

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675985	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Focused Care at Midland		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45399</p> <p>Based on observation, interview, and record review, the facility failed to ensure the dignity right was respected for 2 of 20 residents (Resident#33 and Resident #72) reviewed for privacy and dignity.</p> <p>Resident #33 and Resident #72 had urinary catheter drainage bags that were not covered with privacy bags, and the urine content of the bag was visible to other residents, visitors, and facility employees.</p> <p>This failure placed residents at risk for violation of privacy.</p> <p>The findings included:</p> <p>Review of Resident #33's Admission Record revealed he was an [AGE] year-old male who was admitted to the facility on [DATE].</p> <p>The Admission Record documented her diagnoses included congestive heart failure (heart fails to pump), type 2 diabetes (body's inability to control blood sugars), retention of urine, prostate hypertrophy (prostate gland enlargement which causes urinary difficulty).</p> <p>Record review of the quarterly MDS dated [DATE] for Resident #33 indicated BIMS was 05, required extensive assistance by two persons for bed mobility, dressing and toilet use and used an indwelling catheter.</p> <p>Review of the Physician Orders for Resident #33 dated 12/05/22 revealed orders to do Foley Catheter Care every shift. Check Foley catheter placement, ensure Foley was secured via velcro strap (fastner) to reduce friction/pulling.</p> <p>Foley: change catheter and drainage bag PRN 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. Foley Catheter 16 French 30 ml bulb to continuous drainage related to Prostate Hypertrophy.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the comprehensive care plan for Resident #33 dated 01/20/24, revealed there was no care plan for a urinary catheter.</p> <p>Observation on 04/09/2024 at 12:00 am revealed Resident #33 and Resident#72 sitting in dining room awaiting lunch. Resident #33's catheter drainage bag and Resident #72's drainage bag were not placed in a privacy bags.</p> <p>Record review of Admission Record for Resident #72 revealed resident was an [AGE] year-old male who was admitted to the facility on [DATE]. The admission record documented his diagnoses included Acute kidney failure (kidneys unable to filter waste from blood), retention of urine, and major depression disorder (persistently low and depressed mood).</p> <p>Record review of the quarterly MDS dated [DATE] for Resident #72 indicated Resident #72's BIMS was 15, required extensive assistance by two persons for bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. Resident #72 used an indwelling catheter.</p> <p>Review of the Physician Orders dated 05/26/23 revealed the following:</p> <p>Foley Catheter 16 French 30 ml bulb to continuous drainage related to obstructive uropathy due to benign prostatic hyperplasia. Foley Catheter Care every shift. Check Foley catheter placement, ensure Foley was secured via Velcro strap to reduce friction/pulling. Foley: change catheter and drainage bag PRN 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.</p> <p>Review of the comprehensive care plan, dated 1/22/24, revealed Resident #72 had no indwelling catheter care plan in place.</p> <p>Observation on 4/9/24 at 12:00 Residents #33 and #72 were seated in dining room, no privacy bag on their indwelling catheter bag.</p> <p>Observation on 4/10/24 at 10:00am Resident #72 was seated in dining room attending bible study with 8 other residents, no privacy bag on the indwelling catheter bag.</p> <p>Observation on 4/10/24 at 12:00PM Residents #33 and #72 were seated in dining room, no privacy bag on their indwelling catheter bag.</p> <p>Interview on 4/11/24 at 10:00AM with CRC, stated that the facilities policy was that all catheter bags should be covered with a privacy bag when the resident was outside of their room.</p> <p>Interview on 4/11/24 at 11:00AM with RN H stated the facility policy that all catheter bags should be covered with a privacy bag. The problem was that the bags fall off often. RN stated that she was assisting Resident #72 today when she noticed he had no privacy bag. Upon entering Resident #72 room, the privacy bag was in the trash can. RN stated that Resident #33 had his urinary catheter replaced yesterday (04/10/2024) and now has a privacy bag on his.</p> <p>Interview on 4/11/24 at 11:50 AM with Resident #72 stated that the privacy bag falls off when he tries to empty the foley himself. Resident #72 stated that he sometimes becomes frustrated and removes it himself.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 4/11/24 at 1:00 PM DON stated that the drainage bags should be in a privacy bag to protect the dignity of the residents.