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	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Webster	17231 Mill Forest Rd. 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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who are unable to carry out activities of daily living receive the necessary treatment and services, consistent with professional standards of practice, to maintain personal hygiene. Video footage of in room surveillance revealed the facility failed to provide Resident #1, who was totally dependent on staff for ADL care, with timely incontinent care. Resident #1 did not receive incontinent care for more than 15 hours on 5/24/26 and 5/25/26, and on 05/25/26, was subsequently diagnosed with a Stage 3 pressure ulcer to his sacrum. This failure could place residents at risk for skin breakdowns, diminished quality of life, and a decline in personal hygiene. Findings Include:Record review of Resident #1's admission record revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. His admitting diagnoses were cerebrovascular disease (conditions that affect blood circulation to the brain), bacterial pneumonia (an infection of your lungs caused by a certain bacteria), protein calorie malnutrition (insufficient intake of protein and calories), aphasia (impairment of the ability to understand, speak, read, or write), dysphagia (difficulty swallowing), aphonia (the loss or reduction of vocal ability), and lack of coordination, abnormalities of gait and mobility, bilateral hand contractures (tightening and stiffen of hands limiting movement), and atrophy (reduction in muscle mass and strength). At admission, Resident #1 did not have a diagnosis for the Stage 3 sacral pressure ulcerRecord review of Resident #1's comprehensive care plan revealed focus on incontinence of bowel and bladder on 09/12/24 (goal revised on 05/05/26) Resident #1 will remain clean, dry, and odor free with no occurrence of skin breakdown. Interventions noted were to monitor for incontinence as required and prn, change promptly and apply protective skin barrier, monitor for s/s of skin break down and report abnormal findings to MD/RP, assess for causes of incontinence, labs as ordered by MD, monitor for s/s of infection and notify MD/RP promptly. Further review of comprehensive care plan revealed focus on ADL self-care performance deficit r/t disease processes, impaired balance, limited mobility, stroke, and required maximum assistance of staff initiated 09/13/24. The goal was to improve current level of function in bed mobility and transfers through implementation of requirement of maximum assist of two staff members to turn and reposition in bed, provide skin care to keep clean and prevent skin breakdown, total dependence on one staff for personal hygiene, and skin inspection daily to observe for redness, open areas, scratches, cuts, or bruises and report change to the nurse. Review of comprehensive care plan shows on 11/13/24 (revision date 05/05/26) Resident #1 has a potential bladder incontinence and is at risk for skin breakdown r/t incontinence of urine r/t impaired mobility. The goal states Resident #1 will remain free from skin breakdown due to incontinence and brief use. Interventions listed were to clean peri-area with each incontinence episode. Review revealed on 01/31/25, Resident #1 would receive care from hospice by working cooperatively with hospice team to ensure spiritual, emotional intellectual, physical, and social needs are met. In further review of his comprehensive care plan, initiated on 03/02/26 revealed focus on Resident #1's current skin condition of MASD (inflammation and erosion of the skin caused by prolonged exposure to moisture) sacrum and left posterior (back) ear to resolve concerns without complications. Interventions listed were to perform treatments per (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 0677 Level of Harm - Actual harm Residents Affected - Few	MD orders, monitor areas for increase breakdown, s/s of infection and report to MD, monitor for pain, give med per order, monitor for relief, keep MD and RP informed of Resident #1's progress and assess skin weekly and record findings in clinical records. Record review of Resident #1's Care Plan Report revealed that the care plan was updated on 05/26/26 to include his injury to the left sacrum r/t immobility, incontinence, and disease process. It includes administering medications/treatments as ordered and monitor for effectiveness, educate Resident #1/FM as to causes of skin breakdown, including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning; weekly