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	04/01/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs for 1 out of 4 (Resident #1) residents reviewed for pharmacy service in that: The facility failed to ensure MA B did not leave Resident #1 medications on top of the bedside table. This failure could place residents at risk of not receiving their medications, choking and respiratory distress.Findings include: Record review of Resident #1's face sheet dated 4/1/25 revealed she was an [AGE] year-old-female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: unspecified dementia (cognitive decline or memory loss), unspecified severity (recognizes a condition exists and causes impairments), without behavioral disturbance (does not exhibit significant agitation), psychotic disturbance (a severe mental state characterized by a loss of contact with reality, manifesting as hallucinations, delusions, and disorganized thinking), anxiety disorder (mental health condition characterized by excessive, persistent, and uncontrollable fear), cognitive communication deficit (an impairment in communication due to underlying cognitive issues like poor memory), essential primary hypertension (chronic high blood pressure with no single, identifiable medical cause), and need for assistance with personal care. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 03 out of 15, indicating severely impaired cognition. Further review revealed Resident #1 needed extensive assistance with ADL. Record review of Resident #1's care plan dated 04/01/2026 revealed Resident #1 was at Risk for potential side effects due to missed medication. Record review of Resident #1's order summary report dated 04/01/26 read in part, Memantine HCl Oral Tablet 10MG, give one tablet by mouth two times a day for dementia ordered date 03/31/26. Metoprolol Tartrate Tablet 25 MG, give one tablet by mouth two times a day for High Blood Pressure ordered date 01/29/24. During an observation and interview on 04/01/26 at 1:51p.m., surveyor observed two pills in a cup on Resident #1's bedside table. When surveyor asked about the medication, Resident #1 stated she was not taking the pills and reported she did not know what the medication was for. Resident #1 told the surveyor, You can have it because I'm not taking it, and repeated that she was over [AGE] years old and does not believe in continuing tests or medications. During an interview on 04/01/26 at 4:17p.m, Medication Aide (MA B) said that residents in the facility are not permitted to self-administer medications. The MA B described the facility's medication administration protocol as requiring staff to observe the resident taking medications, ensure adequate fluid intake, and confirm Resident #1 swallows each medication prior to leaving the room. The MA B said she prepared Resident #1 medications in a cup and used water from Resident #1's personal cup. The MA B said Resident #1 typically takes medications one at a time or occasionally two at a time, but not all at once. The MA B said she initially observed Resident #1 taking the medications, however, MA B said she turned her back and began preparing for the resident next door. The MA B said she assumed Resident #1 had taken all medications, as this is Resident #1's usual practice. The MA B said she exited the room without confirming all medications were consumed. The MA B said the (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	potential risk to Resident #1's failure to take blood pressure medication could result in elevated blood pressure which could increase the risk of a stroke or a headache. The MA B said the potential risk to Resident #1's failure to take dementia medication could result in increased confusion. The MA B said if another resident ingested the medication there is a risk that residents will have an adverse or allergic reaction. During an interview on 04/01/26 at 4:43 p.m., Director of Nursing (DON) said that medication aides are responsible for administering medications and confirming that each resident has taken their medication. The DON said currently no residents in the facility are permitted to self-administer medications. The DON said the failure to administer high blood pressure medication to Resident #1 could result in an elevated pulse. She said the failure to administer dementia medications may negatively impact Resident #1's cognitive status. She said if medications are left unattended another resident could take the medication and the risk to that resident can result in an adverse reaction. During a telephone interview on 04/01/26 at 5:02 p.m., Nurse Practitioner (NP) said that his expectation for medication administration is that staff follow physician orders exactly as prescribed. The NP said missing high blood pressure mediation could place Resident #1 at risk for elevated blood pressure medication potentially causing adverse health outcomes. During an interview on 04/01/26 at 5:25 p.m., Administrator (ADM) said medications must not be left in a resident's room. The ADM said his expectation of the MA is that they must follow facility policy regarding proper medication administration. The ADM said the risk to Resident #1 missing her blood pressure medication could result in elevated blood pressure or a stroke. He said the risk to Resident #1 not receiving dementia medication could lead to ongoing cognitive issues. The Policy for Medication Administration requested on 04/01/26 at 3:08 p.m., surveyor was not provided with all the documents for the policy requested.