</p> <p>Record review of the Catheters and care: Indwelling, dated 04/2021 revealed in part:</p> <p>Place catheter bag in a privacy cover to preserve the dignity of the resident.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45399</p> <p>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 5 of 10 (Residents # 33, #37, #72, #79 and #137) residents reviewed for comprehensive care plans.</p> <ol style="list-style-type: none"> 1.The facility failed to ensure Resident #33 dated 01/20/24 had a care plan in place regarding his urinary catheter. 2.The facility failed to ensure Resident #37 had a care plan in place regarding her PEG (percutaneous endoscopic gastrostomy) tube. 3.The facility failed to ensure Resident #72 had a care plan in place regarding his urinary catheter. 4.The facility failed to ensure Resident #79 had a care plan in place for significant, unplanned weight loss. 5.The facility failed to ensure Resident #137 had a care plan in place for the use of psychotropic medication. <p>These failures could place residents at risk for not receiving appropriate care and supervision.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1.Review of Resident #33's face sheet revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. The Admission Record documented his diagnoses included congestive heart failure (heart fails to pump), type 2 diabetes (body's inability to control blood sugars), retention of urine, prostate hypertrophy (prostate gland enlargement which causes urinary difficulty). <p>Record review of the quarterly MDS dated [DATE] for Resident #33 indicated BIMS (Brief Interview for Mental Status) was 05, required extensive assistance by two persons for bed mobility, dressing and toilet use and used an indwelling catheter.</p> <p>Review of the Physician Orders for Resident #33 dated 12/05/22 revealed orders to do Foley Catheter Care every shift. Check Foley catheter placement, ensure Foley is secured via velcro strap to reduce friction/pulling. Foley: change catheter and drainage bag PRN 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. Foley Catheter 16 French 30 ml bulb to continuous drainage related to Prostate Hypertrophy.</p> <p>Review of the comprehensive care plan for Resident #33 dated 01/20/24, revealed no care plan for urinary catheter.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of Resident #37's Admission Record revealed she was an [AGE] year-old female originally admitted to the facility 9/1/20 with a most recent admitted [DATE]. She had diagnoses which included dysphagia (difficulty swallowing) and late onset Alzheimer's disease.</p> <p>Review of Resident #37's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 00 indicating severe cognitive impairment, total dependence on staff for all ADLs, use of a feeding tube while a resident in the facility, and hospice services while a resident in the facility.</p> <p>Review of Resident #37's Order Summary Report dated 4/11/24 revealed the following:</p> <p>NPO diet (order date 7/22/23, start date 7/22/23).</p> <p>Change flush kit/piston syringe every night shift (order date 7/14/23, start date 7/14/23).</p> <p>Check placement and residual prior to administering feeding or medication. Notify MD and hold administration if residual greater than 200ml. Reassess hourly until residual less than 200ml or change in orders obtained. (order date 7/14/23).</p> <p>Cleanse stoma site with normal saline or wound cleanser, pat dry, apply split dressing between skin and disk every day shift (order date 7/14/23, start date 7/15/23).</p> <p>Flush with 10ml water before and after medication/feeding (order date 7/14/23).</p> <p>Maintain head of bed 30 degrees while administering feeding (order date 7/14/23).</p> <p>May cocktail (combine crushed medications in one cup mixed with water for ease of administration) G Tube meds during administration (order date 4/10/24).</p> <p>Jevity 1.5Cal/Fiber Oral Liquid (Nutritional Supplement) - give 45ml via PEG tube 22 hours continuous via pump (order date 2/15/24, start date 2/16/24).</p> <p>Review of Resident #37's care plan revealed no care plan in place addressing her PEG tube.</p> <p>3. Record review of Admission Record for Resident #72 revealed resident was an [AGE] year-old male who was admitted to the facility on [DATE]. The Admission Record documented his diagnoses included Acute kidney failure (kidneys unable to filter waste from blood), retention of urine, and major depression disorder (persistently low and depressed mood).</p> <p>Record review of the quarterly MDS dated [DATE] for Resident #72 indicated Resident #72's BIMS was 15, required extensive assistance by two persons for bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. Resident #72 used an indwelling catheter.