treatment documentation to include measurement of each area of skin's breakdown's width, length, depth, type of tissue and exudate. Record review of Resident #1's admission MDS revealed that no BIMS score was recorded. Under section H titled Bladder and Bowel, completed by RN A on 02/25/26 revealed, Resident #1 was always incontinent with urine and bowel. Under section M titled Skin Conditions completed by RN A revealed that Resident #1 was at risk of developing a pressure ulcer/injury. The assessment shows that Resident #1 had no unhealed pressure ulcers/injuries. Under section GG titled functional abilities: Self-Care, Resident #1 was coded as requiring substantial/maximal assistance (helper does more than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides more than half the effort) with toileting, upper and lower body dressing, and personal hygiene. Under section GG titled functional abilities: Mobility, Resident #1 was coded as requiring substantial/ maximal assistance with rolling left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed). On admission and completion of the MDS, Resident #1 was coded as not attempting, nor did he perform the activity of toilet transfer prior to his current illness. Record review of the video dated 05/24/26 reflectedat 4:36 a.m. after brief change, Resident #1 was lying on his back in the center of the bed with the head of bed elevated and his positioning wedge on his bedside table. Resident #1 received medication from a nurse at 5:47 a.m. At 7:29 a.m. it was observed that he was receiving medication again by a nurse. CNA B entered Resident #1's room at 7:40 a.m. and turned on lights for his roommate and she left. She returned at 8:07 a.m. to administer care to the roommate. Resident #1 was in the same position and positioning wedge on bedside table. CNA B returned at 8:10 a.m. and fed Resident #1 and his roommate simultaneously while wearing the same gloves. CNA B began watching Resident #1 television at 8:17 a.m. and completed feeding Resident #1 and his roommate at 8:18 a.m. CNA B returned to Resident #1's room at 9:09 a.m. to turn off the light over his roommate and stated to Resident #1 I'm doing blood pressures and I'll be back. At 9:30 CNA B returned to Resident #1's room with a plastic bin filled with adult briefs and placed on his roommate's nightstand. CNA B began to provide care to the roommate and at 9:49 a.m. she is seen wheeling Resident #1's roommate. During this time Resident #1 was seen lying on his back with the head of bed elevated. At 9:54 a.m. CNA B returns to the room, and she removes the bin of adult briefs and turns off the lights. 10:19 a.m. housekeeping is seen mopping room. CNA B returns to Resident #1's room at 11:21 a.m. and obtains Resident #1's television remote on his bedside table is seen looking at his television, he is still in the center of the bed lying on his back with the head of the bed elevated. Another staff member enters Resident 1's room is seen and heard talking with CNA B. Both CNA B and the unknown staff member leave the room at 11:21 a.m. At 11:51 a.m. dietary staff member is seen leaving lunch tray for Resident #1. CNA B returns to Resident #1's room at 12:34 p.m. and she proceeds to feed him without wearing gloves. CNA B leaves at 12:34 p.m. and does not return until 4:08 p.m. during this time she watches Resident #1's television and adjusts the window blinds. She then walks out of the view area of the camera. Resident #1 was seen in the center of the bed lying on his back with head of the bed elevated and his positioning wedge was on his right side near his feet not in use. She returns to Resident #1 at 1640 and exchanges towel on his chest. CNA B returns to Resident #1 bedside at 6:09 p.m. and leaves. At 7:54 p.m. Resident #1's brief was changed by CNA C. Record review of video dated 05/25/26 revealed at 4:26 a.m. CNA C changed Resident #1's brief. Resident #1 is lying on his back close to the left side of the bed. The head of his bed is elevated, and positioning wedge is not in sight. