Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675849	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Burnet Bay	3921 N Main Baytown, TX 77521

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 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on interviews and records reviewed, the facility failed to ensure at the time each resident was admitted , they had physician orders for immediate care for 1 (CR #1) of 5 residents reviewed for admission orders. -The facility failed to have physician orders for the use of a magnet device used when CR #1 was in respiratory distress on [DATE] and passed away at the facility. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of not receiving appropriate care and treatment services resulting in serious harm and/or risk of death. The findings included: Record review of CR #1's Admission Record, dated [DATE], revealed a [AGE] year-old male who was admitted to the facility on [DATE]. The resident's diagnoses included sepsis (infection of the blood stream), UTI (an infection that affects a part of the urinary tract), Marfan syndrome (genetic disorder that affects the connective tissue), and epilepsy (seizures). Record review of CR #1's orders revealed there was no order for a magnet device. Record review of CR #1's Quarterly MDS assessment, dated [DATE], revealed a BIMS score of 10, indicating moderate cognitive impairment. Further review revealed he required substantial/maximal assistance with toileting, bathing, and dressing. Section I-Active Diagnoses, Neurological, revealed I5400. Seizure Disorder or Epilepsy was checked. Record review of CR #1's undated care plan revealed it was opened but not initiated. Record review of CR #1's Baseline Care Plan, dated [DATE], read in part .D. Nursing Summary, Input from Care Givers: a. Concerns/needs .Full code status .magnet in chest (diastatin); neurostimulant . (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's hospital admission paperwork read in part .seizures - magnetic device noted . In an interview on [DATE] at 9:01 a.m., Nurse A said the CNA (could not remember her name) got her around noon. She said the CNA told her she was trying to get CR #1 fed, but he was making a gurgling sound. She said she assessed him, that he only responded to painful stimuli, was still making the gurgling sound, and had a pulse. She said she could not get an O2 sat or BP reading. She said she put the non-rebreather on him and within 2 to 3 minutes he had no pulse, was not making the gurgling sound, and said she started CPR at approximately 12:04 p.m. She said she saw him the morning of [DATE]. She said he was a little drowsy, would open his eyes, and was heavily sedated, but around 10ish in the morning he started to become more aroused. She said he was heavily sedated because the ER gave him Ativan for a seizure he had at the ER the day before, [DATE]. In an interview on [DATE] at 11:21 a.m., CNA B said she was assigned to CR #1 on [DATE]. She said she first saw him at approximately 6:05 a.m. and he was asleep. She said she woke him up for breakfast around 7:10 a.m. and he was very sleepy. She said he was eating slowly and was not in distress. She said he did not finish his breakfast and later on, about an hour or two, he asked for water. She said when she went back to give the water to him it sounded like he had a lot of mucus when he was breathing. She said she could hear it in his lungs, and his breathing did not sound normal. She said she got Nurse A and Nurse A said it looked like he was seizing. She said Nurse A said the resident's family member gave the facility a device to pass along his chest to stop his seizures. She said Nurse A passed the device across his chest, but he did not respond. She said Nurse A started screaming out CR #1's name and tapping his chest, but he still did not respond. She said Nurse A directed her to get Nurse C and to tell her to call 911 and go to his room. She said Nurse A started CPR and was not doing it for long because EMS showed up and took over. She said EMS worked on him for 20 minutes and pronounced him deceased at 12:21 p.m. In a follow-up interview on [DATE] at 12:05 p.m., Nurse A said CR #1's family member gave them a device (she said did not know what it was) and said that when he had a seizure to pass it over his heart area. She said the resident had a magnet over his heart area that was a round raised area. She said she was not sure if he was having a seizure but said she passed the device over his chest because he may have been having a possible seizure. She said the resident had a seizure the previous day, [DATE], at the hospital after he was sent out and thought it could have been a seizure. She said it did not look like he was having a seizure, but she did not know what his seizure activity looked like because he was so new to the facility. She said she was not sure if the doctor was aware of the device. She said there was no change in his condition when it was passed over chest and that he still had a gurgle. She said she was not sure what the name of the device was. In an interview on [DATE] at 12:18 p.m., the family member said CR #1 had a nerve stimulator and a magnet that got passed across his chest for seizure activity. In an interview on [DATE] at 12:51 p.m., the Doctor said he was not aware CR #1 had a device over his heart area or a magnet device. He said there should always be an order for anything used on a patient. (continued on next page)

