STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675000	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Beechnut	12777 Beechnut St Houston, TX 77072

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observations, interviews, and record review, the facility failed to care for residents in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 2 of 5 residents (Resident #20, Resident #33, and Resident # 54), reviewed for resident rights. -CNA K was standing while feeding Resident #54 his breakfast on 06/25/24. -LVN B did not provide privacy when administering insulin to Resident #33 on 06/25/2024. -RN A did not provide privacy when administering Resident # 20 G-tube medications on 06/25/2024. This failure placed residents at risk for feeling embarrased, disrespected and diminished quality of life. The findings were: Record review of Resident #54's face sheet dated 06/25/24 revealed a [AGE] year-old male admitted to the NF on 05/08/2017. Resident diagnoses included the following: Parkinson's Disease (disorder that affects movement, often including tremors) without dyskinesia (unwanted or involuntary movement), muscle weakness, dysphagia (difficulty swallowing), major depression, age related physical debility, and attention-deficit hyperactivity disorder (not being able to focus). Record review of Resident #54's quarterly MDS dated [DATE] revealed that resident had a BIMS score of 3 indicating that resident cognition was severely impaired. Further review of the MDS section G reflected that resident was totally dependent and required full staff performance. Record review of Resident #54's Physician Order Summary Report reflected the following order: -Dated 05/11/2024 Carb Controlled diet pureed texture, regular consistency. Record review of Resident #54's Comprehensive Care Plan dated 10/03/2019 and revised on 11/20/2023 reflected that resident was being care planned for requiring assistance with all ADL's self-care performance deficit r/t disease processes. The interventions included eating: resident being totally dependent on skilled nurses for nutritional intake. (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: 675000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Focused Care at Beechnut		STREET ADDRESS, CITY, STATE, ZIP CODE 12777 Beechnut St Houston, TX 77072	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/25/24 at 9:30AM revealed during breakfast on Station A, CNA K standing on Resident #54's right side feeding resident his breakfast. In an interview on 06/25/24 at 10:00AM CNA K said she had been working at the NF for approximately 2 months. CNA K said the reason she was standing while feeding Resident #54 was because she did not have a chair to sit on. CNA K said she was taught in CNA school to sit whenever feeding a resident but had forgotten the reason why she should be sitting instead of standing when feeding a resident. In an interview on 06/25/24 at 11:55AM LVN B (on Station A) said she worked the 6AM-6PM shift. LVN B said when a resident was being fed, the staff should be sitting while feeding the resident. LVN B said this was done to provide the resident with dignity. In an interview on 06/25/24 at 11:05AM the DON said she had been working at the NF for 5 weeks. The DON said whenever she had to assist with feeding a resident, she would sit to feed the resident. The DON said she would have to review the NF policy because it depended on the resident if they wanted the staff to sit while feeding them. Resident # 33 Record review of Resident #33's face sheet revealed a 63-year- old male admitted to the NF on 05/03/2023 with diagnoses that included the following: hemiplegia (muscle weakness or partial paralysis on one side of the body) and hemiparesis (paralysis that affects only one side of the body) following cerebrovascular (decrease in blood flow to the brain) disease affecting the right dominant side, and type two diabetes mellitus (too much sugar in blood). Record review of Resident #33's quarterly MDS dated [DATE] revealed that resident had a BIMS score of 2 indicating that resident cognition was severely impaired. Record review of Resident #33's Comprehensive Care Plan revised 11/15/2023 revealed that resident was care planned for diabetes mellitus with intervention that included to administer insulin as ordered. Record review of Resident #33's Physician Order Summary Report reflected the following order: -Dated 05/23/2024 Humalog (fast acting insulin to treat diabetes) subcutaneous inject 10 units before meals for dm (diabetes mellitus), if blood sugar was below 150 do not give insulin. Observation on 06/25/24 at 11:49AM revealed LVN B entering Resident #33's room to take the residents blood sugar. LVN B did not close Resident #33's door or pull the resident privacy curtain. LVN B continued to care for the resident by taking resident's blood sugar. Resident blood sugar was 272 requiring 10 units of Humalog subcutaneously. LVN B administered 10 units of Humalog subq to resident's left lower abdomen (belly or stomach region). In an interview on 06/25/24 at 12:00PM with LVN B she said she forgot to close Resident #33's door and pull the resident privacy curtain when administering the insulin. Resident #20 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #20's face sheet revealed a 51-year- old male admitted to the NF on 03/19/2023 with diagnoses that included the following: cerebral infarction (decrease blood flow to the brain), dysphagia (difficulty swallowing), gastrostomy (surgical procedure that creates an opening in the stomach to deliver food), aphasia (language disorder that affects a person's ability to communicate), and hemiplegia (muscle weakness or partial paralysis on one side of the body) and hemiparesis (paralysis that affects only one side of the body) following cerebral infarction. Record review of Resident # 20's MDS annual assessment 04/29/2024 reflected that resident had a BIMS score of 1 indicating that resident cognition was severely impaired. Record review of Resident #20's Physician Orders reflected the following: -Dated 04/26/2023 flush with 30ml (water) before and after medication pass with 5 ml between each medication. Record review of Resident #20's Comprehensive Care Plan dated 10/28/2023 and revised 04/29/2024 reflected the following: -Resident #20 required tube feeding r/t dysphagia with an intervention that included resident was dependent with tube feeding and water flushes. Observation on 06/25/24 at 4:10PM of medication administration for Resident #20 via gastrostomy tube by RN A. When RN A entered resident's room to administer resident medications, she did not close the door, nor did she pull Resident 20's privacy curtain. Resident #20 was sitting up in his specialized wheelchair watching a movie on his laptop. Resident #20 had a G-tube with a dressing at the site. RN A proceeded to check the resident's G-tube placement by raising the resident's shirt to auscultate (listen) resident's abdomen (stomach). When RN A was done, she continued with checking the G-tube for any residual. RN A proceeded to administer the resident's medication via G-tube by gravity. In an interview on 06/25/24 at 4:30PM RN A said whenever providing care for a resident, she was supposed to provide the resident with privacy by closing the door or pulling the curtain. RN A said she became nervous and forgot to provide privacy for Resident #20. In an interview on 06/25/24 at 12:07PM the DON said whenever the staff provide care for the resident's they were supposed to provide privacy for the residents. Record review of the NF policy on Meal Service dated 04/2022 revealed in part: .The dining experience will enhance the resident's quality of life .The staff member does not stand, when feeding or assisting the resident with eating. Staff converse with the residents during mealtime . Record review of the NF policy on Resident Rights revised December 2016 revealed in part: .Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence, be treated with respect, kindness, and dignity .privacy and confidentiality .

