

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/29/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 5 residents (CR #1) reviewed for care plans. The facility failed to ensure CR #1's stage 3 sacral wound was care planned with interventions from 6/6/26 - 6/20/26. The failure could place residents at risk of worsening pressure ulcers and hospitalization. Findings included: Record review of CR #1's face sheet, dated 06/24/26, revealed a [AGE] year-old who admitted on [DATE]. Her diagnoses included peripheral vascular disease (a slow and progressive disorder of the blood vessels), Alzheimer's disease, muscle weakness, and need for assistance with personal care. She was discharged to an acute care hospital on 6/20/26. Record review of CR #1's discharge MDS assessment dated [DATE] revealed her cognitive skills for daily decision making were severely impaired. She was dependent on staff for toileting hygiene needs and was always incontinent of bowel and urine. She had one unstageable pressure injury presenting as a deep tissue injury. Record review of CR #1's care plan revised on 6/16/26 revealed she was at risk for skin breakdown related to history of fragile skin, vitamin deficiency, decreased sensation, incontinence, physical impairment, decreased mobility, muscle weakness and use of wheelchair for mobility propelled by staff. Interventions included all staff to be aware of resident's skin fragility and follow facility policies/protocols for the prevention/treatment of skin breakdown. CR #1 was also on antibiotics related to wounds. Interventions were to encourage fluids, give all medications and monitor for any adverse reactions report to MD asap, monitor vital signs. CR #1's sacral wound was not care-planned and there were no interventions related to her sacral wound. Record review of CR #1's change in condition evaluation dated 6/6/26 completed by LVN J revealed she had a new open area to the coccyx (tailbone). Record review of CR #1's Order Summary Report revealed the following orders: -Stage 3 sacral wound clean with NS, apply Santyl, calcium alginate, cover with dry dressing as needed, order date 6/11/26; -Santyl ointment 250 unit/gm apply to per additional directions every day shift for wound care order date 6/12/26. In an interview on 6/29/26 at 11:20 a.m., WCN said the MDS nurse was mainly covering the care planning for the wounds, but had been out of the facility since Thursday 6/25/26. She (WCN) was new to the position but expected to soon conduct all care plans for the wounds. She said if the MDS nurse did not care plan CR #1's sacral wound then she and the two ADCOs were responsible to do it. She said it was important to ensure CR #1's sacral wound was on her care plan, because it was individualized for treatment, and should include interventions, goals, and everything needed to promote healing for better health. She said almost all staff utilized the care plan. She said there could if not her sacral wound waws not listed. She said something could get missed and could maybe cause more symptoms. She said staff were made aware of interventions through individualized in-services and through the electronic record which populated from the care plan, MD orders, and interviews with resident families. In an interview on 6/29/26 at 11:31 a.m., ADCO said WCN was responsible to care (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan wounds. She said the MDS nurse was responsible for quarterly care planning. She said they had weekly standards of care meetings, and if something was needed to be added on the care plan, the MDS nurse would care plan it. She said wound interventions should be care planned immediately so everyone knew the plan of care. In an interview on 6/29/26 at 12:22 pm, DCO said the MDS nurse care planned chronic issues, but nursing staff care planned acute concerns. She said WCN was responsible for care planning wounds. She said WCN was new and they tried to do the care planning during the weekly standards of care meetings. She said the care planning for CR #1's sacral wound was missed, because on the last two Wednesdays when they held the meetings (6/10 and 6/17), she had visitors from the State in the building. She said it should have been caught. The purpose of the care plan was to update changes so everyone was aware. She said there was no risk if CR #1's sacral wound was not on the care plan. Record review of the facility's Comprehensive Care Plan policy revised 4/25/21 read in part, .Every resident will have an individualized interdisciplinary plan of care in place. The Care Plan is revised every quarter, significant change of condition, Annual or as the resident condition changes on an individualized basis. The Care Plan process is an ongoing review process. The Interdisciplinary Team will review the healthcare practitioner's notes and orders, (e.g., dietary needs, medications, routine treatments, etc.) and implement a Comprehensive Care Plan to meet the residents' immediate are needs including but not limited to:. b.Physician orders, g. Skin Prevention, . Any updated information based on the details of the comprehensive care plan, as necessary.		