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	He received medication from nursing staff at 5:44 a.m. At 8:03 a.m. CNA B is seen in Resident #1's room turning on the light on his roommate's side. Resident #1 received medication from nurse at 8:30 a.m. CNA B returns to room at 9:26 a.m. but moves out of view of camera, she returns to Resident #1 bedside to feed him. CNA B adjusts blinds on Resident #1 side at 9:56 a.m. and returns at 10:17 a.m. to his bedside and leaves. Resident #1 is seen lying on his back in the same position as earlier. Unknown nursing staff member is seen at Resident #1 bedside at 11:37 looking under his sheets and adjusting his bedside table. CNA B returns to his bedside with a dietary in her hand, draws the curtain between the roommates and walks away. She returns at 1:31 p.m. to feed Resident #1 and leaves at 1:35 p.m. She is seen in view at 1:41 p.m. but leaves again and returns to room at 3:48 p.m. on Resident #1's roommate side. At 4:41 p.m. CNA B returns to Resident #1 bedside to offer a pain pill. He replies but his communication is not easily understandable. CNA B walks out of room. Resident #1 is still lying on his back close to the left side of the bed with no positioning wedge within sight. CNA B returns at 4:47 p.m., placing Resident #1's dinner tray at bedside and is seen walking away. CNA B does not return. At 6:53 p.m. CNA C discovers tray at Resident #1's bedside and walks way to determine if she could still feed him. CNA C returns to Resident #1's bedside at 7:45 p.m. and changes his brief. Record review of Progress Notesdated 5/24/26 revealed no documentation related to incontinent care on this date. Record review of Resident #1's Wound Consultant Follow Up assessment on 05/27/26 revealed Resident #1 was bed bound, with bilateral upper extremity contractures, and bilateral lower extremity muscle weakness. Records revealed that the status of the Pressure Ulcer was new with measurements of 2.2 cm (length) x 1 cm (width) X 0.1 cm (depth). The actual area was noted as 2.2 cm and volume 0.22 cm3. The wound base was 100% granulation (new tissue forming), periwound is fragile (the skin around the wound), exudate (bodily fluid that is discharged from tissue during body response from injury) is moderate amount of clear drainage. Recommendations include implementation of pressure relieving measures and offloading (reducing or removing pressure from a specific area to promote wound healing and prevent further tissue damage). Treatment recommendations are to clean the pressure ulcer with wound cleaner, apply calcium alginate (moist, absorbent dressing for draining wounds) and dry dressing; change dressing daily or as needed if dislodged, saturated or soiled. Record review of Resident #1's Progress Note of Skin/Wound Care note by WCN entered on 05/26/26 at 1:03 pm. WCN noted that Resident #1 had what appears to be a pressure injury noted to right gluteal measuring 1 x 1.1 no obvious s/s of infection nor bleeding present. New order to apply med-honey and cover with dry dressing daily and prn for soilage/dislodgement. RP notified. Air mattress and heel protectors in place. At 1:13 p.m., WCN documented an SBAR (used to convey critical information to care team members) receiving Primary Care Provider Feedback with recommendations of Med-Honey and dry dressing. Record review of Resident #1's Progress Notes from WCN on 05/27/26 at 6:26 p.m. revealed wound care provider rounded on Resident #1. WCN noted Resident #1 has one Stage 3 pressure ulcer to left sacrum, no s/s of infection. Treatment order updated. Resident #1 tolerated well, air mattress in place to facilitate wound healing, wedge in place for offloading while Resident #1 is in bed, heel protectors in place, RP aware, plan of care ongoing. Record review of Progress Notes dated 06/05/26 revealed NP A documented on 06/05/26 at 5:21 p.m. that Resident #1 had a Braden Scale (tool used to assess a resident's risk for developing pressure injuries) score of 14 (score of 13 - 14 per Braden Scale places the patient in the moderate risk category) on 05/26/26, placing the resident at moderate to high risk for pressure injury development. NP A notes continued with stating that Resident #1 was evaluated by the RD on 05/13/26. Per NP A, documentation by the RD at that time stated Goal: Support comfort care by providing adequate nutrition to promote wound healing. The resident is under the care of hospice; weight loss and skin breakdown anticipated related to current medical condition. NP A documented that despite implementation of appropriate preventative measures including routine skin assessments, pressure injury prevention protocols, repositioning as tolerated, nutritional support, hospice oversight, and nursing interventions consistent with the resident's goal of care, Resident #1 developed a Stage 3 (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	pressure injury on 05/26/26. Record review of Resident #1's Physician Orders on revealed that on 03/13/26 an order for a pressure reducing mattress to bed. Records revealon 03/14/26 Resident #1 received an order for admission to hospice d/t CVA. Records