STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675848	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Webster	17231 Mill Forest Webster, TX 77598

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on record review and interview, the facility failed to immediately inform the resident representative(s) of the need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) for one (Resident #1) of five residents reviewed for notification of changes. -The facility failed to ensure they reported, to Resident #1's Representative on 09/30/2024, Resident #1's change of condition with moisture associated skin damage (MASD) on the sacrum and buttock to include new orders for zinc oxide (used to treat and prevent diaper rash and other minor skin irritations). - The facility failed to ensure they reported, to Resident #1's Representative on 09/30/2024, when noted blanching redness to the left lateral forefoot and the left heel on Resident#1. These failures could place residents at risk for harm and not allowing the opportunity for consent of care. Findings included: Record review of Resident #1's (undated) face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, remembering information, responding accurately, understanding jokes or metaphors, or following directions), dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage) and cellulitis (a common, potentially serious bacterial skin infection). Further review revealed Resident #1's family member was identified as Resident #1's Medical and Financial Power of Attorney, Responsible Party, and Emergency Contact. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed she had a BIMS score 08 out of 15 which indicated she had moderately impaired cognition. She required partial/moderate assistance with toileting hygiene, shower/bathe self and required substantial/maximal assistance with personal hygiene. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident#1's care plan initiated 09/30/2024 and revised on 10/10/2024 revealed the following read in part: . Focus: The resident has potential/actual impairment to skin integrity of the Buttock r/t Incontinence and immobility. Goal: The resident will maintain or develop clean and intact skin by the review date. Target Date: 12/31/2024. The resident will have no complications r/t (SPECIFY skin injury type) of the (SPECIFY location) through the review date. Target Date: 12/31/2024. Interventions: Follow facility protocols for treatment of injury. Reposition resident while in bed every 2 hours to relieve pressure. Educate resident/family/caregivers of causative factors and measures to prevent skin injury . Record review of Resident #1's Physician orders dated 09/30/2024 revealed an order to apply zinc oxide to MASD on the sacrum and buttock area every shift and PRN until healed. Every shift for Skin integrity. Record review of Resident #1's Treatment Administration Record for the month of October 2024 revealed that Resident #1 was receiving zinc oxide on the 6am to 6pm shift and 6pm to 6am shift. Record review of Resident #1's nurse's notes dated 09/30/2024 at 4:19 pm written by the Wound Care Nurse read in part: .Resident has noted MASD to the buttock zinc applied and treatment in place. Resident has blanching redness to the left lateral forefoot and the left heel . Record review of Resident #1's electronic Medical Record revealed no documentation that the family representative was informed about that change in medication/skin impairment. In a telephone interview on 10/21/2024 at 12:12 p.m., Resident #1's representative stated she had not received any communication that her loved one had bed sores until she learned herself by visiting Resident #1 at the hospital on 10/15/2024. In an interview on 10/21/2024 at 4:05 p.m., with the Wound Care Nurse stated she reviewed Resident #1's nurses notes with the Surveyor. The Wound Care Nurse stated that resident's responsible party should have been informed about the new order. The Wound Care Nurse stated that she did not see any documentation that she notified the Responsible party I forgot to notify the family . In an interview on 10/21/2024 at 4:49 p.m., with LVN A, she stated any time a new mediation was ordered or there was a change in condition, family needed to be notified, so that they were aware of the resident's new order and document in the progress notes. In an interview on 10/21/2024 at 5:04 p.m., with the Wound Care Nurse and the DON. The DON stated that nurses were to notify the family at the start of a new medication or change in condition. The DON stated she re-educated the Wound Care Nurse on the change of conditions protocols to include notifications for residents and their representatives any new orders and or treatments in their care. DON stated family/representatives needed to know so they could have ease of mind. Nurses needed to notify plan of care as it prevents the family from feeling their loved ones are not neglected and in the know of any changes in patients. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of the facility's Change in a Resident's Condition or Status policy (Revised May 2017) read in part: .Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: b. There is a significant change in the resident's physical, mental, or psychosocial status; 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on observation, interview, and record review, the facility failed to ensure that residents received the necessary treatment and services, to promote healing, prevent infection for 1 of 5 residents (Resident #2) reviewed for pressure ulcers in that: -The facility failed to ensure Resident #2's right buttock stage 3 wound had a dressing covering the wound on 10/25/24. This failure could affect residents with wounds placing them at risk of infection, a decline in health, pain, and hospitalization . Findings included: Record review of Resident #2's (undated) face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included pressure ulcer of sacral region, stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and bed confinement status (which is meant for patients confirmed to be bedridden). Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed he had a BIMS score 10 out of 15 which indicated he had moderately impaired cognition. He required substantial/maximal assistance with toileting hygiene, shower/bathe self, and personal hygiene. Record review of Resident #2's care plan initiated 03/21/2019 and revised on 10/25/2024 revealed the following: Focus: The resident has Stage 3 pressure injury to the Rt. Buttock D/T immobility. Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date. Target Date: 12/31/2024. Interventions: Monitor dressing daily to ensure it is intact and adhering. Report lose dressing to Treatment nurse. Record review of the Physician's orders for Resident #2 revealed an order to Cleanse stage 3 Pressure Injury to the Rt. buttock with moistened 4x4 gauze with WC/NS, Pat dry, apply Honey and calcium alginate, cover with border gauze dressing daily and PRN for soilage/dislodgement until healed. as needed for soilage/dislodgment Observation and attempted interview on 10/25/24 at 12:13 p.m., revealed Resident #2 was resting in his bed. He was alert and well groomed. The resident mumbled for 5 minutes while being interviewed and could not make himself understood and did not respond appropriately to asked questions about his pressure sore/injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/25/24 at 12:18 p.m., revealed the Wound Care Nurse providing wound care for Resident #2. The Wound Care Nurse was assisted by ADON A. An open area of approximately 2.0 centimeters in diameter, was observed without a dressing on the right buttock. The Wound Care Nurse said, WCD did the dressing yesterday it must have come off. In an interview on 10/25/24 at 12:36 p.m., with CNA BB, she stated she provided peri care and got the resident dressed for his appointment that morning around 7:20 am. She stated there was 1 patch on the resident's bottom which was pretty soiled with BM. She stated she did not notify the Wound Care nurse or the floor nurse that the dressing needed to be changed because the transport was already in the room waiting to take the resident. In an interview on 10/25/24 at 12:41 p.m., with the Wound Care Nurse, she confirmed Resident #2's right buttock wound did not have a dressing on it. She said the CNA should have immediately notified her or the floor nurse because there were prn orders if the dressing became soiled or dislodged. The WCN stated it was important to provide dressings on the wound to keep it protected from infections. Wound bed could damage by scaping on brief itself . Feces can get in it and cause delayed healing. In an interview on 10/25/24 at 1:01 p.m., the DON stated the Wound Care Nurse was responsible for wound care Monday through Friday and the floor nurses were responsible for wound care on the weekends. The Surveyor shared the observation from earlier. The DON said her exception was for wound dressings to be changed daily and as needed if soiled or dislodged according to physician's orders. She stated the CNA should have notified the charge nurse/wound care nurse so they could dress the wound. She stated it was important to dress the wound to prevent infection. If the wound was left open it can get germs, delayed wound healing and for patient's comfort . In an interview on 10/25/24 at 2:11 p.m., with LVN Z, she said the CNA did not notify her that Resident #2's dressing had come off. She said the CNAs were supposed to come and tell the nurses right away so the nurse can dress the wound as there were prn orders for dressing change. Record review of the facility's Skin Management policy (Last Revised: 10/06/2022) revealed read in part: . POLICY: The purpose of this procedure is for prevention and treatment of skin breakdown such as pressure injuries, diabetic ulcers, arterial ulcers, and skin wounds. 4. Treatment: Wound care dressings are dated and initialed .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40249 Based on interview, and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for clinical records. -The facility failed to ensure the treatment administration records (TAR) for Resident #1 reflected that the administration of the treatment orders was accurately documented . This failure could result in further error and a decline in heath. Findings included: Record review of Resident #1's (undated) face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included cognitive communication deficit (difficulty paying attention to a conversation, staying on topic, remembering information, responding accurately, understanding jokes or metaphors, or following directions), dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage) and cellulitis (a common, potentially serious bacterial skin infection). Further review revealed Resident #1's (family member) was identified as Resident #1's Medical and Financial Power of Attorney, Responsible Party, and Emergency Contact. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed she had a BIMS score 08 out of 15 which indicated she had moderately impairment cognition. She required partial/moderate assistance with toileting hygiene, shower/bathe self and required substantial/maximal assistance with personal hygiene. Record review of Resident#1's care plan initiated 09/30/2024 and revised on 10/10/2024 revealed the following: Focus: The resident has potential/actual impairment to skin integrity of the Buttock r/t Incontinence and immobility. Goal: The resident will maintain or develop clean and intact skin by the review date. Target Date: 12/31/2024. The resident's will have no complications r/t (SPECIFY skin injury type) of the (SPECIFY location) through the review date. Target Date: 12/31/2024. Interventions: Follow facility protocols for treatment of injury. Reposition resident while in bed every 2 hours to relieve pressure. Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Record review of Resident #1's Physician orders dated 09/30/2024 revealed an order to apply zinc oxide to MASD on the sacrum and buttock area every shift and PRN until healed. Every shift for Skin integrity. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's TAR for the month of October 2024 for MASD on the sacrum and buttock area had blanks on the TAR on 10/1/24, 10/2/24, 10/3/24, 10/4/24, 10/5/24, 10/6/24, 10/9/24, 10/10/24, 10/11/24, 10/12/24, 10/13/24. Record review of Resident #1's nurses note for the month of October 2024 revealed there was no documentation of Resident #1's treatments not being done, notification to the MD or a Nurse Practitioner of treatment not being done, or of Resident #1 refusing treatment. There was no documentation indicating why the scheduled treatment was withheld or not administered as ordered. In an interview on 10/25/2024 at 12:41p.m., with the WCN, she stated she was the wound care nurse and responsible for administering wound care treatments during the week and the facility Charge Nurses were responsible for administering wound care treatments on the weekend/night shift. The WCN stated she did not know why the TAR had blanks. WCN said that she was performing the treatments and the failure was that the TAR did not accurately reflect the treatment. In an interview and record review on 10/25/24 at 1:01p.m., the Surveyor reviewed Resident #1's TAR, physician order, and nurses' notes with the DON. The DON confirmed the Wound Care Nurse, and the floor nurses did not document on the TAR after performing the treatments in October 2024. She stated there should not be any open/blank spaces in the TAR and that if it was not documented it means it was not completed. The DON stated, there was no explanation for the holes in the MAR. The DON stated the facility had a wound care nurse who did wound care Monday through Friday and the floor nurses did wound care on Saturday/Sunday. The DON stated it was important to follow through with wound care orders, to decrease the risk of infection and to monitor the progress of the wound and make sure it is healing. If the TAR did not reflect wound care was not done, then it could not be determined if it was completed. The DON stated she and the 2 ADONs audited the TAR to ensure wound care was done per orders and documented. Record review of facility's Charting and Documentation policy (Revised July 2017)) read in part: . Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation: 2. The following information is to be documented in the resident medical record: c. Treatments or services performed; 7. Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Notification of family, physician or other staff, if indicated; and g. The signature and title of the individual documenting .