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 5 residents (Resident CR# 1) reviewed for quality of care.1.The facility failed to provide wound treatment according to the NP orders from 6/9/26 to 6/10/26 and from 6/16/26 to 6/20/26 for CR #1 who experienced a worsening sacral wound that increased in size and became infected. CR #1 was sent to the hospital on 6/20/26 and was diagnosed with severe sepsis with septic shock (life threatening condition where an infection triggers dangerously low blood pressure and organ dysfunction, requiring immediate medical intervention).2.The facility failed to complete a Sepsis UDA assessment for CR #1 on 6/19/26 according to MD orders. An Immediate Jeopardy (IJ) situation was identified on 06/26/2026. While the IJ was removed on 06/27/2026, the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of worsening pressure ulcers, sepsis, hospitalization, and death. Findings included: Record review of CR #1's face sheet, dated 06/24/26, revealed an [AGE] year-old who admitted on [DATE]. Her diagnoses included peripheral vascular disease (a slow and progressive disorder of the blood vessels), Alzheimer's disease, muscle weakness, and need for assistance with personal care. She was discharged to an acute care hospital on 6/20/26. Record review of CR #1's discharge MDS assessment dated [DATE] revealed her cognitive skills for daily decision making were severely impaired. She was dependent on staff for toileting hygiene needs and was always incontinent of bowel and urine. She had one unstageable pressure injury presenting as a deep tissue injury. Record review of CR #1's care plan revised on 6/16/26 revealed she was at risk for skin breakdown related to history of fragile skin, vitamin deficiency, decreased sensation, incontinence, physical impairment, decreased mobility, muscle weakness and use of wheelchair for mobility propelled by staff. Interventions included all staff to be aware of resident's skin fragility and follow facility policies/protocols for the prevention/treatment of skin breakdown. CR #1 was also on antibiotics related to wounds. Interventions were to encourage fluids, give all medications and monitor for any adverse reactions report to MD asap, monitor vital signs. CR #1's sacral wound was not care-planned. Record review of CR #1's Braden scale for predicting pressure sore risk dated 4/12/26 revealed she was at high risk with a score of 12 due to very limited ability to respond meaningfully to pressure-related discomfort, very moist degree to which skin is exposed to moisture, chairfast degree of physical activity, very limited mobility, adequate nutrition, and a problem with friction and shear. Record review of CR #1's change in condition evaluation dated 6/6/26 completed by LVN J revealed she had a new open area to the coccyx (tailbone). Record review of CR #1's Wound Assessment Report dated 6/8/26 by Wound Care NP revealed she had a stage 3 sacral wound that measured 4.7 cm (l) x 2.30 cm (w) x 0.20 cm (d). The wound had 50% epithelial (a type of body tissue that forms protective layers covering internal and external surfaces, lining organs, cavities, and glands.), 45% granulation (the formation of granulation tissue, a vital part of the wound healing process that indicates the transition from inflammation to tissue repair), and 5% slough (dead tissue that appears as yellow, white, or tan material and can impede healing if not properly managed). The treatment was to clean the wound with normal saline. The primary treatment was Santyl, calcium alginate, and dry dressing daily. Record review of CR #1's wound initial dated 6/8/26 by Wound Care NP revealed there were no signs of infection of the stage 3 pressure ulcer of sacral region. Record review of CR #1's Wound Assessment Report dated 6/15/26 by Wound Care NP revealed she had a stage 3 sacral wound that measured 7.50 cm (l) x 5.20 cm (w) x 0.20 cm (d). The wound was worsening and had 10% granulation and 90% slough. The peri-wound was fragile, edema (swelling caused by too much fluid trapped in the body's tissues), (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	erythema (superficial reddening of the