

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675848	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Webster		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from Misappropriation of property for one (Resident #15) of 18 residents reviewed for misappropriation of property.</p> <p>The facility failed to ensure Resident #15 was free from misappropriation of property when an employee used her credit card for personal benefit.</p> <p>The non-compliance was identified as past non-compliance. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk of Exploitation/Misappropriation of Property and financial distress.</p> <p>Findings include:</p> <p>Record review of Resident #15's face sheet dated 01/29/25 revealed [AGE] year-old female, with an original admitted [DATE] and re admitted on [DATE]. Her diagnosis included acute pyelonephritis (A sudden and severe inflammation of kidney due to a bacterial infection). Muscle wasting, Hypothyroidism (a condition where the thyroid gland does not make enough hormone) communication deficit (Difficulty in communication that arises from impairments in cognitive process), unspecified lack of coordination, Unsteadiness on feet.</p> <p>Record review of Resident #15's Admission MDS assessment dated [DATE] revealed she had a BIMS score of 12 out of 15, which indicated moderate cognitive impairment. Resident #15 was independent with ADLs for toileting and personal hygiene coded as limited assistant.</p> <p>Record review of PIR (Form 3613-A of Texas Health and Human Services) dated 12/30/24 read in part</p> <p>Resident #15's responsible party reported that there were fraudulent charges on Resident #15's debit card. RP stated that Resident #15's debit card was mission and there were charges on the debit card.</p> <p>Record review of Facility's communication with Resident #15's RP revealed Resident #15's debit card was stolen at the facility and two charges were made on the debit card as \$30.66 at a gas station on Hwy 3 and \$73.61 for margaritas down in Lake [NAME] Texas.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on interview on 01/27/25 at 10:00AM, revealed Resident #15 was present at the facility in her room, in bed, alert and oriented. During an interview she said she was doing well and sleepy.</p> <p>In an interview with Resident #15 on 01/27/25 at 1:00PM, she said she remembered the incident very well. She said she wanted a cup of coffee and the girl (CNA T) said she was on her break and would get her the coffee. Resident #15 said e CNA T sat at the edge of her bed. Resident #15 said she took the \$6 from her purse and her debit card might have fallen out and she did not know until her daughter called her to ask if she gave her debit card to anyone. Resident #15 said she told her RP no and explained to her RP that she sent someone out to the store to get her coffee but gave the staff the sum of # \$6.00 for the coffee. Resident #15 said she remembered the staff very well and called CNA T by name and described her as golden girl because CNA T had some earrings on her face and nose.</p> <p>Phone call was made to Resident #15's RP on 01/27/25 at 4:00pm, no answer. Second phone call was made on 01/28/24 at 11:00am and at 4:30pm no answer voice message was with a phone #.</p> <p>During an interview with the Facility's Administrator and the DON on 01/28/24 at 2:00pm, the DON said the facility know exactly who the staff was by Resident #15's description of the staff, the schedule and sign in sheet. The DON identified the CNA' as CNA T. The DON said the police was called by Resident #15's RP as soon as she discovered that Resident #15's debit card was stolen and there were charges made on it. The DON said as soon as she received the e-mail, herself, the Administrator, and the Social Worker started an investigation and reported it to the State as required. The DON on said the police walk walked in almost at the same time while she was doing the investigation. She said the police asked for the staff that worked on the 29 and the 30th of December 2024. The DON said CNA T had gone out through the back door out of the facility. The DON said she called CNA T and CNA T told her that she had a ticket in at another county, and she was on her way to pay the ticket. The DON said the police gave a case # and a copy of the video that shows CNA T purchasing goods from the store. The DON said CNA CAN T worked from 12/11/24 through 12/30/24 the day the police showed up for the investigation. The DON provided CNACAN T. signed schedules and timecard that indicated CNA clocked in and out.