showed on 03/17/26, an order to apply zinc oxide to sacrum daily as needed for MASD until healed and to apply one time a day every other day for skin integrity. Records revealed on 05/27/26, order placed to provide wound care to left sacrum pressure by cleansing with wound cleaner/normal saline and pat dry, apply calcium alginate and cover with dry daily and PRN for soilage/dislodgement, one time a day for wound healing/skin integrity to begin on 05/28/26. Record review of Resident #1's MAR/TAR revealed that on 05/21/26 and 05/29/26 zinc oxide to sacrum area for MASD was not documented on days scheduled for administration as ordered. Further review of MAR/TAR reveals on 05/29/26 and 05/31/26 left sacrum pressure ulcer dressing change was not documented as ordered. Observation of Resident #1 on 06/05/26 at 10:30 a.m., noted he was lying on his back with the head of his bed elevated, with pillow to his right of head, arms were contracted and on his chest. Resident #1 was nonverbal. Returned to Resident #1's room at 12:45 p.m., he was still lying on his back and pillow to right side of his head, blood stains on bottom of his sheet. CNA A and RN B were called into the room to change his position of pillow and provide a new sheet for Resident #1. Observation at 2:00 p.m., Resident #1 could be heard moaning at door entry of his room. Resident #1 was moved between 1:00 p.m. and 2:00 p.m.to center of bed, lying on his back with pillow now behind his head. Observation at 4:35 p.m. resident was lying on his back with pillow behind his head. Incontinent care was observed being provided by RN B and CNA A. In interview with DON, she stated that it is excepted for staff to round on resident's every two hours. On 06/05/26 at 5:55 p.m., interview was conducted with NP. During the interview, the NP stated She is not in the facility enough to address the frequency of incontinence care. She discussed other medical treatment being provided to prevent pressure ulcers. She is unsure of how frequent incontinent care is performed. Phone interview was conducted with CNA B on 06/05/26 at 6:24 p.m. During the interview, CNA B stated that she recalled taking care of Resident #1 on 05024/26. She stated on that day, she changed Resident #1's briefs a total of three - four times however she could not list the times. CNA B stated that she enlisted the help of LVN B d/t the resident being a two person assist. When asked how often she changes Resident #1 and why did she enlist the help of LVN B who was not assigned to her hall, CNA B stated he's different from other residents so it depends how often to change. How busy we get every 2 hours they're not coming, so I got the LVN B to get what needs to be done. When CNA B was asked if she would be surprised there was a video of her not providing incontinent care of Resident #1 during her 12-hour shift on 05/24/26, CNA B replied, I wasn't aware. Interview conducted at 6:40 PM with HRN/NCO. When asked to explain the gap of service from 05/22/26 - 05/26/26 provided to Resident #1 by hospice, the HRN/NCO replied care is not provided over the weekends and there was a holiday on 05/25/26 which we do not provide care on those days unless emergency. When speaking with the HRN/NCO she stated that the hospice nursing aide visits daily to provide grooming and bed bath for Resident #1. It was not noted in her daily assessment on Friday, 05/22/26 that Resident #1 had a pressure ulcer. In a telephone interview with Resident #1's FM1 on 06/05/26 at 12:11 p.m., she stated that she had previously notified the DON and Ombudsman by phone of her concerns of not changing Resident #1's brief nor repositioning in bed. She stated that Resident #1 is not moved by staff when she is visiting and requests that his position is changed. FM1 stated last request was on 06/04/26 at around 1:00 p.m. FM1 stated iN no, they don't have anyone to do it. FM1 stated that she would review Resident #1's camera in his room to view days that he was not changed by staff and provide footage. Interview with Resident #1's FM2 was conducted on 06/05/26 at 5:00 p.m. FM2 stated that while visiting Resident #1 he is kept in the same position throughout the duration of his visit despite asking staff to reposition Resident #1. FM2 was able to provide video recording of Resident #1's care on 05/24/26. FM2 stated that after watching the video he noticed that no staff members provided care after 4:36 a.m. to 7:54 p.m. Record review of the requested policy Skin Management revealed that DON submitted a blank sign-in sheet for review of policy by staff with no attached policy.