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 32422 Based on observations, interviews, and record review, the facility failed to immediately consult with the physician and notify the resident representative when the resident experienced a change in condition for 1 of 5 residents (Resident #72) reviewed for a change of condition. The facility failed to notify the physician regarding Resident #72's missed urologist appointments on 3/14/2024 and 5/23/24, and failed to communicate Resident #72's changing skin condition of the groin and resident's report of pain until around 06/10/2024, at which time the penis split measured 8 cm length by 1 cm width by .4 cm depth and appeared red and raw. On 6/28/24 at 5:44PM an Immediate Jeopardy (IJ) was identified and the template was presented to the Administrator and the Interim DON. While the IJ was removed 7/2/2024 at 3:45PM, the facility remained out of compliance at a scope of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. Findings: Record review of the facility facesheet dated 6/28/2024 revealed Resident #72 was a 58- year-old male admitted to the facility on [DATE] and readmitted on [DATE] and with diagnoses that included neuromuscular dysfunction of bladder (the nerves and muscles don't work together very well. As a result, the bladder may not fill or empty correctly.), unspecified and hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (paralysis of partial or total body function on one side of the body, whereas hemiparesis is characterized by one?sided weakness, but without complete paralysis). Record review of Resident #72's care plan with dated 09/05/2023: Focus: Resident #72 had indwelling catheter and is at risk for increased Urinary Tract Infections diagnosis: Neurogenic bladder: Goal: Resident will be/remain free from catheter related trauma through review date, will show no sign/symptom of Urinary Infection through review date: Interventions: Catheter changed PRN change (Size 18FR), check Foley catheter placement, ensure Foley was secured via Velcro strap to reduce friction/pulling q shift, and monitor/record/report to MD for sign/symptom UTI, pain, burning blood-tinged urine, cloudiness, no output, deepening of urine color, increase pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. Record review of Resident #72's quarterly MDS dated [DATE], revealed a BIMS score of 9, indicating moderately impaired cognition. Record review of the weekly skin assessment from April 2024 to June 13, 2024, revealed no documentation for slit on penis. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident # 72's physician orders for March revealed the following order: Urology Consult on 3/14/2024 and 3/30/2024. Physician orders for April included: order dated 04/29/2022 reflected Foley Catheter 18 FR 15 cc bulb to continuous drainage related to diagnosis and on 5/13/20220 reflected another physician's order for Foley catheter 18 FR 15cc bulb to continuous drainage related to (diagnosis renal disease with Hematuria), order with a start date of 4/30/2024 for a wound care consult; one time only for penal wound for 2 days. Physician orders for March 2024 to June 2024, revealed an order: every day and every night shift, monitor for open penial area and notify MD and NP of any change dated 5/2/2024. Record review of Resident #72's TAR (Treatment Administration Record) for May 2024 through June 2024 revealed orders to monitor every shift open penile area and notify MD/NP of any changes. Monitored area on every shift for skin integrity except on 5/13/2024 and 5/14/2024 on night shifts and 5/17/2024 during the day shift. Record review also revealed to monitor every shift the foley insertion site for redness, irritation every day and night shift for skin integrity, and monitor Foley Cath, stripe placement for redness, irritation every shift was provided on 6/28/2024, night shift and through 7/30/2024. Further review revealed the resident did not report pain. Record review of the weekly skin assessment for Resident #72 from April 2024 to June 13, 2024, revealed no documentation for slit on penis. NP notified, awaiting response. Treatment nurse provided care, notified family member. There was no assessment and measurement to opening in the penile area. Record review of Resident #72's progress notes revealed the physician was notified of the blood in the urine on 03/14/24 and 03/30/2024. Record review of progress notes dated 4/14/2024 revealed Resident #72 was documented to have blood in his urine. Record review of progress notes dated 4/30/2024 revealed the first documentation of Resident # 72 was observed to have opening in the penile area due to prolonged foley catheter use. Record review of nurse's progress note revealed on 5/2/24: MD in facility rounding on Resident #72. Documented Nurse follow-up with resident penile area opening with the MD. Resident MD said urologist consult will further evaluate. Resident #72 have urology consult appointment 5/23/24. Further review revealed there were no other NP notes addressing the issue with Resident #72's penis after 05/02/24 and the only physician visit noted was on 05/02/24. Record review of Resident #72's nurse's progress notes and multiple interviews with staff revealed Resident # 72 did not see the Urologist until 6/20/24 due to the Urologist office relocating and the facility was not aware. Record review of Resident 72's Urology consult dated 6/20/2024 revealed diagnoses that included Neurogenic Bladder (the name given to a number of urinary conditions in people who lack bladder control due to a brain, spinal cord, or nerve problem), gross hematuria (when you can see the blood in your urine) and Hyperplasia of prostate (a noncancerous enlargement of the prostate gland) with lower urinary tract symptoms, and now has a penoscrotal hypospadias (in perineal hypospadias, the scrotum is abnormally divided and the urethral opening is located along the center of the divided sac). (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 6/27/2024 at 10:22am during in-dwelling catheter and incontinent care, revealed Resident # 72 had a Velcro strap to his mid-thigh, not securing the catheter. Further observation revealed a slit to Resident #72's penis head to the scrotum. In an interview with Resident #72 at 6/27/2024 at 10:46am, he said that he had pain to the side of the penis and the foley catheter has always been rubbing and pulling on him and his slit grew over time. In an interview on 6/28/2024 at 8:39 am with the MDS Nurse, she said that Resident # 72 went to his urology appointment on May 25th, 2024, but for some reason it was rescheduled, so they did not see him that day. She said that they received the documentation from his urology appointment from 6/20/24 this morning and provided a copy. Observation of Resident #72 at 6/28/2024 at 3:15pm, the Velcro was at the knee of the resident and not securing the in-dwelling catheter. Measurement of the slit length was 8 centimeters, the width was 1 centimeter, and the depth was 0.4 centimeter. The area was pinkish. In an interview on 6/28/2024 at 2:32pm with the Treatment Nurse, she said she identified Resident #72's slit during a skin assessment around March or April 2024. She informed the DON, the MDS Nurse, the family representative, and the doctor. The doctor wrote an order for the resident to see a urologist and wait for their recommendations. The nurse said the resident's penis had a little opening, but no redness and the resident told her he was not in pain. The resident has never told the nurse he felt pain from the split. The nurse said she always made sure the resident had the catheter strap. She said since she noticed the split it has remained that way, although she has not measured the slit length. The nurse said she knew that there was a urology appointment scheduled but she did not know if he made it to that appointment. She never noticed blood in the urine and the resident never mentioned blood in the urine. Interview with the Administrator and Interim DON on 7/1/2024 at 4:12PM regarding failure to notify the physician, DON said the Medical Director is notified when his own residents have a change in condition while the Primary Physician is notified as soon as a change in condition is found. The Charge Nurse was responsible for notifying the physician. The Unit Managers are to follow-up to confirm that the Primary Physicians were notified in the facility's morning meetings. On 7/1/24 at 3:04PM called Resident #72's MD and left message with the answering service. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the MD (Medical Director) on 07/01/2024 at 3:22pm, he said he knew the resident and he was on dialysis. The MD has seen him at the facility. The facility called him about the blood in resident's urine and he does not remember how long ago it was. He said he remembered the call and that the resident was supposed to see a urologist. He doesn't know how long ago the resident was supposed to see the urologist. The MD said someone told him about the slit in the penis. He doesn't know if it was evaluated, but that the resident had a foley catheter and was referred to the urologist to get it repaired. The MD said all communication between the resident's NP and the physician, regarding the resident should be in PCC in the notes. He was informed of the resident's delayed urology consult last week and knew the resident was waiting to go but unsure if the appointment was delayed or cancelled. The MD knows the resident had gone to a urology appointment before and that a follow-up was scheduled. He stated all the appointment information should be in the nursing notes. The MD said he has a group practice, and an NP also sees the MD's patients. Changes in condition were reported to a resident's primary physician and the MD would be notified about his residents. The MD was also notified of significant changes in condition for other residents since he was also the Medical Director of this facility. At QA/QAPI meetings, the MD and the facility will discuss patient care at that time about all patients. The MD does not know how long the slit was, he did not see bleeding from the area last time he saw the resident. When asked if he knew how long the resident had the slit, the MD replied, If you have to put words in my mouth it would be three weeks, but he could not say for sure. The MD said he has seen the resident twice and that the NP has seen this patient as well. Record review of the policy and procedure entitled Change in Resident's Condition or Status dated read in part . Policy Statement- Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) Policy Interpretation and Implementation: The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): d. significant change in the resident's physical/emotional/mental condition, need to alter the resident's medical treatment significantly, refusal of treatment or medications two (2) or more consecutive times), need to transfer the resident to a hospital/treatment center. This was determined to be an Immediate Jeopardy (IJ) on 06/28/2024 at 5:44PM. The Administrator and Interim DON were notified. The Administrator was provided with the IJ template on 07/01/2024 at 4:35PM. The following plan of removal submitted by the facility was accepted on 7/2/2024 at 9:54 am. Plan of Removal Immediate Jeopardy[the facility] . On 7/1/2024 an incident survey was initiated at [the facility] . On 7/1/2024 the state surveyor provided an Immediate Jeopardy (IJ) Template notification that the regulatory services have determined that the condition at the facility