</p> <p>Phone call placed to CNA T on 01/28/25 at 3:00PM. No answer; message was left with a returned phone #.</p> <p>During a phone interview on 1/29/25 at 2:30PM, CNA T said she worked at the facility for 3 days and she did not work with Resident #15. She said she worked with another CNA, CNA K that worked with Resident #15. She said the CNA K gave her ride to the store because CNA K was going to get coffee for Resident #15. CNA T said she bought some goods and paid for what she bought with her card. She said she does not remember CNA CAN K's full name. She gave a name that did not exist on the employee list provided by the facility. CNA T said she did not clock in at the facility because she did not have a pin # to clock in since she was on orientation. She said she wrote her hours on a paper and submitted it to the DON. She said she did not work at the facility on 12/29/2024 to 12/30/20244 because she lost her son on the 12/29/24. She said she did not go back to the facility to work due to poor working condition of not being trained and not having enough staff.</p> <p>Phone call was made to Local Police department that investigated that investigated the case on 01/30/25 at 3:30pm. Message left with a returned call phone # and case #-2403057. Second attempt was made on 01/30/25 at 5:00pm.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility's schedules with signatures revealed CNA T was hired on 12/10/24. She had two-day orientation on 12/11/24 and 12/12/24. Record review of signed schedules revealed CNA T worked till 12/30/24.</p> <p>Record review of facility of facility's provided policy on abuse, neglect and exploitation dated 02/01/2017 revised 01/01/2023 read in part The purpose of this policy is to ensure that each resident has the right to be free from any type of Abuse, Neglect, Intimidation, Involuntary Seclusion/Confinement, and or Misappropriation of property.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51036</p> <p>Based on observation, interview and record review, the facility failed to provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement described in S483.70(f) for 1 (Resident #3) of 5 residents reviewed for pharmacy services.</p> <p>The facility failed to provide Mucinex DM as ordered for Resident #3.</p> <p>The failure could place residents at risk of receiving less than therapeutic benefits from medications.</p> <p>Findings include:</p> <p>Mucinex DM is a medication that has two ingredients which are guaifenesin and dextromethorphan. Guaifenesin is a medication that helps to clear chest congestion and dextromethorphan is a cough suppressant that relieves cough. Resident #3 was given only guaifenesin instead of Mucinex DM.</p> <p>Record review of Resident 3's Progress Notes dated 1/28/25 at 5:02 p.m. revealed that LVN B spoke to the resident's NP and that new order was received to discontinue Mucinex DM and restart Guaifenesin 400 mg oral twice a day routine for cough and congestion.</p> <p>Record Review of Resident 3's face sheet dated 1/30/25 revealed resident is a [AGE] year old male admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (Stroke), Dysphagia (difficulty swallowing), Type 2 Diabetes Mellitus, Hypertensive Disease with Heart Failure with history of acute upper respiratory infection and acute bronchitis.</p> <p>Record review of Resident 3's quarterly MDS dated [DATE] revealed a BIMS score of 15 that suggests Resident #3's cognition is intact.</p> <p>Record review of Resident 3's January Medication Administration Record printed on 1/30/25 revealed Mucinex DM Oral Tablet Extended Release 12 Hour 30-600 mg (Dextromethorphan-Guaifenesin) Give 1 tablet by mouth every 12 hours for Cough and congestion for 7 days with a start date of 1/22/25 at 9 a.m. and discontinue date of 1/28/25 at 4:57 p.m. Mucinex DM was documented as being administered from 1/22-1/27/25 at 9 a.m. and 9 p.m. and on 1/28/25 at 9 a.m.</p> <p>Record review of Resident 3's Care Plan provided on 1/30/25 revealed a focus that Resident 3 is at risk for frequent infections related to diabetes mellitus with goal that Resident 3 will have no complications related to diabetes through the review date.</p> <p>Observation of Resident 3's medication administration on 1/28/25 at 8:23 a.m. revealed that Resident 3 was administered guaifenesin 400 mg for order of Mucinex DM Oral Tablet Extended Release 12 Hour 30-600 mg (Dextromethorphan-Guaifenesin) Give 1 tablet by mouth every 12 hours by CMA A.