skin), induration (thickening and hardening of soft tissue due to inflammation). There was moderate serous exudate (clear to pale yellow, thin, watery fluid that is a normal part of the early wound healing process but excess amounts may indicate complications such as infection). The treatment was to clean the wound with Dakins 0.125% solution. The primary treatment was Santyl, calcium alginate and dry dressing daily. Record review of CR #1's Wound Follow Up note dated 6/15/26 by Wound Care NP read in part, .Sacral wound not improved with increase in size, peri wound erythema and induration from 9 o'clock to 12 o'clock, cellulitis (bacterial skin infection) present, increase in necrotic tissue (dead, non-functioning tissue). Change treatment, added Dakin's cleanse. Recommend Bactrim DS BID x 10 days. Monitor for any changes in status or worsening of wound and notify MD/NP. Reviewed with treatment nurse. Signs of wound infection: signs symptoms present, recommend Bactrim DS BID x 10 days. Record review of CR #1's Order Summary Report revealed the following orders: -Stage 3 sacral wound clean with NS, apply Santyl, calcium alginate, cover with dry dressing as needed, order date 6/11/26;-Santyl ointment 250 unit/gm apply to per additional directions every day shift for wound care order date 6/12/26.-Bactrim DS give 1 tablet by mouth two times a day for wound infection for 10 days, order date 6/15/26 (d/c'd).-Bactrim DS give 1 tablet by mouth two times a day for wound infection/cellulitis for 10 days, order date 6/16/26.-Monitor for signs & symptoms of sepsis development throughout the entire antibiotic course and 72 hours post antibiotic completion as well as VS Q 8 hours. Symptoms of possible sepsis may include the following- 1. temperature >100.4 or <96.8 2. Pulse >90 3. O2 sats <90% 4. SBP <90 5. increase in pain level 6. increase need for O2 If any of the above present, complete the Sepsis UDA assessment. Every 8 hours for monitoring for S & S of sepsis until 06/28/2026 13:40 Additional symptoms of sepsis to monitor: skin redness/swelling, decreased urine, c/o of pain, chills, labored breathing, warmth/foul odor in wound, elevated pulse, hot/cold, or clammy skin, urine with foul odor, foul odor of breath, decreased appetite, order date 6/16/26. There were no orders added for Dakin's 0.125% cleanse according to the wound assessment report dated 6/15/26. Record review of CR #1's Medication Administration Record for June 2026 revealed Stage 3 sacral wound clean with normal saline, apply Santyl, calcium alginate, cover with dry dressing every day shift had a start date of 6/11/26 and had no documentation of administration prior to this date. Santyl ointment had a start date of 6/12/26 and there was no documentation of administration prior to this date. On 6/18/26 the order for Stage 3 sacral wound clean with NS, apply Santyl, calcium alginate, cover with dry dressing every day shift and the order for Santyl ointment were blank and had no documentation of administration. Record review of CR #1's temperature revealed on 6/19/26 at 4:48 p.m. it was 100.7 F. Record review of CR #1's administration nursing note dated 6/19/26 at 5:34 p.m. by RN T read in part, .The client took this medication for a fever of 100.8 F at 4:48 p.m., her fever is now 98.9 F .Record review of CR #1's nursing note dated 6/20/26 at 12:07 a.m. by LVN W read in part, .Resident received resting comfortably in bed, no s/s of acute distress. Day 3/10 Bactrim Ds r/t DX cellulitis of wound. tolerated well; no rash or GI upset noted. Upon assessment, initial temp noted at 99.0 F. PRN Acetaminophen 1g PO administered per standing orders at 2336. Reassessed 1 hour later: temp decreased to 96.7 F. Other vitals stable. Wound cellulitis site on sacrum remains localized with moderate redness and warmth; dressing clean, dry, and intact. Record review of CR #1's pulse readings from 6/18/26 - 6/20/26 revealed the following were abnormal (greater than 100): 6/18/26 at 9:19 a.m. - 139 bpm (machine) 6/19/26 at 4:48 p.m. - 130 bpm (machine) 6/19/26 at 4:49 p.m. - 88 bpm (manual) -recheck of the machine reading at 4:48 p.m. 6/19/26 at 9:27 p.m. - 117 bpm irregular new onset (machine) 6/19/26 at 9:30 p.m. - 113 bpm irregular new onset (machine) 6/20/26 at 4:12 p.m. - 118 bpm (machine) Record review of CR #1's assessments revealed there were no Sepsis UDA assessments completed per the MD order. Record review of CR #1's nursing note dated 6/20/26 at 4:22 p.m. by RN T read in part, Day 4/10 Bactrim for sacral wound. The resident was stable until 2:49 p.m. when her temperature read 99.9 F, 2 500 mg acetaminophen were administered and temperature rechecked at 4:03 p.m. and