</p> <p>Review of the Physician Orders dated 05/26/23 revealed orders:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Foley Catheter 16 French 30 ml bulb to continuous drainage related to obstructive uropathy due to benign prostatic hyperplasia. Foley Catheter Care every shift. Check Foley catheter placement, ensure Foley is secured via Velcro strap to reduce friction/pulling. Foley: change catheter and drainage bag PRN based on clinical indications such as infection, obstruction, when the closed system is compromised, or when physician or nurse practitioner indicates a change was necessary.</p> <p>Review of the comprehensive care plan, dated 1/22/24, revealed Resident #72 had no indwelling catheter care plan in place.</p> <p>4. Review of Resident #79's Admission Record revealed she was an [AGE] year-old female admitted to the facility 12/20/23 with diagnoses which included recurrent major depressive disorder, anxiety disorder, pain, and cognitive communication deficit.</p> <p>Review of Resident #79's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 5 indicating severe cognitive impairment, she required moderate assistance with most ADLs but was able to feed herself, she had weight loss of 5% or more in the last month or 10% or more in the last 6 month not on a physician-prescribed weight-loss regimen.</p> <p>Review Of Resident #79's weight log on 4/10/24 revealed that on 1/11/24 she weighed 164 pounds and on 4/5/24 she weighed 145.4 pounds, indicating a 11.34% decrease in her weight in 85 days.</p> <p>Review of Resident #79's care plan revealed no care plan in place addressing her unplanned weight loss.</p> <p>5. Review of Resident #137's Admission Record revealed she was an [AGE] year-old female originally admitted to the facility 10/26/22 with a most recent admitted [DATE]. Her diagnoses included psychosis, generalized anxiety disorder, and cerebral infarction (stroke).</p> <p>Review of Resident #137's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 indicating she was cognitively intact, she did exhibit behaviors of rejecting care 1-3 days during the look back period, she required moderate to maximum assistance for ADLs, and she was receiving an antipsychotic medication and an antianxiety medication both of which had physician documentation noting that a GDR (gradual dose reduction - tapering of a medication's dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication can be discontinued) was contraindicated.</p> <p>Review of Resident #137's order summary report dated 4/11/24 revealed the following:</p> <p>Bupirone HCL tablet 5mg - give 1 tablet by mouth three times a day for anxiety (start date 7/24/23).</p> <p>Divalproex Sodium 250mg - give 1 tablet by mouth two times a day for bipolar disorder, give 500mg + 250mg = 750mg BID (start date 4/3/24).</p> <p>Divalproex Sodium 500mg - give 1 tablet by mouth two times a day for bipolar disorder, give 500mg + 250mg = 750mg BID (start date 4/3/24).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Quetiapine Fumarate 100mg - give 1 tablet by mouth two times a day for psychosis (start date 10/22/23).</p> <p>Review of Resident #137's care plan revealed no care plan addressing her use of psychotropic medications.</p> <p>During an interview on 04/11/2024 at 10:00 AM the CRC stated that he was responsible for completing MDS and care plans. The CRC stated that care plans were updated quarterly and as needed. The CRC stated as MDS were updated the care plan should have been updated, and the care plan should reflect all changes. The CRC stated that care plans were reviewed by the IDT team, which consisted of the DON, MDS Coordinator, Social Worker, Activity Director and Dietary and that he attends morning meetings so that he can be made aware of all changes to resident's care. The CRC stated that he updated the MDS for Resident #33 and Resident #72 but failed to update the care plan.</p> <p>During an interview on 4/11/24 at 12:00 PM the Administrator stated her expectation was that care plans be complete and accurate. The Administrator stated the CRC was responsible for completing MDS and care plans. The Administrator stated that the DON would assist with monitoring and completion of the care plans.</p> <p>During an interview on 4/11/24 at 3:08 PM the CRC stated that care plans were mostly left to him and there were a lot of residents, so things did get missed. He stated that technically any of the nurses were able to add to the care plans or start a new care plan, but he did not think they did. He stated that the DON did add to them, and she did do audits to make sure everything was on them that needed to be. The CRC stated that staff nurses were supposed to be able to help with care plans and it would be great if they did but he did not know if they were trained to or if it was enforced or if they were trained. He acknowledged that Resident #79's weight loss was not addressed in the care plan and that was a problem that should have been addressed by dietary as well as nursing. The CRC stated that the Dietary Manager was supposed to do the diet/nutrition related care plans, but he was not sure who oversaw delegating that to her. He stated that Resident #137 should have care plans in place for each diagnosis and the medication she was taking for it along with the appropriate interventions regarding her psychotropic medications. He stated that Resident #37's care plan had not been revised in a very long time and he acknowledged that there was nothing in the care plan addressing the resident's PEG tube.