STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675985	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Midland	2000 N Main 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 5 residents (Resident #2, #3, and 4) reviewed for care plans in that: The facility failed to ensure Resident #2 had a care plan in place to address EBP addressing his pressure ulcers or catheter. The facility failed to ensure Resident #3 had a care plan in place to address EBP addressing his catheter, feeding tube, or pressure ulcer. The facility failed to ensure Resident #4 had a care in place to address EBP addressing his catheter and pressure injury. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings include: RESIDENT #2 Review of Resident #2's Admission Record, dated 8/29/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis including stoke, chronic osteomyelitis (bone infection) of left ankle and foot), stage IV pressure ulcer of sacral region (tail bone), stage III pressure ulcer of right hip, and neuromuscular dysfunction of bladder (muscles in bladder do not work). Review of Resident #2's quarterly MDS Assessment, dated 8/15/24 revealed: He had a mental status exam score of 15 of 15 (indicating his cognition was intact) He was dependent on staff for most ADLs He had an indwelling catheter and was frequently incontinent of bowel. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He had one or more unhealed pressure ulcers, including a stage III that was present upon admission (stage 3 pressure ulcer: full thickness tissue loss, under the skin fat may be visible but bone, tendon, or muscle is not exposed. Dead tissue may be present but does not hide the depth of the tissue loss. May include undermining and tunneling) Review of Resident #2's Care Plan revealed: Revised on 8/28/24 Focus: The resident has Stage 4 Pressure injury Sacrum, history of ulcers, immobility. (Sacrum, cleanse with normal saline and 4x4, pat dry, apply calcium alginate dressing to wound bed and cover with dry dressing.) Goal: The resident's will Pressure ulcer will show signs of healing and remain free from infection by/through review date. Interventions included Assess/record/monitor wound healing weekly and as needed. If the resident refuses treatment, confer with the resident, interdisciplinary team and family to determine why and try alternative methods to gain compliance. Monitor dressing daily to ensure it is intact and adhering. Teach resident/family the importance of changing positions for prevention of pressure ulcers. The resident needs assistance to turn/reposition at least every 2 hours. The resident prefers to positioned on sides. The resident requires pressure reducing boots on feet. Weekly treatment documentation. (There was nothing about Enhanced Barrier Precautions either as its own focus or as an intervention for the pressure ulcer.) Review of Resident #2's Order Summary Report, dated 8/29/24, revealed active wound care orders for the right posterior thigh and sacrum. There were no orders about enhanced barrier precautions. RESIDENT #3 Review of Resident # 3's Admission Record dated 8/29/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included stroke, dementia, seizures, gastrostomy (feeding tube), benign prostatic hyperplasia with urinary tract symptoms (swollen prostate causing difficulty urinating), Review of Resident #3's Significant Change MDS Assessment, dated 8/2/24 revealed: He had a mental status of 0 of 15 (indicating severe cognitive impairment). He had an indwelling catheter. He had a feeding tube that he received 51% or more of his nutrition and hydration through. He had a stage III pressure ulcer on re-entry (full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon or muscle was not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) Review of Resident #3's Care Plan revealed: No care plan specific to enhanced barrier precautions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident was Nothing Per Oral related to dysphagia (difficulty swallowing) and need for PEG tube. Initiated on 9/7/22 Review of the interventions showed anything about enhanced barrier precautions. The resident required a tube feeding related to swallowing problem following stroke initiated 4/13/24. None of the interventions showed anything about enhanced barrier precautions. The resident [NAME] 16 French cubic centimeter catheter and is at risk for increased urinary tract infections: Neurogenic bladder. None of the interventions showed anything about enhanced barrier precautions. Review of Resident #3's Order Summary Report revealed diagnoses of stroke and presence of feeding tube. Review of the orders revealed: Check Foley Catheter placement, ensure Foley is secured via Velcro strap to reduce friction/pulling dated 5/2/24. Clean stoma site with normal saline or wound cleanser pat dry, split dressing between skin and disk every day beginning 3/2/24. Right heel, apply betadine and let it dry every day. Beginning 8/22/24. RESIDENT #4 Review of Resident #4's Admission Record, dated 8/29/24, revealed he as an [AGE] year-old male admitted to the facility on [DATE] with diagnosis including hydronephrosis with renal and ureteral calculous obstruction (one or both kidneys swell due to a buildup of urine due to blocked urinary tract caused by kidney