read 98.8 F. At 4:10 her temperature had risen to 100.4 F and she was (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	having tremors. Her BP dropped from 102/74 to 96/63, and pulse went to 118. After ensuring the patients safety . I got on the telehealth app to do a visit for her. She instructed to transport her out so that she can get the infection taken care of. She would meet CR #1 at the local hospital.Record review of CR #1's emergency department notes dated 6/20/26 at 5:33 p.m. revealed CR #1 presented with fever.according to EMS, she had a sacral wound for the past 2 to 3 weeks, facility was concerned for infection. Today, started having body aches and fevers as upon presentation to the ER.CT Chest abdomen pelvis final result 1. Sacral midline pressure wound with a collection of gas and fluid measuring 5 cm x 4 cm x 4 cm, with gas extending into the ishchiorectal fossa (fat-filled, wedge-shaped space situated on either side of the anal canal), lower buttocks, and left gluteus maximus muscle (largest muscle of the buttocks) caudally with associated swelling, consistent with infection with gas-forming organism/gas gangrene (rare, rapidly progressing bacterial infection that destroys muscle and soft tissue and is a medical emergency). Diagnosis as of 6/20/26 at 11:06 p.m. Septic shock. Patient is a 88 y.o. female presenting with sacral wound. On presentation chronically ill-appearing but no distress. Febrile (having or showing the symptoms of a fever) and tachycardic (fast heart rate exceeding 100 beats per minute) on arrival with soft BPs (low blood pressure). Given IV fluids, IV antibiotics. imaging demonstrates findings concerning for necrotizing infection of the sacral wound. Scusset case [sic] with on-call general surgeon who will take patient emergently to the OR for debridement given her critical illness. Will admit to the ICU afterwards.Record review of CR #1's general surgery notes dated 6/20/26 revealed there was a 4 x 6 cm stage 4 sacral decubitus ulcer with overlying eschar (thick, dry, dead layer of tissue that forms over a wound, often appearing dark brown, or black). Under this eschar, there was necrotic fascia (flesh-eating disease a severe bacterial infection that affects the tissue under the skin called the fascia), gas gangrene, foul smelling, grayish discharge, and area of necrosis, and gas-forming gangrene, and myositis (chronic muscle inflammation) extended all the way to the left gluteal area, then the ischiorectal fossa ((fat-filled, wedge-shaped space situated on either side of the anal canal).the patient tolerated the procedure well and was then discharged to the recovery room in stable condition.In an interview on 6/24/26 at 10:45 a.m. CR #1's family member #1 said the resident was at the local hospital under hospice care. She said CR #1 had gangrene and infection in her blood stream. In an interview on 6/24/26 at 2:26 p.m., WCN said she started the wound care nurse position on 5/25/26. She had not been a wound care nurse before but was knowledgeable because of school. She said on Mondays she rounded with Wound Care NP and put any new treatment orders in when she got them. She said over the weekend (6/6/26 - 6/7/26) one of her colleagues did a change in condition for CR #1's sacrum. The following Monday (6/8/26) she received orders for vitamin therapy, air mattress, and treatment for her sacrum. She said between 6/8/26 and 6/11/26 CR #1's treatment orders were not documented in CR #1's orders but she was sure she was doing the treatments during that time. She said she applied normal saline with calcium alginate and dry dressing without the Santyl but did not remember how she documented the treatment. She said she was not completing the treatment according to MD orders. She said Santyl was a debrider (removal of dead, damaged, infected, or nonviable tissue) and removed the slough and ickiness and Calcium alginate aided wound healing and debridement. She said if Santyl was not applied to the wound, you would have to physically remove the slough with Theraworx (gentle cleanser that supports the skin's natural antimicrobial barrier) for preventative measures and to lessen infections and aid in healing. She said she did not notify Wound Care NP that the Santyl was not applied to CR #1 for 2-3 days. She said treatment orders should be entered into the system within 24 hours and there was no justifiable reason that it was not. She said in just one week (6/15/26) CR#1's sacral wound darkened, hardened and had drainage coming out. She said the Wound Care NP prescribed her Bactrim (antibiotic) and debrided the wound with an instrument because she wanted the area to be