</p> <p>During an interview on 4/11/24 at 4:32 PM the DON stated that she, the social worker, the CRC, and all nurses could create a care plan, but anything could be brought up to anybody to be care planned. She stated that she did care plan audits monthly to make sure things were accurate. The DON stated when she does audits, she picked one area and looked at all residents for that area to audit then picked a different area to audit the next round. The DON stated she (DON) had been doing dietary/nutrition care plans but since the facility hired a dietary supervisor, she had taken over doing them, however she (dietary manager) had only been doing them for about a month and was still learning. She stated that there was an action plan in place for weights per the QAPI (Quality Assessment and Performance Improvement) Committee because of facility wide inconsistencies in weight documentation, but there still should have been a care plan for the weight loss on Resident #79 because she had lost weight. The DON stated she was shocked that Resident #37's PEG tube was not addressed in her care plan and had no explanation why it had been missed. She stated that things like catheters and psychotropic medications should automatically be care planned without question.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility policy titled, Comprehensive Care Plan, dated 04/25/2021 revealed in part: Every resident will have an individualized interdisciplinary plan of care in place.</p> <p>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.</p> <p>45411</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>30057</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and that the resident environment remained as free of accident hazards as possible for all of the residents in the facility's 3 secured units (Hall C, E and F) reviewed for accidents and supervision.</p> <p>The facility failed to ensure the secure units exit doors at the end of each hall had alarms to indicate and alert staff that the residents were going outside to the secure unit patios on 04/09/24 through 04/11/24.</p> <p>This failure placed residents at risk of injury due to not being supervised and placed at risk of accidents/hazards.</p> <p>Findings included:</p> <p>During observations from 04/09/24 through 04/11/24 several residents were observed in the men's and women's secure units going in and out to the secure unit patios. Residents were seen sitting down in the chairs provided outside and then seen walking back inside. Staff were seen in the secure units monitoring the residents that were inside but not necessarily the residents that were out in the patios.</p> <p>During an observation on 04/11/24 at 12:04 PM the male secure units exterior doors did not have an alarm to alert staff that residents were going out into the secure unit patio. The exterior door on E hall did not have a latch that would allow the door to close.</p> <p>During an interview on 04/11/24 at 12:05 PM CNA G said she would monitor the residents in the secure units by sitting in the unit and doing rounds. CNA G said she would check on the residents that went outside by going outside with them. CNA G said the exit door did not have an alarm to alert them someone had gone outside to the patio so they would go outside and look around for them. CNA G said as far as she knew no residents had gotten hurt while going out in the secure unit patio since she had been working at the facility which was about 6 months.</p> <p>During an interview on 04/11/24 at 12:07 PM CNA C said she would monitor the residents that went out into the male and female secure unit patios by looking out into the patio whenever she worked in the units. CNA C said she did not know of the exit doors ever having alarms to alert staff that residents were going out to the patio. CNA C said the residents would come and go outside as they pleased.</p> <p>During an interview on 04/11/24 at 12:09 PM CNA D said he had worked the female and male secure units and never noticed the exit doors that led to the outside secure patio had alarms. CNA D said the way he would keep an eye on the residents that went out into the patio was to go and physically look outside for them. CNA D said the residents would come and go out the door throughout the day as they enjoyed going outside.