STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675089	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on interviews and record reviews, the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 (Resident #1) of 5 residents reviewed for quality of care, in that: The facility failed to monitor, treat, and reassess a wound to Resident #1's lower back. LVN A documented that Resident #1 had a pressure, venous, arterial, diabetic, or surgical wound (no location, no description disclosed) in a weekly skin assessment on 05/27/24 and 06/03/24 but did not notify the WCN. On 06/06/24, RCP B informed the WCN about an open area on Resident #1's lower back (WCN identified area as the very bottom of spine area - tailbone). The WCN assessed, documented a Stage II wound to Resident #1's lower back, notified the PCP and started treatment to the wound. No treatment was provided to the wound site before 06/06/24. Resident #1 was discharged to the hospital on 06/13/24 for a non-wound related reason. This failure could place residents with wounds at an increased and unnecessary risk of complications such as pain, acquiring new wounds, worsening of existing wounds, and infection. Findings included: A record review of Resident #1's Quarterly MDS Assessment, dated 03/15/24, revealed a [AGE] year-old female, admitted to the facility on [DATE]. Resident #1 had diagnoses of non-Alzheimer's disease (a progressive disease beginning with mild memory loss); Abrasion of lower back and pelvis; and HF. Resident #1's BIMS Summary Score was 06, which suggested severe impaired cognition. Resident #1's functional abilities required one-person supervision with ADLs. Resident #1 was frequently incontinent of bowel and bladder. Section M - Skin conditions of the Annual MDS Assessment revealed Resident #1 had one or more unhealed pressure ulcers/injuries. The Quarterly MDS Assessment revealed Resident #1 had an unhealed Stage 2 pressure ulcer. Record review of Resident #1's comprehensive care plan reflected: [Resident #1] had a Stage 2 pressure ulcer on right buttocks. The pressure ulcer measured 1.5 cm x 2 cm [Date initiated: 03/12/24; Resolved: 03/14/24]. (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: 675089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER Focused Care at Sherman		STREET ADDRESS, CITY, STATE, ZIP CODE 817 W Center Sherman, TX 75090	

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[Resident #1] had actual impairment to skin integrity r/t abrasion to right buttock. 03/14/24: 1.7 cm x 2 cm; 03/19/24: 1.2 cm x 1.5 cm; 3/26/24: 1.0 x 0.5 cm [Date initiated: 03/14/24; Resolved: 04/02/24]. [Resident #1] had a Stage 2 pressure injury to coccyx. Wound 1 measured 3 cm x 6 cm x 0.1 cm. [Date initiated: 05/13/24; Cancelled: 05/17/24]. [Resident #1] had potential/actual impairment to skin integrity of the buttocks and perineum. 05/16/24: 7.5 cm x 5 cm x 0.1 cm. [Date initiated: 05/17/24; Resolved: 05/23/24]. [Resident #1] had current skin concerns: Wound 3: lower back 06/06/24 4 cm x 8 cm [Date initiated: 06/21/24]. Care plan goals indicated [Resident #1] pressure ulcer will show signs of healing and remain free from infection by/through review date [Initiated: 03/12/24; Resolved: 03/14/24] and [Initiated: 05/13/24; Cancelled: 05/17/24]; will have intact skin, free of redness, blisters or discoloration by/through review date. [Initiated 03/12/24; Resolved: 03/14/24]; will have no complications r/t abrasion of the right buttock through the review date [Initiated: 03/14/24; Resolved: 04/02/24]; will have no complications r/t (SPECIFY skin injury type) of the (SPECIFY location) through the review date [Initiated: 05/17/24; Resolved: 05/23/24]; Area will be free from complications by review date. [Initiated: 06/21/24]. (Target Date: 08/08/24). Interventions/tasks reflected Monitor/document location, size and treatment of skin injury .; Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. [Initiated: 05/17/24; Resolved: 05/23/24]; Perform treatments per MD orders, monitoring, administering pain medication PRN, encourage fluid intake within dietary limits, assess skin weekly and record findings in clinical record. [Initiated: 06/21/24] Other interventions included encourage good nutrition and hydration in order to promote healthier skin, follow facility protocols for treatment of injury, and identify/document potential causative factors and eliminate/resolve where possible. A record review of Resident #1's Order Summary Report reflected: - Start Date 02/24/24: Nursing to perform weekly skin assessment every Saturday 2-10 every evening shift - Start Date 05/14/24: Wound Care MD to evaluate and treat. - Start Date 05/14/24: Wound Care to evaluate and treat. - Start Date 06/08/24: Lower back wound: Cleanse with NS and pat dry. Apply honey and silicone dressing QOD and PRN. Every 48 hours for Wound Healing. - Start Date 06/21/24: Lower back wound: Cleanse with NS and pat dry. Apply honey and