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| 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 10/08/2025 |
| 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from abuse for 1 of 5 residents (Resident #1) reviewed for resident abuse.-The facility failed to ensure that Resident #1 was free from sexual abuse when Resident #1 wandered into Resident #2's room in the facility on 9/23/25, and Resident #2 sexually assaulted Resident #1.An Immediate Jeopardy (IJ) was identified on 10/02/2025 at 4:41 p.m. The IJ template was provided to the Administrator and DON on 10/02/25 at 4:41 p.m. While the IJ was removed on 10/06/25 at 1:28 p.m. the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that was not an immediate jeopardy and a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems.This failure could place residents at risk of physical harm, mental anguish, and/or emotional distress. Record review of Resident #1's facility admission record dated 10/1/25 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with most current admission date of 6/26/18. Resident #1 admitted with diagnoses that included anoxic brain damage (a condition where the brain experiences a complete lack of oxygen supply. This deprivation of oxygen can lead to widespread damage to brain cells, resulting in severe neurological impairment or death) and epilepsy and epileptic syndromes (Epilepsy is a brain disorder characterized by recurrent, unprovoked seizures, while an epileptic syndrome is a specific, complex constellation of signs and symptoms that define a unique epilepsy condition. An epileptic syndrome includes specific seizure types, other clinical features). Record review of Residents #1's care plan date Initiated 9/15/21 and revised on 9/24/25 revealed she was care-planned for a high elopement risk/wandering in male residents' room and was at risk for possible injury r/t impaired safety awareness and diagnosis of dementia, Anoxic brain damage. Date Initiated: 09/15/2021. Revision on: 09/24/2025. Goals: Resident #1's safety will be maintained throughout the review date. Date Initiated: 09/15/2021. Revision on: 09/12/2025. Target Date: 10/19/2025 Interventions: Assess for fall risk. Date Initiated: 09/15/2021. Provide structured activities: Toileting, walking inside and outside, reorientation strategies, including signs, pictures, and memory boxes. Date Initiated: 09/15/2021. Wander guard placed for resident's safety, bracelet will alert staff if and when resident attempts to exit doors of facility. Staff to monitor daily. Date Initiated: 09/15/2021. Redirect resident. Date Initiated: 09/24/2025. A care plan to address Resident #1 identifies as a trauma survivor. 1.possible trigger of aggressive vocal stimuli. 2. Childhood trauma memories, Domestic abuse memories , Physical Abuse memories, Sexual Abuse memories. Date Initiated: 11/14/2019. Revision on: 05/07/2020. Goals: SHE will remain stable and adjusted to her environment. Date Initiated: 11/14/2019 Revision on: 09/12/2025. Target Date: 10/19/2025. Interventions: Ask for permission to enter resident's room, perform care, and/or assist with ADLs. Date Initiated: 09/08/2023. Explain all procedures to the resident before starting and allow the resident (X minutes) to adjust to changes when necessary. Date Initiated: 09/08/2023. Reduction of possible triggers in her environment. Date Initiated: 11/14/2019. A care plan to address Resident #1's impaired cognitive function or impaired thought processes r/t ANOXIC BRAIN INJURY. SHE has cognitive loss (loss of memory, time sense and requires assistance with decision making r/t Impaired decision-making abilities, is not always understood or able to understand verbal and non-verbal expression. Date Initiated: 05/07/2020. Revision on: 05/07/2020. Resident #1 will improve current level of cognitive function through the review date. Date Initiated: 02/09/2021. Revision on: 09/12/2025. Target Date: 10/19/2025.Record review of Resident #1's Quarterly MDS dated [DATE] revealed Cognitive Skills for Daily Decision Making (section C1000) were coded at 3, indicating her cognition was severely impaired. Resident #1 was coded to require substantial/maximal assistance with ADLs. She was always incontinent of bowels and bladder and used a wheelchair for mobility. Record review of Resident #1's physician orders dated September 2025 revealed orders with a start date of 9/25/25 to administer Emtricitabine- Tenofovir oral tablet 200-300 MG (Emtricitabine- Tenofovir Disoproxil Fumarate) Give 1 tablet by mouth one time a day for antiviral for 28 days at 9:00 AM. An order for Tivicay Oral (Dolutegravir Sodium) Tablet 50 MG Give 1 tablet by mouth one time a day for antiviral for 28 days at 9:00 AM. An order for Plan B One-Step Oral Tablet 1.5 MG (Levonorgestrel Emergency OC) Give 1 tablet by mouth one time only for contraceptive for 1 day with a start date of 9/24/25. Record review of Resident #1's MAR dated September 2025 revealed that Resident #1 was administered Emtricitabine and tenofovir antiretroviral medication (used to treat and prevent HIV infection) on 9/25/25 through 9/30/25. Resident #1 was administered Tivicay Oral (Dolutegravir Sodium) Tablet 50 MG Give 1 tablet by mouth one time a day</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 out of 5 residents (Resident #1 and Resident #2) reviewed for adequate supervision.- The facility failed to ensure Resident #1 who was severely cognitively impaired and nonverbal and Resident #2 who was moderately cognitively impaired and had behaviors of inappropriate sexual comments to staff received adequate supervision to prevent abuse after she wandered into Resident #2's room in facility on 9/23/25. Resident #1 was sexually assaulted by Resident #2. An Immediate Jeopardy (IJ) was identified on 10/02/2025 at 4:41 p.m. The IJ template was provided to the Administrator and DON on 10/02/25 at 4:41 p.m. While the IJ was removed on 10/06/25 at 1:28 p.m. the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that was not an immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. This deficiency exposed residents living in the facility to potential harm, injury, or death due to not being adequately monitored. Record review of Resident #1's facility admission record dated 10/1/25 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with most current admission date of 6/26/18. Resident #1 admitted with diagnoses that included anoxic brain damage (a condition where the brain experiences a complete lack of oxygen supply. This deprivation of oxygen can lead to widespread damage to brain cells, resulting in severe neurological impairment or death) and epilepsy and epileptic syndromes (Epilepsy is a brain disorder characterized by recurrent, unprovoked seizures, while an epileptic syndrome is a specific, complex constellation of signs and symptoms that define a unique epilepsy condition. An epileptic syndrome includes specific seizure types, other clinical features). Record review of Residents #1's care plan date Initiated 9/15/21 and revised on 9/24/25 revealed she was care-planned for a high elopement risk/wandering in male residents' room and was at risk for possible injury r/t impaired safety awareness and diagnosis of dementia, Anoxic brain damage. Date Initiated: 09/15/2021. Revision on: 09/24/2025. Goals: Resident #1's safety will be maintained throughout the review date. Date Initiated: 09/15/2021. Revision on: 09/12/2025. Target Date: 10/19/2025 Interventions: Assess for fall risk. 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