STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675722	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Fort Stockton	501 N Sycamore Fort Stockton, TX 79735

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse or neglect, for 1 of 8 residents (Residents #46) and 5 of 5 residents in the surveyor's confidential resident group meeting reviewed for abuse and neglect. The facility failed to ensure staff did not talk ugly to residents in the resident council meeting or make residents feel bullied (Resident #46). The facility failed to ensure staff did not talk ugly to residents, did not [NAME] the resident when the staff thought resident made a complaint against the the staff, or played favorites with the residents This failure could place residents at risk for emotional distress, fear, decreased quality of life and further abuse. Findings included: Review of Resident #46's Admission Record, dated 11/12/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including depression and diabetes mellitus. Review of Resident #46's Quarterly MDS Assessment, dated 10/4/24 revealed: Resident #46 had a mental status score of 10 of 15. (Indicating moderate cognitive impairment) Review of Resident #46's care plan showed no history of making false allegations. Review of Resident #46's Electronic Record showed the facility completed a Customer Satisfaction Survey on 11/8/24. Resident #46 reported: Please rate your meal and or dining experience: dissatisfied: If dissatisfied with meals/dining, please let us know how we can improve: staffing bulling residents. (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: 675722	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 11/5/24 Resident Council Meeting Minutes dated, 11/5/24 revealed Resident #46 attended and the residents complainted there were issues with some staff members, still have having issues with two particular [NAME] CNA B is still an issues she picks and chooses who to shower, hears a lot of verbal abuse to depenendent residents anstate she's very unprofessional Interview on 11/11/24 at 2:53 p.m. the AD informed the surveyor that the residents had made some complaints about verbal abuse including Resident #46. The AD stated she reported it to the Administrator. The AD stated she did not feel the residents were blowing allegations out of proportion and were afraid to say something. During the confidential resident council meeting on 11/12/24 unprompted, two residents complained about staff playing favorites, being ugly to residents, making ugly faces at residents, and were rude to residents. One resident reported being shunned because the staff thought the resident complained and this made the resident feel bad. The resident said they did not report it because if they did the shunning/silent treatment would get worse. Residents reported staff talked down to them. One resident stated the facility took down the Ombudsman's card because they did not want the resident to have it. No resident knew where the abuse hotline number was posted and wanted to know where it was. Residents resported an aide took things away from a resident in the dining room intentionally making her scream, the residents reported they would give the resident a lollipop so she would quit screaming. Interview on 11/12/24 at 3:54 p.m. the SSD reported that residents reported being uncomfortable with CNA B since SSD started 1/31/24. The SSD stated the residents were uncomfortable because CNA B talked ugly and picked favorites and if she (CNA B) did not want to do something, she would not. The SSD stated families were afraid of retaliation. The SSD reported she had seen staff talk to residents ugly, and the cognitively impaired residents got talked to uglier. The SSD stated the definition of emotional abuse was yelling, cussing around them, belittling the residents. The SSD stated talking ugly to the resident was a way of belittling them, so yes, it would be a form of emotional abuse. The SSD stated she reported the aide's behavior to the previous DON probably twice and to the currently DON twice plus the family complaint on 11/6/24 (Resident #212). Interview on 11/12/24 at 4:48 p.m. the Resident Care Ambassador (RCA) stated she had been at the facility for three months. She stated she did surveys with the staff and families about staff treatment and satisfaction. The RCA reported she had received complaints about CNA B being mean and most of her staff complaints were about CNA B. The RCA stated she was aware of a situation when there was an (unidentified) resident buzzing (using the call light) for an hour and CNA B was the aide on the hall. The RCA stated CNA B told her (the RCA) that she knew the resident had activated the call light for an hour. The RCA stated she reported it to the administrator. The RCA stated aides talked ugly to residents and told residents that they were nasty because they lived in the facility. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/12/24 at 5:17 p.m., the Administrator stated the October Resident Council minutes just had complaints about missing clothing. The Administrator stated apparently the CNA B situation had been a topic of disciplinary actions way before he got to the facility and had been going on for a year or more. The Administrator stated CNA B was currently suspended and they were going to terminate her because it was a never-ending cycle. He stated topics that kept coming up was her not cleaning up urine, there was a similar allegation that occurred during lunch while a family was there. The Administrator stated this was probably her normal behavior. The Administrator stated intentionally not providing care to resident could be interpreted as a form of neglect. The Administrator stated he received two or three formal complaints about CNA B but he did not have enough fingers to report the unofficial complaints he received from staff. The Administrator stated he received allegations she left a resident soiled and went to lunch. The Administrator stated the staff were taught not providing care was neglect. The Administrator stated not changing a resident intentionally was neglect. The Administrator stated he wasn't privy to documents because the staff were afraid they would be written up. Surveyor pointed out he had access to the Resident Council Minutes and the complaint book. Interview on 11/13/24 at 9:47 a.m. the ADON stated CNA B previously worked at the facility but the previous Administrator fired CNA B. The ADON did not know what the situation was - allegedly it was because CNA B was mean. Interview on 11/13/24 at 10:36 p.m., the DON stated the care complaints started in the last 2 weeks and it was because of some outside family dynamics. The DON stated the big, big complaint about CNA B was the way she talked to staff was a little aggressive and she may be a little aggressive to get residents to shower. The DON stated if she was a dependent resident, she might feel like CNA B was mean to her or that CNA B did not like them or stuff like that. The DON stated if anyone was afraid, no one had told her. The DON stated if a resident reported feeling bullied was an allegation was a hard question to answer. The DON said she guessed it would depend on how the resident perceived it. The DON said to investigate an allegation of bullying she would talk to staff and other residents until she found out what the cause was. The DON stated she was not aware a resident said that they felt bullied. The DON stated the only other complaint she received about CNA B was when CNA B drew blood on Resident #2. The DON said CNA B said the nurses were showing her. The DON said CNA B was not in a formal phlebotomy program or on a formal training course with the facility to draw blood. The DON stated if the resident did not give consent, it would be mistreatment (twice) and then louder said she did not know if the residents gave consent for the lab draw or not. The DON stated she did not know why residents did not feel safe reporting concerns to her. Interview on 11/14/24 at 10:08 a.m. CNA F stated CNA B liked to make funny jokes but was sloppy with the residents. CNA F stated she would believe a resident if a resident told her CNA B was ugly to the resident or played favorites. CNA F said CNA B liked to take things away from one of the cognitively impaired residents to make her scream in the dining room. CNA F said there was no point in reporting it because the ADON and DON had seen her do it. CNA F said the ADON or DON told CNA B to stop, and it did for a little while but then started again. Interview on 11/14/24 at 1:46 p.m. the Administrator stated the families did not report feeling unsafe for their loved ones in the facility and he did not know why surveyor's findings were so different. The Administrator stated when he became aware of the complaint with Resident #212 CNA B was suspended. The Administrator said when he found out CNA B took labs from the residents he was appalled at the situation and found the behavior was highly unsatisfactory. The Administrator said the labs were done with the consent of the residents. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Council Minutes dated 10/2/24 revealed 5 residents reported two particular CNAs making faces and making it uncomfortable asking for things. Written above it were CNA B and CNA H. Review of the Resident Council Minutes dated 11/5/24 revealed five different residents from the 10/2/24 Resident Council reported still having issues with two particular aides - CNA B is still an issue she picks and choses who to shower, hears a lot of verbal abuse to resident especially Resident #31 and state she's very unprofessional, CNA H gives a lot of attitude as well. Review of the complaint book revealed: 8/8/24, the administrator took a complaint that CNA H was rude to a resident while the resident was in the shower. The Administrator documented no signs or evidence of abuse were discovered. Review of the Resident Concern Log revealed: - 11/6/24 Resident's family voiced concern at loved one's care with staff. Resolution was DON re-educated all staff in-services sent out for abuse and neglect. All named staff have been properly reprimanded. - 8/20/24 Resident stated to our EDO (Administrator) verbal abuse from CNA Resolution: DON, ADON, and EDO suggested the specific CNA is not allowed in room alone. (Complaint not provided) - 4/2024 - 7/2024 complaint log missing. - 3/20/24 Resident's son came in with a complaint his mother stated being shoved back into bed. Resolution: Due to resident's foggy memory we spoke with all CNA Staff and educated them on Abuse and encouraged them to follow POA of resident. Review of CNA B's employee file did not have her previous employment or any of her previous verbal written counseling. Review of the facility's in-services included: 8/14/24 Customer Care 10/24/24 - Abuse and Neglect Undated - Workplace Behavior - four types of inappropriate behavior which included sexual relations, bullying, undiversified environment, and inappropriate behavior such as raising voices, talking over people, interrupting others making unreasonable demands. 10/29/24 - Abuse/Neglect/Exploitation - long term care provider letter 11/6/24 - all staff will perform their duties within their scope of practice. Nurses will make rounds every 2 hours to ensure CNAs are providing proper care for residents. Nurses will do more frequent rounds on residents on 24-hour report. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Policy and Procedure on Abuse, revised 1/1/23, revealed: The purpose of this policy is to ensure that each resident has the right to free from any type of Abuse, Neglect, Intimidation, Involuntary Seclusion/Confinement, and or Misappropriation of property. The facility staff will adhere to the policies and procedures and will follow the guidelines in the written policies and procedures and will follow the guidelines in the written policy and procedure. Abuse is the willful inflection of injury or negligent, unreasonable confinement, intimidation, or punishment with resulting physical or emotional pain to a resident. Residents will not be subjected to abuse by anyone, including but not limited to community staff. Procedure The administrator and/or designee are responsible for maintain ALL facility policies that prohibit abuse, neglect. - Train all employees. - Identification of possible problems that need investigation. - Protecting residents during investigation. Protection. The facility will initiate immediate procedures to ensure that these residents are protected fully from any further harm or potential harm.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on observations, interview, and record review, the failed to implement their written abuse prevention policy and investigate allegations for 2 of 11 Residents (Residents #23 and #46) of eight residents reviewed for resident abuse and 5 of 5 residents in the confidential group interview. 1. The facility failed to ensure the staff did not retaliate against family members of Resident #23 for allegedly making a report of abuse or neglect against a staff member . As a result, the family member was afraid to visit Resident #23. 2. The facility failed to ensure Resident #46 did not feel bullied by staff 3. The facility failed to have mechanism in place to ensure families and residents felt safe to report allegations of abuse, neglect, or misappropriation. 4. The facility failed to have the number for the HHS Hotline Posted. These failures places residents at risk of abuse along with allegations of abuse identified and investigated thoroughly. Findings included: Record review of the facility's Policy and Procedure on Abuse, revised 1/1/23, revealed The purpose of this policy is to ensure that each resident has the right to free from any type of Abuse, Neglect, Intimidation, Involuntary Seclusion/Confinement, and or Misappropriation of property. The facility staff will adhere to the policies and procedures and will follow the guidelines in the written policies and procedures and will follow the guidelines in the written policy and procedure. Abuse is the willful inflection of injury or negligent, unreasonable confinement, intimidation, or punishment with resulting physical or emotional pain to a resident. Residents will not be subjected to abuse by anyone, including but not limited to community staff. Procedure The administrator and/or designee are responsible to maintain ALL facility policies that prohibit abuse, neglect. - Train all employees. - Identification of possible problems that need investigation. - Investigating allegations (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Reporting incidents, investigations, and facility response to results of investigation within mandated time frames. - Protecting residents during investigation - Posting of HHS abuse hotline number Reporting the law requires the abuse coordinator/designee, or employee of the facility who believe that physical or mental health of welfare of a resident has been or may be adversely affected by abuse, neglect or exploitation caused by another person to report the abuse, neglect or exploitation. Upon notification of an allegation of physical or mental abuse, neglect or involuntary seclusion, the facility will conduct interviews that include documented statement summaries from the alleged perpetrator, the alleged victim, family members, visitors who may have made observations, roommates, and any staff who worked prior to and during the time of the incident. All events that involve an allegation of abuse or involve a suspicious serious bodily injury of unknown origin must be reported immediately or not later than 2 hours of alleged violation. If the allegation does not involve abuse and the event does not result in serious bodily injury the allegation should be reported within 24 hours. Protection. The facility will initiate immediate procedures to ensure that these residents are protected fully from any further harm or potential harm. Upon notification of allegation, the Abuse Coordinator or designee will - Identify the perpetrator that is identified by eyewitnesses or during investigation and remove the perpetrator from further contact with the resident pending outcome of the investigation. Resident #23 Review of Resident #23's Admission Record dated 11/13/24 revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnosis including dementia. Review of Resident #23's Quarterly MDS assessment dated [DATE], revealed: Resident #23 has a BIMS of 0 of 15 (indicating severe cognitive impairment) and resided on the secured unit. Interview on 11/11/24 at 4:54 PM Resident #23's family member stated the staff were not talking to the resident or the resident's family because CNA B was suspended a couple of weeks ago. Resident #23's family member stated Resident #23's oldest family member was not comfortable coming to the facility because CNA G (CNA B's sister) got in her (the oldest' s family member's) face and yelled at the oldest family member. Resident #23's family stated they did not why CNA B was suspended. Resident #23's family stated they did not report CNA G because they were afraid Resident #23's care would suffer. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #46 Review of Resident #46's Admission Record, dated 11/12/24, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including depression and diabetes mellitus. Review of Resident #46's Quarterly MDS Assessment, dated 10/4/24 revealed: Resident #46 had a mental status score of 10 of 15. (Indicating moderate cognitive impairment) Review of Resident #46's care plan showed no history of making false allegations. Review of Resident #46's Electronic Record showed the facility completed a Customer Satisfaction Survey on 11/8/24. Resident #46 reported: Please rate your meal and or dining experience: dissatisfied: If dissatisfied with meals/dining, please let us know how we can improve: staffing bulling residents. Review of the Resident Council Meeting Minutes dated 11/5/24 revealed Resident #46 attended. Resident #46 and 4 other residents reported old business: issues with some staff members. Clinical Services Department: Still having issues with aides: CNA B ise still and issue she picks and chooses who to shoawer, hears a lot of verbal abuse to resident especially dependent resident states she's very unprofessional. Interview on 11/11/24 at 2:53 p.m. the AD warned surveyor that the residents had made some complaints about verbal abuse, including Resident #46 The AD stated she reported it to the Administrator. The AD stated staff would report allegations and nothing would get done. The AD stated many allegations were brushed under the rug and if the staff said something they would get resentment. The AD stated she did not feel the residents were blowing allegations out of proportion and were afraid to say something. During the confidential resident council meeting on 11/12/24 unprompted two residents complained about staff playing favorites, being ugly to residents, making ugly faces at residents, and were rude to residents. One resident reported being shunned because the staff thought the resident complained and this made the resident feel bad. The resident said they did not report it because if they did the shunning/silent treatment would get worse. Residents reported staff talked down to them. One resident stated the facility took down the Ombudsman's card because they did not want the resident to have it. No resident knew where the abuse hotline number was posted and wanted to know where it was. The residents reported an aide would take things away from a resident in the dining room just to make her scream, the residents reported they would give the screaming resident a lollipop just to make her quit screaming. Observation and interview on 11/12/24 at 2:21 p.m. revealed the complaint hot line was not posted. At that time the ADON and DON confirmed it was not posted anywhere. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/12/24 at 3:54 p.m. the SSD reported that residents reported being uncomfortable with CNA B since SSD started 1/31/24. The SSD stated the residents were uncomfortable because CNA B talked ugly and picked favorites and if she (CNA B) did not want to do something she would not. The SSD stated she reported it to the previous DON, and she was not sure how the previous DON handled it. The SSD said she reported it to the current DON who dealt with it by in-servicing all staff. The SSD stated families were afraid of retaliation. The SSD stated she got in trouble for reporting the allegation of neglect. The SSD said she got dirty looks from staff and the staff would not respond to requests to change the residents because she wasn't clinical. The SSD stated she did not know she could report abuse anonymously. She stated, they're not stupid, they're going to retaliate. The SSD reported she had seen staff talk to residents ugly, and the cognitively impaired residents got talked to uglier. The SSD stated the definition of emotional abuse was yelling, cussing around them, belittling the residents. The SSD stated talking ugly to the resident was a way of belittling them, so yes, it would be a form of emotional abuse. The SSD stated she reported the aide's behavior to the previous DON probably twice and to the currently DON twice plus the family complaint on 11/6/24. Interview on 11/12/24 15 4:07 p.m. the AD stated she was unaware she could report abuse to the State Agency without the Administration's involvement and/or anonymously. The AD stated every time she reported something, the Administrator stated he would handle it and the Regional Management could come and belittle or retaliate against her for reporting. Interview on 11/12/24 at 4:48 p.m. the Resident Care Ambassador (RCA) stated she had been at the facility for three months. She stated she did surveys with the staff and families about staff treatment and satisfaction. The RCA reported she had received complaints about CNA B being mean and most of her staff complaints were about CNA B. The RCA was told to keep her mouth shut or everyone would be against her. The RCA stated she brought up the results of the surveys in morning meeting to the Administrator, but nothing was done so she emailed the Director of Customer Relations (Corporate Position). Then the Regional Nurse became aware and a lot of aides became aware. The RCA stated there was an (unidentified) resident buzzing (using the call light) for an hour and CNA B was the aide on the hall. The RCA stated CNA B told her (the RCA) that she knew the resident had activated the call light for an hour. The RCA stated she kept reporting concerns and the facility kept sweeping it under the rug and nothing ever got done. The RCA stated aides talked ugly to resident and told residents that they were nasty because they lived in the facility. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/12/24 at 5:17 p.m. the Administrator stated the October Resident Council minutes just had complaints about missing clothing. The Administrator stated apparently the CNA B situation had been a topic of disciplinary actions way before he got here and had been going on for a year or more. The Administrator stated CNA B was currently suspended and they were going to terminate her because it was a never-ending cycle. He stated topics that kept coming up was her not cleaning up urine, there was a similar allegation that occurred during lunch while a family was there. The Administrator stated this was probably her normal behavior. The Administrator stated intentionally not providing care to resident could be interpreted as a form of neglect. The Administrator stated he did an investigation. The Administrator stated he did not report the allegation to the State Office because after discussing with his superiors it was determined that it wasn't . The Administrator stated he received two or three formal complaints about CNA B but he did not have enough fingers to report the unofficial complaints he received from staff. The Administrator stated he received allegations she left a resident soiled and went to lunch. He stated he investigated that incident, and CNA B alleged she told the charge nurse. The Administrator stated he wrote CNA B and the nurse up. The Administrator stated the staff were taught not providing care was neglect. The Administrator stated not changing a resident intentionally was neglect. The Administrator stated he was not made aware of these allegations because the staff hid it from him and he had to uncover it. The Administrator stated he wasn't privy to documents because the staff were afraid they would be written up. Surveyor pointed out he had access to the Resident Council Minutes and the complaint book. Interview on 11/13/24 at 9:47 a.m. the ADON stated the Corporate RN stated she had to do an investigation because there was a complaint. The ADON stated CNA B previously worked here but the previous Administrator fired CNA B, but the ADON did not know what the situation was - allegedly it was because CNA B was mean. Interview on 11/13/24 at 10:36 p.m. the DON stated the care complaints started in the last 2 weeks and it was because of some outside family dynamics. The DON stated the big, big complaint about CNA B was the way she talked to staff was a little aggressive and she may be a little aggressive to get residents to shower The DON stated if she was a dependent resident, she might feel like CNA B was mean to her or that CNA B did not like them or stuff like that. The DON stated if anyone was afraid no one had told her. The DON stated if a resident reported feeling bullied was an allegation was a hard question to answer. The DON said she guessed it would depend on how the resident perceived it. The DON said to investigate an allegation of bullying she would talk to staff and other residents until she found out what the cause was. The DON stated she was not aware a resident said that they felt bullied. The DON stated she did not know why residents did not feel safe reporting concerns to her. The DON said staff training including SNF Clinic (electronic training) and verbal in-services. The DON stated they taught staff treatment of residents, resident rights, the proper way to take care of residents and how to talk to residents. The DON added the facility taught the staff to treat the residents like people. The DON stated the facility taught the staff the reporting chain of command was the Administrator and if he was not available to contact her (the DON) or the ADON. The DON added if that was not cleared up to report to the Regional RN. The DON stated they did teach staff to report to state but agreed if the number was not posted they could not. The DON stated CNA B was fired when she was a floor nurse, and the previous Administrator brought her back. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/14/24 at 10:08 a.m. CNA F stated CNA B liked to make funny jokes but was sloppy with the residents. CNA F stated she would believe a resident if a resident told her CNA B was ugly to the resident or played favorites. CNA F said CNA B liked to take things away from one of the cognitively impaired residents to make her scream in the dining room. CNA F said there was no point in reporting it because the ADON and DON had seen her do it. CNA F said the ADON or DON told CNA B to stop and it did for a little while but then started again. Interview on 11/14/24 at 1:46 p.m. the Administrator stated the families did not report feeling unsafe for their loved ones in the facility and he did not know why surveyor's findings were so different. The Administrator stated when he became aware of the complaint with Resident #212 CNA B was suspended. He stated he did not report the incident because he knew what happened and the family was happy with the outcome of the facility's actions. The Administrator stated he did not know the family used the word neglect with the SSD. The Administrator stated it crossed his mind to notify the State Agency, but he did not because the facility knew what happened. The Administrator said when he found out CNA B took labs from the residents he was appalled at the situation and found the behavior was highly unsatisfactory. The Administrator said the labs were done with the consent of the residents. Interview on 11/14/24 at 2:23 p.m. the Regional RN Consultant stated any willful action should be reported within two hours. The Regional RN Consultant stated she was not aware of any reports made to the State Agency. The Regional RN Consultant said if a family alleged the staff were not emptying a catheter it was neglect and it was a reportable incident and the possible impact to the resident was infection. The Regional RN Consultant stated a staff member getting into a family member's face was abuse. Review of the Resident Council Minutes dated 10/2/24 revealed 5 residents reported two particular CNAs making faces and making it uncomfortable asking for things. Written above it were CNA B and CNA H. Review of the Resident Council Minutes dated 11/5/24 5 different resident residents from the 10/2/24 Resident Council reported still having issues with two particular aides - CNA B is still an issue she picks and choses who to shower, hears a lot of verbal abuse to resident especially Resident #31 and state she's very unprofessional, CNA H gives a lot of attitude as well. Review of the complaint book revealed: 8/8/24 the administrator took a complaint that CNA H was rude to a resident while the resident was in the shower. The Administrator documented no signs or evidence of abuse were discovered. Review of the Resident Concern Log revealed. 11/6/24 Resident's family voiced concern at loved one's care with staff. Resolution was DON re-educated all staff in-services sent out for abuse and neglect. All named staff have been properly reprimanded. 8/20/24 Resident stated to our EDO (Administrator) verbal abuse from CNA Resolution: DON, ADON, and EDO suggested the specific CNA is not allowed in room alone. (Complaint not provided) 4/2024 - 7/2024 complaint log missing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675722	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Focused Care at Fort Stockton		STREET ADDRESS, CITY, STATE, ZIP CODE 501 N Sycamore Fort Stockton, TX 79735	