beefy red. In an interview on 6/24/26 at 3:55 p.m., LVN J said she was a charge nurse who also helped with wound care on the weekend. She noted CR #1 had a small, open wound in the crease of her buttock. She completed a change in condition, notified (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the family, and reported it to Wound Care NP. On Monday 6/8/26 she completed wound rounds with Wound Care NP which was a new duty for her. She received the wound orders but did not enter them into the system, and it did not cross her mind to enter them. She said she left the orders in the office for the weekday WCN to enter. She said the nurse who received the order was typically responsible for putting the order in the system, but no one showed her how to put the wound care orders in, and she was not really told to put them in. She said there were gaps in communication. She said when she returned to work a few days later, she noticed the wound care orders for CR #1 were not in, so she put them in the system. She was unsure if the wound was treated before the order was put in. She said Wound Care NP sent a copy of the orders to DCO; and the ADCOs could also enter the orders, but they normally left that task to the nurse. She did not recall nurse management asking her about the wound care orders for CR #1. Observation on 6/24/26 at 4:50 p.m. of CR #1 at the local hospital revealed she was lying in bed asleep with a foley catheter in place. She did not respond to verbal attempts to arouse her. In an interview on 6/24/26 at 4:54 p.m., CR #1's family member #2 said CR #1 had surgery and had not been awake since. He said her wound was necrotic and the hospital staff went in to clean it. In an interview on 6/24/26 at 5:00 p.m., CR #1's family member #3 said CR #1's wound was beyond bad. She said the resident was septic and had MRSA. In an interview on 6/24/26 at 5:34 p.m. CR #1's family member #1 said on 6/6/26, she was at the facility and was informed CR #1 had a sacral wound. She said the hospital MD called her on Sunday 6/21/26 and said CR #1 needed emergency surgery or she would die. She said the surgery went well and all the infection was drained out. She said the resident was placed on hospice care and they did not expect her to make it. In an interview and observation on 6/25/26 at 9:16 a.m., WCN said on 6/8/26, LVN J completed wound care rounds with Wound Care NP. She said LVN J had to leave the building and would be back, but she did not know what happened with the wound care orders. She said she found out about CR #1's treatment orders two days later when she saw it in the MAR. She said on 6/11/26, she had Santyl samples from the representative that she used on CR #1's sacral wound. She said she put the order in for Santyl ointment on 6/12/26. On 6/15/26, she completed wound care rounds with Wound Care NP. She said Wound Care NP ordered an oral antibiotic for CR #1, but did not change the treatment order from Santyl, calcium alginate and dry dressing. She said she treated CR #1's wound according to the order in the system. She said Dakins was another form of wound cleanser, but CR #1 did not have an order for Dakins and she would have applied the normal saline. WCN was shown the treatment order for Dakins cleanse on 6/15/26 from Wound Care NP's report. WCN said she did not recall seeing the Dakins in Wound Care NP's handwritten notes, as she did not review the report. She said she was trained to receive treatment orders written or oral. Review of Wound Care NP's handwritten notes for CR #1 dated 6/15/26 revealed Dakins cleanse was handwritten in the notes. WCN said she missed the order for Dakins cleanse and it was an oversight. She said there was no risk to the resident as Dakins was a cleanser. She said while treating the wound, she could not tell that something (such as negative changes) was going on. She said no swab was done. She said when she accepted the position as wound care nurse, she completed a skills check off with DCO and ADCO. She said the facility offered a wound care certification class and wanted her to be wound care certified, but she had not started it yet. In an interview on 6/25/26 at 9:26 a.m., WCN was asked about the hole/missing treatment documentation for CR #1 on 6/18/26. She said she should have worked on 6/18/26 (but was unable to confirm) and might have forgotten to go back (and document it). She said a check mark on the MAR meant the wound care was done, but she was unsure what the blank space meant. In an interview on 6/25/26 at 11:21 a.m., Wound Care NP said the initial assessment on CR #1's sacral wound was on 6/8/26. She said during rounds, a facility nurse rounded