stones). Review of Resident #4's quarterly MDS assessment dated [DATE] revealed: He scored a 7 of 15 on his mental status exam (indicating severe cognitive impairment) He was dependent on staff for ADLs. He had an indwelling catheter. He had an unhealed pressure ulcer. He had a stage III pressure ulcer that was present upon entry. Review of Resident #4's care plan revealed: Revised on 11/12/20: The resident was at risk for pressure injury related to bed mobility, self-performance = extensive assistance, incontinence. The identified goal was the resident will have intact skin, free of redness, blisters or discoloration by/through review date. Identified interventions included: Follow facility policy/protocols for the prevention/treatment of skin breakdown. Inform the resident/family/caregivers of any new areas of skin breakdown. Monitor nutritional status. Monitor/document/report as needed any changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size, stage. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Revised on 5/3/24 The resident had a Stage 3 pressure injury Coccyx due to comorbidities, diabetes, generalized weakness, incontinence, dependence of ADL's. Goal: the resident's will pressure ulcer will show signs of healing and remain free from infection by/through review date. Identified interventions included: administer medications as ordered; administer treatments as ordered and monitor for effectiveness; wound care specialists to treat resident; assess/ record/ monitor wound healing (weekly and as needed). Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage). Revised on 4/18/24 The resident had a Foley Catheter and is at risk for increased urinary tract infections, obstructive and reflux uropathy. The identified goals were the resident will be/remain free from catheter-related trauma through review date and the resident show no signs or symptoms of urinary infection through the review date. Interventions included: catheter care every shift; change catheter and drainage bags as needed based on clinical indications such as infection, obstruction, when the closed system is compromised, or when physician or nurse practitioner indicates a change is necessary. Check foley catheter placement, ensure Foley is secured via Velcro strap to reduce friction/pulling. Monitor and document intake and output as per facility policy. Monitor for signs and symptoms of discomfort or urination and frequency. Monitor/document for pain/discomfort due to catheter. Monitor/ report to Medical Doctor for signs or symptoms urinary tract infections. Review of Resident #4's Order Summary Report, dated 8/29/24 revealed: Orders to be seen by a wound care consultant company beginning 8/25/21 Check the foley catheter placement and ensure it was secured beginning 2/14/24. Wound care orders to the sacrum dated 8/27/24. There was nothing in the order about EBP. In an interview on 8/29/24 at 4:57 p.m. with the MDS Coordinator and the Administrator, the MDS Coordinator stated he was responsible for the care plans overall. The MDS Coordinator stated he looked at the MDS report, the outcome summary, and care-planned anything to could affect care - falls, diagnoses, medications, special diets, code status, diets, allergies, pretty much anything that will help them to take care of the residents. The MDS Coordinator stated EBP would be care planned if the resident had an infectious disease. The MDS Coordinator stated the State Quality Monitor came in and mentioned EBP, but he did not know what it was, so it was not care planned. After the Administrator explained the difference between isolation and EBP to the MDS Coorindator (isolation being the person had an infectious disease and EBP was precautions the staff took to prevent the resident from getting an infectious disease), the MDS Coordinator stated EBP needed to be care planned. The MDS Coordinator stated it needed to be care planed because those residents were at particular risk for infection, so everyone needed it done. The MDS Coordinator stated EBP would be an intervention and not a Focus for the resident because it would be one more step in taking care of that resident's need. The MDS Coordinator stated the outcome to not care planning EBP was a higher risk for infection to the resident and cross contamination. The MDS Coordinator stated there was no additional information to look at, to his knowledge, because it just was not done. Review of the facility's policy and procedure for Comprehensive Care plans, revised 4/25/21 revealed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy: Every resident will have an individualized interdisciplinary plan of care in place. The interdisciplinary Team will develop the plan in conjunction with the Resident Assessment Instrument and Care Area Assessments, completing and conducting Comprehensive Care Plan Meeting and Reviews by day 21 after Admission. Procedure: The interdisciplinary Team will review the healthcare practitioner's notes and orders (e.g. dietary needs, medications, routine treatments etc.) and implement a Comprehensive Care Plan to meet the residents' immediate care needs including but not limited to: Initial goals based on admission to include Discharge goals, physician orders, skin prevention, specific care plan on the main reason for Admission to the community. The resident and their representative will be provided a summary, at their request, of the baseline care plan that includes but not limited to any services and treatment to be administered by the community and personnel acting on behalf of the community; and Any updated information based on the details of the comprehensive care plan, as necessary.