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Focused Care at Burnet Bay	3921 N Main Baytown, TX 77521

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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 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 2:23 p.m., Nurse C said she could feel what was like a wire that ran down from behind CR #1's ear and down his neck and could see it because he was thin. She said the device the was a vagus nerve stimulant magnet. She said there was not an order in the order summary and there should be an order for everything used or given. She said her understanding was that the resident's family member brought it from home. She said she was not sure if there was enough time to get an order due to his condition, because he was fragile. She said she was not sure if the family member provided an order or if they were supposed to get it. In an interview on [DATE] at 2:40 p.m., the DON said CR #1's family member brought the magnet device to the facility and that it did not come with him from the hospital. She said the charge nurse would have been the one to notify the doctor about the device. She said CR #1 went to the hospital 1 time within a 24-hour period, and it was for respiratory distress and not a seizure. She said both instances were for respiratory distress and not a seizure. She said they did not have him long enough to know what his seizure activity looked like. She said the resident's family member brought the device to the facility on [DATE] when he was at the ER. She said she did not know if there was an order for the device. She said she did not think it was a device since it was a magnet. She said on [DATE], Nurse A called her down to the resident's room and said he had shallow breathing and was in respiratory distress again. She said she assessed the resident and CPR was initiated with absence of breathing. She said Nurse A and B performed CPR. She said ,d+[DATE] rounds of CPR was given before EMS arrived and took over. She said she could not recall if Nurse A said the device was used. In a follow-up telephone interview on [DATE] at 5:03 p.m., Nurse A said she had not personally requested doctor's orders for the magnet device. She said she thinks CR #1's family member brought the device on [DATE] when he was still at the hospital. She said all she knew was that the resident was in respiratory distress, and she started CPR after no pulse was detected. She said if there was an order it would be in the system. In a follow-up telephone interview on [DATE] at 12:01 p.m., the Doctor said a vagus nerve stimulator activated the vagus nerve to parasympathetic (part of the automatic nervous system that counterbalances the action of the sympathetic nerves. It consists of nerves arising from the brain and the lower end of the spinal cord and supplying the internal organs, blood vessels, and glands) activity. He said it helped relax the body, lower heart rate, and made one more relaxed. He said it could help with depression and seizures. He said when he saw CR #1, he performed a full physical, but was not sure he saw the vagus nerve stimulant at the time. He said it would be hard to say if using the magnet would accelerate anything as CR #1 was having acute respiratory failure. Record review of the facility's policy titled Admission Criteria, dated ,d+[DATE], read in part . 5. Prior to or at the time of admission, the resident's Attending Physician must provide the community with information needed for the immediate are of the resident, including orders covering at least .c. Routine care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed Interdisciplinary Care Plan . This was determined to be an Immediate Jeopardy (IJ) and the Administrator was notified on [DATE] at 10:48 a.m. The IJ template was presented to the facility and the POR was requested at this time. The following Plan of Removal submitted by the facility was accepted on [DATE] at 9:01 a.m. and included: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Focused Care at Burnet Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 3921 N Main Baytown, TX 77521	

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 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Name of Facility: [] Date: [DATE] Immediate action: Plan of Removal F635: Admission Physician Orders for Immediate Care: The facility failed to obtain orders upon CR# 1's admission for the use of his magnet device. CR # 1's had a medical emergency on [DATE] and passed away at the facility. Status of resident is deceased . * The Regional Director of Clinical Operations initiated Inservice on [DATE] with Licensed nurses on Obtaining Physician orders for Adaptive devices prior to utilizing device for resident care. All Licensed Nurses will receive in-service prior to starting their next shift. Completion Date [DATE] * The Regional Director of Clinical Operations initiated Inservice on [DATE] with Licensed Nurses on how to properly assess