

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Humble		STREET ADDRESS, CITY, STATE, ZIP CODE 93 Isaacks Rd Humble, TX 77338	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident received adequate supervision for 1 of 5 residents (CR #1) reviewed for accidents.</p> <p>-CR #1 walked out of the facility unattended with a wander guard on and was missing for approximately 20 minutes on 8/6/24.</p> <p>The noncompliance was identified as PNC. The IJ began on 8/6/24 and ended on 8/9/24. The facility had corrected the noncompliance before the investigation began.</p> <p>This failure could place residents at risk of elopement.</p> <p>Findings Include:</p> <p>Record review of CR #1's face sheet revealed she was an [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, history of falling, muscle weakness, abnormalities of gait and mobility, cognitive communication deficit, and type 2 diabetes mellitus with unspecified complications.</p> <p>Record review of CR #1's Elopement assessment dated [DATE] revealed a score of 5 which indicated she was a medium risk. She was cognitively impaired with poor decision-making skills, ambulated independently, and was a new admission who did not accept the new situation.</p> <p>Record review of CR #1's Order Summary Report revealed orders for:</p> <p>Wander guard to right ankle, order date 5/24/23;</p> <p>Monitor wander guard device to right ankle. Ensure that device is activated and working every shift, order date 5/24/23;</p> <p>Monitor every 15 minutes x 72 hours for exit seeking, order date 5/24/23.</p> <p>(continued on next page)</p>

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
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of CR#1's nursing note dated 6/26/24 at 4:48 p.m. signed by the Social Worker revealed she provided a list of secure unit options to residents' RP. Currently waiting on RP decision of secure unit to send referral. Resident RP emailed Social Worker back informing her that she would like residents' information to be sent to [name] and [name]. Call was placed to both facilities, information has been sent.</p> <p>Record review of CR #1's Progress Note dated 7/13/24 at 2:01 p.m. and signed by LVN W revealed CR #1 was observed exit seeking but was easily redirected without difficulty resident in room at this time but will continue to monitor.</p> <p>Record review of CR #1's Licensed Nurse MAR for August 2024 indicated staff monitored her wander guard device to right ankle twice a day from 8/1/24 - 8/6/24 to ensure it was activated and worked.</p> <p>Record review of CR #1's Incident report dated 8/6/24 at 4:26 p.m. prepared by LVN W read in part, notified by beautician next door name [name] that resident was next door sitting in a chair Resident Description: resident stated I was taking a walk going to meet my daughter .Immediate action taken . head to assessment completed, rp [name] notified, 1:1 applied, NP notified. Wander guard in place to right ankle .</p> <p>Record review of CR #1's nursing note dated 8/6/24 at 4:45 p.m. written by the previous DON read in part, . The nurse and assigned nurse were notified by a neighboring business customer that resident had entered the business and appeared to be lost. Resident's assigned nurse immediately went to retrieve resident. Resident was immediately assessed. Skin assessment was conducted by assigned nurse-no skin issues noted. Resident appeared calm, no distress noted. Resident was immediately placed on 1:1 behavior monitoring. Resident's RP [name] notified, and requested for resident to be transferred out to hospital for eval .</p> <p>Record review of CR #1's nursing note dated 8/6/24 at 4:45 p.m. written by the previous Administrator read in part, .Conducted f/u interview with resident. Resident reports that she went with her [family member] to try to see what it (the beauty shop) was about. She explained that she was walking out with her [family member] and she came back by herself. Resident was in a calm and pleasant mood. No signs or symptoms of distress observed.</p> <p>Record review of CR#1's Care Plan dated 08/09/2024 revealed wander guard device on 06/02/2024, for verbalizations of wanting to leave the facility. CR #1 was an elopement risk/wanderer related to adjusting to the nursing home, impaired safety awareness, and resident wanders aimlessly. CR # 1 wanders around building and exit seeks. Interventions included structured activities, food, conversation, television, and books . Identify pattern of wandering .Provide reorientation strategies including signs, pictures, and memory boxes .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the provider investigation report dated 8/13/24 read in part. Individual involved: (CR #1) . Independently ambulatory? Yes. Interviewable? Yes. Capacity to make informed decisions? No. Wearing wander guard at time of incident? Yes. History of: wandering . Investigation Summary: During investigation it was noted that (CR #1) who is an [AGE] year-old female waws reported to have walked into a neighboring business. It was reported to the staff at approx. 3:25 p.m. on 8/6/24. The facility interviews with the staff revealed that the resident was last seen in the facility was approx. 3:05 p.m. on 8/6/24. Facility staff brought resident back to the building. The nurse conducted a head-to-toe assessment on resident and there were no injuries, and NO negative outcomes noted. Resident was in a pleasant mood with no s/s of distress noted. Elopement assessment completed on resident. Resident was placed on 1:1 pending further evaluation. A complete facility round and bed check was conducted and all residents were accounted for. Surrounding area grounds was assessed for hazards. The MD/NP was notified. Resident was sent to the ER for evaluation and returned the same day with no new orders. Resident resumed 1:1 until discharged [sic] to another facility with secured unit on 8/9/2024 . The Investigation Findings were confirmed.