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on interview and record review, the facility failed to ensure that residents who required dialysis (treatment that filters water and waste from the blood when the kidneys are no longer able to do so) received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 1 resident (Resident #1) reviewed for dialysis. The facility failed to ensure post-dialysis assessments were completed for Resident #1 after returns from dialysis treatment. This deficient practice could affect residents who received dialysis treatments and placed them at risk for complications and not receiving adequate care and treatment to meet their needs. Findings included: Review of Resident #1's Admission Record, dated 8/28/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including diabetes, stage 5 chronic kidney disease (end stage renal disease usually accompanied by dialysis). Resident #1 discharged [DATE]. Review of Resident #1's Significant Change MDS Assessment, dated 7/25/24, revealed: 0 of 15 on his mental status exam (indicating severe cognitive impairment) with signs of delirium including inattention and disorganized thinking. He received hemodialysis (while a resident and on admission) and peritoneal dialysis (on admission) Review of Resident #1's Care plan initiated on 7/23/24 revealed: Focus: History of Unspecified Kidney Failure and receivedhas dialysis Mondays Wednesdays, and Fridays at [company] . Goal: Resident will have no signs or symptoms of kidney failure throughout the review date and Resident will attend to dialysis as directed. Interventions included Administer medications as ordered and monitor for decreased urine output, dry itchy skin, nausea and vomiting, swollen ankles/feet, fatigue, shortness of breath, dizziness, flank (hip) pain, confusion, and ammonia breath. Review of Resident #1's Order Summary, dated 8/28/24, revealed orders: Monitor AV shunt for thrill/bruit / Check site for redness, swelling, increase in pain or signs/symptoms of infection every shift dated 7/1/24. Resident to attend hemodialysis on Tuesday, Thursday, Saturday with chair time of __ dated 7/1/24. Review of Resident #1's entire Dialysis Notebook revealed: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/7/24 Pre-Dialysis Assessment Completed, Dialysis Assessment Completed, no Post Dialysis Assessment completed on the form or in the computer to include vital signs or assessments of the Thrill or Bruit. 8/9/24 Pre-Dialysis Assessment Completed, Dialysis Assessment Completed, no Post Dialysis Assessment completed on the form or in the computer to include vital signs or assessment of the Thrill or Bruit. 8/12/24 Pre-Dialysis Assessment Completed. Dialysis Assessment Completed. No Post Dialysis Assessment completed on the form or in the computer to include vital signs or assessment of the Thrill or Bruit. 8/14/24 Pre-Dialysis Assessment Completed. Dialysis Assessment Completed. No Post Dialysis Assessment completed on the form or in the computer to include vital signs or assessment of the Thrill or Bruit. 8/16/24 Pre- Dialysis Assessment Competed. Dialysis Assessment Completed. No Post Dialysis Assessment completed on the form or in the computer to include vital signs or assessment of the Thrill or Bruit. 8/19/24 Pre-Dialysis Assessment Completed. Dialysis Assessment Completed. No Post Dialysis Assessment completed on the form or in the computer to include vital signs or assessment of the Thrill or Bruit. In a phone interview on 8/28/24 at 2:58 p.m., the DON stated she remembered Resident #1 . The DON stated Resident #1 was primarily Spanish speaking only, dialysis, and impulsive. The DON said Resident #1 would frequently get to dialysis and then refuse to do the dialysis session. In an interview on 8/28/24 at 4:13 p.m., the Administrator stated the DON was on vacation and she had to call her for the location of the dialysis information. The dialysis pre- and post-information was all kept in a notebook and was eventually loaded into the electronic medical record. In an interview on 8/28/24 at 5:33 p.m. the Administrator reviewed Resident #1's entire Dialysis notebook. The Administrator asked if surveyor found any of the follow up in Resident #1's electronic record. The Administrator said all the pre-Dialysis assessments were completed, all of the Dialysis communications were completed, but none of the post-Dialysis assessments were completed. The Administrator said did we do any of them? They did their documentation like he was fine, he's back and that's it. The Administrator said, I guess we need to do an in-service on follow ups. Surveyor requested the dialysis policy. In a phone text on 8/28/24 at 8:16 p.m., the DON stated the follow ups for Dialysis should be on the nurse's notes or the post assessment forms. The DON stated the ADONs were responsible for verifying the assessments were completed depending on the orders received from the physician. The DON normally wrote the Dialysis company would call if there were any concerns or changes in the resident's condition. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/29/24 at 2:54 p.m. the ADON stated they were supposed to be checking charts. The ADON said they were supposed to be checking to make sure chart documentation was complete and done appropriately, make sure if there was an incident that the right people were notified, and to make sure everything was in the chart. The ADON said she remembered Resident #1. She described him as dialysis dependent, a two-person assist, he had unspecified behaviors, and he just wanted to go home. The ADON stated Resident #1 started declining fast once he got to the facility and sometimes just did not want to go to dialysis. The ADON said when Resident #1 returned from dialysis, the nurses should complete the post-dialysis assessment on the form. The ADON said she would do the pre-dialysis assessment and document on the form what time he was given a pain medication, but the ADON was not in the building when Resident #1 returned from Dialysis . The ADON stated consequences of not completing the post-dialysis assessment was not identifying a change in condition. The ADON said a post-dialysis assessment consisted of vitals, checking the bruit and thrill. The ADON stated that was important because that would show if there was something wrong with the resident. The ADON stated if the resident's temperature was spiking or if the thrill was not working properly, it would show something was wrong with the resident. No policy on dialysis was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 of 4 residents (Residents #2, #3, and #4) reviewed for Enhanced Barrier Protections (EBP) for infection control practices. The facility failed to ensure Residents #2, #3, and #4 were identified for and had implemented Enhanced Barrier Precautions. This failure could place resident's risk for cross contamination and the spread of infection. Finding included: RESIDENT #2 Review of Resident #2's Admission Record, dated 8/29/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosis including stoke, chronic osteomyelitis (bone infection) of left ankle and foot), stage IV pressure ulcer of sacral region (tail bone), stage III pressure ulcer of right hip, and neuromuscular dysfunction of bladder (muscles in bladder do not work). Review of Resident #2's quarterly MDS Assessment, dated 8/15/24 revealed: He had a mental status exam score of 15 of 15 (indicating he was cognitively intact) He was dependent on staff for most ADLs He had an indwelling catheter and was frequently incontinent of bowel. He had one or more unhealed pressure ulcers, including a stage III that was present upon admission (stage 3 pressure ulcer: full thickness tissue loss, under the skin fat may be visible but bone, tendon, or muscle is not exposed. Dead tissue may be present but does not hide the depth of the tissue loss. May include undermining and tunneling) Review of Resident #2's Care Plan revealed: (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 - Some	Revised on 8/28/24 Focus: The resident had Stage 4 Pressure injury Sacrum, history of ulcers, immobility. (Sacrum, cleanse with normal saline and 4x4, pat dry, apply calcium alginate dressing to wound bed and cover with dry dressing.) Goal: The resident's will Pressure ulcer will show signs of healing and remain free from infection by/through review date. Interventions included Assess/record/monitor wound healing weekly and as needed. If the resident refuses treatment, confer with the resident, interdisciplinary team and family to determine why and try alternative methods to gain compliance. Monitor dressing daily to ensure it is intact and adhering. Teach resident/family the importance of changing positions for prevention of pressure ulcers. The resident needs assistance to turn/reposition at least every 2 hours. The resident prefers to positioned on sides. The resident requires pressure reducing boots on feet. Weekly treatment documentation. (There was nothing about Enhanced Barrier Precautions either as its own focus or as an intervention for the pressure ulcer.) Review of Resident #2's Order Summary Report, dated 8/29/24, revealed active wound care orders for the right posterior thigh and sacrum. There were no orders about enhanced barrier precautions. Observation on 8/28/24 at 12:20 p.m. revealed Resident #2 in bed facing the wall. There was nothing posted at the door or at Resident #2's bedside notifying anyone of Resident #2's EBP status. There was no linen cart observed on Resident #2's hall (hall A). RESIDENT #3 Review of Resident # 3's Admission Record dated 8/29/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included stroke, dementia, seizures, gastrostomy (feeding tube), benign prostatic hyperplasia with urinary tract symptoms (swollen prostate causing difficulty urinating), Review of Resident #3's Significant Change MDS Assessment, dated 8/2/24 revealed: He had a mental status of 0 of 15 (indicating severe cognitive impairment). He had an indwelling catheter. He had a feeding tube that he received 51% or more of his nutrition and hydration through. He had a stage III pressure ulcer on re-entry (full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) Review