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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 receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. Video footage of in room surveillance revealed the facility failed to provide Resident #1, who was totally dependent on staff for ADL care, with timely incontinent care. Resident #1 did not receive incontinent care for more than 15 hours on 5/24/26 and 5/25/26, and on 05/25/26, was subsequently diagnosed with a Stage 3 pressure ulcer to his sacrum. The failure could place residents at risk for worsening skin breakdowns, progression of the ulcer to move to more severe stages, and overall decline in quality of life. Findings Include:Record review of Resident #1's admission record revealed a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. His admitting diagnoses were cerebrovascular disease (conditions that affect blood circulation to the brain), bacterial pneumonia (an infection of your lungs caused by a certain bacteria), protein calorie malnutrition (insufficient intake of protein and calories), aphasia (impairment of the ability to understand, speak, read, or write), dysphagia (difficulty swallowing), aphonia (the loss or reduction of vocal ability), and lack of coordination, abnormalities of gait and mobility, bilateral hand contractures (tightening and stiffen of hands limiting movement), and atrophy (reduction in muscle mass and strength). At admission, Resident #1 did not have a diagnosis for the Stage 3 sacral pressure ulcerRecord review of Resident #1's comprehensive care plan revealed focus on incontinence of bowel and bladder on 09/12/24 (goal revised on 05/05/26) Resident #1 will remain clean, dry, and odor free with no occurrence of skin breakdown. Interventions noted were to monitor for incontinence as required and prn, change promptly and apply protective skin barrier, monitor for s/s of skin break down and report abnormal findings to MD/RP, assess for causes of incontinence, labs as ordered by MD, monitor for s/s of infection and notify MD/RP promptly. Further review of comprehensive care plan revealed focus on ADL self-care performance deficit r/t disease processes, impaired balance, limited mobility, stroke, and required maximum assistance of staff initiated 09/13/24. The goal was to improve current level of function in bed mobility and transfers through implementation of requirement of maximum assist of two staff members to turn and reposition in bed, provide skin care to keep clean and prevent skin breakdown, total dependence on one staff for personal hygiene, and skin inspection daily to observe for redness, open areas, scratches, cuts, or bruises and report change to the nurse. Review of comprehensive care plan shows on 11/13/24 (revision date 05/05/26) Resident #1 has a potential bladder incontinence and is at risk for skin breakdown r/t incontinence of urine r/t impaired mobility. The goal states Resident #1 will remain free from skin breakdown due to incontinence and brief use. Interventions listed were to clean peri-area with each incontinence episode. Review revealed on 01/31/25, Resident #1 would receive care from hospice by working cooperatively with hospice team to ensure spiritual, emotional intellectual, physical, and social needs are met. In further review of his comprehensive care plan, initiated on 03/02/26 revealed focus on Resident #1's current skin condition of MASD (inflammation and erosion of the skin caused by prolonged exposure to moisture) sacrum and left posterior (back) ear to resolve concerns without complications. Interventions listed were to perform treatments per MD orders, monitor areas for increase breakdown, s/s of infection and report to MD, monitor for pain, give med per order, monitor for relief, keep MD and RP informed of Resident #1's progress and assess skin weekly and record findings in clinical records. Record review of Resident #1's Care Plan Report revealed that the care plan was updated on 05/26/26 to include his injury to the left sacrum r/t immobility, incontinence, and disease process. It includes administering medications/treatments as ordered and monitor for effectiveness, educate Resident #1/FM as to causes of skin breakdown, including transfer/positioning requirements; importance of taking care during ambulating/mobility, good (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	nutrition and frequent repositioning; weekly treatment documentation to include measurement of each area of skin's breakdown's width, length, depth, type of tissue and exudate. Record review of Resident #1's admission MDS revealed that no