residents for Change in Condition to include signs and symptoms of Seizure activity and signs and symptoms of Respiratory Distress. All Licensed Nurses will receive Inservice prior to starting their next shift. Completion Date [DATE] * The Director of Clinical Operations and/or designee will complete an audit of all residents who have adaptive devices to ensure there is a Physician Order for Device and Staff have received adequate training on device. The audit was conducted and completed on [DATE]. No issues identified and No residents found with adaptive devices. * The Director of Clinical Operations and/or Designee will review all Admission Orders during the daily clinical meeting to ensure any Adaptive Devices are on a proper Physician order and Licensed Staff has prior training for using the device for resident care and any devices received after admissions. Not a new policy. * ALL newly hired licensed nursing staff will be trained in adaptative devices during orientation prior to taking care of residents. DCO and/ or designee will review hospital records on new residents prior to admissions. Once admission is confirmed, in-service and training will be conducted, and care plan will be completed , d+[DATE] hours after admission. DCO and/or designee will train after hours and weekend staff on adaptive devices. Nursing Staff will use the 24-hr report to identify residents with adaptive devices. * The Medical Director notified of alleged facility noncompliance with Admission Physicians Orders for Immediate Care and Competent Nursing Staff on [DATE]. * In-service was done for Executive Director of Operations and Director of Clinical Operations (Via phone [DATE] and will sign when she returns on [DATE]) by Regional Director of Operations Inservice covered *Admission is to be reviewed in morning clinical meeting, any adaptive devices must have physicians order and licensed nurses must have training on devices prior to utilizing device for resident care. Monitoring of the POR included: (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on [DATE], between 10:09 a.m. and 3:46 p.m., with staff from all shifts, revealed the following licensed nurses were able to verbalize an understanding on obtaining physician orders for adaptive devices prior to utilizing the device for resident care and how to properly assess residents for change in condition to include signs and symptoms of seizure activity and signs and symptoms of respiratory distress: MDS Coordinator, DON, Nurse A, B, C, D, E and F. Interviews on [DATE] at 11:34 a.m. with the Administrator and at 1:46 p.m. with the DON, revealed they were able to verbalize an understanding of reviewing admission orders for adaptive devices and proper physician orders and that all licensed nursing staff receives training prior to the use of the device or any device for resident care. Record review of in-service sign in sheet, dated [DATE], for Assessing: Knowing the difference between a seizure and respiratory distress a change in condition, revealed 12 signatures. Record review of in-service sign in sheet, dated [DATE], for MD Orders for Resident Care, revealed 12 signatures. Record review of audit findings revealed one was completed on [DATE] by the MDS Coordinator and no residents were found to have external adaptive devices. The Administrator was informed the Immediate Jeopardy was removed on [DATE], at 4:03 p.m. The facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems/plan of correction.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 32677 Based on interview, and record review, the facility failed to provide treatment and care in accordance with the comprehensive person-centered care plan and in accordance with professional standards of practice for 1 (CR #1) of 5 residents reviewed for quality of care. -The facility failed to assess and provide treatment for CR #1's vagus nerve stimulator. On [DATE], facility staff used a magnet device when CR #1 was in respiratory distress and he passed away at the facility. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of not receiving appropriate care and treatment services resulting in serious harm and/or risk of death. The findings included: Record review of CR #1's Admission Record, dated [DATE], revealed a [AGE] year-old male who was admitted to the facility on [DATE]. The resident's diagnoses included sepsis (infection of the blood stream), UTI (an infection that affects a part of the urinary tract), Marfan syndrome (genetic disorder that affects the connective tissue), and epilepsy (seizures). Record review of CR #1's orders revealed there was no order for a magnet device. Record review of CR #1's Quarterly MDS assessment, dated [DATE], revealed a BIMS score of 10, indicating moderate cognitive impairment. Further review revealed he required substantial/maximal assistance with toileting, bathing, and dressing. Section I-Active Diagnoses, Neurological, revealed I5400. Seizure Disorder or Epilepsy was checked. Record review of CR #1's undated care plan revealed it was opened but not initiated. Record review of CR #1's Baseline Care Plan, dated [DATE], read in part .D. Nursing Summary, Input from Care Givers: a. Concerns/needs .Full code status .magnet