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/20/24 Resident's son came in with a complaint his mother stated being shoved back into bed. Resolution: Due to resident's foggy memory we spoke with all CNA Staff and educated them on Abuse and encouraged them to follow POA of resident. Review of CNA B's employee file did not have her previous employment or any of her previous verbal written counseling. Review of the facility's in-services included: 8/14/24 Customer Care 10/24/24 - Abuse and Neglect Undated - Workplace Behavior - four types of inappropriate behavior which included sexual relations, bullying, undiversified environment, and inappropriate behavior such as raising voices, talking over people, interrupting others making unreasonable demands. 10/29/24 - Abuse/Neglect/Exploitation - long term care provider letter 11/6/24 - all staff will perform their duties within their scope of practice. Nurses will make rounds every 2 hours to ensure CNAs are providing proper care for residents. Nurses will do more frequent rounds on residents on 24-hour report. Resident rights

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 26221 Resident #212 Abuse 11/13/24 05:20 PM no res satisfaction survey

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 26221 Resident #212 Abuse 11/13/24 05:20 PM no res satisfaction survey

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 30057

Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible, in 4 rooms (Rooms #101, #102, #104 and #113) out of sixteen resident rooms on 100 hall reviewed for accident hazards, in that;

The facility failed to ensure that the hot water temperatures in the sinks for 5 resident rooms did not exceed the maximum of 110 degrees Fahrenheit.

This failure could place residents at risk for injuries related to hot water temperatures.

The findings included:

Record review of Resident #18's admission record dated 11/13/2024 indicated he was admitted to facility on 02/20/2014 with diagnoses of dementia and muscle weakness. He was [AGE] years of age.

Record review of Resident #18's MDS dated [DATE] indicated in part: BIMS = 0 indicating resident was severely impaired.

Record review of Resident #37's admission record dated 11/13/2024 indicated he was admitted to facility on 08/30/2024 with diagnoses of dementia and muscle weakness. He was [AGE] years of age.

Record review of Resident #37's MDS dated [DATE] indicated in part: BIMS = 2 indicating resident was severely impaired.

Record review of Resident #57's admission record dated 11/13/2024 indicated he was admitted to facility on 09/17/2024 with diagnoses of lack of coordination and muscle weakness. He was [AGE] years of age.

Record review of Resident #57's MDS dated [DATE] indicated in part: BIMS = 9 indicating resident was moderately impaired.

Record review of Resident #58's admission record dated 11/13/2024 indicated she was admitted to facility on 10/11/2024 with diagnoses of lack of coordination and muscle weakness. She was [AGE] years of age.

Record review of Resident #58's MDS dated [DATE] indicated in part: BIMS = 8 indicating resident was moderately impaired.

During an observation and interview on 11/11/2024 at 11:54 AM, the water temperature was taken with the surveyors thermometer and was found to be 125 degrees F in resident room [ROOM NUMBER]'s sink. The water took 22 seconds to reach that temperature. Resident #18 who resided in that room said he had washed his hands in the sink but had not noticed the water was too hot nor had he burned himself. There was a total of 2 residents in that room.

(continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 11/11/2024 at 12:04 PM, the water temperature was taken with the surveyors thermometer and was found to be 124 degrees F in resident room [ROOM NUMBER]'s sink. The water took 22 seconds to reach that temperature. Resident #37 who resided in room [ROOM NUMBER] said he had washed his hands in his rooms sink and had never burned his hands and did not think the water was too hot. There was a total of 2 residents in that room. During an observation and interview on 11/11/2024 at 12:18 PM, the water temperature was taken with the surveyors thermometer and was found to be 123 degrees F in resident room [ROOM NUMBER]'s sink. The water took 20 seconds to reach that temperature. Resident #57 who resided in room [ROOM NUMBER] alone, said the water was not too hot that he had noticed and hot not burned his hands while washing. During an observation and interview on 11/11/2024 at 12:20 PM, the water temperature was taken with the surveyors thermometer and was found to be 122 degrees F in resident room [ROOM NUMBER]'s sink. The water took 20 seconds to reach that temperature. Resident #58 who resided in room alone, said the water at her sink was fine and had not noticed it being too hot nor had she burned herself with it. Record review of the facility's hot water temperature logs for October 2024 indicated in part: Day of the months from 1st thru the 28th indicated Temp 100 (Hall 100), Temp 200 (Hall 200), Temp 300 (Hall 300) and Temp 400 (Hall 400) were listed as temperatures ranging from 106 degrees F to 108 degrees F. None past 110 degrees F documented. During an interview on 11/11/2024 at 3:32 PM, the Administrator said that they currently did not have a maintenance person in the facility, and he was the one that monitored the water temperatures. The Administrator said that the previous maintenance person had left about a week ago and the regional maintenance person had currently been overseeing the facility. The Administrator said the previous maintenance person had conducted regular checks of the water temperature and would be providing a copy of the records. The Administrator said the water temperature was not to exceed 110 degrees Fahrenheit. The Administrator said if the water was higher than that, it could lead to residents getting burned. The Administrator was made aware of the water temperatures in hall 100. The Administrator said they had installed new water heaters and that could be the reason the temperatures were higher on hall 100. The Administrator said they had not had any issues with resident's getting burned with hot water. The Administrator said he was not aware of the water temperature being that high. During an interview on 11/12/2024 at 2:18 PM, the Administrator said that after the previous maintenance person had documented the water temperatures on 10/28/2024, they (water temperatures) had not been monitored anymore since the maintenance person had quit. The Administrator said that the facility had been monitored by the regional maintenance person since the maintenance person quit but the regional maintenance person had not been on site to check the water temperatures. The Administrator said the regional maintenance person would be there that day and he would adjust the temperature of the water heater. During an interview on 11/12/2024 at 4:24 PM, the Regional Maintenance person was at the facility and he said he was going to adjust the water temperature on the water heater to bring the temperature down to a safe level of about 100 degrees Fahrenheit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's document titled Safety of water temperatures and dated 12/2009 indicated in part: Tap water in the facility shall be kept within a temperature range to prevent scalding of residents. Water heaters that service resident rooms, bathrooms, common areas and tub/shower areas shall be set to temperatures of no more than 110 degrees or the maximum allowable temperature per state regulation. Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on interviews, and record reviews, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 (Residents #212) reviewed for indwelling catheters. The facility failed to ensure Resident #212 indwelling catheter was emptied when full to prevent it from exploding. The failure could place residents at risk for discomfort, urethral trauma and urinary tract infections. Findings included: Review of Resident #212's Admission Record, dated 11/12/24 revealed she was an [AGE] year-old female admitted to the facility 11/8/24 with diagnosis including pneumonia, pressure ulcers. Review of Resident #212's complaint dated 11/6/24 revealed: The family stated they were upset with Resident #212 care lately . the family . noticed that Resident #212's foley bag was filled to the top and had not been emptied causing the bag to rip and leak out everywhere. The family called on the call light and CNA B came in and saw the bag spilling out. The Family stated CNA B said oh there's a hole let me tell the nurse and walked out. CNA B failed to clean it up the spilled urine on the floor. The family also documented it took a while for someone to get back in there to help clean it up. So the family ended up putting paper towels up to clean it up themself. The family stated they did make the DON aware and sent pictures, and also expressed her anger with the charge nurse. The family alleged via text, dated 11/6/24, to the SSD I know you're probably tired of hearing this but [Resident #212] pays to be taken care of not to be neglected like this like they leave there to Later in the exchange the family asked if the DON and ADON would know it was them who complained because they were sure it will get around and she was told CNA B was on the DON's good list. In an interview on 11/13/24 at 9:47 a.m., the ADON stated it would probably take approximately 24 hours for Resident #212's catheter bag to fill to bursting. Interview on 11/14/24 at 2:23 p.m. the Regional RN Consultant stated if a family alleged the staff were not emptying a catheter it was neglect and the possible impact to the resident was infection.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on interview and record review , the facility failed to provide residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 2 of 2 (Resident #2 and Resident #5) residents reviewed for care, in that: The facility failed to ensure CNA B did not performed blood draws on Resident's #2 and #5 before becomingwithout being a certified phlebotomist and without the assistance of a nurse. This failure could affect residents by placing them at an increased and unnecessary risk of exposure to infections. Findings Included: Record review of Resident #2's admission record dated 11/13/2024 indicated he was admitted to facility on 10/18/2023 with diagnoses of reduced mobility and muscle weakness. He was [AGE] years of age. Record review of Resident #2's physician orders indicated in part: CBC,CMP,TSH, Lipid Panel, HgA1c Every 6 months for DX: DM, HTN, Hypothyroid, Afib. (November & May). (CBC - Complete Blood Count. CMP - Complete Metabolic Profile. TSH - Thyroid Stimulating Hormone. HgA1c - Hemoglobin check for sugar/glucose/diabetes. DX diagnosis. DM - Diabetes. HTN high blood pressure. Afib - Atrial Fibrillation - Heart disease.). Active 11/01/2023. Record review of Resident #2's care plan revised date 08/19/2024 indicated in part: Focus: Potential for complications, signs and symptoms (s/s) related to diagnosis of hypertension (high blood pressure). Resident receives anti-hypertensive and is at risk for side effects. Goals: Blood pressure will stay within their normal limits, will not have s/s of hyper/hypo tension throughout the review date. Interventions: Monitor labs as ordered. Report abnormalities to physician. Record review of Resident #2's MDS assessment dated [DATE] indicated in part: BIMS (Brief Interview Mental Status) = 10 indicating resident was moderately impaired. Record review of Resident #5's admission record dated 11/14/2024 indicated he was admitted to facility on 09/19/2023 with diagnoses of dementia, muscle wasting and atrophy. He was [AGE] years of age. Record review of Resident #5's physician orders indicated in part: Pre-Albumin every 3 months. (April, July, October, January) Active 04/05/2024. Record review of Resident #5's care plan revised date 06/25/2024 indicated in part: Focus: Potential for complications, Signs and symptoms (s/sx) related to diagnosis of hyperlipidemia Goals: Will remain free of s/sx or complications related to diagnosis of hyperlipidemia. Interventions: Monitor labs as ordered by MD (Medical Doctor) and notify promptly of abnormal values. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's MDS assessment dated [DATE] indicated in part: BIMS = 0 indicating resident was severely impaired. During an interview and an observation on 11/13/2024 at 03:10 PM, Resident #2 was in his bed resting awake and alert. Resident's left inner forearm was noted to have two areas that were bruised measuring approximately 2 inches by 2 inches each and at different stages of healing. Resident #2 said a staff member had come and drawn blood and filled 2 tubes of blood one from each bruises area. Resident #2 said he knew who the staff member was, but he could not remember her name. Resident #2 said it must have been the first time the staff member drew blood because she could not find a vein to draw it from. Resident #2 said the staff member was a CNA and that she worked at the facility. Surveyor asked if the staff's named sounded like CNA B's name and he said it could be, but he was not sure. Resident #2 said the blood drawn had occurred last Friday or Monday on the day shift. Resident #2 said the staff member had not told him that she was practicing blood drawing on him and that she just came in and told him she had to draw some blood. Resident #2 said he did find it odd that a CNA was drawing blood on him, but thought that maybe someone like the doctor had given her an order to do it. Resident #2 said he was not hurting or had suffered any injuries just that he had the bruising on his arm and that it would get better in a few weeks. Resident #2 said he did not blame the CNA for doing what she did because she might have been told to do it and she was just following orders. Resident #2 said beside the bruising the blood draw had gone fine and had no complaints about it. During an observation and interview on 11/14/24 at 03:10 PM, Resident #5 was in his room sitting up on his wheelchair awake and alert. Resident #5 was asked if he knew who CNA B was and he said he did know who she was. Resident #5 said that CNA B had drawn blood from him a few weeks ago in his room. Resident #5 again said he was sure the blood draw had happened in his room. Resident #5 said the blood draw went fine and had no complaints about it and the CNA had done a good job. During an interview on 11/13/2024 at 09:47 AM, the ADON stated Resident #2 was found with bruises on his arm., tThe DON did an investigation and found CNA B drew blood. The ADON stated she did not know if CNA B was qualified to do labs and did not know if nurses could delegate drawing labs. The ADON stated the DON did that part of the evaluation. During an interview on 11/13/2024 at 10:36 AM, the DON stated she received one complaint about CNA B doing a blood draw on Resident #2. The DON stated to delegate a blood draw, it would have to be a formal, written training program by an RN. The DON stated she did no such training because she would not be comfortable with an aide drawing blood under her license. The DON said it was not part of a CNA's job description to do lab draws. The DON said without the proper training the CNA was working outside the scope of her certification. The DON said as far as she was aware, it happened just that one time and she did not know of any issues before that. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and an observation on 11/13/2024 at 03:10 PM Resident #2 was in his bed resting awake and alert. Resident's left inner forearm was noted to have two areas that were bruised measuring approximately 2 inches by 2 inches each and at different stages of healing. Resident #2 said a staff member had come and drawn blood and filled 2 tubes of blood one from each bruises area. Resident #2 said he knew who the staff member was, but he could not remember her name. Resident #2 said it must have been the first time the staff member drew blood because she could not find a vein to draw it from. Resident #2 said the staff member was a CNA and that she worked at the facility. Surveyor asked if the staff's named sounded like CNA B's name and he said it could be, but he was not sure. Resident #2 said the blood drawn had occurred last Friday or Monday on the day shift. Resident #2 said the staff member had not told him that she was practicing blood drawing on him and that she just came in and told him she had to draw some blood. Resident #2 said he did find it odd that a CNA was drawing blood on him but thought that maybe some like the doctor had given her an order to do it. Resident #2 said he was not hurting or had suffered any injuries just that he had the bruising on his arm and that it would get better in a few weeks. Resident #2 said he did not blame the CNA for doing what she did because she might have been told to do it and she was just following orders. Resident #2 said beside the bruising the blood draw had gone fine and had no complaints about it. During an interview on 11/13/24 at 10:08 AM, CNA F stated she saw CNA B draw blood one resident one time. CNA F stated she saw CNA B draw blood from Resident #2 one time and he did not look like he was in any pain or distress. CNA F stated she walked into Resident #2's room because his light was on and she (CNA B) was tapping on Resident #2's arm like she was looking for a vein and then poked Resident #2's arm with a needle. CNA F said she knew CNA B was in classes to be a phlebotomist at one time. CNA F said she asked CNA B what she was doing and CNA B just laughed. CNA F said she asked Resident #2 if he needed anything, and Resident #2 said no. CNA F said she did not report what she had seen becasue she believed CNA B was allowed to do blood draws. During an interview on 11/14/24 at 10:57 AM, LVN C said on a Sunday CNA B had told her that the DON had given her the names of residents that needed blood draws. LVN C said she was outside monitoring the resident's while they smoked. LVN C said CNA B told her to hold on as she first needed to call the ADON and ask her what labs had already been done. LVN C said she was not aware if CNA B was allowed to do lab work and that she had not asked her if she was allowed as well. LVN C said she recalled CNA B holding a Baggy which contained the tubes that needed to be filled with blood and orders for the blood draw. LVN C said the baggies were left at the nurse station and the bags contained the face sheet and lab orders and the tubes that need to be filled. LVN C said the last she heard CNA B was in phlebotomy class. During an interview on 11/14/2024 at 11:26 AM, the DON said she had never ordered CNA B to do blood draws., She said she was aware of CNA B wanting to be a phlebotomist, but as far as she knew, the CNA was not in the class. The DON said the lab cart was located in the middle area of the nurse's station and the lab book was there as well. The DON said that CNA B could have gotten the orders from there. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 11/14/2024 at 11:46 AM, CNA B said that she was currently suspended from work and as far as she knew she was still employed there. CNA B said that she was supposed to take the phlebotomy class but had not because the Administrator gave her the run around about payment for the class. sSo she ended up dropping out of the class and not taking it. CNA B said that she had observed the nurses doing blood draws because she wanted to learn. CNA B said that she had drawn blood on two residents (Resident #5 and Resident #2) and that she was not a certified phlebotomist and she apologized for doing that and that she should have not done that. CNA B said the needles to conduct the blood draws and the lab sheets were located at the nurses station and that was where she got the orders and needles from. CNA B said that LVN C and LVN D were present when she had drawn Resident #5's blood and that LVN C had let her because she was unable to draw the resident's blood or at least not enough. CNA B said she had entered Resident #2's room and told him that she was there to draw some blood. CNA B said that the DON had not told her to do the blood draws and that she had taken it upon herself to just do the blood draw and she should have not done that. During an interview on 11/14/2024 at 12:37 PM, LVN C said she had drawn some blood on Resident #5 about 2 weeks ago on a Sunday and was only able to obtain a small amount of blood in the tube. LVN C said later CNA B called Resident #5 to go to the nurses station for halls 2 and 3 where LVN D was working at. LVN C said she went around to see what was going on and saw that CNA B had already started the blood draw on Resident #5. LVN C said she recalled seeing LVN D by the nurses station but did not know if LVN D was aware of what happened. During a telephone interview on 11/14/2024 at 01:22 PM, LVN D said she had never observed CNA B perform blood draws in the facility. LVN D said she had never trained CNA B to perform blood draws on the residents. LVN D said she recalled seeing CNA B at the nurse station about 2 weeks ago on a Sunday and had Resident #5 with her. LVN D said she had not noticed CNA B drawing blood from Resident #5. LVN D said she had asked CNA B why she was looking at Resident #5's veins and the CNA told her that she had been checked off on performing blood draws. LVN D said she did not recall who CNA B said had checked her off for conducting blood draws. LVN D said she had never given CNA B permission to conduct blood draws on the residents. During an observation and interview on 11/14/24 at 03:10 PM Resident #5 was in his room sitting up on his wheelchair awake and alert. Resident #5 was asked if he knew who CNA B was and he said he did know who she was. Resident #5 said that CNA B had drawn blood from him a few weeks ago in his room. Resident #5 again said he was sure the blood draw had happened in his room. Resident #5 said the blood draw went fine and had no complaints about it and the CNA had done a good job. During a telephone interview on 11/14/24 at 04:48 PM, the physician was made aware of the CNA drawing blood for Resident's #2 and #5. The physician said he had been at the facility and had seen both resident's as they were his patients. The physician said he had not noticed any bad outcome due to the CNA drawing the blood. The physician said he was aware of the bruising on Resident #2's arm but it was not a long-term consequence. The physician said neither of the 2 residents had suffered any consequences or complications that he noticed. The physician said the facility had to be more aware about who was drawing the blood. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675722	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Fort Stockton	501 N Sycamore Fort Stockton, TX 79735