with her and she provided a verbal and a paper report (of her orders and visit). She said Santyl was an enzymatic debrider, not antimicrobial (agent that kills or stops the growth of microorganisms), and debrided dead tissue while Calcium alginate decreased the amount of drainage and promoted autolytic debridement. She said the facility did not mention that they had not applied the Santyl for a few days and said they should do the (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	wound care that was ordered. She said if the facility did not have the Santyl immediately that was pretty typical, because sometimes it took a while to get from the pharmacy. She said Santyl was more aggressive, but she realized it might not be available and other components of the treatment order managed the drainage. She said on 6/15/26, CR #1's sacral had not improved, and the treatment was changed to add Dakins cleanse. The action of Dakins was to assist with debridement and aid with infection. She said she was not notified that the Dakins cleanse was not applied and the main treatment was antibiotic. She said the Dakins would not stay on the wound, and was just ordered to cleanse it. She said CR #1's clinical status and wounds were complex. Her age, immobility, and other complex contributions could contribute to her immune function. She said if there were changes in the resident's status or worsening of the wound, facility staff should notify herself or the MD. In an interview on 6/25/26 at 11:51 a.m., CR #1's NP said her sacral wound was mostly unavoidable; the resident was unable to ambulate. He said once the sacral wound opened it was difficult (to manage). He said he did not have concerns with her wound treatments, but was not aware CR #1 was not treated with Dakins cleanse. He said he ordered Bactrim for CR #1 and was treating the infection empirically. He said staff should monitor for malodorous (smelling very unpleasant) and increased drainage. He stated signs and symptoms of sepsis included fever (temperature over 100.4F) and tachycardia (fast heart rate exceeding 100 beats per minute). He said he would not get too concerned over a temperature of 99 F but might start hydration. He said he was not made aware of anything regarding CR #1 on Friday 6/19/26 when he rounded and she was stable. He said he would have liked to been notified of her fever (100.7F on 6/19/26) He said it might have been a nursing judgement to give Tylenol. He said he would have given the Tylenol once and notified the NP. If the temperature was over 99.6 F, he would also notify the NP but if it was 99.1 he might not have made the call but would complete an assessment. He said if the blood pressure dropped below 100 and heart rate was above 100, he would have tried to send her out to the hospital due to the vital signs. He said he was unsure if the facility knew the signs of sepsis, but vital signs like that would be alarming especially since the resident had a known infection. He said he did not see where any more systemic damage could have been caused, but said it was important to treat residents as soon as possible. He said on Monday morning 6/22/26, he was made aware CR #1 was sent to the hospital on 6/20/26. In an interview on 6/25/26 at 12:19 p.m., RN T said she worked with CR #1 since the beginning of June 2026. She said on 6/6/26 her sacral wound was very tiny and looked chafed (skin damaged or sore by rubbing). She stated she applied Zinc Oxide and notified the wound care nurse. She said it was amazing how quickly the wound got bad due to infection, and she was prescribed antibiotics for cellulitis. She said on 6/19/26 CR #1's heart rate elevated once but did not go above 100. This Surveyor showed RN T where she took CR #1's heart rate on 6/19/26 at 4:48 p.m. and it was 130 bpm. RN T said she did not have a concern about the heart rate of 130 because she rechecked it manually one minute later and it was 88 bpm. She said when CR #1's temperature was 100.7 F (at the same time, on 6/19/26 at 4:48 p.m.) she gave her Tylenol and said that might have been a reason to notify the MD. She said she was not a doctor and was unsure why someone would spike a temperature while on antibiotics. She said if the resident had a known infection, a fever could be a concern. She said it was important to monitor vital signs because the resident could be on the wrong antibiotic and the MD should be notified if the resident was showing signs of sepsis. She said she was monitoring CR #1 for sepsis per the MD order, but did not complete a sepsis UDA assessment because she thought all the vitals had to be abnormal. She said on 6/20/26 CR #1 ate all her lunch and was stable all day. CR #1 then had a temperature of 99.9 F and was shivering, the nurse administered Tylenol. She said the resident then had a temperature of 100.4 F, and her heart rate and temperature increased. She sent CR #1 to the hospital due to her vital signs. In an interview on 6/25/26 at 1:42 p.m. DCO said WCN oversaw order entry for wounds, but no one oversaw WCN to ensure the orders were entered. She said she told staff to review Wound Care NP notes when putting the orders in. She said regarding the treatment orders from 6/8/26, LVN J thought another person (continued on next page)		

