

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

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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 07/15/2026
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were stored in locked compartments and permit only authorized personnel to have access to the keys for 2 (Resident #47, Resident #38) of 17 residents reviewed for medication storage. The facility failed to ensure Resident #47's Tums (a fast-acting antacid that neutralizes stomach acid to relieve heartburn, acid indigestion, and upset stomach) were not left by the bedside on 7/13/26. The facility failed to ensure Resident #38's Systane (lubricant for eye drops) were not left by the bedside on 07/13/2026. This failure could place residents at risk of access to medications not approved for administration by their physician. Findings included: Record review of Resident #47's admission record dated 7/13/26 revealed an [AGE] year-old female who readmitted on [DATE]. Her diagnoses included moderate dementia (middle stage of cognitive decline, where memory loss and confusion become serious enough that a person needs regular help with everyday activities), osteoarthritis (degeneration of joint cartilage and underlying bone, leading to pain, stiffness, and reduced mobility), cognitive communication deficit (a condition where a person's ability to communicate effectively is compromised by an underlying impairment in mental processes, rather than a primary problem with language or speech), need for assistance with personal care, and major depressive disorder. Record review of Resident #47's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15 which indicated severe cognitive impairment. Her functional status was not assessed. Record review of Resident #47's care plan revised on 6/8/26 revealed she resided in the secure unit and was at risk for injury from wandering in an unsafe environment related to diagnosis of dementia; as evidenced by impaired safety awareness. interventions included: keep environment free from possible hazards, explain procedures using terms/gestures resident can understand. She also had impaired cognitive function and impaired thought processes; decisions were poor; she required reminders, cues, supervision in planning, organizing, and correcting daily routines related to dementia. Interventions were to administer medications as ordered by the MD and monitor effectiveness. Record review of Resident #47's Order Summary Report revealed orders for: Secure unit placement for safety and security due to elopement risk secondary to dementia, order date 5/12/25; Calcium carbonate chewable 500 mg give 1 tablet by mouth before meals for hypocalcemia (low calcium), order date 9/2/25. In an observation on 7/13/26 at 10:14 a.m. in Resident #47's room on the secure unit, Resident #47 was lying in bed with her eyes closed. There was a broken tablet in a medication cup sitting on her bedside table alongside her bed. In an observation and interview on 7/13/26 at 10:16 a.m. LVN T said Resident #47 had Tums (Calcium carbonate) medication that the resident saved and would not take at the time it was administered. She said staff should not leave medication at the bedside. In an (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation at 10:17 a.m. LVN T entered Resident #47's room, picked up the medication cup with the Tums and administered it to the resident. Resident #47 consumed the medication. LVN T said Resident #47 would normally take all her other morning medication but would not consume the Tums unless she (the resident) had it herself. She said that was her bad and staff did sometimes leave the Tums for the resident. LVN T said some residents wandered on the secure unit and there could be a risk of other residents getting into her room. In a continued interview on 7/13/26 at 10:28 a.m. LVN T said she was the nurse who administered Resident #47's medication this morning and thought the resident consumed all her medication. LVN T said she should pay better attention and did not know the resident did not take the Tums. In an interview on 7/14/26 at 11:11 a.m. the DON said no resident on the secured unit self-administered their medication, including Resident #47. She said nursing staff had to watch the resident consume the medication and ensure there was no choking. She said the charge nurses were responsible for ensuring no medications were left at the bedside. Record review of Resident #38's admission record dated 07/15/2026 revealed a [AGE] year-old male who admitted into the facility on [DATE]. His diagnoses included Parkinson's Disease (a brain disorder that affects movement), Lack of Coordination (poor muscle control that causes clumsy, jerky, or unsteady movements), Type II Diabetes (your body either doesn't make enough insulin or ignores the insulin it does make), Contracture of Muscle (when a muscle, tendon, or surrounding tissue tightens, shortens, or stiffens), and Muscle Weakness. Record review of Resident #38's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 07 out of 15 which indicated severe cognitive impairment. His functional range of motion revealed no impairment for upper and lower extremities. Record review of Resident #38's Care Plan revised on 07/07/2026 did not reveal a focus, goal, or interventions pertaining to his eyes. Record review of Resident #38's Physician Order Summary dated 07/15/2026 did not reveal any eye medications or if he could self-administer medications. During an Interview and Observation on 07/15/2026 at 4:12pm with Resident #38, Systane (lubricant for eye drops) was on the bedside table. Resident #38 stated he administered the Systane (lubricant for eye drops) eye drops himself. Resident #38 stated he had recently seen his eye doctor, who told him during the appointment that it was acceptable for him to use the drops on his own. Resident #38 reported that the facility had never told him he could not keep or use the drops and stated he needed them until he received new glasses. [NAME] an Interview on 07/15/2026 at 4:55pm with RN O, she stated that she was not aware of Resident #38 having eye drops on his bedside table. RN O stated the expectation for medication storage is once the medication has been administered, they are supposed to put it on the cart and make sure it is secured. RN O stated the risk of medications being left out is the medication not being secured and another resident could be walking by and taking it. RN O stated that Resident #38 does not have a physician order to administer medication. During an Interview on 07/15/2026 at 4:58pm with RN D, she stated the expectation for medication storage is for medication to be stored, secured and away from residents. RN D stated the risk of medications not being secured is, the medication could be stolen and taken. RN D stated that she was unaware of Resident #38 having any medication in the room. Record review of the facility's Storage of Medications policy revised on 8/2024 read in part, .Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for one of 6 residents (Resident #66) reviewed for infection control. CNA A failed to perform hand hygiene with glove changes during incontinent care on Resident #66. These failures could place residents who required incontinent care at risk for cross contamination and infection. Findings included: Record review of Resident #66's face sheet dated 07/14/26 revealed a [AGE] year old admitted to the facility on [DATE] and initially admitted on [DATE] with diagnoses including: Diabetes (a chronic condition that occurs when the body cannot properly use blood sugars), immunodeficiency d/t conditions classified elsewhere (failure of the immune system to adequately protect d/t absence or insufficiency of some component process or substance), vitamin deficiency, Hyperlipidemia (a condition that causes the high levels of lipids, or fats in the blood), dementia, Schizophrenia (a serious mental disorder, characterized by symptoms such as hallucinations, delusions and disorganized thinking) and extrapyramidal and movement disorders (involuntary or abnormal motor activities caused by a dysfunction in the brain). Record review of the quarterly Minimum Data Set (MDS) resident assessment dated [DATE] revealed Resident #66 had a BIMS score of 7 out of 15 indicating severe cognitive impairment. Resident #66 required supervision with toileting hygiene, personal hygiene, toilet transfers and sit to stand positions. Resident #66 was frequently incontinent of bowel and of urine. Record review of Resident #66's undated care plan revealed in part: Focus - Resident #66 was continent of bowel/bladder with episodes of incontinence with bathroom privileges with limited assistance by one staff member for toilet use and incontinent care. Goal - Resident #66 will remain free from skin breakdown due to incontinence and brief use. Interventions - Resident #66 uses disposable brief for incontinent care with changes every 2 hours and as needed. wash, rinse and dry perineum, change clothing PRN after incontinence episodes. Focus - Resident #66 is at risk or potential for frequent infections. r/t diabetes with vision loss. Interventions - observe/monitor/document/report PRN for s/sx of infection to any open areas. Observation and interview on 07/14/26 at 10:45AM, Resident #66 was alert and was getting himself into the bed to lay down. The back of his sweatpants was visibly wet with urine and there was an odor of urine. CNA A brought a bag of supplies into Resident #66's room: clean brief, a package of disposable wipes and one pair of gloves. CNA A provided incontinent care to Resident #66. CNA A put on clean disposable gloves, removed the soiled pants, unfastened the brief, then cleaned the resident's groin and penis using three separate disposable cleansing wipes. The resident turned to his left side and CNA A gathered the soiled brief, placed the brief in a plastic trash bag, then cleaned the buttocks and anal area using separate cleansing wipes. CNA A touched the clean brief, positioned and fastened the brief onto the resident without changing gloves and performing hand hygiene. CNA A touched the clean shorts and assisted the resident in putting them on. CNA A then removed used gloves, placed them into the trash bag. CNA A stated she would usually use hand sanitizer but did not have it with her. CNA A stated usually she was told ahead of time when incontinent care would be observed so she would have all the supplies ready including hand sanitizer. CNA A stated, I guess I will wash my hands, then washed her hands with soap and water in the residents bathroom. CNA A put on clean gloves from the box that was on the bathroom wall then assisted Resident #66 to his wheelchair. CNA A picked up the trash bag, placed the bag in the trash can that was in the hallway and sanitized her (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands. CNA A stated the purpose of hand hygiene between glove changes was for hygiene and cleanliness. In an interview on 07/14/26 at 11:00 AM, the DON stated, when performing incontinent care, she expected nursing staff to perform hand hygiene before entering the room, between changing of gloves and before exiting the room. The DON stated the purpose was to control cross contamination. The DON stated she expected the staff to use hand sanitizer and if not available then to use soap and water. In an interview on 07/14/26 at 4:00 PM, the DON and the Administrator stated, when doing incontinent care, the nursing staff should change gloves when moving from clean area to dirty area, then change gloves after the care and before touching clean items to prevent cross contamination. Record review of the facility policy: Infection Control - Hand Hygiene, last revised on 10/24/2022, read in part: Hand hygiene is used to prevent the spread of pathogens in healthcare settings. Hand hygiene is a general term that describes hand washing using soap and water or the use of an alcohol-based hand rub (ABHR) to destroy harmful pathogen, such as bacteria or viruses, on the hands. 1. You should always perform hand hygiene: Before applying and after removing personal protective equipment (e.g. gloves.) Before and after providing any type of care. 2. You must perform hand hygiene (hand washing or the use of an ABHR) after contact with bodily fluids, such as urine or blood.		