in chest (diastatin); neurostimulant . Record review of CR #1's hospital admission paperwork read in part .seizures - magnetic device noted . (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 9:01 a.m., Nurse A said the CNA (could not remember her name) got her around noon. She said the CNA told her she was trying to get CR #1 fed, but he was making a gurgling sound. She said she assessed him, that he only responded to painful stimuli, was still making the gurgling sound, and had a pulse. She said she could not get an O2 sat or BP reading. She said she put the non-rebreather on him and within 2 to 3 minutes he had no pulse, was not making the gurgling sound, and said she started CPR at approximately 12:04 p.m. She said she saw him the morning of [DATE]. She said he was a little drowsy, would open his eyes, and was heavily sedated, but around 10ish in the morning he started to become more aroused. She said he was heavily sedated because the ER gave him Ativan for a seizure he had at the ER the day before, [DATE]. In an interview on [DATE] at 11:21 a.m., CNA B said she was assigned to CR #1 on [DATE]. She said she first saw him at approximately 6:05 a.m. and he was asleep. She said she woke him up for breakfast around 7:10 a.m. and he was very sleepy. She said he was eating slowly and was not in distress. She said he did not finish his breakfast and later on, about an hour or two, he asked for water. She said when she went back to give the water to him it sounded like he had a lot of mucus when he was breathing. She said she could hear it in his lungs, and his breathing did not sound normal. She said she got Nurse A and Nurse A said it looked like he was seizing. She said Nurse A said the resident's family member gave the facility a device to pass along his chest to stop his seizures. She said Nurse A passed the device across his chest, but he did not respond. She said Nurse A started screaming out CR #1's name and tapping his chest, but he still did not respond. She said Nurse A directed her to get Nurse C and to tell her to call 911 and go to his room. She said Nurse A started CPR and was not doing it for long because EMS showed up and took over. She said EMS worked on him for 20 minutes and pronounced him deceased at 12:21 p.m. In a follow-up interview on [DATE] at 12:05 p.m., Nurse A said CR #1's family member gave them a device (she said did not know what it was) and said that when he had a seizure to pass it over his heart area. She said the resident had a magnet over his heart area that was a round raised area. She said she was not sure if he was having a seizure but said she passed the device over his chest because he may have been having a possible seizure. She said the resident had a seizure the previous day, [DATE], at the hospital after he was sent out and thought it could have been a seizure. She said it did not look like he was having a seizure, but she did not know what his seizure activity looked like because he was so new to the facility. She said she was not sure if the doctor was aware of the device. She said there was no change in his condition when it was passed over chest and that he still had a gurgle. She said she was not sure what the name of the device was. In an interview on [DATE] at 12:18 p.m., the family member said CR #1 had a nerve stimulator and a magnet that got passed across his chest for seizure activity. In an interview on [DATE] at 12:51 p.m., the Doctor said he was not aware CR #1 had a device over his heart area or a magnet device. He said there should always be an order for anything used on a patient. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 2:23 p.m., Nurse C said she could feel what was like a wire that ran down from behind CR #1's ear and down his neck and could see it because he was thin. She said the device the was a vagus nerve stimulant magnet. She said there was not an order in the order summary and there should be an order for everything used or given. She said her understanding was that the resident's family member brought it from home. She said she was not sure if there was enough time to get an order due to his condition, because he was fragile. She said she was not sure if the family member provided an order or if they were supposed to get it. In an interview on [DATE] at 2:40 p.m., the DON said CR #1's family member brought the magnet device to the facility and that it did not come with him from the hospital. She said the charge nurse would have been the one to notify the doctor about the device. She said CR #1 went to the hospital 1 time within a 24-hour period, and it was for respiratory distress and not a seizure. She said both instances were for respiratory distress and not a seizure. She said they did not have him long enough to know what his seizure activity looked like. She said the resident's family member brought the device to the facility on [DATE] when he was at the ER. She said she did not know if there was an order for the device. She said she did not think it was a device since it was a magnet. She said on [DATE], Nurse A called her down to the resident's room and said he had shallow breathing and was in respiratory distress again. She said she assessed the resident