</p> <p>In an interview on 4/24/25 at 10:43 a.m. the Receptionist stated she had been employed at the community since April 21, 2025. She said she was aware the wander guard alert device was secure throughout the building. She said to her knowledge the residents on hallway two were the only residents who wore a wander-guard device. She stated she had not witnessed residents coming to the front door with the wander guard device and setting off the alert system. She stated she had not observed how the wander-guard worked with a resident trying to elope. She stated she was not trained on the wander-guard elopement protocol. She stated she was aware of where the hotline was posted in the community for reporting purposes, she stated she had no concerns of any abuse, neglect, or elopement.</p> <p>In an interview on 4/24/25 at 10:56 a.m. LVN A stated she worked on hallways two, three, and four. She stated she had been employed at the community for nine months. She said she had residents on halls three and four with the wander guard devices attached to them. She stated the front door was the main focus for resident's entry and exit. She said the other doors were always locked, but she had not witnessed a resident trying to leave. She said CR #1 was a walker/roamer in the community. She said CR #1 was very busy and hard to get her to rest. She said CR #1 was on hallway five and was not one of her assigned residents. She said she did not know the exact details of which door the resident left or the exact time. She said when she was first notified about CR #1 eloping, she was unsure of who CR #1 was. She said the other staff members had to describe the resident to her for her to remember exactly who exited the community. She said CR #1 had a best friend that she always walked with every day, but on 08/06/2024 CR #1's best friend was observed walking in the hallways by herself, so that was very odd behavior. She stated it was very important to monitor residents who roam a lot around lunchtime because families were in and out of the community and would hold the door open for a resident to exit, not knowing they were not capable of leaving the community alone. She said immediately when the elopement was discovered, the facility did a lockdown of the community followed protocol with a resident count and documentation. She stated all concerns of abuse or neglect to be reported to Executive Director of Operations. She said we in-serviced staff on elopement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 4/24/25 at 12:55 p.m. the Fire/Safety staff said the magnetic guard and red color notification at the top of the doors throughout the facility indicated if the door was locked, not the keypad to the right of the door. He expressed that all doors had a magnetic lock at the top and could be seen by the indicated color if it was fully active. He stated the safety metal bar on the door was not necessary. He said the keypad was an entry measure and if the code was not entered the door would remain locked. He stated the wander bar at the bottom of the doors would pick up the bracelet attached to residents. He stated the codes were installed as a double measure to prevent exit.</p> <p>In an observation on 4/24/25 revealed the front door, hallway one, and smoking/patio had a wander guard alert system. Hallways 2, 3, 4,5, 6 did not have wander guard protection but had security code pads.</p> <p>In an observation on 4/24/25, a facility staff member demonstrated an attempt to exit with wander-guard attached. The alarm was triggered immediately and sounded until the code was entered.</p> <p>In an interview on 4/24/25 at 1:56 p.m. the Executive Director of Operations stated the community had magnetic locks at the facility for a long time to her knowledge. She said all the doors had codes and could be opened for entry. She stated the front, the smoking area/patio, and hallway one exit doors all led to driveways which were equipped with the wander-guard alert system. She said for emergency purposes the doors had a 15 second hold and could open but would set off the alarm. She said the alarm would sound on all doors. She stated if any resident went out of a wander guard equipped door, the system would go off. She stated the code would have to be entered by a staff member to disarm the alarm when there was an entry or an exit with a wander-guard resident. She said she was not employed at the facility when CR #1 eloped but read the details of the report and was aware that staff were in-serviced and there were currently no additional concerns of elopement.</p> <p>In an interview on 5/8/25 at 9:54 a.m., the previous Administrator said she did not have any recollection of what happened. She said everything was in the Provider Investigation Report. She said CR #1 was ultimately discharged and transferred to another facility. She said elopement training should be in the staff's orientation packet.</p> <p>In an interview on 5/8/25 at 10:06 a.m., the previous DON said staff had to check the light on the wander guard to make sure it was on and had to take the resident to the door to make sure the alarm went off. She said CR #1 walked around the facility with another resident but was not exit seeking. She said the beautician walked her back into the facility and the wander guard alarm sounded upon entry. She said she did not know if anyone was at the receptionist desk. She said she believed the elopement training was quarterly.</p> <p>In an observation on 5/8/25 at 11:35 a.m., the DON tested the wander guard system at the front door which was unlocked and closed. The wander guard sounded approximately one foot away from door and had to be disarmed by the receptionist.