silicone dressing QOD and PRN. Every 48 hours for Wound Healing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Focused Care at Sherman		STREET ADDRESS, CITY, STATE, ZIP CODE: 817 W Center Sherman, TX 75090	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #1's Licensed Nurse TAR for June 2024 reflected LVN C signed off that weekly skin assessments were performed on Saturday, 06/01/24 and Saturday, 06/08/24. The June 2024 Licensed Nurse TAR reflected LVN D completed the cleansed Resident #1's lower back wound with NS and patted dry, applied honey and silicone dressing QOD, every 48 hours for wound healing wound care on 06/08/24 and the WCN completed wound care on 06/10/24. The Licensed Nurse TAR was blank on 06/12/24 that indicated wound care was not performed. Record review revealed that there were no completed Weekly Skin Assessments by LVN C noted in Resident #1's chart. Record review of Resident #1's WMD visit reports reflected: Date: Thursday, 05/16/24: Wound #2 bilateral buttocks is a Moisture Associated Skin Damage (MASD) - Not Healed. Initial wound encounter measurements are 7.5 cm x 5 cm x 0.1 (LxWxD) . there was no drainage noted. Wound bed has 40% epithelialization. Periwound skin does not exhibit signs or symptoms of infection. Wound Orders: Cleanse/irrigate wound with NS/water. Apply barrier cream. Apply Collagen dressing. Change Dressing Every Day and as needed. -lota (leave open to air). Date: Thursday, 05/23/24: Wound #2 bilateral buttocks is a Moisture Associated Skin Damage (MASD) and has received an outcome of Resolved. Record review of Resident #1's completed Weekly Wound Assessments reflected: Date: Thursday, 05/23/24. Wound #2. Location: buttocks and perineum; Type: excoriation (skin is scraped or worn away by friction or erosion [a breakdown of the outer layers of the skin]). Resolved Date: Thursday, 06/06/24. Wound #3. Location: lower back; Type: Stage 2. Record review of Resident #1's completed Weekly Skin Assessments reflected: Date: Monday, 05/27/24: LVN A selected Yes to the question, Does the resident have a pressure, venous, arterial, diabetic, or surgical wound? If yes, complete the Weekly Wound Assessment. LVN A did not document the location or type of skin impairment. Date: Monday, 06/03/24: LVN A selected Yes to the question, Does the resident have a pressure, venous, arterial, diabetic, or surgical wound? If yes, complete the Weekly Wound Assessment. LVN A did not document the location or type of skin impairment. Record review of Resident #1's progress notes reflected: Effective Date - 05/29/24 [Nurses Note]: ADON C wrote, Active protein supplement d/c at this time d/t wound resolved. Effective Date - 06/06/24 [Nurses Note]: The WCN wrote LATE ENTRY. Given verbal orders from MD for wound care QOD (every other day) with therahoney and silicone dressing. Wound care provided at this time. Resident tolerated well. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Effective Date - 06/10/24 [Orders - Administration Note]: The WCN wrote Lower back wound: Cleanse with NS and pat dry. Apply honey and silicone dressing QOD and PRN. Every 48 hours for Wound Healing. Effective Date - 06/13/24 [Nurses Note]: LVN E wrote [Resident #1] was in therapy they stated she did not seem to be herself . did assessment . called 911 . [Resident #1] was awake upon leaving facility. Effective Date - 06/21/24 [Nurses Note]: The WCN wrote Upon review of [Resident #1's] medical record, noted missing entry on 06/12 for wound care. Wound care was indeed performed by [WCN] on 06/12/24. No changes noted, other than slight increase in drainage. Drainage was sanguineous, without s/s of purulent drainage. No s/s of infection. Resident tolerated well. During an interview on 06/21/24 at 2:40 PM, RCP B stated that she worked with Resident #1 since March 2024. RCP B stated that Resident #1 was sleepy and lay in bed all day. RCP B stated that she did not see the wound one day and then the next day it was there when she went to change her and discovered the open area (on 06/06/24). RCP B said that Resident #1 was having bad diarrhea and the feces got on top of the dressing that covered the open area. RCP B said that she never saw the dressing before 06/06/24. RCP B said that she removed the dressing and went to get the WCN to inform that the dressing had bowel movement on it. RCP B said that she guessed the WCN did not know about the wound by the way she reacted. RCP B said she did not know who applied the dressing. RCP B said the open area looked like a blister that popped and the skin peeled up. RCP B said the open area was around her tailbone area. During an interview on 06/25/24 at 1:18 PM, the WCN indicated she worked at the facility a little over 2 months. The WCN said that she was responsible for performing wound care, rounding with the WMD every Thursday, and making sure that the nurses completed weekly skin assessments. The WCN said the last known skin issue Resident #1 