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's document titled Job descriptions dated 11/2020 indicated in part: Job title: Certified Nurse Aide. Reports to: Director of nursing. Position summary: Responsible for assisting residents with activities of daily living to promote resident independence and dignity. Must have current Nurse Aide Certification in the State of Texas. Essential functions: To assure resident safety. Bathe, shower, shampoo, shave, com, hair, dress appropriately, nail care of any residents assigned. Lift, move and transfer residents as required. Answer call lights in a timely manner. Assist or feed residents. Keep resident clean and dry, toileting or providing incontinent care. (Note: There were no indication where CNA was allowed to conduct blood draws).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675722	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Focused Care at Fort Stockton		STREET ADDRESS, CITY, STATE, ZIP CODE 501 N Sycamore Fort Stockton, TX 79735	

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Resident #2 FTag Initiation t: [NAME] JR, [NAME] (4680) Search Note Type: Orders - Administration Note Focus: Effective Date: 11/1/2024 06:59:00 Department: Nursing Position: LPN Created By: DORALEE [NAME] Created Date : 11/1/2024 06:59:59 Note Text: CBC,CMP,TSH, Lipid Panel, HgA1c Q 6 months for DX: DM, HTN, Hypothyroid, Afib. (November & May) Q 6 months every 6 month(s) starting on the 1st for 28 day(s) NOVEMBER & MAY collected from left arm, sent to PCMH ype: Orders - Administration Note Focus: Effective Date: 11/2/2024 16:45:00 Department: Nursing Position: LVN Created By: [NAME] SERRANO (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675722	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER: Focused Care at Fort Stockton		STREET ADDRESS, CITY, STATE, ZIP CODE: 501 N Sycamore Fort Stockton, TX 79735	

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Created Date : 11/2/2024 16:45:38 Note Text: CBC,CMP,TSH, Lipid Panel, HgA1c Q 6 months for DX: DM, HTN, Hypothyroid, Afib. (November & May) Q 6 months every 6 month(s) starting on the 1st for 28 day(s) NOVEMBER & MAY Already collected Type: Orders - Administration Note Focus: Effective Date: 11/3/2024 15:00:00 Department: Nursing Position: LVN Created By: [NAME] SERRANO Created Date : 11/3/2024 15:00:57 Note Text: CBC,CMP,TSH, Lipid Panel, HgA1c Q 6 months for DX: DM, HTN, Hypothyroid, Afib. (November & May) Q 6 months every 6 month(s) starting on the 1st for 28 day(s) NOVEMBER & MAY already collected Type: Orders - Administration Note Focus: Effective Date: 11/6/2024 07:57:00 Department: Nursing Position: LPN Created By: [NAME] Created Date : 11/6/2024 07:57:44 Note Text: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675722	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Focused Care at Fort Stockton		STREET ADDRESS, CITY, STATE, ZIP CODE 501 N Sycamore Fort Stockton, TX 79735	

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CBC,CMP,TSH, Lipid Panel, HgA1c Q 6 months for DX: DM, HTN, Hypothyroid, Afib. (November & May) Q 6 months every 6 month(s) starting on the 1st for 28 day(s) NOVEMBER & MAY previously drawn Resident #5 FTag Initiation 11/2/2024 08:07 Orders - Administration Note Note Text: OOP Basaglar KwikPen 100 UNIT/ML Solution pen-injector Inject 46 unit subcutaneously two times a day for DM2 Nursing Y Y view 11/2/2024 08:06 Orders - Administration Note Note Text: OOP Fiasp Injection Solution 100 UNIT/ML Inject as per sliding scale: if 0 - 69 = 0 units; 70 - 179 = 2 units; 180 - 239 = 4 units; 240 - 319 = 6 units; 320 - 399 = 8 units; 400 - 450 = 12 units, subcutaneously before meals and at bedtime for DM Nursing Y Y view 11/2/2024 08:06 Orders - Administration Note Note Text: OOP Fiasp Injection Solution 100 UNIT/ML Inject 35 unit subcutaneously before meals for DM Nursing Y Y (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675722	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER: Focused Care at Fort Stockton		STREET ADDRESS, CITY, STATE, ZIP CODE: 501 N Sycamore Fort Stockton, TX 79735	

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	view 11/2/2024 08:05 Orders - Administration Note Note Text: OOP BD AutoShield Miscellaneous 29G X 5MM Inject 1 applicator subcutaneously before meals and at bedtime for diabetes Nursing Y Y view 11/1/2024 17:34 Nurses Note Note Text: Resident going out on pass with family with medication and personal belongings, to return on Sunday, no complaints voiced or noted Last labs on record: Type: Nurses Note Focus: Effective Date: 10/10/2024 16:00:00 Department: Nursing Position: LVN Created By: [NAME] SERRANO Created Date : 10/10/2024 17:29:35 Note Text: F/u with PCMH lab on CBC, CMP. Stated results were ready. WBC are slightly elevated. PCMH lab to fax results to our facility. RR of skin assessments 10/14/24 and 10/21 document no bruises. Resident #18 FTag Initiation 30057 Resident #2 FTag Initiation (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675722	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Fort Stockton	501 N Sycamore Fort Stockton, TX 79735

