STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675910	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Hogan Park	3203 Sage St Midland, TX 79705

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure the assessment accurately reflected the residents' status for 2 of 6 residents (Resident #3 and Resident #4) whose assessments were reviewed:Resident #4's quarterly MDS did not accurately reflect the resident's level of consciousness.This failure could place residents at risk for inadequate care due to inaccurate assessments. Findings included:Resident #4Record review of Resident #4's admission Record dated 11/06/25, revealed admission on [DATE] and a readmission on [DATE]. Resident #4 was a [AGE] year-old male with diagnoses of heart failure and Type 2 Diabetes Mellitus.Record review of Resident #4's MDS dated [DATE], revealed: Section B-Hearing, Speech, and Vision; and B0100 Comatose, Persistent vegetative state with a code of 1. Yes-Skip to GG0100. This error resulted in sections C. Cognitive Patterns (BIMS), D. Mood, and E. Behavior to be skipped. Observation on 10/29/25 at 1:25 PM, revealed Resident #4 in his wheelchair, conscious, conversing, and following instructions provided by staff. Interview with Resident #4 on 11/10/25 at 12:37 PM, revealed Resident #4 said he has not been in a comatose state while in the facility.Interview with the MDS Coordinator on 11/10/25 at 3:00 PM, revealed the MDS Coordinator said she was not aware of the error, it was a typo, and Resident #4 had not been in a comatose state while at the facility. The MDS Coordinator said she was responsible for generating the MDS's. The MDS Coordinator said the risk of inaccurate MDS's is inappropriate care.Interview with the DON on 11/12/25 at 12:00 PM, revealed the DON said she performs random reviews of MDS's, and she was not aware of the error on Resident #4's MDS. The DON said the MDS Coordinator was responsible for completing the MDS's for each resident. The DON said whichever nurse is working at the time the Safe Smoking Assessment is due, is responsible for completing it. The DON said she started reviewing all Safe Smoking Assessments about 1 month ago, but she had not reviewed Resident #3's Safe Smoking Assessment.

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were maintained on each resident that were accurately documented for 1 of 6 residents (Resident #3) reviewed for medical records. The facility failed to ensure Resident #3's Safe Smoking Assessment record did not accurately document the resident's smoking status. This failure could place residents at risk of inaccurate records with the potential for inadequate care and treatment. Record review of Resident #3's admission Record dated 11/06/25, revealed admission to the facility on [DATE]. Resident #3 was a [AGE] year-old female with diagnoses of acute respiratory failure and Type 2 Diabetes Mellitus (a disease in which the body does not control the amount of sugar in the blood and kidneys).Record review of Resident #3's MDS dated [DATE], revealed a BIMS score of 10, indicating moderate cognitive impairment.Record review of Resident #3's care plan dated 10/09/25, revealed: Focus-Resident is a smoker; Goal-The resident will not smoke without supervision through the review date; and Intervention-The resident requires supervision while smoking.Record Review of Resident #3's Safe Smoking Assessment completed by RN B, dated 08/09/25, revealed Section B Summary, the following items were check-marked:The resident is safe to smoke unsupervised, at this time.The resident requires direct supervision while smoking.The resident requires a fire-resistant smoking apron while smoking.All smoking materials will be kept at the nurse's station.Care plan is up to date or dated.The evaluation has been discussed with the resident.An interview with Resident #3 on 11/10/25 at 12:19 PM, revealed, Resident #3 said she has been able to smoke unattended since she was admitted and she does not have to wear a smoking apron. Resident #3 said staff hold her supplies and light cigarettes for her.An interview with RN B on 11/12/25 at 10:32 AM, revealed, RN #B said the error on the Safe Smoking Assessment for Resident #3 must have been a typo and she was not sure what she meant to check because it had been 3 months, and she has worked at different facilities.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #6) of 3 residents reviewed for infection control. 1. The facility failed to ensure CNA A, and the Treatment Nurse turned the water faucets off with a paper towel after washing hands while providing wound care to Resident #6.2. The facility failed to ensure the Treatment Nurse used each 4X4 gauze once while performing wound care to Resident #6. These failures could place residents at risk for cross contamination and the spread of infection. Findings include:Record review of Resident #6's admission record dated 10/29/25, indicated a [AGE] year-old male admitted to the facility on [DATE] with a readmission on [DATE]. Diagnoses included Type 2 Diabetes Mellitis (a disease in which the body does not control the amount of sugar in the blood and kidneys), metabolic encephalopathy (a change in how your brain works due to an underlying condition), and chronic heart failure. Record review of Resident #6's MDS dated [DATE], indicated: BIMS of 00, meaning the resident was severely cognitively impaired and never/rarely made decisions. Section M - Skin Conditions = Resident had a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Record review of Resident #6's care plan, dated 10/27/25, indicated: Focus- The resident has DTI (deep tissue injury) right great toe; Goal- The resident's Pressure ulcer will show signs of healing and remain free from infection by/through review date; Interventions/Tasks- The resident requires supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing, treat pain as per orders prior to treatment/turning etc. to ensure the resident's comfort, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate.Focus- The resident has stage 4 pressure injury to left heel, history of ulcers; Goal- The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date; Interventions/Tasks- Administer medications as ordered, monitor/document for side effects and effectiveness, administer treatments as ordered and monitor for effectiveness, educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning.Record review of Resident #6's Order Summary Report dated 10/29/25 revealed: Right great toe DTI Dressing Change Frequency: Daily, Clean Wound With: Wound Cleanser Primary, Treatment: Betadine open to air every day shift for wound healing, effective 10/07/25; Left heel stage 4 Dressing Change Frequency: Daily, Clean Wound With: Wound Cleanser Primary, Treatment: Betadine Other Dressings: Gauze, Wrap with Kerlix, wear heel protectors every day shift for wound healing, effective 10/07/25.Observation of wound care on Resident #6's right big toe on 10/29/25 starting at 10:50 AM revealed: the Treatment Nurse used one 4x4 gauze, wet with wound cleanser, and wiped the wound three times; and the Treatment Nurse used one 4x4 gauze, wet with Betadine, and wiped the wound four times. Observation of wound care on Resident #6's left heel on 10/29/25 starting at 11:15 AM revealed: CNA A turned the faucet on with contaminated hands, performed handwashing, and turned the water faucet off with bare hands; the Treatment Nurse turned the faucet on with contaminated hands, performed handwashing and turned the faucet off with bare hands; the Treatment Nurse removed the dressing on Resident #6's heel, performed hand hygiene; the Treatment Nurse used one 4x4 gauze, wet with wound cleanser, and wiped the wound four times; the Treatment Nurse used one 4x4 gauze, wet with Betadine, and wiped the wound four times; and dressed the wound with gauze and Kerlix. Interview on 11/12/2025 at 12:00 PM, the DON said her expectations after performing hand washing is for all staff to use a paper towel to turn the faucet off. The DON said gauzes, wipes, etc. should never be used more than 1 swipe/wipe due to possibility of cross contamination and infections. The DON said the Treatment Nurse has been trained in wound care and preventing infections, and all CNAs have been trained on hand washing.