BIMS score was recorded. Under section H titled Bladder and Bowel, completed by RN A on 02/25/26 revealed, Resident #1 was always incontinent with urine and bowel. Under section M titled Skin Conditions completed by RN A revealed that Resident #1 was at risk of developing a pressure ulcer/injury. The assessment shows that Resident #1 had no unhealed pressure ulcers/injuries. Under section GG titled functional abilities: Self-Care, Resident #1 was coded as requiring substantial/maximal assistance (helper does more than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides more than half the effort) with toileting, upper and lower body dressing, and personal hygiene. Under section GG titled functional abilities: Mobility, Resident #1 was coded as requiring substantial/ maximal assistance with rolling left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed). On admission and completion of the MDS, Resident #1 was coded as not attempting, nor did he perform the activity of toilet transfer prior to his current illness. Record review of the video dated 05/24/26 reflectedat 4:36 a.m. after brief change, Resident #1 was lying on his back in the center of the bed with the head of bed elevated and his positioning wedge on his bedside table. Resident #1 received medication from a nurse at 5:47 a.m. At 7:29 a.m. it was observed that he was receiving medication again by a nurse. CNA B entered Resident #1's room at 7:40 a.m. and turned on lights for his roommate and she left. She returned at 8:07 a.m. to administer care to the roommate. Resident #1 was in the same position and positioning wedge on bedside table. CNA B returned at 8:10 a.m. and fed Resident #1 and his roommate simultaneously while wearing the same gloves. CNA B began watching Resident #1 television at 8:17 a.m. and completed feeding Resident #1 and his roommate at 8:18 a.m. CNA B returned to Resident #1's room at 9:09 a.m. to turn off the light over his roommate and stated to Resident #1 I'm doing blood pressures and I'll be back. At 9:30 CNA B returned to Resident #1's room with a plastic bin filled with adult briefs and placed on his roommate's nightstand. CNA B began to provide care to the roommate and at 9:49 a.m. she is seen wheeling Resident #1's roommate. During this time Resident #1 was seen lying on his back with the head of bed elevated. At 9:54 a.m. CNA B returns to the room, and she removes the bin of adult briefs and turns off the lights. 10:19 a.m. housekeeping is seen mopping room. CNA B returns to Resident #1's room at 11:21 a.m. and obtains Resident #1's television remote on his bedside table is seen looking at his television, he is still in the center of the bed lying on his back with the head of the bed elevated. Another staff member enters Resident 1's room is seen and heard talking with CNA B. Both CNA B and the unknown staff member leave the room at 11:21 a.m.At 11:51 a.m. dietary staff member is seen leaving lunch tray for Resident #1. CNA B returns to Resident #1's room at 12:34 p.m. and she proceeds to feed him without wearing gloves. CNA B leaves at 12:34 p.m. and does not return until 4:08 p.m. during this time she watches Resident #1's television and adjusts the window blinds. She then walks out of the view area of the camera. Resident #1 was seen in the center of the bed lying on his back with head of the bed elevated and his positioning wedge was on his right side near his feet not in use. She returns to Resident #1 at 1640 and exchanges towel on his chest. CNA B returns to Resident #1 bedside at 6:09 p.m. and leaves. At 7:54 p.m. Resident #1's brief was changed by CNA C.Record review of video dated 05/25/26 revealed at 4:26 a.m. CNA C changed Resident #1's brief. Resident #1 is lying on his back close to the left side of the bed. The head of his bed is elevated, and positioning wedge is not in sight. He received medication from nursing staff at 5:44 a.m. At 8:03 a.m. CNA B is seen in Resident #1's room turning on the light on his roommate's side. Resident #1 received medication from nurse at 8:30 a.m. CNA B returns to room at 9:26 a.m. but moves out of view of camera, she returns to Resident #1 bedside to feed him. CNA B adjusts blinds on Resident #1 side at 9:56 a.m. and returns at 10:17 a.m. to his bedside and leaves. Resident #1 is seen lying on his back in the same position as earlier. Unknown nursing staff member is seen at Resident #1 bedside at 11:37 looking under his sheets and adjusting his bedside table. CNA B returns to his bedside with a dietary in her hand, draws the curtain between (continued on next page)