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 06/29/2026
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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	was going to enter the orders and there was miscommunication between LVN J and WCN. CR #1's treatment orders from 6/8/26 were put in the system late on 6/11/26. She said her understanding was that the treatments were completed for CR #1 on 6/8/26 and 6/10/26. She said she was unsure if they were done on 6/9/26. She said she expected staff to put orders in the system within 24 hours. She said there was no risk to the CR #1 because of her comorbidities and she was hospice appropriate. She said she found out today (6/25/26) about the Dakins cleanse not being applied and did not see the order for it in CR #1's electronic record. She said Dakins was more of a cleaning agent in combo with whatever else was ordered. She said the purpose of the Sepsis UDA assessment was to see if the resident had signs and symptoms of sepsis. She said she would expect nurses to notify the MD if CR #1 had a fever that would not go down or got higher, or if the vitals did not go down. She said if the vitals were abnormal, she would have completed a sepsis UDA assessment. She said the nurses knew how to identify signs and symptoms of sepsis due to the MD orders and care pathways. In an interview on 6/27/26 at 1:20 p.m., MA A said she could not remember any abnormal blood pressure or heart rate vital signs for CR #1. She said if the heart rate was too high, she would notify the nurse. She said the vital sign was also sent to the computer and the nurse should be able to see it. Record review of the facility's Skin Management: Prevention and Treatment of Wounds policy revised 10/6/22 read in part, .The purpose of this procedure is for prevention and treatment of skin breakdown such as pressure injuries, diabetic ulcers, arterial ulcers, and skin wounds. 2. Prevention. Theraworx skin products will be used for general cleansing after incontinent care to help maintain skin pH balance. 4. Treatment: a licensed nurse will obtain orders from physician for new skin wounds and transcribe onto resident's treatment record for follow up. Record review of the facility's Change in Condition policy dated 11/1/2019 read in part, .[facility name] will use the interact definition for a change in condition. It will be the policy that once the nurse has notified the physician for a change in condition the resident/patient will be monitored for 1 hour until the physician has responded. The monitoring will include vital signs, pulse ox. A physical assessment should be completed relative to the symptoms present. This was determined to be an Immediate Jeopardy (IJ) on 6/26/26 at 12:12 p.m. The Administrator, DCO, and AIT was notified. The Administrator was provided with the IJ template on 6/26/26 at 12:24 p.m and a POR was requested. The following Plan of Removal submitted by the facility was accepted on 6/26/26 at 9:12 p.m. On 6/24/26 Complaint Survey was initiated. On 6/26/26 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to provide wound treatment in accordance with the NP orders from 6/9/26 to 6/10/26 and from 6/16/26 to 6/20/26 for CR #1 who experienced a worsening sacral wound that increased in size and became infected. CR #1 was sent to the hospital on 6/20/26 and was diagnosed with severe sepsis with septic shock. F-686 Action: CR#1 was discharged to hospital 6/20/26, and remains in hospital at time of Plan of Removal report 6/26/26 100% Skin audit initiated and completed by Director of Nurses/Designee, with no wounds noted without proper orders in place. 6/26/26. 100% audit of wound care orders initiated by Director of Nurses/Designee, wound care orders are identified as accurately transcribed as ordered by physician. 