and CPR was initiated with absence of breathing. She said Nurse A and B performed CPR. She said ,d+[DATE] rounds of CPR was given before EMS arrived and took over. She said she could not recall if Nurse A said the device was used. In a follow-up telephone interview on [DATE] at 5:03 p.m., Nurse A said she had not personally requested doctor's orders for the magnet device. She said she thinks CR #1's family member brought the device on [DATE] when he was still at the hospital. She said all she knew was that the resident was in respiratory distress, and she started CPR after no pulse was detected. She said if there was an order it would be in the system. In a follow-up telephone interview on [DATE] at 12:01 p.m., the Doctor said a vagus nerve stimulator activated the vagus nerve to parasympathetic (part of the automatic nervous system that counterbalances the action of the sympathetic nerves. It consists of nerves arising from the brain and the lower end of the spinal cord and supplying the internal organs, blood vessels, and glands) activity. He said it helped relax the body, lower heart rate, and made one more relaxed. He said it could help with depression and seizures. He said when he saw CR #1, he performed a full physical, but was not sure he saw the vagus nerve stimulant at the time. He said it would be hard to say if using the magnet would accelerate anything as CR #1 was having acute respiratory failure. Record review of the facility's policy titled Admission Criteria, dated ,d+[DATE], read in part . 5. Prior to or at the time of admission, the resident's Attending Physician must provide the community with information needed for the immediate are of the resident, including orders covering at least .c. Routine care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed Interdisciplinary Care Plan . This was determined to be an Immediate Jeopardy (IJ) and the Administrator was notified on [DATE] at 10:48 a.m. The IJ template was presented to the facility and the POR was requested at this time. The following Plan of Removal submitted by the facility was accepted on [DATE] at 9:01 a.m. and included: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Name of Facility: [] Date: [DATE] Immediate action: Plan of Removal Status of resident is deceased . * The Regional Director of Clinical Operations initiated Inservice on [DATE] with Licensed nurses on Obtaining Physician orders for Adaptive devices prior to utilizing device for resident care. All Licensed Nurses will receive in-service prior to starting their next shift. Completion Date [DATE] * The Regional Director of Clinical Operations initiated Inservice on [DATE] with Licensed Nurses on how to properly assess residents for Change in Condition to include signs and symptoms of Seizure activity and signs and symptoms of Respiratory Distress. All Licensed Nurses will receive Inservice prior to starting their next shift. Completion Date [DATE] * The Director of Clinical Operations and/or designee will complete an audit of all residents who have adaptive devices to ensure there is a Physician Order for Device and Staff have received adequate training on device. The audit was conducted and completed on [DATE]. No issues identified and No residents found with adaptive devices. * The Director of Clinical Operations and/or Designee will review all Admission Orders during the daily clinical meeting to ensure any Adaptive Devices are on a proper Physician order and Licensed Staff has prior training for using the device for resident care and any devices received after admissions. Not a new policy. * ALL newly hired licensed nursing staff will be trained in adaptative devices during orientation prior to taking care of residents. DCO and/ or designee will review hospital records on new residents prior to admissions. Once admission is confirmed, in-service and training will be conducted, and care plan will be completed , d+[DATE] hours after admission. DCO and/or designee will train after hours and weekend staff on adaptive devices. Nursing Staff will use the 24-hr report to identify residents with adaptive devices. * The Medical Director notified of alleged facility noncompliance with Admission Physicians Orders for Immediate Care and Competent Nursing Staff on [DATE]. * In-service was done for Executive Director of Operations and Director of Clinical Operations (Via phone [DATE] and will sign when she returns on [DATE]) by Regional Director of Operations Inservice covered *Admission is to be reviewed in morning clinical meeting, any adaptive devices must have physicians order and licensed nurses must have training on devices prior to utilizing device for resident care. Monitoring of the POR included: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on [DATE], between 10:09 a.m. and 3:46 p.m., with staff from all shifts, revealed the following licensed nurses were able to verbalize an understanding on obtaining physician orders for adaptive devices prior to utilizing the device for resident care and how to properly assess residents for change in condition to include signs and symptoms of seizure activity and signs and symptoms of respiratory distress: MDS Coordinator, DON, Nurse A, B, C, D, E and F. Interviews