</p> <p>In an observation on 5/8/25 at 11:38 a.m., the DON tested the wander guard system at the door which led to the smoking patio area that was unlocked and closed. The wander guard sounded when she was right next to the door, and it had to be unarmed by another staff member.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/8/25 at 11:58 a.m., Hospitality Aide/Medication Aide/previous receptionist said she worked at the facility for 39 years and this month would be 40 years. She said she was the receptionist in August of 2024. She said she worked from 10 a.m. to 3 p.m. on 08/06/24. She said when she sits at desk located by the entrance door, no resident goes out unless the nurse tells her the resident can go out. She said when she left at 3 p.m. the nurses at the nurse's station would take over. She said CR # 1 never walked out the front door in front of her. She said when a resident with a wander guard approached the door, the alarm would sound, and the door would automatically lock. She said the resident was not one that could go outside alone. She said she did not know if the resident wore a wander guard and did not remember if she saw the resident that day. She said if they did give her in-service on elopement procedures, she did not remember but she would not let a resident walk out of the building. The inservice training record was reviewed with the previous receptionist and she confirmed her signature was not on the sign in sheet dated 08/06/24. She said after a resident left out the building it needed to be reported to the charge nurse. Staff would check all the rooms, check outside, and notify the Administrator and the DON.</p> <p>In an interview on 5/8/25 at 12:34 p.m. CNA G said she had been working at the facility for almost 3 years and worked the 2 p.m. to 10 p.m. shift. She said she did not think she was assigned to CR #1 that day but could not remember. She said the resident did have a wander guard on but said she had no idea if the wander guard was working that day. She said the resident had a pattern of trying to leave the facility. She was always walking around and could not remember the last time she saw the resident that day. She said if the resident got close to the door, the door would lock and alarm. She did not know how the wander guard worked when the door was already opened. She said she did not recall if her wander guard sounded that day. She said she received elopement training prior to CR #1's elopement. She said if someone were to elope, she would get help and try to redirect them to the facility. She said the facility has a code pink to alert all staff and locate the resident.</p> <p>In an interview on 5/8/25 at 1:17 p.m. LVN W said at the time of the incident the facility did not have a full-time receptionist. She said the previous receptionist did not work 5 days a week and thinks it was 3 days a week. She said she worked the 6 a.m.-6 p.m. shift and could not remember if the previous receptionist worked on 8/6/24. She said once the receptionist left, it was everyone's responsibility to monitor the doors at that time. She said she was working, and the beauty shop person came to the facility and informed her that the resident was at their beauty shop. She said the person asked if they had a resident who was missing, and she had everyone stop and do a resident count. She said the beauty shop person took her to the shop and the resident was sitting in a stationary chair and the resident said she was okay, no pain, and was taking a walk to get her hair done. She said the beauty shop person took her and the resident back to the facility. She said the back of the salon and the facility were behind each other and approximately 0.3 miles away from the facility. She said they entered through the front door, but as soon as they got close, the door locked, and someone had to let them inside the facility. She said she did not recall who the last person to see the resident was. She said the DON let them back inside. She said she did not have to disarm any wander guard alarms that day.</p> <p>In an interview on 5/8/25 at 12:55 p.m. the Executive Director of Operations said if the exit doors were open the wander guard would still sound and would have to be turned off manually.</p> <p>In an observation on 5/8/25 at 1:53 p.m., a resident demonstrated the use of the wander guard with the door closed and opened. The alarm sounded on both instances.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Elopement in-service dated 2/13/24 and 06/22/24 revealed Hospitality Aide/Medication Aide/previous receptionist was listed.</p> <p>Record review of Elopement in-service dated 6/22/24 and 8/6/24 revealed LVN W was listed.</p> <p>Record review of the facility's undated Elopement policy read in part, Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. A resident who leaves a safe area may be at risk of heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Examples of criteria that put a resident at higher risk of elopement . cognitive impairment . exit-seeking behaviors . new admission wanting desperately to leave .System Highlights: all residents are assessed by the licensed nurse upon admission, quarterly, or with a significant change in condition for the risk of elopement. Interventions are added to the care plan and monitored for effectiveness. A notebook should be maintained at each nurses station containing a picture and a completed missing resident profile for all residents at risk for elopement. Elopement drills are conducted quarterly as training exercises for staff to practice what to do in case of an elopement. If a resident is missing: Check the resident sing out book and check to see if they are at an appointment, with activities, transportation, or with family. Code pink is called if the resident cannot be immediately located after a search of the inside and outside parameters .</p>