had, was resolved on 05/23/24. The wound was excoriation of the buttocks and perineum. The WCN said Resident #1 had diarrhea which caused the excoriation. The WCN said that she was informed by RCP B on 06/06/24 of an open area on Resident #1 lower back [described area as the very bottom of spine area - tailbone]. The WCN said that she assessed and evaluated the wound site and notified the FPCP to obtain orders for treatment and WMD consult. The WCN said that the wound site was discovered after the WMD had already done rounds. The WCN said that she was not informed that Resident #1 had skin breakdown on the lower back or buttocks since the excoriation was resolved on 05/23/24. The WCN said that Resident #1 was discharged to the hospital on 06/13/24 before she could be assessed by the WMD. The WCN said that she reviewed a weekly report that would reflect if a weekly skin assessment was not completed. The WCN said that she did not read the weekly skin assessment and expected the nurse to inform of any skin breakdown or changes observed during weekly skin assessments. The WCN said that the RCPs inspect the residents' skin for redness, bruising, or break in skin when assisting with showers, bed baths, and incontinent care. The WCN said that the RCPs should report any skin issues to the charge nurse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and records review on 06/25/24 at 1:54 PM, LVN A indicated that she worked 6A - 2P shifts and worked Monday, 05/27/24 and Monday, 06/03/24. LVN A said that weekly skin assessments should be 7 days from the date of admission, but the Nurse Administration Record would trigger the day the skin assessment was due and that is how she knew it needed to be completed. LVN A said that she looked at the UDA (User-Defined Assessments) section of the chart to see when the next skin assessment was due. LVN A agreed that she recalled completing the weekly skin assessments on 05/27/24 and 06/03/24. LVN A said that she selected Yes that indicated Resident #1 had a wound. LVN A said that she usually enters the location and a brief description or write that there were wound orders and treatment in place. LVN A said that she remembered seeing a red area with the skin pushed back (described as loss of the top layer of skin). LVN A described the size of the wound by making a circle with both hands together (approximately 5 cm in diameter). LVN A said that she was sure she told the WCN about it the open area when she discovered it during the skin assessment. During an interview on 06/25/24 at 2:28 PM, the DCO indicated a skin sweep was conducted on 06/21/24 to ensure that there were no unknown resident skin issues. The DCO said there was wound and skin management protocols in place to prevent missing skin issues, such as RCP documentation on shower sheets about skin issues and verbally notifying the resident's assigned nurse. The DCO stated the nurses should complete wound care on their shift during the weekends and if unable to complete, to notify the oncoming nurse of the treatments that were incomplete for completion by the nurse on the next shift. The DCO stated not performing weekly skin assessments by visualizing the resident skin from head to toe or not providing wound care as ordered could prevent the wounds from healing, miss skin breakdown, or possibly cause infection. Review of the Wound Care policy and procedure provided by the facility, revised September 2016 indicated: - Verify that there is a physician's order. - Review the resident's care plan to assess for any special needs of the resident. - Documentation should include the type of wound care given, date and time, all assessment data, how the resident tolerated the procedure and any problems or complaints made by the resident related to the procedure. If a resident refused and why. Review of the facility's Pressure Ulcers/Skin Breakdown - Clinical Protocol policy and procedure, revised December 2010 indicated: Assessment and Recognition - The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores . - The physician and staff will examine the skin of a new admission for ulcerations or indications of a Stage 1 pressure area that has not yet ulcerated at the surface. - The physician will help the staff define the type and characteristics of an ulceration. Cause Identification (continued on next page)

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The physician will help identify factors contributing or predisposing residents to skin breakdown . Treatment/Management - The physician will authorize pertinent orders related to wound treatments . - The physician will help identify medical interventions related to wound management. - The physician will help staff characterize the likelihood of wound healing . Monitoring - During resident visits, the physician will evaluate and document the progress of wound healing . - The physician will help the staff review and modify the care plan as appropriate .