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and an observation on 11/13/2024 at 03:08 PM Resident #18 [NAME] Duarte was in his room sitting on the side of his bed awake and alert. The resident was noted to have some bruising on his right upper/inner arm approximately 2 inches by 2 inches each and at different stages of healing stages. The resident was asked what happened to his arm. The resident said he did not know what occurred whether he had bumped it or something. Resident #18 was asked if someone had poked him with a needle such as to draw blood but he said no that he did not recall how he got the bruise. During an interview and an observation on 11/13/2024 at 03:10 PM Resident #2 [NAME] Jr. was in his bed resting awake and alert. Resident's left inner forearm was noted to have two areas that were bruised measuring approximately 2 inches by 2 inches each and at different stages of healing. Resident #2 said a staff member had come and drawn blood and filled 2 tubes of blood one from each bruises area. Resident #2 said he knew who the staff member was, but he could not remember her name. Resident #2 said it must have been the first time the staff member drew blood because she could not find a vein to draw it from. Resident #2 said the staff member was a CNA and that she worked here. Resident #2 again said he knew her name but could not remember. Surveyor asked if the staff's named sounded like Kasmira and then he said it could be Kasmira but not sure. Resident #2 said the staff member was a Hispanic girl that had a small child because she had told him about it. Resident #2 said the Hispanic girl was like five feet by like four inches or so. Resident #2 said the blood drawn had occurred last Friday 11/08/24 or last Monday 11/11/24 on the day shift. Resident #2 said the staff member had not told him that she was practicing blood drawing on him and that she just came in and told him she had to draw some blood. Resident #2 said he did find it odd that a CNA was drawing blood on him but thought that maybe some like the doctor had given her an order to do it. Resident #2 said he was not hurting or had suffered any injuries just that he had the bruising on his arm and that it would get better in a few weeks. Resident #2 said he did not blame the CNA for doing what she did because she might have been told to do it and she was just following orders. During an interview on 11/14/24 at 10:06 AM CNA [NAME] De La [NAME] been here almost [AGE] years, work hall 1, familiar with residents, Kasmira did blood draw, walked into resident room [NAME] because call light on and seen her, taping on his arm and then started to draw blood, one time asked me if she could draw blood from me and I asked if she was going to phlebotomy class, I did not know whether she could or couldn't and she just laughed and I asked [NAME] if need anything and said no, Resident [NAME] not appear to be in any pain, this was only resident, she's funny makes jokes out of anything, both got in trouble onetime because resident had BM in shower room and she did not clean it, the housekeeper found the mess in shower and reported it to the Administrator and we got in trouble, Administrator gave us verbal warning, she's with the residents she likes to agitate Resident Elfida and take things away from her said she told her to stop and that ADON had seen her doing that and they told her to stop and she does stop, Not change, ask for water, physical, sexual, physical abuse hit a resident, emotional tell resident something ugly like telling them their ugly, if you suspect abuse report it to Administrator and if Administrator not do nothing, then DON then ADON then State. Any other resident blood drawn, not seen her do it on another resident. Saw bruises on Resident [NAME] but not know Did you report it no because Kasmira said she was doing I, said she told her she was doing it for a nurse, she had mentioned that she wanted to be a phlebotomist so thought it was okay for her to do that. Happened about 2 weekends like on a Sunday. Not see here cover the site. (continued on next page)

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/24 at 10:57 AM LVN [NAME] Serrano, said she would work all halls, said Kasmira been her CNA before, no problems with her does showers answers call lights, heard that some people don't like her personality, not have to teach her anything, not aware CNA Kasmira drawing blood from residents, Did not ask her to draw blood, last time Sunday before she was asked to go home, working on 100 hall, said that DON gave her the names of residents that needed blood draws, said she was outside with smoke break, said she was going to go do lab draws because DON had given her a list of blood draws, she called ADON and asked what labs she had done but did not ask her directly if Kasmira could do lab work, not seen anything written that indicated Kasmira could do labs, she had a baggy that contains the names of the residents such as face sheets and did not know how she got a hold of them, not recall seeing the needles. These bags are left at the nurse station somethings these bags contain the face sheet and lab orders and the tunes that need to be filled, said she had not known about her doing this before. said last she heard CNA was in phlebotomy class. During an interview on 11/14/2024 at 11:26 AM the DON said she had never ordered CNA Kasmira [NAME] to do blood draws, said she was aware of CNA Kasmira wanting to be a phlebotomist but as far as she knew the CNA was not in the class. The DON said the lab cart was located in the middle area of the nurse's station and the lab book was there as well. The DON said that CNA Kasmira could have gotten the orders from there. During a telephone interview on 11/14/2024 at 11:46 AM CNA Kasmira [NAME] said that she was currently suspended and as far as she knew she was still employed there. CNA [NAME] said that she was supposed to take the phlebotomy class but had not because the Administrator gave her the run around about payment for the class so she ended up dropping out of the class and not taking it. CNA [NAME] said that she had observed LVN Abi [NAME], LVN [NAME] and LVN [NAME] Serrano doing blood draws because she wanted to learn. CNA [NAME] said that she had drawn blood on two residents (Resident #5 and Resident #2) and that she was not a certified phlebotomist and she apologized for doing that and that she should have not done that. CNA [NAME] said the needles to conduct the blood draws and the lab sheets were located at the nurses station and that was where she got the orders and needles from. CNA [NAME] said that LVN [NAME] and LVN [NAME] were present when she had drawn Resident #5's blood and that LVN [NAME] had let her because she was unable to draw the resident's blood or at least not enough. CNA Kasmira said she had entered Resident #2's room and told him that she was there to draw some blood. CNA Kasmira said that the DON had not told her to do the blood draws and that she had taken it upon herself to just do the blood draw. CNA Kasmira said that she was sorry for doing that (The blood draw) as she was not certified and knew she was not supposed to do that. During an interview on 11/14/2024 at 12:37 PM LVN [NAME] Serrano said she had drawn some blood on Resident #5 [NAME] about 2 weeks ago on a Sunday and was only able to obtain a small amount of blood in the tube. LVN [NAME] said later she heard CNA Kasmira calling Resident #5 down to the hall 2 and 3 nurses station where LVN Abi [NAME] was working at. LVN [NAME] said she was in the hall 1 nurses station when she heard CNA Kasmira calling the resident and when she went around to see what was going on she saw that CNA Kasmira had already started the blood draw on Resident #5. LVN [NAME] said she recalled seeing LVN Abi [NAME] by the nurses station but did not know if LVN [NAME] was aware of what happened. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/2024 at 12:50 PM LVN [NAME] said CNA Kasmira [NAME] had asked her if she could draw blood on her ([NAME]) but she had told her no. LVN [NAME] said she had never taken time to train CNA Kasmira on drawing blood. LVN [NAME] said CNA Kasmira had asked her if she any labs to do but that she had told her no. LVN [NAME] said CNA Kasmira was just like that - that she liked to ask if she could do extra things but at no time did she ask CNA Kasmira to draw blood on the residents for her. During a telephone interview on 11/14/2024 at 01:22 PM LVN Abi [NAME] said she had never observed CNA Kasmira [NAME] performing blood draws in the facility. LVN [NAME] said she had never trained CNA Kasmira to perform blood draws on the residents. LVN [NAME] said she recalled seeing CNA Kasmira at the nurse station about 2 weeks ago on a Sunday and looking at Resident #5's veins on his arm. LVN [NAME] said she had not noticed CNA Kasmira drawing blood on Resident #5. LVN [NAME] said she had asked CNA Kasmira why she was looking at Resident #5's veins and the CNA told her that she had been checked off on performing blood draws. LVN [NAME] said she did not recall who CNA Kasmira said had checked her off for conducting blood draws. LVN [NAME] said she had never given CNA Kasmira permission to conduct blood draws on her residents as the CNA had asked her if she needed help conducting blood draws on her residents. During an observation and interview on 11/14/24 at 03:10 PM Resident #5 was in his room sitting up on his wheelchair awake and alert. Resident #5 was asked if he knew who CNA Kasmira was and he said he did know who she was. Resident #5 said that she had drawn blood from him a few weeks ago. Resident #5 said he was sure it had been CNA Kasmira.