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys to meet the needs for 1 out of 4 (Resident #1) residents reviewed for pharmacy service in that: The facility failed to ensure MA B did not leave Resident #1 medications on top of the bedside table.MA B failed to ensure that the medication was secure when she walked away and left two pills in the cup unsupervised. This failure could place residents at risk of not getting their medications as ordered. Findings include: Record review of Resident #1's face sheet dated 4/1/25 revealed she was an [AGE] year-old-female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: unspecified dementia (cognitive decline or memory loss), unspecified severity (recognizes a condition exists and causes impairments), without behavioral disturbance (does not exhibit significant agitation), psychotic disturbance (a severe mental state characterized by a loss of contact with reality, manifesting as hallucinations, delusions, and disorganized thinking), anxiety disorder (mental health condition characterized by excessive, persistent, and uncontrollable fear), cognitive communication deficit (an impairment in communication due to underlying cognitive issues like poor memory), essential primary hypertension (chronic high blood pressure with no single, identifiable medical cause), and need for assistance with personal care. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 03 out of 15, indicating severely impaired cognition. Further review revealed Resident #1 needed extensive assistance with ADL. Record review of Resident #1's care plan dated 04/01/2026 revealed Resident #1 was at Risk for potential side effects due to missed medication. Record review of Resident #1's order summary report dated 04/01/26 read in part, Memantine HCl Oral Tablet 10MG, give one tablet by mouth two times a day for dementia ordered date 03/31/26. Metoprolol Tartrate Tablet 25 MG, give one tablet by mouth two times a day for High Blood Pressure ordered date 01/29/24. During an observation and interview on 04/01/26 at 1:51p.m., surveyor observed two pills in a cup on Resident #1's bedside table. When surveyor asked about the medication, Resident #1 stated she was not taking the pills and reported she did not know what the medication was for. Resident #1 told the surveyor, You can have it because I'm not taking it, and repeated that she was over [AGE] years old and does not believe in continuing tests or medications. During an interview on 04/01/26 at 4:17p.m, Medication Aide (MA B) said that residents in the facility are not permitted to self-administer medications. The MA B described the facility's medication administration protocol as requiring staff to observe the resident taking medications, ensure adequate fluid intake, and confirm Resident #1 swallows each medication prior to leaving the room. The MA B said she prepared Resident #1 medications in a cup and used water from Resident #1's personal cup. The MA B said Resident #1 typically takes medications one at a time or occasionally two at a time, but not all at once. The MA B said she initially observed Resident #1 taking the medications, however, MA B said she turned her back and began preparing for the resident next door. The MA B said she assumed Resident #1 had taken all medications, as this is Resident #1's usual practice. The MA B said she exited the room without confirming all medications were consumed. The MA B said the potential risk to Resident #1's failure to take blood pressure medication could result in elevated blood pressure which could increase the risk of a stroke or a headache. The MA B said the potential risk to Resident #1's failure to take dementia medication could result in increased confusion. The MA B said if another resident ingested the medication there is a risk that residents will have an adverse or allergic reaction. During an interview on 04/01/26 at 4:43 p.m., Director of Nursing (DON) said that medication aides are responsible for administering medications and confirming that each resident has (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taken their medication. The DON said currently no residents in the facility are permitted to self-administer medications. The DON said the failure to administer high blood pressure medication to Resident #1 could result in an elevated pulse. She said the failure to administer dementia medications may negatively impact Resident #1's cognitive status. She said if medications are left unattended another resident could take the medication and the risk to that resident can result in an adverse reaction. During a telephone interview on 04/01/26 at 5:02 p.m., Nurse Practitioner (NP) said that his expectation for medication administration is that staff follow physician orders exactly as prescribed. The NP said missing high blood pressure mediation could place Resident #1 at risk for elevated blood pressure medication potentially causing adverse health outcomes. During an interview on 04/01/26 at 5:25 p.m., Administrator (ADM) said medications must not be left in a resident's room. The ADM said his expectation of the MA is that they must follow facility policy regarding proper medication administration. The ADM said the risk to Resident #1 missing her blood pressure medication could result in elevated blood pressure or a stroke. He said the risk to Resident #1 not receiving dementia medication could lead to ongoing cognitive issues. The Policy for Medication Administration requested on 04/01/26 at 3:08 p.m., surveyor was not provided with all the documents for the policy requested.