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	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Webster	17231 Mill Forest Rd. 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 0686 Level of Harm - Actual harm Residents Affected - Few	the roommates and walks away. She returns at 1:31 p.m. to feed Resident #1 and leaves at 1:35 p.m. She is seen in view at 1:41 p.m. but leaves again and returns to room at 3:48 p.m. on Resident #1's roommate side. At 4:41 p.m. CNA B returns to Resident #1 bedside to offer a pain pill. He replies but his communication is not easily understandable. CNA B walks out of room. Resident #1 is still lying on his back close to the left side of the bed with no positioning wedge within sight. CNA B returns at 4:47 p.m., placing Resident #1's dinner tray at bedside and is seen walking away. CNA B does not return. At 6:53 p.m. CNA C discovers tray at Resident #1's bedside and walks way to determine if she could still feed him. CNA C returns to Resident #1's bedside at 7:45 p.m. and changes his brief. Record review of Progress Notesdated 5/24/26 revealed no documentation related to incontinent care on this date. Record review of Resident #1's Wound Consultant Follow Up assessment on 05/27/26 revealed Resident #1 was bed bound, with bilateral upper extremity contractures, and bilateral lower extremity muscle weakness. Records revealed that the status of the Pressure Ulcer was new with measurements of 2.2 cm (length) x 1 cm (width) X 0.1 cm (depth). The actual area was noted as 2.2 cm and volume 0.22 cm3. The wound base was 100% granulation (new tissue forming), periwound is fragile (the skin around the wound), exudate (bodily fluid that is discharged from tissue during body response from injury) is moderate amount of clear drainage. Recommendations include implementation of pressure relieving measures and offloading (reducing or removing pressure from a specific area to promote wound healing and prevent further tissue damage). Treatment recommendations are to clean the pressure ulcer with wound cleaner, apply calcium alginate (moist, absorbent dressing for draining wounds) and dry dressing; change dressing daily or as needed if dislodged, saturated or soiled. Record review of Resident #1's Progress Note of Skin/Wound Care note by WCN entered on 05/26/26 at 1:03 pm. WCN noted that Resident #1 had what appears to be a pressure injury noted to right gluteal measuring 1 x 1.1 no obvious s/s of infection nor bleeding present. New order to apply med-honey and cover with dry dressing daily and prn for soilage/dislodgement. RP notified. Air mattress and heel protectors in place. At 1:13 p.m., WCN documented an SBAR (used to convey critical information to care team members) receiving Primary Care Provider Feedback with recommendations of Med-Honey and dry dressing. Record review of Resident #1's Progress Notes from WCN on 05/27/26 at 6:26 p.m. revealed wound care provider rounded on Resident #1. WCN noted Resident #1 has one Stage 3 pressure ulcer to left sacrum, no s/s of infection. Treatment order updated. Resident #1 tolerated well, air mattress in place to facilitate wound healing, wedge in place for offloading while Resident #1 is in bed, heel protectors in place, RP aware, plan of care ongoing. Record review of Progress Notes dated 06/05/26 revealed NP A documented on 06/05/26 at 5:21 p.m. that Resident #1 had a Braden Scale (tool used to assess a resident's risk for developing pressure injuries) score of 14 (score of 13 - 14 per Braden Scale places the patient in the moderate risk category) on 05/26/26, placing the resident at moderate to high risk for pressure injury development. NP A notes continued with stating that Resident #1 was evaluated by the RD on 05/13/26. Per NP A, documentation by the RD at that time stated Goal: Support comfort care by providing adequate nutrition to promote wound healing. The resident is under the care of hospice; weight loss and skin breakdown anticipated related to current medical condition. NP A documented that despite implementation of appropriate preventative measures including routine skin assessments, pressure injury prevention protocols, repositioning as tolerated, nutritional support, hospice oversight, and nursing interventions consistent with the resident's goal of care, Resident #1 developed a Stage 3 pressure injury on 05/26/26. Record review of Resident #1's Physician Orders on revealed that on03/13/26 an order for a pressure reducing mattress to bed. Records revealon 03/14/26 Resident #1 received an order for admission to hospice d/t CVA. Records showed on 03/17/26, an order to apply zinc