constituted an immediate jeopardy to resident health and safety. The facility failed to notify the physician regarding Resident #72's missed urologist appointments and communicate Resident #72's changing skin condition of the groin. F580 - Notify of Changes (Injury/Decline/Room) (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediate Action: o Resident #72's physician was notified of the missed appointment on 5/23/24 on 7/1/24 by the Director of Clinical services. o Resident #72's head to toe assessment was completed by the Treatment Nurse and ADCO on 6/28/24. The weekly skin assessment was updated to show the measurement and description of the split. o All residents with appointments were reviewed, only 1 missed appointment for 7/1/24 due to the Doctor's office not accepting Resident#1's insurance. His physician was notified. The Social worker with his Nurse practitioner was locating another MD that takes resident's insurance. No changes with resident's condition. Facilities Plan to ensure compliance quickly: o The treatment Nurse was provided with 1:1 training notifying the Physician on changes in the skin and updating care plan by the Director of Nursing and was completed on 6/28/24. o The Director of Nursing/Designee initiated an in-service to all charge Nurses on reporting alteration of skin integrity to physician to be completed on 7/2/24. All charge Nurse's will be provided with an in-service prior to the beginning of their shift. o Daily focused rounds will be completed by Nurse management daily on all residents with foley catheter to ensure they have leg strap on, and to identify any irritation and trauma to the penis. If there was any to ensure Physician notification was completed, and the new order received. Nurse managers were in-serviced by the Director of Nursing, completed on 7/1/24. o The Medical Director was notified of the Immediate Jeopardy on 7/1/2024. The medical Director reviewed change of condition/notification of physician policies and made no changes to the policy, this was completed 7/1/24. o The current practice of making outside appointment was reviewed by the IDT, it was determined that the social worker / Designee will oversee making appointment, validating insurance, and appointment before resident goes to the appointment. This will be validated by EDO/designee from the resident's progress note. The physician will be notified of any missed appointments, and the follow-up will be completed. The staff were in-serviced by the Director of Nursing, completed on 7/1/24. o The Social worker/Designee was educated by the Administrator on 7/1/24 to make future urology appointments and discuss with the IDT if they were having any difficulty in getting timely appointments for further direction and to notify the physician of any missed appointments. Monitoring/Observation/Interviews/Record Review: Record review of Resident #72's pain level assessment on 06/29/2024 revealed a pain level of 0. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation and interview on 6/30/2024 at 11:00 am with Resident #72 was sitting in wheelchair eating a snack. He was well-groomed with no odors. Resident #72 said he is feeling okay but wondered why it took the facility so long to address his catheter. He said he was now afraid of an infection from his stoma to g-tube. Resident #72 raised his shirt at that time and a small pea-sized area was observed in what appeared to be a white cream. Resident #72 consented for the DON to come assess him with another staff member. He was then transported back to his room. The DON later came and said that the white substance was not an infection but a cream that they used to treat the stoma called theravox, which was confirmed by viewing the container and conducting a record review of Resident #72's physician orders. In an interview with the Administrator and the DON on 06/30/2024 at 9:38AM, the DON said that Resident #72's doctor told the nurses he will send his paperwork, he did not return from his 06/20/2024 appointment with it. The Administrator and the DON said they were not aware of this situation regarding the facility not following up after the Urologist appointment. The Administrator started on 06/03/2024 and the DON started 05/16/2024 and that they were not aware the follow-up doctor's visit system was broken. They believed the SW was assigned to run the system. The DON said if a resident missed an appointment, it could have caused a delay in care. She also found out that nurses were calling the Urologist's office but not documenting it. Now the facility will send the resident with an envelope to their visit, make sure the doctor's office returns documents, and items needing follow-up back with the resident. If not, the charge nurse will contact the office. The monitoring system will include the DON, the ADON, the Unit Managers, and the SW. In an interview with the SW on 06/30/2024 at 10:33AM, he said that he used to make specialist appointments, and now nursing will assist him with paperwork and documentation. He said that appointments were to be documented in the electronic medical records. The nursing staff will be in charge of managing the communication and will follow-up with the doctor's office. The appointments and changes in condition would be discussed at the morning meetings, and if there were any issues or concerns, he would let the DON and the ADON know. In an interview with RN A on 07/02/2024 at 12:09PM, she said that she was in-serviced on reporting changes in condition to the DON and MD. In an interview with LVN M on 07/02/2024 at 1:51PM, she was in-serviced on foley catheter care, pain management, and scheduling and documenting appointments for residents. In an interview with CNA M on 07/02/2024 at 1:51pm, she said she was in-serviced on foley catheter care for residents. In an interview on 7/1/2024 at 2:40 pm and 7/2/2024 at 1:42 pm with the Social Worker, he acknowledged in-services on notification of changes in condition to the physician, arranging and follow-up processes to ensure resident appointments were coordinated with the physician to include arranging transportation, communication to confirm location of appointment, and communication with the ADON, the DON, and the nursing staff. Documentation of physician appointments and follow-up to ensure the resident's appointment was completed. In an interview on 07/02/2024 at 2:04PM, Social Worker was in-serviced on making appointments and reporting changes in condition to the ADON, the DON, and the MD, including missed appointments. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Focused Care at Beechnut		STREET ADDRESS, CITY, STATE, ZIP CODE: 12777 Beechnut St Houston, TX 77072	

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with LVN N on 07/02/2024 at 2:08PM, he was in-serviced on scheduling and documenting appointments. In an interview with the treatment nurse on 07/02/2024 at 2:15PM, she was in-serviced on appointments and notifying the MD and the DON with changes in condition. In an interview with LVN B on 07/02/2024 at 1:38PM, she was in-serviced on scheduling and following up with residents' appointments and notifying physicians with changes in condition. In an interview with RN C on 07/02/2024, she said she was in-serviced regarding documenting, confirming, and following up with appointments. Record review of in-services, all staff completed the following: Record review of policies/procedures, in-services provided 6/28/2024 to 7/2/2024 Policy: Skin Management: Prevention and Treatment of Wounds Effective: 11/01/2019 Last Revised: 10/06/2022 Catheter Policy: Indwelling, straight, Supra-Pubic and external, dated effective 4/20/2021. Social Worker/Designee in-service on documentation of appointments. Pain Assessment. Department Head, Nurse Management Appointment In-service. Wound Care Nurse Competencies. Wound Care one on one-disciplinary action form. Cath and Foley Care/securing catheter, skin assessment. The Administrator and Interim DON was informed the Immediate Jeopardy was removed on 07/02/2024 at 3:45PM. The facility remained out of compliance at a severity level of 2 and a scope of E due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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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** 32422 Based on interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet residents' physical, mental, and psychosocial needs for 1 of 1 resident (Resident #72) reviewed for anticoagulants. The facility did not develop and implement a comprehensive person-centered care plan to address Resident #72's use of anticoagulants. There was no documentation in his care plan of measurable objectives, interventions, or timeframes for how staff would meet his needs. This failure affected 1 resident and has the potential to affect residents who use anticoagulants by not having his needs met and putting him at risk of being inappropriately cared for. Findings include: Record review of the facility face dated 6/28/2024 revealed Resident #72 was a 58- year-old male admitted to the facility on [DATE] and readmitted on [DATE] and with diagnoses that included anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), unspecified and hemiplegia and hemiparesis following cerebral infarction affecting left dominant side(paralysis of partial or total body function on one side of the body, whereas hemiparesis is characterized by one?sided weakness, but without complete paralysis). Record review of Resident #72's care plan, no date provided revealed there were no care plans to address anticoagulants. Record review of Resident #72's quarterly MDS dated [DATE] in section N-Medications revealed that Resident #72 received anticoagulants. Record review of Resident #72's physician orders for June 2024 for Apixaban Oral Tablet 5 MG (Apixaban):Give 1 tablet orally every 12 hours for anticoagulant with a start date of 4/17/2024 and discontinue date of 7/1/2024. Record Review of Resident #72's Medication Administration Record for April 17, 2024, to June 30,2024 revealed that Resident #72 was administered Apixaban 5mg at 8:00 am and 8:00 pm. July 1, 2024, Resident #72 was administered Apixaban 5mg at 8:00 am. Interview on 6/26/2024 with the MDS Coordinator, she said that there used to be another MDS Coordinator along with her and she had recently taken the responsibility for completing all of the care plans, she said that Resident #72 should have had a care plan for anticoagulants. She said the care plan is important because it showed how to provide care to a resident. She said that the facility had access to the Corporate MDS staff and the DON for monitoring the process as well. She said that the facility used the RAI Manual and they also had a comprehensive care plan policy. (continued on next page)

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	675000	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy and procedure entitled Comprehensive Care Plan dated: Effective: 1/20/2021, Last Revised: 4/25/2021 read in part .every resident will have an individualized interdisciplinary plan of care in place. A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of Admission. The Interdisciplinary Team will continue to develop the plan in conjunction with the RAI (MDS 3.0) and CAAS, completing and conducting Comprehensive Care Plan Meeting and Reviews by day 21 after Admission. The Care Plan is revised every quarter, significant change of condition, Annual or as the resident condition changes on an individualized basis. The Care Plan process is an ongoing review process.