6/26/26 The Regional Director of Clinical Operations will provide education on Company's policy related to physician and/or family notification of new orders and/or resident change in condition to the Director of Nurses. The Director of Nursing received this in-service 6/26/26. The Regional Director of Clinical Operations will provide education on company's protocol related to Sepsis Assessment, Sepsis Orders and completion of Sepsis UDA to the Director of Nurses. The Director of Nursing received this in-service 6/26/26. In-Service on company's policy related to Sepsis Assessment, Sepsis Orders and completion of Sepsis UDA by the Director of Nurses. In-Service Read: All nurses must be familiar with the signs and symptoms manifested with sepsis, follow facility protocol and notify the NP/MD immediately. S/S of sepsis includes but is not limited to increased heartrate, decreased BP, SOB, etc. All nursing staff expected to be in-serviced prior to the (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	next shift worked. All nursing staff expected to be in-serviced by 6/27/26. This education will also be included in all new nurse orientations for any newly hired nurses. 6/26/26 In-service on company's policy related to physician and/or family notification of new orders and/or resident change in condition to all nursing staff conducted by the Director of Nurses/Designee. Inservice Read: Nursing staff must complete a thorough head to toe assessment on all residents with a noted COC. Doctors/NP must be notified immediately to give nursing staff guidance/orders to follow; Clinical and/or nonclinical staff must complete a stop and watch form for any noted changes and notify the nurse in charge immediately. All nursing staff expected to be in-serviced prior to the next shift worked. All nursing staff expected to be in-serviced by 6/27/26. This education will also be included in all new nurse orientations for any newly hired nurses. In-service on company's policy related to following physician orders and properly transcribing new physician orders to include risks related to inaccurate transcription of orders into electronic monitoring system to all nursing staff conducted by the Director of Nurses/Designee. Inservice Read: following physicians written orders for skin or wound care require strict adherence to documented instructions. A compliant order specifies the exact wound location, cleansing solution, dressing changes, and frequency changes. Always verify orders, place the order in [electronic medical record], and document it to ensure safety and clinical efficacy immediately. All nursing staff expected to be in-serviced prior to the next shift worked. All nursing staff expected to be in-serviced by 6/27/26. This education will also be included in all new nurse orientations for any newly hired nurses. Certified Nurse Aides were re-educated on utilization of the Stop and Watch notification in [electronic medical record] for changes in condition to include changes in skin condition on 6/26/26. All expected to be in-serviced prior to the next shift worked. All Certified Nurse Aides expected to be in-serviced by 6/27/26. This education will also be included in all new nurse orientations for any newly hired nurses. Director of Nurses or Assistant Director of Nurses will review new orders related to wound care daily to ensure Weekly Wound Assessment is in place if appropriate and/or change in conditions are happening. Weekend supervisor will review on weekends. At the time of the weekly wound rounds, the Treatment nurse will enter the order immediately into [electronic medical record], while still in the presence of the Practitioner. On the day Wound Care rounds the Director of Nursing/Designee will audit Wound Care Paperwork to verify that all physician orders have been accurately entered into the electronic medical record, treatments are correctly scheduled, and no discrepancies exist between physician orders and treatment documentation. Any identified deficiencies are corrected immediately. This process was put in place effective 6/26/26. Director of Nurses initiated disciplinary actions for Treatment Nurse and Weekend Treatment Nurse for failure to provide wound treatment in accordance with NP orders. 6/27/26 Director of Nurses initiated In-services on Change in Condition, Following Physician Orders, Properly Transcribing Orders, Assessing for Sepsis with Charge Nurses, Treatment Nurse and Weekend Treatment Nurse. All Nurse will be in-serviced by 6/27/26. Staff will not be allowed to provide direct care until training is completed. Competency Checks for wound treatment, transcribing orders in Electronic Medical Records were initiated for Treatment Nurse and Weekend Treatment Nurse. Treatment Nurse and Weekend Treatment expected to be in-serviced, and all competencies completed prior to the next shift worked.6/27/26 Upon finding a new wound, the nurse will obtain a		