

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 01/02/2026
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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (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
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments, including the storage of schedule II medications in separately locked, permanently affixed compartments, permitting only authorized personnel to have access except when the facility uses single unit medication distribution systems in which the quantity stored was minimal and a missing dose can be readily detected for 1 of 6 medication carts (600 hall) reviewed. The facility's medication cart was not kept locked or under direct observation of authorized staff in an area where residents could access it. No medications were taken by residents but the potential for more than minimal harm exists for 1 of 6 medication carts (600 hall) reviewed. The facility failed to ensure medications were stored and secured from unauthorized residents. Findings included: During an observation on 01/02/2026 at 10:22am, 1 lidocaine patch and 2 unidentifiable pills were observed on the top of the nurse medication cart on the 600 hall, in front of a resident room. The medication cart was also observed to be unlocked. In an interview on 01/02/2026 at 10:27am with RN R, she stated the expectation is to not leave medications unattended and medication cart must be locked. RN R stated she was trying to quickly assist another staff member with another resident, and she did not have enough time to put medications away and lock the medication cart. RN R stated the risk of medications being left out and the medication cart being unlocked was residents could take the medications and could possibly get into any needles. In an interview on 01/02/2026 at 10:48am the ADMN stated the expectation was there should be no medications on top of the medication cart. Medication should be locked, along with the medication cart. The risk of medications being left out was that anyone passing by could possibly consume medications that were not prescribed and the same for the medication cart being unlocked. In an interview on 01/02/2026 at 11:11am with MA J stated the expectation for medication pass was to wash hands, compare medications, MAR match, pour medications into cup, lock the cart, provide medications to the resident, and make sure residents are taking their medications. If the medication cart is left unlocked, she would lock it and inform the person who the medication cart belonged to that it was left unlocked and unattended. The last in-service for medication storage was last week. In an interview on 01/02/2026 at 11:27am MA R stated the expectation for medication pass was the resident having the right route, right time, and right to refuse. They are to sanitize hands, check blood pressure if required, lock the medication cart, and speak to the residents to inform them of what they are being given. She stated that she has a habit of locking the medication cart and has never left it unlocked and unattended, but if she did witness medications left out, she would inform the staff. If the medications were left unattended, she would take the medication to the nurse and ensure the cart was locked. The last in-service for medication storage was 01/02/2026. In an interview on 01/02/2026 at 11:47am ADON L stated the expectation for passing medication was to make sure the staff are using the 7 rights when administering medications to the residents, ensure the cart is always locked, and document refusals. If medications are left on top of the medication cart she would take the medications and store them safely and make sure everything is secure. The risk of leaving medications on the cart unattended along with leaving the medication cart unlocked could result in a resident taking the medications, which could cause harm. Medication Storage/Labeling policy requested but was not received by the facility.</p>		