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	03/10/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, based on the comprehensive assessment for 1 of 5 residents (Resident #1) reviewed for quality of care in that: Resident #1's skin was not thoroughly assessed on 2/25/26 when he had moisture-associated skin damage behind both ears that was not identified. Resident #1 had moisture-associated skin damage behind both ears that was not being treated between 2/20/26 and 2/27/26. This deficient practice placed residents at risk of delayed treatment and developing avoidable pressure injuries.Findings include:Record review of Resident #1's Order Summary Report generated on 3/10/26 revealed he was admitted to the facility on [DATE] and had diagnoses of hypertension (a chronic condition where blood forcefully pushes against artery walls), hyperlipidemia (condition characterized by elevated levels of lipids (fats), such as LDL cholesterol or triglycerides, in the blood), shortness of breath, pneumonia (causes inflammation and fluid or pus in the air sacs, usually triggered by bacteria, viruses, or fungi), and respiratory failure. He was [AGE] years old. An order for continuous oxygen at a rate of 4 L/min via nasal cannula was initiated on 1/30/25. Record review of Resident #1's annual MDS assessment dated [DATE] revealed ithe was rarely/never understood, and had short-term and long-term memory problems. He required substantial/maximal assistance for personal hygiene and transfers. Record review of Resident #1's Care Plan Report revised on 1/30/26 revealed he was at risk for pressure injuries related to immobility. Interventions included to follow facility policies/protocols for the prevention and treatment of skin breakdown and inform the resident/family of any new area of skin breakdown. Record review of Resident #1's weekly skin assessment completed by the Treatment Nurse dated 2/25/26 at 4:27pm revealed no bruises, skin tears, abrasions, lacerations or moisture-associated skin damage was identified. In the section under ?other skin issues,' the nurse indicated that he had two wounds on his right hand, but no other skin conditions were identified. In an observation on 2/27/26 at 11:45am, Resident #1 was wearing an oxygen nasal cannula, and the concentrator was set at a rate of 4 L/min. In a telephone interview on 2/27/26 at 1:24pm, Resident #1's family member stated that she identified that he had wounds behind his ears and noticed they were not being treated. She said she took pictures and will would send them to the surveyor. Record review of a photo provided by Resident #1's family member dated 2/20/26 at 5:36pm revealed a picture of Resident #1. Resident #1's right ear was raw, and the skin was broken and red where the ear met the scalp at the top of his ear. Record review of a photo provided by Resident #1's family member dated 2/20/26 at 5:36pm revealed a picture of Resident #1's left ear. Resident #1's left ear was raw, and the skin was broken and red where the ear met the scalp at the top of his ear. In an interview on 2/27/26 at 3:30pm, the Treatment Nurse stated she completed weekly skin assessments for all residents. She said she completed skin assessments by looking at residents from head to toe. She said if a new wound or skin issue was identified, she would reach out to the wound care provider and put in any orders they give, then add a progress note. She said Resident #1 had two wounds on his hand and no other wounds. In an interview on 2/27/26 at 4:40pm, RN B said the treatment nurse was providing care for (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the wounds on his hand. She said she was not aware of Resident #1 having any other skin breakdown. In an interview on 2/27/26 at 4:30pm, CNA L said she had not seen Resident #1 with skin breakdown or rashes. In an observation on 2/27/26 at 5:27pm, LVN R and CNA L assisted with observing Resident #1's skin. Observation of his right ear revealed there was a scabbed area and redness where his ear met his scalp. The skin was raw and red, and some of his skin was peeling. Observation of his left ear revealed it was raw, and red and the skin was peeling where the ear met his scalp. Record review of Resident #1's progress note dated 2/27/26 at 6:33pm revealed LVN R noted blanchable redness behind both ears. She indicated she called a nurse practitioner who gave new orders for Zinc Oxide to both ears daily and ear protectors. Record review of Resident #1's Order Summary Report generated on 3/10/26 revealed an order for Nystatin External Powder 100,000 Unit/GM, apply to bilateral back of ears topically two times a day for moisture associated skin damage (inflammation and skin erosion caused by prolonged exposure to moisture) with a start date of 3/9/26. In a telephone interview on 