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview of CMA A on 1/28/25 at 12:54 p.m. revealed that the process to order over the counter medications that are needed is to write the medication needed on a paper and give to the person who is over central supply. CMA A stated that over the counter medications are ordered twice a month.</p> <p>Observation of the facility's medication room on 1/28/25 at 1:01 p.m. accompanied by CMA A revealed that no Mucinex DM could be found with the over the counter medications stock.</p> <p>Interview of LVN B on 1/28/25 at 1:02 p.m. revealed that she was not aware that Resident #3 was receiving guaifenesin 400 mg instead of Mucinex DM and that the Mucinex DM was not in stock. LVN B said that when Mucinex DM was first ordered she found a box of Mucinex DM and had given it to the CMA. LVN B said that Resident #3 had been taking guaifenesin 400 mg for years and it was changed to Mucinex DM for seven days last week when resident got sick.</p> <p>Interview of Central Supply/Transportation on 1/28/25 at 1:10 p.m. revealed that staff will notify her when medications are not in stock. Central Supply/Transportation said that orders are placed once a week on Mondays, but she can run to a local pharmacy to purchase medications if needed.</p> <p>Observation of the facility's medication room on 1/28/25 at 1:25 p.m. accompanied by Central Supply/Transportation. No Mucinex DM could be found in the medication room with the assistance of Central Supply/Transportation.</p> <p>Interview of Central Supply/Transportation on 1/28/25 at 1:25 p.m. revealed that Mucinex DM was ordered and was suppose to be delivered last week but was delayed due to the winter storm that occurred on 1/21/25.</p> <p>Observation of 100 hallway medication cart on 1/28/25 at 4:55 p.m. with CMA A revealed that no Mucinex DM could be found with either the over the counter medications or with Resident #3's medications from the pharmacy.</p> <p>Interview of Central Supply/Transportation on 1/29/25 at 9:21 a.m. revealed that she will notify the DON and administrator if the supply truck does not arrive. Central Supply/Transportation said that if the supply truck does not arrive that she will reach out to sister facility for supplies. Central Supply/Transportation said that she makes the orders on Monday and the truck usually comes on Tuesday but she will wait a day before checking on the order. Central Supply/Transportation said she reached out on 1/22/25 regarding the order that should have arrived on 1/21/25 and was told the truck should arrive by 1/23-1/24/25 and by 1/27-1/28/25 at the latest. Central Supply/Transportation said the truck arrived early this morning on 1/29/25.</p> <p>Interview of DON on 1/29/25 at 11:06 a.m. revealed that the central supply person orders the over the counter medication after she is given a list from staff and that they inventory the over the counter stock as well. The DON stated that if there is a new order then the central supply person can go purchase the medication from a local pharmacy if needed.</p> <p>Interview with LVN C on 1/29/25 at 11:22 a.m. revealed she could not remember administering specific medication to Resident #3 but was not aware of him missing any medications. LVN C said she was responsible for refilling missing medications from medication cart if needed. LVN C said she would check the over the counter medication stock and the automated medication dispensing system if she was unable to find a medication that was ordered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview of CMA B on 1/29/25 at 11:45 a.m. revealed that if she needs an over the counter medication then she will check the medication room and if she is unable to find the medication that she would notify the charge nurse. CMA B said she would make a list for Central Supply/Transportation and give them the list directly.</p> <p>Record review of facility's policy House Supplied (Floor Stock) Medications revealed that the facility may maintain a supply of commonly used over-the-counter (OTC) medications considered floor stock or house medications (not resident-specific), to be administered only upon receipt of an order from an authorized prescriber.</p> <p>Record review of facility's policy General Guidelines for Medication Administration revealed that the facility is to have a sufficient medication distribution system to ensure safe administration of medications with unnecessary interruptions.</p>