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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** 48923 Based on observations, interviews, and record review, the facility failed to ensure the resident environment was as free of accident hazards as possible for 1 of 6 residents (Resident #86) reviewed for accident hazards. The facility failed to prevent a disposable razor and hygiene products from being located unsupervised in Resident #86's room. This deficient practice could result in residents coming into contact with dangerous materials which could place them at risk of injury or death. Findings: Record review of Resident #86's face sheet revealed a [AGE] year-old who was originally admitted on [DATE]. His medical diagnoses included hyperlipidemia (high amount of fats in the blood), dementia (unspecified), Major Depressive Disorder, Rhabdomolysis (breakdown of skeletal muscle), cognitive communication deficit, and abnormalities of gait and mobility. Record review of Resident #86's Quarterly MDS dated [DATE] revealed a BIMS (a brief interview which assesses mental status) score of 11, indicating mild cognitive deficit. Further review showed Resident #86 required supervision or touching assistance throughout the following activities: personal hygiene (shaving, washing/drying face and hands), oral hygiene, showering, toileting, and eating. Record review of Resident #86's care plan last reviewed 06/06/2024 revealed: -Resident #86 has an ADL self-care performance deficit due to Dementia. He required supervision and set up assist from staff to eat, dress, and for personal hygiene and oral care to maximize independence. Observation and interview with Resident #86 on 7/1/2024 at 12:25pm revealed he was sitting on his bed, fully dressed. There was a disposable uncovered razor on Resident #86's dresser, there were 3 bottles of body wash, and 2 deodorant sticks on his window ledge. Resident #86 stated he had no concerns and felt safe at the facility. In an interview with CNA C on 7/1/2024 at 12:29pm, she observed the disposable razor on Resident #86's dresser and the hygiene products on the ledge and said it should not be there. CNA C said Resident #86's family member usually helped him get ready for doctor's appointments and most likely brought the hygiene products into the room. CNA C said it could be dangerous to have the razor in the room for his roommate who could hurt himself. She would tell the charge nurse who would talk to the family about taking hygiene products with them when they're done. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #86's room on 7/1/2024 at 12:30pm, Resident #86 had left the room. The body wash bottle was observed on the ledge; it was 16 oz. and had a warning which read, Keep out of reach of children. If swallowed get medical help or contact the Poison Control Center right away. The other body wash bottles and 2 deodorant sticks from the same brand had the same warning on the back of the product. In an interview with the DON on 7/2/2024 at 2:40pm, she said the razor should not be in there because residents who wander can enter the room and get access to the razor. The DON did not believe Resident #86 would swallow the razor or body washes due to his level of cognition. She said she will make sure that nurses know after hygiene care to go back in and remove products. She will talk to Resident #86's family member and make them aware to take the products back with them after use. She will also conduct in-services to make her staff were aware of this situation. In an interview with the Administrator on 7/2/24 at 3:05pm, he said Resident #86 had an appointment which was why the products were in his room. The Administrator said he wouldn't want the razor or body wash on the unit and those items should have been locked up for safety. If it was left unattended a resident who has wandering behaviors might get into them and that the best the facility can do was to educate and reduce the issue. The Administrator said he will follow up with the family about the razor and body wash. Record review of the facility's Resident Rights policy revised December 2016 revealed that resident have a right to retain and use personal possessions to the maximum extend that space and safety permit. The policy did not specify razors or hygiene products, nor did other policies the facility provided review and discuss personal items.

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 2 of 4 residents (Resident #72 and #54) reviewed for quality of care. 1. The facility failed to assess, follow-up with treatment, update the care-plan, obtain new order due to a change in resident # 72's skin condition of the groin and resident's report of pain, at which time the penis split measured 8 cm length by 1 cm width by .4 cm depth and appeared red and raw, and failed to ensure that Resident #72's indwelling catheter (drains urine from your bladder into a bag outside your body) had a securement device to anchor catheter. 2. The facility failed to ensure that CNA B changed her gloves and perform hand hygiene while providing indwelling catheter and incontinent care to Resident #72. On 6/28/24 at 5:44PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 6/30/2024 at 12:27 pm, the facility remained out of compliance at a scope of isolated and a severity of harm with potential for more than the minimal harm that was not an immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. 3. The facility failed to ensure CNA G and CNA H did not place foley bag on Resident #54's bed during foley and incontinent care. These failures could affect residents in delay of appropriate medical treatment leading to pain, discomfort, and death. Findings included: Resident #72 Record review of a facility face sheet dated 6/26/2024 indicated Resident # 72 was a [AGE] year-old male and admitted on [DATE] and was readmitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (paralysis of partial or total body function on one side of the body, whereas hemiparesis is characterized by one?sided weakness, but without complete paralysis), obstructive and reflux uropathy (the urine backs up into the kidney and cannot drain through the urinary tract), chronic kidney disease, major depressive disorder, neurogenic bladder (nerves that communicate between the bladder and spinal cord and brain malfunction and cause symptoms such as dribbling urine, loss of feeling the bladder is full and being unable to control urine), muscle wasting and atrophy (wasting away of tissue or organ). Record review of a Quarterly MDS assessment dated [DATE] indicated Resident #72 had a BIMS score of 09 indicating moderately impaired cognition, and he required an indwelling catheter. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a comprehensive care plan dated 09/05/23 indicated Resident #72 was at risk for complications related to Foley catheter and goal will be/remain free from catheter-related trauma through review date. Interventions: Catheter changed PRN (size 18 FR), check Foley catheter placement, ensure Foley was secured via Velcro to provide catheter care every shift. Record review of Resident #72's care plan with dated 09/05/2023: Focus: Resident #72 had indwelling catheter and is at risk for increased Urinary Tract Infections diagnosis: Neurogenic bladder: Goal: Resident will be/remain free from catheter related trauma through review date, will show no sign/symptom of Urinary Infection through review date: Interventions: Catheter changed PRN change (Size 18FR), check Foley catheter placement, ensure Foley was secured via Velcro strap to reduce friction/pulling q shift, and monitor/record/report to MD for sign/symptom UTI, pain, burning blood-tinged urine, cloudiness, no output, deepening of urine color, increase pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. Record review of the weekly skin assessment from April 2024 to June 13, 2024, revealed no documentation for slit on penis. Record review of Resident # 72's physician orders for March revealed that he had orders for a Urology Consult on 3/14/2024 and 3/30/2024. Record review Physician's order dated 04/29/2022 reflected Foley Catheter 18 FR 15 cc bulb to continuous drainage related to diagnosis and on 5/13/20220 reflected another physician's order for Foley catheter 18 FR 15cc bulb to continuous drainage related to (diagnosis renal disease with Hematuria). Record review of Resident # 72's physician orders for March revealed that he had orders for a Urology Consult on 3/14/2024 and 3/30/2024. Record review of Resident # 72 doctor's progress notes on 3/30/2024 revealed Please schedule urology consult SPT placement to avoid Foley related hematuria on 3/14/24 and UROLOGY CONSULT TO RULE OUT HEMATURIA. Record review of Resident #72's skin assessment sheets from February 2024 to June 2024 revealed there were no skin assessments identifying the split in the penile area. Record review of nurse's progress notes dated 4/14/2024 revealed Resident #72 was documented to have blood in his urine. A progress note dated 4/30/2024 revealed Resident #72 was observed to have opening in the penile area due to prolonged Foley catheter use. NP notified, awaiting response. Treatment nurse provided care, notified family member. There was no assessment and measurement to opening in the penile area. Record review of nurse's progress note revealed on 5/2/24: MD (medical doctor in facility rounding on Resident #72. Documented Nurse follow-up with resident penile area opening with the MD. Resident MD said urologist consult will further evaluate. Resident #72 have urology consult appointment 5/23/24. Further review revealed there were no other NP notes addressing the issue with Resident #72's penis after 05/02/24 and the only physician visit noted was on 05/02/24. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #72's physician order included: start date of 4/30/2024 for a wound care consult, one time only for penal wound for 2 days; start date of 5/2/2024 revealed an order for every day and every night shift, monitor for open penial area and notify MD and NP of any change. Record review of Resident #72's TAR (Treatment Administration Record) for May 2024 through June 2024 revealed orders to monitor every shift open penile area and notified MD/NP of any changes. were performed. Monitored area on every shift for skin integrity except on 5/13/2024 and 5/14/2024 on night shifts and 5/17/2024 during the day shift. Record review also revealed treatment to monitor every shift the foley insertion site for redness, irritation every day and night shift for skin integrity, and monitor Foley Cath, stripe placement for redness, irritation every shift was was provided on 6/28/2024, night shift and through 7/30/2024. Record review revealed Resident # 72 did not see the Urologist until 6/20/24 due to the Urologist office relocating and the facility was not aware. Record review of Resident 72's Urology consult dated 6/20/2024 revealed diagnosis that includedwere Neurogenic Bladder (t,he name given to a number of urinary conditions in people who lack bladder control due to a brain, spinal cord, or nerve problem), gross hematuria (when you can see the blood in your urine) and Hyperplasia of prostate (a noncancerous enlargement of the prostate gland) with lower urinary tract symptoms, .managed with Foley catheter but has caused and urethral breakdown now has a penoscrotal hypospadias (in perineal hypospadias, the scrotum is abnormally divided and the urethral opening is located along the center of the divided sac). During an interview on 6/25/24 at 9:55 am, CNA B said that when care was provided to a resident with a catheter, she made sure the catheter was not pulled but did not check for a securement device. She said the nurses were responsible for placing the securement device. She said a catheter that was not secure could come out or cause pain. During an interview on 6/25/24 at 1:11 pm, LVN A said she had been at the facility for 4 years. She said that residents with an indwelling catheter should be checked every shift and a securement device should be in place to prevent discomfort and dislodgment. She said she had received competency training on indwelling catheters and care. During an observation and interview on 06/26/24 at 9:45 am, Resident # 72 was observed with an indwelling catheter with no securement device for the catheter. Resident # 27 said there was a pulling feeling in his private area at times. During an interview on 6/26/24 at 10:43 am, the DON said the charge nurses were responsible for checking residents with catheters each shift and each resident with a catheter should have a securement device. She said she was responsible for all nursing oversight and training and nurses had been trained on catheter assessment and ensuring a securement device was in place. She said if a catheter was not secure it could cause abrasions and become dislodged. During an interview with the DON regarding Resident #72 on 6/27/24 at 4:10 PM the DON was not sure why Resident #72 did not see a Urologist on 3/14/24, 3/30/24, and 5/2/24. She stated she would check on chart and call the Urologist's office. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation of indwelling catheter care on 6/27/24 at 10:22 AM, Resident #72 was transferred from the wheelchair to the bed by C.NA B and MA D assisting. Resident #72 had Velcro strap on, that did not secure the catheter, the strap was on the resident mid-thigh. Incontinent care done by C.NA B. She did not wash her hands before donning clean gloves. C.NA B used wet wipes to clean the Foley catheter twice. Resident #72's penis head was slit from the base to the scrotum and was red and raw. C.NA B did not change gloves when they repositioned Resident #72 to the left side. The resident had a moderate amount of bowel movement. C.NA B picked up a clean brief and placed it on the bed. C.NA picked up wet wipes and cleaned the BM, folding the wipes in half twice, once after each wipe. Using the same gloves, C.NA B picked up the clean brief and placed it on the resident, pulled up the pant without securing the indwelling catheter. Observation of Resident #72 on 6/28/2024 at 3:15pm, the Velcro was at the knee of the resident and not securing the in-dwelling catheter. Measurement of the slit length was 8 centimeters, the width was 1 centimeter, and the depth was 0.4 centimeter. The area was pinkish. During an interview on 06/27/24 at 10:43 AM, Resident #72 was observed with an indwelling catheter with securement device (Velcro) not securing the catheter. Resident # 72 said the foley catheter has always been rubbing and pulling on him and his slit grew over time. He said it was very painful. During an interview on 06/27/24 at 10:50 AM, CNA B said that when care was provided to a resident with a catheter, she made sure the catheter was not pulled but did not check for a securement device. She said the nurses were responsible for placing the securement device. She said a catheter that was not secure could come out or cause pain. She said she forgot to wash her hands and change gloves. She said she has been working with the facility for 1 year and did have the skills check off done. She said that the resident had not complained of pain before and she knew to report to the charge nurse when any resident complained of pain. During an interview on 6/27/24 at 11:00 AM, LVN A said she had been at the facility for 1 year. She said that residents with an indwelling catheter should be checked every shift and a securement device should be in place to prevent discomfort and dislodgment. She said she had received competency training on indwelling catheters and care. During an interview on 6/27/24 at 11:43 AM, the DON said the charge nurses were responsible for checking residents with catheters each shift and each resident with a catheter should have a securement device. She said she was responsible for all nursing oversight and training and nurses had been trained on catheter assessment and ensuring a securement device was in place. She said if a catheter was not secure it could cause abrasions and become dislodged. On 6/28/24 at 7:45AM, the DON said she had sent the facility marketing director to the urologist office to pick up the results. In an interview on 6/28/2024 at 8:39 am with the MDS Nurse, she said that Resident # 72 went to his urology appointment on May 25th, 2024, but for some reason it was rescheduled, so they did not see him that day. She said that they received the documentation from his urology appointment from 6/20/24 this morning and provided a copy. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 6/28/24 at 11:37 AM RN A said the nurses changed catheters monthly or as needed when there was a leak. She said she was aware of the slit to Resident #72's penis when she changed the catheter a month or 2 months ago. She stated the resident had a urologist appointment on 5/23/24 and she thought the treatment nurse did the slit measurement. She cannot remember the length and width of the slit to the penis. RN A said the nurses secured the Velcro to the catheter to avoid it pulling and trauma. In an interview on 6/28/2024 at 2:32pm with the treatment nurse, she said she identified the split during a skin assessment around March or April 2024. She informed the DON, the MDS Nurse, the family representative, and the doctor. The doctor wrote an order for the resident to see a urologist and wait for their recommendations. The nurse said the resident's penis had a little opening, but no redness and the resident told her he was not in pain then. Resident #72 has never told the nurse he felt pain from the slit. The treatment nurse said she always made sure that Resident #72 had the catheter strap. She said since she noticed the slit it has remained that way, although she has not measured the slit length. The nurse said she knew that there was a urology appointment scheduled but she did not know if Resident #72 made it to that appointment. She never noticed blood in the urine and the resident never mentioned blood in the urine. In an interview on 6/28/2024 at 3:20pm with the treatment nurse, after measuring she stated she did not know the slit was that long. In an interview with the DON on 6/28/24 at 3:30 PM, regarding resident urologist consult from 3/14/24 3/30/24 for hematuria, consult for slit on penis on 4/30/24 and 5/2/24. DON said she would check for the results because there no result on the PCC. At 4:30 PM on 6/27/24, DON said she would be calling the urologist office for the result. DON said she did not get any respond from the doctor's order and the results were not documented in the progress notes and she just found out Resident #72 visited the urologist on 6/20/24 and there was no result om the chart. In an interview with the DON on 06/28/2024 at 4:30 PM, the DON stated he was made aware by the CNA involved about the infection control issue during incontinent care. The DON said every staff should wash their hands before and after every care. He said gloves should be changed and the hands should be sanitized after cleaning the resident's buttocks or the resident's front part before touching the any clean items. He said not washing the hands, not changing the gloves, and not sanitizing the hands in between changing of gloves could result to cross contamination and infection. The DON also added if the brief had fallen to the floor, it should not be used anymore for a simple reason that it was already dirty. The DON said the expectation was for the staff to remember to wash their hands and change their gloves when transitioning from a dirty area to a clean area, sanitize their hand when changing their gloves, and not to use items that had fallen to the floor. The DON said he already did a one-on-one in-service with CNA D but would do an infection control in-service for all the staff. He concluded that he would continually remind the staff to be attentive to the procedures for infection control and that he would personally monitor infection control. On 7/1/24 at 3:04PM called the MD left message on answering service. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Focused Care at Beechnut		STREET ADDRESS, CITY, STATE, ZIP CODE 12777 Beechnut St Houston, TX 77072	