on [DATE] at 11:34 a.m. with the Administrator and at 1:46 p.m. with the DON, revealed they were able to verbalize an understanding of reviewing admission orders for adaptive devices and proper physician orders and that all licensed nursing staff receives training prior to the use of the device or any device for resident care. Record review of in-service sign in sheet, dated [DATE], for Assessing: Knowing the difference between a seizure and respiratory distress a change in condition, revealed 12 signatures. Record review of in-service sign in sheet, dated [DATE], for MD Orders for Resident Care, revealed 12 signatures. Record review of audit findings revealed one was completed on [DATE] by the MDS Coordinator and no residents were found to have external adaptive devices. The Administrator was informed the Immediate Jeopardy was removed on [DATE], at 4:03 p.m. The facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems/plan of correction.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675849	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Focused Care at Burnet Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 3921 N Main Baytown, TX 77521	

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on interviews and records reviewed, the facility failed to ensure that licensed nurses had the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for 1 (CR #1) of 5 residents reviewed for nursing services. -The facility failed to train nursing staff on how to use CR #1's magnet device. The magnet device was used on [DATE] when CR #1 was in respiratory distress and passed away at the facility. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of being cared for by insufficiently trained staff during a medical emergency resulting in serious injury and risk of death. The findings included: Record review of CR #1's Admission Record, dated [DATE], revealed a [AGE] year-old male who was admitted to the facility on [DATE]. The resident's diagnoses included sepsis (infection of the blood stream), UTI (an infection that affects a part of the urinary tract), Marfan syndrome (genetic disorder that affects the connective tissue), and epilepsy (seizures). Record review of CR #1's orders revealed there was no order for magnet device. Record review of CR #1's Quarterly MDS assessment, dated [DATE], revealed a BIMS score of 10, indicating moderate cognitive impairment. Further review revealed he required substantial/maximal assistance with toileting, bathing, and dressing. Section I-Active Diagnoses, Neurological, revealed I5400. Seizure Disorder or Epilepsy was checked. Record review of CR #1's undated care plan revealed it was opened but not initiated. Record review of CR #1's Baseline Care Plan, dated [DATE], read in part .D. Nursing Summary, Input from Care Givers: a. Concerns/needs .Full code status .magnet in chest (diastatin); neurostimulant . Record review of CR #1's hospital admission paperwork read in part .seizures - magnetic device noted . (continued on next page)

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 9:01 a.m., Nurse A said the CNA (could not remember her name) got her around noon. She said the CNA told her she was trying to get CR #1 fed, but he was making a gurgling sound. She said she assessed him, that he only responded to painful stimuli, was still making the gurgling sound, and had a pulse. She said she could not get an O2 sat or BP reading. She said she put the non-rebreather on him and within 2 to 3 minutes he had no pulse, was not making the gurgling sound, and said she started CPR at approximately 12:04 p.m. She said she saw him the morning of [DATE]. She said he was a little drowsy, would open his eyes, and was heavily sedated, but around 10ish in the morning he started to become more aroused. She said he was heavily sedated because the ER gave him Ativan for a seizure he had at the ER the day before, [DATE]. In an interview on [DATE] at 11:21 a.m., CNA B said she was assigned to CR #1 on [DATE]. She said she first saw him at approximately 6:05 a.m. and he was asleep. She said she woke him up for breakfast around 7:10 a.m. and he was very sleepy. She said he was eating slowly and was not in distress. She said he did not finish his breakfast and later on, about an hour or two, he asked for water. She said when she went back to give the water to him it sounded like he had a lot of mucus when he was breathing. She said she could hear it in his lungs, and his breathing did not sound normal. She said she got Nurse A. She said Nurse A said it looked like he was seizing. She said Nurse A said the resident's family member gave the facility a device to pass along his chest to stop his seizures. She said Nurse A passed the device across his chest, but he did not respond. She said Nurse A started screaming out CR #1's name and tapping his chest, but he still did not respond. She said Nurse A directed her to get Nurse C and to tell her to call 911 and go to his room. She said Nurse A started CPR and was not doing it for long because EMS showed up and took over. She said EMS worked on him for 20 minutes and pronounced him deceased at 12:21 p.m. In a follow-up interview on [DATE] at 12:05 p.m., Nurse A said CR #1's family member