oxide to sacrum daily as needed for MASD until healed and to apply one time a day every other day for skin integrity. Records revealed on 05/27/26, order placed to provide wound care to left sacrum pressure by cleansing with wound cleaner/normal saline and pat dry, apply calcium alginate and cover with dry daily and PRN for soilage/dislodgement, one time a day for wound healing/skin (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	integrity to begin on 05/28/26. Record review of Resident #1's MAR/TAR revealed that on 05/21/26 and 05/29/26 zinc oxide to sacrum area for MASD was not documented on days scheduled for administration as ordered. Further review of MAR/TAR reveals on 05/29/26 and 05/31/26 left sacrum pressure ulcer dressing change was not documented as ordered. Observation of Resident #1 on 06/05/26 at 10:30 a.m., noted he was lying on his back with the head of his bed elevated, with pillow to his right of head, arms were contracted and on his chest. Resident #1 was nonverbal. Returned to Resident #1's room at 12:45 p.m., he was still lying on his back and pillow to right side of his head, blood stains on bottom of his sheet. CNA A and RN B were called into the room to change his position of pillow and provide a new sheet for Resident #1. Observation at 2:00 p.m., Resident #1 could be heard moaning at door entry of his room. Resident #1 was moved between 1:00 p.m. and 2:00 p.m.to center of bed, lying on his back with pillow now behind his head. Observation at 4:35 p.m. resident was lying on his back with pillow behind his head. Incontinent care was observed being provided by RN B and CNA A. In interview with DON, she stated that it is excepted for staff to round on resident's every two hours.On 06/05/26 at 5:55 p.m., interview was conducted with NP. During the interview, the NP stated She is not in the facility enough to address the frequency of incontinence care. She discussed other medical treatment being provided to prevent pressure ulcers. She is unsure of how frequent incontinent care is performed. Phone interview was conducted with CNA B on 06/05/26 at 6:24 p.m. During the interview, CNA B stated that she recalled taking care of Resident #1 on 05024/26. She stated on that day, she changed Resident #1's briefs a total of three - four times however she could not list the times. CNA B stated that she enlisted the help of LVN B d/t the resident being a two person assist. When asked how often she changes Resident #1 and why did she enlist the help of LVN B who was not assigned to her hall, CNA B stated he's different from other residents so it depends how often to change. How busy we get every 2 hours they're not coming, so I got the LVN B to get what needs to be done. When CNA B was asked if she would be surprised there was a video of her not providing incontinent care of Resident #1 during her 12-hour shift on 05/24/26, CNA B replied, I wasn't aware. Interview conducted at 6:40 PM with HRN/NCO. When asked to explain the gap of service from 05/22/26 - 05/26/26 provided to Resident #1 by hospice, the HRN/NCO replied care is not provided over the weekends and there was a holiday on 05/25/26 which we do not provide care on those days unless emergency. When speaking with the HRN/NCO she stated that the hospice nursing aide visits daily to provide grooming and bed bath for Resident #1. It was not noted in her daily assessment on Friday, 05/22/26 that Resident #1 had a pressure ulcer. In a telephone interview with Resident #1's FM1 on 06/05/26 at 12:11 p.m., she stated that she had previously notified the DON and Ombudsman by phone of her concerns of not changing Resident #1's brief nor repositioning in bed. She stated that Resident #1 is not moved by staff when she is visiting and requests that his position is changed. FM1 stated last request was on 06/04/26 at around 1:00 p.m. FM1 stated iN no, they don't have anyone to do it. FM1 stated that she would review Resident #1's camera in his room to view days that he was not changed by staff and provide footage. Interview with Resident #1's FM2 was conducted on 06/05/26 at 5:00 p.m. FM2 stated that while visiting Resident #1 he is kept in the same position throughout the duration of his visit despite asking staff to reposition Resident #1. FM2 was able to provide video recording of Resident #1's care on 05/24/26. FM2 stated that after watching the video he noticed that no staff members provided care after 4:36 a.m. to 7:54 p.m. Record review of the requested policy Skin Management revealed that DON submitted a blank sign-in sheet for review of policy by staff with no attached policy.