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the MD (Medical Director) on 07/01/2024 at 3:22pm, he said he knew the resident and he is on dialysis. MD has seen him at the facility. The facility called him about the blood in resident's urine and he does not remember how long ago it was. He said he remembered the call and that the resident was supposed to see a urologist. He doesn't know how long the resident was supposed to see the urologist. The MD said someone told him about the slit in the penis. He doesn't know if it was evaluated, but that the resident had a foley catheter and was referred to the urologist to get it repaired. The MD said all communications between the resident's NP, the physician regarding the resident should be in PCC in the notes. He was informed of the resident's delayed urology consult last week and knew the resident was waiting to know but unsure if the appointment was delayed or cancelled. The MD knows the resident had gone to a urology appointment before and that a follow-up was scheduled. All the appointment information should be in the nursing notes. The MD said he has a group practice, and an NP also sees the MD's patients. Changes in conditions are reported to a resident's PCP and the MD gets notified about his residents. The MD is also notified of significant changes in condition for other residents since he is also the Medical Director of this facility. At QA/QAPI meetings, the MD and the facility will discuss patient care at that time about all patients. The MD does not know how long the slit is, he did not see bleeding from the area last time he saw the resident. When asked if he knew how long the resident had the slit, the MD replied, If you have to put words in my mouth it would be three weeks, but he could not say for sure. The MD said he has seen the resident twice and that the NP has seen this patient as well. The result from the urologist dated 6/20/24 presented to the state surveyor on 6/28/24 at 8:20 AM. Consult 6/20/24: Reason for visit: Blood in urine, Progress Notes: Assessment/Plan, Problem List Items Addressed This Visit: Visit Diagnoses: Neurogenic bladder-Primary, gross hematuria, hyperplasia of prostate with lower urinary tract symptoms (LUTS). 1. Neurogenic bladder/urinary retention - from CVA but still makes urine - managed with Foley catheter but has caused urethral breakdown now has a penoscrotal hypospadias. -Discussed risks and benefits of changing to a suprapubic tube and he wants to proceed 2. Penoscrotal hypospadias - due to urethral 3. Hematuria - resolved, obtain Cysto Observation on 6/28/24 at 3:10 PM revealed Resident #72 was back from dialysis and was sitting on the wheelchair. She was propelled by staff to resident #72's room for a skin assessment. CNA A and CNA B transferred Resident #72 to bed and the Velcro was on the resident's knee, not securing the catheter. The treatment Nurse undid the brief then picked up the penis measuring the slit. The length was 8 cm by 1cm width by 0.4cm depth, red and raw. The treatment nurse stated while measuring the slit that she did not know it was that bad and it was her first time measuring it. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	This was determined to be an Immediate Jeopardy (IJ) on 6/28/24 at 5:45PM. The Administrator and the DON were notified The Administrator was provided with the IJ template via email on 6/28/2024 at 5:56PM. The following plan of removal was submitted by the facility and was accepted on 6/29/2024 at 10:14AM. Immediate Jeopardy (the facility) On 6/28/2024 an incident survey was initiated at. On 6/28/2024 the state surveyor provided an Immediate Jeopardy (IJ) Template notification that the regulatory services had determined that the condition at the facility constituted an immediate jeopardy to resident health and safety. The facility failed to assess, follow-up with treatment, update the care-plan, and obtain new order due to a change in resident # 72's skin condition of the groin to the physician. F690 Plan of Removal Immediate Action: o Resident #72 head to toe assessment was completed by Treatment Nurse and ADCO on 6/28/24. The weekly skin assessment was updated to show the measurements and description of the slit. o Resident #72 was assessed for pain by the ADCO on 6/28/24 which he denied having pain. o Resident #72's Physician was updated on the slit by the DCO on 6/28/24, and no new order received. Current monitoring orders were already in place and completed every shift. o Resident #72's care plan was updated on 6/28/24 to reflect the skin changes in the penis and intervention. o All residents with foley catheters were assessed to ensure no slit in the penis, there was a leg strap to anchor their Foley tubing on 6/28/24 by the ADCO. No concern was identified. o The care plan of all resident's with foley catheters was reviewed by the MDS Nurse on 6/28/24 to ensure the care plan was updated with no concerns noted. Facilities Plan to ensure compliance quickly: o The treatment Nurse was provided with 1:1 training on proper skin assessment including weekly measurement of the wound, documentation on weekly skin assessment, updating the Physician on changes in the skin, and updating care plan by the Director of Nursing and was completed on 6/28/24. The monitoring will be placed in the treatment sheet and reviewed during daily clinical meetings by the DCO/Designee. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o The Director of Nursing/Designee initiated an in-service for all Nursing staff to ensure foley catheters were secured with the strap to resident's thigh. Report any trauma or irritation to the meatus to the charge Nurse and attending physician/NP when found. Inservice will be completed on 6/29/24. All staff members will be provided with in-service prior to the beginning of their shift. o Skin assessment competency was completed on the Treatment Nurse by the DCO on 6/28. o Daily focused rounds will be completed by Nurse management daily on all residents with foley catheter to ensure they have leg strap on, and to identify any irritation and trauma to the penis. If there was any to ensure Physician notification was completed and new order received. o The Medical Director was notified of the Immediate Jeopardy on 6/28/2024. o The current policies reviewed on Skin management by the Medical Director on 06-28-2024: Prevention and treatment of wounds, and catheter insertion, and maintenance with no changes to the current policy completed on 6/28/24. This practice will be reviewed monthly with the QA committee to ensure compliance in place. o The Social worker/Designee will be educated by the Administrator on 6/29/24 to make future urology appointments and discuss with the IDT if they were having any difficulty in getting timely appointment for further direction. The surveyors confirmed the plan of removal had been implemented sufficiently to remove the IJ by the following: Observation and interview on 6/30/2024 at 11:00 am with Resident #72 was sitting in wheelchair eating a snack. He was well-groomed with no odors. Resident #72 said he is feeling okay but wondered why it took the facility so long to address his catheter. He said he was now afraid of an infection from his stoma to g-tube. Resident #72 raised his shirt at that time and a small pea-sized area was observed in what appeared to be a white cream. Resident #72 consented for the DON to come assess him with another staff member. He was then transported back to his room. The DON later came and said that the white substance was not an infection but a cream that they used to treat the stoma called theravox, which was confirmed by viewing the container and conducting a record review of Resident #72's physician orders. In an interview on 6/29/2024 at 10: 20 AM RN A said she had been working with the facility for 8 months 6:00 AM to 6:00 PM shift. She had in-services on incontinent care, indwelling catheter care, securing catheter, hanging foley bag below the bladder, and reporting any abnormalities to the charge nurse like skin irritation. If there were any changes in the site notify the NP and check indwelling catheter every shift. They were assessing catheter before daily but now every shift and for any slit to the penis they should document in the progress note. In an interview on 6/29/2024 at 10: 49 AM LVN A said she had been working with the facility for 1 year on the 6:00 AM to 2:00 PM shift. She had in-services on incontinent care, indwelling catheter placement, securing the catheter, and reporting any abnormalities to the doctor like skin irritation and document. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 6/29/2024 at 10: 56 AM RN B, (Weekend Supervisor) said she had been working with the facility for 2 years on the 9:00 AM to 6:00 PM shift. She had in-services on pain, skin assessment, indwelling catheter care, securing the catheter, reporting any abnormalities to the doctor, and SBAR like skin irritation and slit measure daily and document. In an interview on 6/29/2024 at 11: 26 AM RA A (Restorative Aide) said she had been working with the facility for 8 years, on the 6:00 AM to 2:00 PM shift. She had in-services on incontinent care, indwelling catheter care, securing the catheter, and reporting any abnormalities to the charge nurse like skin irritation. In an interview on 6/29/2024 at 11: 14 AM C.NA A said she had been working with the facility for 1 year on the, 6:00 AM to 2:00 PM shift. She had in-services on incontinent care, indwelling catheter care, securing the catheter, free of kinking, and reporting any abnormalities to the charge nurse like skin irritation. In an interview on 6/29/2024 at 11:18 AM MA C said she had been working with the facility for 7 years on the 7:00 AM to 8:30 PM shift (Friday, Saturday, & Sunday). She had in-services on incontinent care, indwelling catheter care, securing the catheter, and reporting any abnormalities to the charge nurse like skin irritation and document. In an interview on 6/29/2024 at 11: 26 AM C.NA B said she had been working with the facility for 1 year on the, 6:00 AM to 2:00 PM shift. She, had in-services on incontinent care, indwelling catheter care, securing the catheter, and reporting any abnormalities to the charge nurse like skin irritation. In an interview on 6/29/2024 at 8:20 PM LVN C said she had been working with the facility on the 6:00 PM to 10 PM shift. She had in-services on skin assessment, indwelling catheter care, securing the catheter, and reporting any abnormalities to the ADON, the DON, and the M.D. In an interview on 6/29/2024 at 8:27 PM, C.NA D said she had been working with the facility for 2 years on the 2:00 PM to 10 PM shift. She had in-services on incontinent care, indwelling catheter care, securing the catheter, and reporting any abnormalities to the charge nurse. In an interview with the Administrator and the DON on 06/30/2024 at 9:38AM, the DON said that Resident #74's doctor told the nurses he will send his paperwork, but he did not return from his 06/20/2024 appointment with it. The Administrator and the DON said they were not aware of this situation regarding the facility not following up after the Urologist appointment. The Administrator started on 06/03/2024 and the DON started 05/16/2024 and that they were not aware the follow-up doctor's visit system was broken. They believed the SW was assigned to run the system. The DON said if a resident missed an appointment, it could have caused a delay in care. She also found out that nurses were calling the Urologist's office but not documenting it. Now the facility will send the resident with an envelope to their visit, make sure the doctor's office returns documents, and items needing follow-up back with the resident. If not, the charge nurse will contact the office. The monitoring system will include the DON, the ADON, the Unit Managers, and the SW. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the SW on 06/30/2024 at 10:33AM, he said that he used to make specialist appointments, and now nursing will assist him with paperwork and documentation. He said that appointments were to be documented in the electronic medical records. The nursing staff will be in charge of managing the communication and will follow-up with the doctor's office. The appointments and changes in condition would be discussed at the morning meetings, and if there were any issues or concerns, he would let the DON and the ADON know. In an interview with CNA J on 06/30/2024 at 10:49AM, she said she worked the 6:00AM to 2:00PM shift. She had in-services on incontinent care, catheter care, pain management, and notifying the charge nurse of changes in condition with catheter and pain. In an interview with LVN K on 06/30/2024 at 10:58AM, she said she worked when she was called and had in-services on catheter care, documentation, documenting for changes in condition, and reporting them to the DON and MD. In an interview with CMA A on 06/30/2024 at 11:06am, she stated she worked the 7:00AM to 8:30PM shift. She had in-services on catheter care and reporting changes in condition to the charge nurse, ADON, DON and MD. In an interview with CMA B on 06/30/2024 at 11:12AM, she stated she worked when she was called. She had in-services on foley catheter, assessing pain, and reporting changes in condition to the nurse, ADON and DON. In an interview with LVN G on 06/30/2024 at 11:21AM, she stated was a Unit Manager from 8:00AM to 5:00PM. She was in-serviced on pain assessment, catheter care, and reporting changes in condition to the MD. In an interview with the ADON on 06/30/2024 at 11:30AM, she stated her shift was from 8:00AM to 5:00PM. She was in-serviced on pain management and reporting changes in condition to the DON and MD, and catheter care. In an interview with LVN H on 06/30/2024 at 11:37am, she was in-serviced on foley catheter, pain, appointments, and reporting changes in condition. She also was trained on scheduling and monitoring appointments. Interview with RN A on 07/02/2024 at 12:09PM, she said that she was in-serviced on reporting changes in condition to the DON and MD. Interview with LVN M on 07/02/2024 at 1:51PM, she was in-serviced on foley catheter care, pain management and scheduling and documenting appointments for residents. Interview with CNA M on 07/02/2024 at 1:51pm, she said she was in-service on foley catheter for residents. The Administrator and Interim DON was informed the Immediate Jeopardy was removed on 06/30/2024 at 12:27PM. The facility remained out of compliance at a severity level of 2 and a scope of E due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #54 Record review of Resident #54's face sheet dated 06/27/24 revealed he was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #54 had diagnoses which included: diabetes mellitus (body do not produce enough insulin or cannot use it properly), hypertension (high or raised blood pressure), urinary tract infection (an illness in any part of the urinary tract), and neuromuscular dysfunction of the bladder (the nerves and muscles do not work together very well). Record review of Resident #54's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 of 15 indicated moderate impaired cognition. Further review revealed the resident had indwelling Foley. Record review of Resident #54's care plan dated 01/28/21 revealed resident had a Suprapubic Catheter and was at risk for increased urinary tract infections related to neuromuscular bladder dysfunction. Interventions: Check tubing for kinks each shift. Monitor for s/sx of discomfort on urination and frequency. Resident placed on EBP program due to him having a Suprapubic catheter. Record review of Resident #54's physician order dated June 2024 read in part . change indwelling F/C PRN, dislodgement/patency .as needed related to obstructive and reflux uropathy start date 06/07/24 . Record review of Resident #54's physician order da [TRUNCATED]

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35897 Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. 1. The facility failed to ensure expired foods were discarded. 2. The facility failed to ensure foods were dated as opened/preparation discarded after 72 hours. 3. The facility failed to thaw frozen Fish Filet These failures could place residents who ate food from the kitchen at risk of food borne illness and disease. Findings Included: Observation of the facility kitchen on [DATE] at 8:15 AM revealed the following. 1. 2 tubs Plastic Container of Cottage Cheese in the walk in cooler with manufacturer expiration date of [DATE]. 2. A Plastic container of Shredded Cheese in the walk in cooler with no date opened and no use by date. 3. A Plastic container of Sliced American Cheese in the walk in cooler with no date opened and no use by date. 4. A Plastic Container of frozen fish fillet submerged in water in the kitchen sink with water temperature of 71.8 degrees F and Fish Filet with a 66.4 degrees Fahrenheit. The fish temperature is in the danger zone (140degrees F or higher to 41degrees or lower.) 5. Scoop left in the ice maker bin equipment in the kitchen. In an interview with the Dietary Food Service Manager on [DATE] at 8:25 AM ; she stated the leftover food stored in the refrigerator should have been used or discarded prior to use by date, she further stated that the proper thawing of frozen food water should be running with a temperature of 70 or below degrees Fahrenheit and the Fish should have at temperature of 41 degrees or lower. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility's policies and procedures for Food Safety for Residents dated ,d+[DATE] read in part .potentially hazardous leftover foods are properly covered, labeled, dated, and refrigerated immediately. They are discarded after 72 hours unless otherwise indicated. Scoops should not be left in food containers or bins.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 35897 Based on observation, interview and record review the facility failed to dispose of garbage and refuse properly for dumpster A and Dumpster B of 2 dumpster reviewed for Food and nutrition services. -The facility failed to ensure dumpster A and dumpster B's lids and doors were secured. This failure could place residents at risk of infection from improperly disposed garbage. Findings included: Observation on 06-26-24 at 1:15 pm, revealed the facility's dumpster area, had 2 commercial -size dumpsters (dumpster A and dumpster B) 3/4 full of garbage and the doors were open. In an interview on 06-26-24 at 3:45 pm, with the Food Service Manager, she stated that the dumpster doors must always be closed to keep vermin, pests, and insects out of the dumpster and from entering the facility. She further stated that housekeeping, and nursing also discard their waste garbage in the dumpster. It was the responsibility of staff from dietary, nursing and housekeeping for ensuring the food waste will properly be removed and disposed for from the community. Record review of facility's Policies and Procedures on waste disposal dated 11/ 2023 revealed that food waste will be properly removed and disposed for from the community to ensure the food safety for the residents. Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests. Outside dumpster provided by garbage pickup services will be kept closed and free of surrounding litter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #72) of four residents observed for infection control. The facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 3 of 5 staff (DHK, LSA, and CNA B) observed for infection control. 