gave them a device (she said did not know what it was) and said that when he had a seizure to pass it over his heart area. She said the resident had a magnet over his heart area that was a round raised area. She said she was not sure if he was having a seizure but said she passed the device over his chest because he may have been having a possible seizure. She said the resident had a seizure the previous day at the hospital after he was sent out and thought it could have been a seizure. She said it did not look like he was having a seizure but did not know what his seizure activity looked like because he was so new to the facility. She said she was not sure if the doctor was aware of the device. She said there was no change in his condition when it was passed over chest and that he still had a gurgle. She said she was not sure what the name of the device was. In an interview on [DATE] at 12:18 p.m., the family member said CR #1 had a nerve stimulator and a magnet that got passed across his chest for seizure activity. In an interview on [DATE] at 12:51 p.m., the Doctor said he was not aware CR #1 had a device over his heart area or a magnet device. In an interview on [DATE] at 2:23 p.m., Nurse C said the device the was a vagus nerve stimulant magnet. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 2:40 p.m., the DON said CR #1's family member brought the magnet device to the facility and that it did not come with him from the hospital. She said the charge nurse would have been the one to notify the doctor about the device. She said CR #1 went to the hospital 1 time within a 24-hour period, and it was for respiratory distress and not a seizure. She said both instances were for respiratory distress and not a seizure. She said they did not have him long enough to know what his seizure activity looked like. She said the resident's family member brought the device to the facility on [DATE] when he was at the ER. She said she did not know if there was an order for the device. She said she did not think it was a device since it was a magnet. She said on [DATE], Nurse A called her down to the resident's room and said he had shallow breathing and was in respiratory distress again. She said she assessed the resident and CPR was initiated with absence of breathing. She said Nurse A and B performed CPR. She said ,d+[DATE] rounds of CPR was given before EMS arrived and took over. She said she could not recall if Nurse A said the device was used. In a follow-up interview on [DATE] at 11:07, Nurse A said after she assessed CR #1 and once CNA B returned to the room, she left the room to get the magnet device prior to the crash cart. She said she was aware that he had a magnet in his chest. She said his family member came to the facility on [DATE] when he was still in the ER and left the magnet device. She said no one told her what signs/symptoms to look for and only that it was for seizure activity and that was what the family member said. She said she did not recall if the family member said how many times to swipe the magnet device over the magnet in CR #1's chest. She said she did not know if the magnet in his chest he had was new or how long he had it. She said she was not that familiar with the resident. In an interview on [DATE] at 12:52 p.m., Nurse B said she was aware CR #1 had the magnet over his chest area because the family member brought a magnet device in a Ziplock bag. She said the family member gave it to the DON and was telling the DON that they were supposed to pass the magnetic device when he was having a seizure. She said she did not see if the magnet was used by the Nurse A, but Nurse A told her she passed it over his chest and that it did not change anything. She said Nurse A did not mention how many times it was passed over. In an interview on [DATE] at 1:15 p.m., Nurse C said when she initially assessed him on the morning of [DATE], she thought CR #1 had a shunt but when she started touching his neck it felt like there were wires and felt a clamp further down and then wires and something where the wires went to (left side, not far below the clavicle). She said he was combative when she did his skin assessment, so she did not antagonize him. She said he was admitted the night of [DATE]. She said she does not recall anyone ever mentioning that he had a magnet implanted. She said she did not know how long he had the implant. She said she did not know if he was seeing a doctor for the implant. She said she did not recall seeing who was following him for magnet. She said CR #1 was not at the facility long enough for her to be educated on his implant. She said she did not know if his care plan had any interventions or mentioned the magnet in chest. In a follow-up interview on [DATE] at 10:15 a.m., Nurse C said she did not receive training on how to use the magnet device. She said the first time she saw it was on [DATE]. In a follow-up interview on [DATE] at 10:24 a.m., Nurse B said she did not receive training on how to use the magnet device. In an interview on [DATE] at 11:24 a.m., the Administrator said the facility did not have a policy on competent nursing staff. (continued on next page)

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