3/10/26 at 2:49pm, the Hospice RN stated she worked for Resident #1's hospice company and she visited him multiple times in February 2026. She said she noticed Resident #1 had skin breakdown behind both of his ears on 2/24/26. She said she notified the hospice doctor about getting orders for ear protectors. She said she called the facility staff on 2/26/26 and asked if they received any orders for his ears because she had not heard back about any orders. She could not recall who she spoke to. She said irritation behind the ear iswas common for residents with oxygen. Record review of Resident #1's hospice communication binder revealed there was a sign-in sheet that indicated Hospice RN visited on 2/24/26. In an interview on 3/10/26 at 3:15pm, the DON stated the Treatment Nurse was responsible for skin assessments. She said she may do complete have done skin assessments while providing wound care. She said they completed skin assessments weekly and expected the nurse to look at a resident from head to toe. She said nurses and CNAs should report skin issues. When asked about the skin breakdown behind Resident #1's ears, she said it may have just developed, because he did not have anything before the observation on 2/27/26. She said he sweated a lot and that could have caused the skin breakdown. She said she interviewed some of the nursing staff and they did not see any skin issues. She said she did not think it was possible that it was missed during a skin assessment. She said if it was there longer, it would characterize differently. In an interview on 3/10/26 at 4:14pm, the Treatment Nurse stated it was not possible that anything was missed during Resident #1's skin assessment on 2/25/26 .

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care and services, including oxygen administration, was provided such care, consistent with professional standards of practice for 1 of 5 residents (Resident #1) reviewed for quality of care in that:Resident #1's oxygen humidifier bottle was empty. This failure could place residents at risk of discomfort, anxiety, and decline in quality of life. The findings were:Record review of Resident #1's Order Summary Report generated on 3/10/26 revealed he was admitted to the facility on [DATE] and had diagnoses of hypertension, hyperlipidemia, shortness of breath, pneumonia, and respiratory failure. He was [AGE] years old. An order for continuous oxygen at a rate of 4 L/min via nasal cannula was initiated on 1/30/25. Record review of Resident #1's annual MDS assessment dated [DATE] revealed he was rarely/never understood and had short-term and long-term memory problems. He required substantial/maximal assistance for personal hygiene and transfers. Record review of Resident #1's Care Plan Report dated 2/27/26 revealed he used oxygen therapy. Interventions included, Monitor for (signs and symptoms) of respiratory distress and report to MD. OXYGEN SETTINGS: O2 via nasal cannula @ 4L. In an observation on 3/10/26 at 11:30am, Resident #1 was wearing an oxygen nasal cannula and the concentrator was set at a rate of 4 L/min. The humidifier bottle contained no water. In an observation and interview on 3/10/26 at 11:38pm, LVN E said the bottle on the oxygen concentrator should have water in it. He looked at the bottle on Resident #1's concentrator, and said it was completely out of water. In an interview on 3/10/26 at 2:35pm, LVN E said when a resident was administered oxygen, he checked the resident's pulse oximeter readings to monitor. He said he would look at tubing and make sure it did not need to be changed. He said the humidifier bottle was typically full of water for two days. He said when he changed the water, he knew he had two days to fill it again. When asked about Resident #1's humidifier bottle, he said they worked 12-hour shifts, and he was off for a few days. He said the water was for humidification to prevent nasal irritation. In an interview on 3/10/26 at 3:15pm, the DON stated there should be water in the oxygen concentrator bottle. She said the water humidified a resident's nasal passages and prevented them from drying out. She said nurses should notice when the water was low and add water to the bottle. In a telephone interview on 3/10/26 at 2:21pm, LVN W said she worked with Resident #1 last night and the night before. She said Resident #1's oxygen tubing was checked every Sunday. She said she checked the humidification bottle to ensure there was water in the bottle. She said she put water in it the day before yesterday. She said when she left last night, it was about half full of water. Record review of the facility's policy regarding oxygen therapy dated 4/2021 read, it is the policy of this community to ensure all oxygen administration is conducted in a safe manner. use distilled water for humidification.