1.The facility failed to ensure that CNA B changed his gloves and perform hand hygiene while providing indwelling catheter and incontinent care to Resident #72. 2.The facility failed to ensure DHK and LS A followed proper infection control procedure in the laundry room, This failure could place the residents at risk of cross-contamination and development of infection. Finding included: Record review of a facility face sheet dated 6/26/2024 indicated Resident # 72 was a [AGE] year-old male and admitted on [DATE] and was readmitted on [DATE] with diagnoses of hemiplegia and hemiparesis following a cerebral infarction affecting left dominant side, obstructive and reflux uropathy, chronic kidney disease, major depressive disorder, neurogenic bladder (dysfunction affecting bladder control), and muscle waiting and atrophy. Record review of a comprehensive care plan dated 09/05/23 indicated Resident #72 was always incontinent for bowel and bladder. Review of Resident #72's Comprehensive Care Plan dated 09/05/2023 reflected resident had an ADL self-care performance deficit related to CVA (cerebrovascular disease: stroke) and one of the interventions was for two staff to assist with ADLs with needed assistance. Record review of a Quarterly MDS assessment dated [DATE] indicated Resident #72 had a BIMS score of 09 indicating moderately impaired cognition and he required an indwelling catheter. Observation of indwelling catheter/continence care on 6/27/24 at 10:22 AM, Resident #72 was being transferred from his wheelchair to his bed by C.NA B and MA D. Incontinent care done by C.NA B. She did not wash her hands before donning clean gloves. C.NA B used wet wipes to clean the Foley catheter twice. Resident #72's penis head was slit from the base to the scrotum and was red and raw. C.NA B did not change gloves when they repositioned Resident #72 to the left side. The resident had a moderate amount of bowel movement. C.NA B picked up a clean brief and placed it on the bed. C.NA picked up wet wipes and cleaned the BM, folding the wipes in half twice, once after each wipe. Using the same gloves, C.NA B picked up the clean brief and placed it on the resident, pulled up the pant without securing the indwelling catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Focused Care at Beechnut		STREET ADDRESS, CITY, STATE, ZIP CODE 12777 Beechnut St Houston, TX 77072	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Resident #72 on 6/27/24 at 10:43 AM about the indwelling catheter, he said it was pulling and rubbing on his skin. He said it was very painful and he had a slit now. In an interview with MA D on 6/27/24 at 10:46 AM, she said CNA did a good job only she did not change gloves and she used the same gloves throughout the procedure. She was supposed to change gloves from soiled to dirty or use hand sanitizer. In an interview with CNA B on 6/27/24 at 10:50 AM she said she forgot to wash her hands and change gloves. She said she has been working with the facility for 1 year and did have the skills check off done. She said that the resident had not complained of pain before and she knew to report to the charge nurse when any resident complained of pain. In an interview with the DON on 06/28/2024 at 4:30 PM, the DON stated he was made aware by the CNA involved about the infection control issue during incontinent care. The DON said every staff should wash their hands before and after every care. He said gloves should be changed and the hands should be sanitized after cleaning the resident's buttocks or the resident's front part before touching the any clean items. He said not washing the hands, not changing the gloves, and not sanitizing the hands in between changing of gloves could result to cross contamination and infection. The DON also added if the brief had fallen to the floor, it should not be used anymore for a simple reason that it was already dirty. The DON said the expectation was for the staff to remember to wash their hands and change their gloves when transitioning from a dirty area to a clean area, sanitize their hand when changing their gloves, and not to use items that had fallen to the floor. The DON said he already did a one-on-one in-service with CNA D but would do an infection control in-service for all the staff. He concluded that he would continually remind the staff to be attentive to the procedures for infection control and that he would personally monitor infection control. Record review of the facility's policy, Hand Hygiene Infection Control Prevention and Control Program revealed Policy: This facility considers hand hygiene the primary means to prevent the spread of infections . b. Before and after direct contact with residents .h. Before moving from a contaminated body site to a clean body site during resident care . i. After contact with a resident's intact skin . j. After contact with blood or bodily fluids . m. After removing gloves . hand hygiene is the final step. During an observation on 06/26/24 at 12:49 p.m., revealed the clean side of the laundry room, which had a clean table for folding clean linen, had the following personal items on the table: two white portion cups with white sauce, one white bowel of fruit, one black plastic spoon, one black comb, OXI cleaner, and they were touching the clean folded linen. The following items: one leg boot, 4 socks, 2 blankets, and three pillowcases were on the floor under the clean rack in the clean area. There were three-yard black plastic bags filled with clean clothes in the dirty section of the laundry room, a white basket with 20 hangers laid sideways on the floor, and 5 hangers on the floor under a rack. There was a full-size rack with clean clothes in the dirty section of the laundry room, one orange sweat jacket with a hoodie, and an orange shirt was on the floor under the rack. The hand-washing soap dispenser on the dirty section of the laundry was broken. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/26/24 at 1:00 p.m., DHK said the staff was not supposed to have their items on the folding table because it was an infection control issue and the staff could transfer their germs to the clean clothes. DHK said the clean clothes should not be stored on the floor because the floor was dirty, and the clothes were contaminated with the germs on the floor. DHK said clean clothes should not be stored in the dirty area or on the floor because of cross-contamination. DHK said the clean donated clothes were stored on the floor in the dirty section of the laundry because there was no storage space. DHK said the soap dispenser had been broken since he started working (05/20/24), and there was no hand sanitizer in the laundry room. DHK said the laundry aide would go out to the hallway restroom and wash her hands after she loaded dirty linens in the washer, which was an infection control issue. During an interview on 04/26/24 at 1:30 p.m., LS A said the soap dispenser had been broken for about two days, and she had been going to the visitor's restroom in the hallway and washing her hands. LS A said it was an infection control issue when staff placed their items on the clean folding table where clean linens were placed because the germs from the staff items could be transferred to the resident. LS A said the resident could get sick because the linens may have been contaminated with germs from the staff's personal items. LS A said she had an in-service on infection control, and the housekeeping director monitored the laundry aide. During an observation and interview on 06/26/24 at 1:34 p.m., the Administrator said he could see the hand-washing soap broken. The Administrator said the laundry aide should not go to the restroom to wash her hands because it was an infection control issue. The Administrator stated LS A left one area to another area to wash her dirty hands, and she could have transferred the germs to the area where she went and washed her hands. The Administrator said LS A could have contaminated her hands on her way back to the clean area in the laundry room and could have transferred the germs to the clean linens, which was an infection control issue. The Administrator said clean linens should not be stored in dirty areas, and no clothes should be on the floor or staff personal items on the clean table for clean linen for infection control reasons. Record review of the facility policy on laundry and bedding, soiled dated 2001 MED-PASS, Inc. (Revised October 2018) read in part . soiled laundry/bedding shall be handled, .processed according to best practices for infection prevention and control .transport #6 . clean linens are stored separately, away from soiled linens, at all times . 36918 During an observation on 06/26/24 at 12:49 p.m., revealed the clean side of the laundry room, which had a clean table for folding clean linen, had the following personal items on the table: two white portion cups with white sauce, one white bowel of fruit, one black plastic spoon, one black comb, OXI cleaner, and they were touching the clean folded linen. The following items: one leg boot, 4 socks, 2 blankets, and three pillowcases were on the floor under the clean rack in the clean area. There were three-yard black plastic bags filled with clean clothes in the dirty section of the laundry room, a white basket with 20 hangers laid sideways on the floor, and 5 hangers on the floor under a rack. There was a full-size rack with clean clothes in the dirty section of the laundry room, one orange sweat jacket with a hoodie, and an orange shirt was on the floor under the rack. The hand-washing soap dispenser on the dirty section of the laundry was broken. (continued on next page)

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