

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  11/18/2025
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)
F 0921  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.  (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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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public in 2 of 17 rooms from hallway 200 affecting 2 of 14 residents (Resident #1 and Resident #2) reviewed for environment. The facility failed to clean food crumbs, and stains from the floor in Resident #1 and Resident #2's rooms that looked like dried coffee. The facility failed to repair the footboard of Resident #2 's bed that had exposed wooden particle board and splintered edges. The facility failed to repair the closet door of Resident #2's closet that was off of the hinges and could not be closed or opened properly. The facility failed to repair the overhead light above Resident #2's bed, which was cracked with jagged edges. These failures could place residents and staff at risk of living, working, and visiting in an unsafe, unsanitary, and uncomfortable environment. Findings included: 1. Record review of Resident # 1's admission record, dated 11/18/2025, revealed an [AGE] year-old female admitted on [DATE], with diagnoses of encephalopathy (disease or damage that affects the brains function or structure causing a change in mental status), dysphagia (difficulty swallowing with an inability to move food or liquids easily from the mouth to the stomach), chronic non-pressure ulcer (chronic non-healing wound of the skin that is not caused by prolonged pressure) of left foot, weakness and falls. Record review of Resident # 1's admission MDS assessment, dated 08/25/2025, revealed a BIMS score of 5 out of 15 indicating severe cognitive impairment. The resident's functional abilities revealed she needed moderate assistance with oral and personal hygiene, and substantial assistance with toileting hygiene, shower, lower body dressing and putting on or taking off footwear and was to remain at the facility long term. 2. Record review of Resident # 2's admission record, dated 11/18/2025, revealed a [AGE] year-old male, admitted [DATE] with diagnoses of cerebral infarction (the death of brain tissue caused by a prolonged lack of blood flow, which leads to stroke), lack of coordination, type II diabetes mellitus (a chronic disease where the body does not use insulin correctly causing blood sugar levels to remain high), hemiplegia (paralysis or weakness of muscles on one side of the body affecting the arm, leg and face), dysphagia (difficulty swallowing with an inability to move food or liquids easily from the mouth to the stomach), chronic obstructive pulmonary disease (a group of progressive lung diseases that block airflow to the lungs, causing breathing problems), alcoholic cirrhosis of the liver (a late stage of liver damage caused by excessive alcohol consumption, where scar tissue replaces healthy liver tissue, leading to liver failure) with ascites (a condition where severe scarring of the liver from chronic alcohol use causes a buildup of fluid in the abdomen) and colostomy (a surgically created opening that connects the colon to the outside of the body, allowing stool and gas to be collected in a pouch). Record review of Resident # 2's admission MDS assessment, dated 02/26/2025, revealed a BIMS score of 13 out of 15 indicating he was cognitively intact. The resident's functional abilities revealed he required maximal assistance with toileting, personal and oral hygiene, showers, lower body dressing and putting on or taking off footwear. In an observation and interview on 11/12/25 at 11:16 a.m. in Resident # 1's room, the floor had stains, food crumbs and plastic wrappers. Resident #1 was seated on her bed and when asked if staff cleaned her room, she said no. Resident #1 said the floors in her room were often dirty, and sticky and rarely swept or mopped. Resident #1 said she had bugs and the pest people would put out traps. Observed several round black disks in all four corners of her room, behind the toilet in the corners of her bathroom and around the entrance of her bifold closet door. During an observation and interview on 11/12/25 at 5:48 p.m. in Resident # 1's room, the floor remained stained with food crumbs and plastic wrappers. Resident #1 was seated to the side of her bed and was eating from a dinner tray. Resident#1's family member was seated in a chair at the bedside. Resident #1 said no one cleaned her room [ROOM NUMBER]/12/25. The family member said they visited Resident # 1 almost daily. The family member said they had not complained or said anything to management because they did not want to cause any trouble and usually when they point out the mess or lack of cleaning in the room to the resident's aide or nurse, someone comes to clean the room shortly thereafter. Resident #1 then said that if she asks someone to clean the room, they usually would I when they got around to it, but no one had on 11/12/25. Resident #1 shrugged her shoulders when asked how it made her feel when her room was not cleaned daily. Resident #1's family member said the facility should clean the residents' rooms daily. In an observation and interview on 11/18/25 at 1:17 p.m. in Resident #2's room, the floor was dirty with food crumbs, and stains that appeared to be dried coffee. The floor felt sticky with surveyor shoes sticking to the floor and the floor making</p>