of Resident #3's Care Plan revealed: No care plan specific to enhanced barrier precautions. Resident was Nothing Per Oral related to dysphagia (difficulty swallowing) and need for PEG tube. Initiated on 9/7/22 Review of the interventions showed anything about enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident required a tube feeding related to swallowing problem following stroke initiated 4/13/24. None of the interventions showed anything about enhanced barrier precautions. The resident had a 16 French cubic centimeter catheter and is at risk for increased urinary tract infections: Neurogenic bladder. None of the interventions showed anything about enhanced barrier precautions. Review of Resident #3's Order Summary Report revealed diagnoses of stroke and presence of feeding tube. Review of the orders revealed: Check Foley Catheter placement, ensure Foley is secured via Velcro strap to reduce friction/pulling dated 5/2/24. Clean stoma site with normal saline or wound cleanser pat dry, split dressing between skin and disk every day beginning 3/2/24. Right heel, apply betadine and let it dry every day. Beginning 8/22/24. Observation on 8/28/4 at 12:28 p.m. revealed Resident #3 in bed asleep his catheter was hooked to the bed and his heels were floated on a pillow. There was nothing posted at his door or at his bedside about EBP. RESIDENT #4 Review of Resident #4's Admission Record, dated 8/29/24, revealed he as an [AGE] year-old male admitted to the facility on [DATE] with diagnosis including hydronephrosis with renal and ureteral calculous obstruction (one or both kidneys swell due to a buildup of urine due to blocked urinary tract caused by kidney stones). Review of Resident #4's quarterly MDS assessment dated [DATE] revealed: He scored a 7 of 15 on his mental status exam (indicating severe cognitive impairment) He was dependent on staff for ADLs. He had an indwelling catheter. He had an unhealed pressure ulcer. He had a stage III pressure ulcer that was present upon entry. Review of Resident #4's care plan revealed: Revised on 11/12/20: The resident is at risk for pressure injury related to bed mobility, self-performance = extensive assistance, incontinence. The identified goal was the resident will have intact skin, free of redness, blisters or discoloration by/through review date. Identified interventions included: Follow facility policy/protocols for the prevention/treatment of skin breakdown. Inform the resident/family/caregivers of any new areas of skin breakdown. Monitor nutritional status. Monitor/document/report as needed any changes in skin status: appearance, color, wound healing, signs/symptoms of infection, wound size, stage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Revised on 5/3/24 The resident has a Stage 3 pressure injury Coccyx due to comorbidities, diabetes, generalized weakness, incontinence, dependence of ADL's. Goal: the resident's will pressure ulcer will show signs of healing and remain free from infection by/through review date. Identified interventions included: administer medications as ordered; administer treatments as ordered and monitor for effectiveness; wound care specialists to treat resident; assess/ record/ monitor wound healing (weekly and as needed). Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage). Revised on 4/18/24 The resident had a Foley Catheter and is at risk for increased urinary tract infections, obstructive and reflux uropathy. The identified goals were the resident will be/remain free from catheter-related trauma through review date and the resident show no signs or symptoms of urinary infection through the review date. Interventions included: catheter care every shift; change catheter and drainage bags as needed based on clinical indications such as infection, obstruction, when the closed system is compromised, or when physician or nurse practitioner indicates a change is necessary. Check foley catheter placement, ensure Foley is secured via Velcro strap to reduce friction/pulling. Monitor and document intake and output as per facility policy. Monitor for signs and symptoms of discomfort or urination and frequency. Monitor/document for pain/discomfort due to catheter. Monitor/ report to Medical Doctor for signs or symptoms urinary tract infections. Review of Resident #4's Order Summary Report, dated 8/29/24 revealed: Orders to be seen by a wound care consultant company beginning 8/25/21 Check the foley catheter placement and ensure it was secured beginning 2/14/24. Wound care orders to the sacrum dated 8/27/24. There was nothing in the order about EBP. In a phone interview on 8/28/24 at 2:58 p.m. the DON said she was not the ICP, the ADON was and the Treatment Nurse was responsible for the hands-on in servicing part. The DON stated for EBP, there was PPE on the linen carts. The DON said staff were supposed to wear them for chronic wounds, catheter, ostomy care. The DON stated the staff knew and had been in-serviced the gowns were on the linen carts. The DON said she did not think there were any signs on EBP posted anywhere in the facility. In an interview on 8/29/24 at 1:05 p.m., GVN A stated she had never heard of EBP and she just completed school. GVN A said she worked at the facility while she was going to school as an as-needed aide and she never