not taken until 2:17pm and was 117.Record review of the facility's policy and procedures on Preventing and Detecting Adverse Consequences and Medication Errors (effective 8/2020) read in part: .Significant medication related problems are assessed, documented, and reported as appropriate to the resident's attending physician, the Quality Assessment and Assurance Committee, the pharmacy; the consultant pharmacist, and the Food and Drug Administration MedWatch Program or (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	USP/ISMP Medication Error Reporting Program (when applicable).The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis in accordance with the policy on Medication Management.Facility staff monitor the resident for possible medication-related adverse consequences, including mental status changes and/or changes in level of consciousness, when the following conditions occur:.Medication error, such as wrong or expired medication. In the event of a significant medication-related error or adverse consequence, immediate action is taken, as necessary, to protect the resident's safely and welfare. Significant is defined as: Requiring medication discontinuation or dose modification. Requiring hospitalization or extending a hospitalization. Resulting in disability. Requiring treatment with a prescription medication. Resulting in cognitive deterioration or impairment. Life threatening. Resulting in death.Data regarding medication adverse consequences and errors (i.e., total number of incidents, number of Incidents by category/type, trends) will be compiled and presented to the Quality Assessment and Assurance (QM) Committee by the Director of Nursing on a monthly basis. The QAA Committee then conducts a root cause analysis of medication administration errors to determine the source of errors and implement process improvement steps and compares results over time to determine that system improvements are effective in reducing errors.		