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F 0925  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.  (continued on next page)

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for 1 of 4 hallways, (Hall 100) and Resident #4's room. The facility had a live roach and live flies in Resident #4's room. This failure could place residents at risk for decreased residents' health, safety, and quality of life. Findings included: Record review of Resident #4's admission Record dated 11/18/2025 revealed a [AGE] year-old female, admitted [DATE] and readmitted [DATE] with diagnoses of encephalopathy (disease or damage that affects the brains function or structure causing a change in mental status), dysphagia (difficulty swallowing with an inability to move food or liquids easily from the mouth to the stomach), history of falls, ataxic gait (an abnormal clumsy and staggering walk characterized by a lack of balance), atrial fibrillation (a common type of arrhythmia[an abnormal heart rate]where the heart's upper chamber beat chaotically and irregularly, often too fast), and intellectual disability. Record review of Resident 4's admission MDS, dated [DATE], revealed a BIMS score of 9 out of 15, which indicated moderate cognitive impairment. The resident's functional abilities in section GG revealed she required maximal assistance with toileting, and personal hygiene, and moderate assistance with showers, lower body dressing and putting on or taking off footwear. Observation and interview with Administrator on 11/18/25 at 1:35 p.m. of an empty resident room # 209 with a live pile of ants or some type of crawling insects in a mound in the corner just inside the door of the room. The Administrator said the room was empty and he would call the pest control company to come out and do an off-schedule treatment. The Administrator said he was doing his best to stay on top of things after returning to the facility and he was just getting up to speed on a lot of things that had fallen through the cracks in his absence. During an observation and interview with the facility Ombudsman on 11/18/2025 at 3:18 p.m., in Resident #4's room with the Ombudsman to show a live roach on the floor in front of her recliner chair and 2 flies flying around in the room. Resident #4 was at an activity and the Ombudsman stepped on the roach killing it. The Ombudsman said the facility had an issue with roaches and other pests and would say they were addressing it but did not feel it was effective because there were pests all over the facility and this was not the first time she had seen or killed a live insect or bug, while visiting with residents at the facility. Observation and interview with Resident #4 on 11/18/25 at 3:27 p.m. in main dining room area. Resident #4 was appropriately dressed and groomed and seated in a chair. When asked if she had ever had any issues with bugs, roaches, flies or pests in her room she said from time to time. When asked what happened when she saw pests in her room, she said she would tell the nurse or aide and someone would kill it. When asked if her room was cleaned daily, she said yes. When asked if she felt like the facility did enough to make sure there were no bugs or pests in her room, she said yes. Resident #4 said she saw the pest control people regularly at the facility at least every few weeks. Interview with Housekeeper B on 11/18/2025 at 3:53 p.m. who was actively cleaning Resident #2's room Housekeeper A said she worked at the facility since June 2025 and had cleaned on the front of 200 hallway earlier in the day but had not made it to the back of 200 hallway yet. She said that the housekeepers usually split 200 hallway because there was no permanently assigned housekeeper for that hall. Housekeeper B said Resident #2's room was dirty on the floors, but she cleaned it daily whenever she worked. Housekeeper B said that she may not always clean her assigned area on 200 hall in the morning but completed it daily prior to the end of her shift. Housekeeper B said having food debris on the floor was not acceptable because it could attract pests or insects which she said she had seen before all around the facility. Housekeeper B said she saw flies, gnats, and roaches on 200 hall in the past. Housekeeper B said she reported any insects to the administrator, her supervisor and maintenance so they could contact pest control. Interview on 11/18/2025 at 4:50 p.m., the Maintenance Director said he started working at the facility on 10/31/25 and was not asked to assist with the building's pest control. He said he was asked to notify the pest control company, which he did. He said residents and staff complained about pests, including roaches and rodents, throughout the facility. He said the pest control program was ineffective because some of the pests could have nests in the walls. He said some areas of the building seemed to be worse than others. He said some of the residents' rooms on 200 hall were affected but could not recall which ones. In an interview on 11/18/2025 at 4:53 p.m. the Administrator said he could not locate the daily room rounding sheets for Resident #2's room or the 200-hallway housekeeping assignment sheet. The Administrator said the housekeeping and laundry departments had a recent large turnover with several housekeepers and the former housekeeping supervisor</p>		