saw a staff member use any extra PPE. GVN A exclaimed, I don't know what you're talking about! and pulled out her cell phone to look up the information. GVN A read information about EBP out loud and said Oh, that makes sense. GVN A said the facility did not go over anything about EBP in orientation with her and she received no in-services about EBP as an aide or as a nurse. In an interview on 8/29/24 at 1:26 p.m., PT B stated EBP was staff needed to wear gown and gloves for individuals with a urinal, feeding tube, or wounds. PT B stated that she thought dressings were changed before they got into the room. PT B said the Director of Rehabilitation gave her a list of residents who needed EBT and the facility had not communicated anything with her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675985	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Midland	2000 N Main Midland, TX 79705

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/29/24 at 1:21 p.m. LVN C said EBP was used when a resident had a wound. LVN C stated staff needed to wear a gown before a dressing change, with a feeding tube, and a catheter. She said she received training on EBP yesterday (8/28/24). LVN C said she just knew her residents for knowing which residents needed EBP and there was no signage posted. In an interview on 8/29/24 at 1:36 p.m. CNA D stated EBP needed to be used when she emptied catheters and helped with wound care. CNA D said PPE was stored on the linen carts but there were enough of them. CNA D stated she received training on EBP two weeks ago. CNA D said she knew who was on EBP because she knew the people on her hall. CNA D said if there was a new resident, the Treatment Nurse would tell the aides if the new residents needed EBP or not. CNA D said the aides learned if a resident needed EBP from the nurses. CNA D said she did not think it was effective. In an interview on 8/29/24 at 2:54 p.m. the ADON stated she was ICP and had been ICP for the last 2 years. The ADON said as ICP she tried to make sure to educate the staff and make sure supplies for wound care were available. The ADON stated EBP was used for residents with wounds, catheters, feeding tubes, tracheostomy, and colostomies. The ADON said staff were supposed to gown up to do care with the appropriate PPE. The ADON said that had been in place for a couple of months. The ADON said anything that was open needed to be on EBP. The ADON said there was supposed to be a sign on the door but she didn't have a chance to put them up. The ADON stated a couple of months ago the staff talked about it but she did not document it. In a follow-up interview on 8/29/24 at 4:29 p.m. the ADON stated she was in-servicing staff one-on-one and putting up the EBP signs for residents with catheters, feeding tubes, tracheostomies, colostomies, and chronic wound. The ADON said she was putting the signs by the resident's bed so the staff knew it was that resident. In a phone interview on 8/29/24 at 5:48 p.m. the DON stated the corporation management came and sort of did rounds once a month. The DON said both the Regional Director and the RN Consultant were both RN and knew nursing. The DON said neither had said anything to her about the facility's EBP processes. The DON stated it was important because it was the safety of the residents with wounds and catheters because they were long-term conditions. The Administrator, who was present, said it was a major process for the entire corporation. The DON said the staff needed to don gowns when doing invasive care. The DON stated if a resident's EBP status changed they did verbal in-services when something changed. The DON said the process was apparently not effective if surveyor was asking about it. Review of the facility's policy and procedure on Enhanced Barrier Precautions, effective 4/1/24, revealed: Enhanced barrier precautions (EBP) are a Centers for Disease Control guidance to reduce the transmission of multi-drug resistant organisms (MDRO) in healthcare settings, including nursing homes. EBP require team members to wear a gown and gloves while performing high- contact care activities with residents who are infected or colonized with a targeted MDRO, or who have open wound or indwelling medical device. Procedure: 1. Determine residents MDRO status on admission to community. (continued on next page)

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	675985	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Determine if a resident has any wounds. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with a band-aid or similar dressing. Examples of chronic wounds include, but are not limited to pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Determine if any of the following indwelling medical devices are in use: urinary catheter, g-tube, tracheostomy, central lines. EBP will be implemented if any of the above wounds or invasive medical devices are present. 3. Place signage on resident's closet door, maintain PPE in residents' room and assure all team members are aware of resident status and need for EBP during high contact care. 4. High contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. Note: in general, gowns and gloves will be used when therapy is assisting with transfers and mobility or close physical contact during treatment.