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/11/24 at 12:12 PM CNA E said she worked the men's and women's secure units and had never noticed the exit doors that led to the secure unit patio having door alarms since she had been working here which was about 6 months. CNA E said the way she would lookout for the residents was to go and look outside in the patio every now and then. CNA E said she had not noticed any residents falling outside. CNA E said she would stay outside with the residents when they went out to smoke but then would come back inside after they were done smoking.</p> <p>During an interview on 04/11/24 at 12:14 PM CNA F said she would monitor the residents in the patio by looking out the windows or going outside to check on them. CNA F said since she had been here none of the residents had fallen outside as far as she knew. CNA F said the exit doors did not have alarms since she had been here which was about 4 months. CNA F said the residents would go in and out as they pleased as most were ambulatory.</p> <p>During an interview on 04/11/24 at 12:20 PM the Maintenance Supervisor said he had not seen any alarms in the secure unit since he had been working at the facility which was almost 2 years now. The Maintenance Supervisor said he was not aware the secure unit doors required alarms.</p> <p>During an interview on 04/11/24 at 12:24 PM the Administrator said the residents that went out in the secure unit patios were supposed to be monitored by the staff. The Administrator said if the residents were not monitored, they could fall and not be seen by staff unless the staff went and looked outside. The Administrator said she was aware the doors did not have alarms but did not think about the doors having alarms as the residents were going out to a secure patio.</p> <p>During exit on 04/11/2024 the facility did not provide or have a specific policy regarding secured doors in the secure unit.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>30057</p> <p>Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that ensure the accurate administering of all drugs to meet the needs of the residents, for 1 of 4 medication carts reviewed for pharmacy services, in that: .</p> <p>The medication cart used for halls A, B and C had two insulin pens dated (03/06/24) that had expired as indicated by the manufacturer's recommendations since they were only good for 28 days after being opened.</p> <p>This failure could place residents at risk of receiving medications that were expired and not produce the desired effect.</p> <p>The findings included:</p> <p>During an interview and observation on 04/09/24 at 11:28 AM the medication cart for halls A, B and C was inspected with LVN A present. Inside the cart was 1 insulin pen with an open date of 3-6-24 and another one dated 3-6-24. Both pens indicated to dispose after 28 days according to manufacturer recommendations. The LVN said she had not noticed the pens had already expired or else she would have replaced them.</p> <p>During an interview on 04/09/24 at 11:32 AM the ADON said it was each nurses responsibility to check the insulin pens and disposed of them if they were expired. The ADON said if an expired insulin was administrated it could lead to the medication not being as effective.</p> <p>During an interview on 04/11/24 at 05:08 PM the Administrator said it was her expectation for the nurses to check their medication carts and dispose of any expired medications. The Administrator said there was no one specific assigned to check the carts for expired medications. The Administrator said the failure occurred because staff did not pay attention to the date on the insulin pens.</p> <p>Record review of the facility's policy, dated August 2020, titled, Administration procedures for all medications indicated in part: Medications will be administered in a safe and effective manner. The guidelines in this policy apply to all medications.</p> <p>Record review of the insulin undated manufacturer instructions indicated in part: Opened pens and vials that have been kept at room temperature or refrigerated will last for 28 days.</p>		

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

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>30057</p> <p>Based on observation, interview and record review , the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys, for one medication carts (the medication cart for halls A, B and C) of four medication carts reviewed for drug storage.</p> <p>The facility failed to ensure medication carts were left unlocked and unsupervised on 04/09/24.</p> <p>These failures could place clients at risk for drug diversion or accidental ingestion.</p> <p>The findings included:</p> <p>During an observation on 04/09/24 at 11:24 AM the medication cart used for halls A, B and C was noted to be unlocked, unattended and unsupervised by staff.</p> <p>During an interview and observation on 04/09/24 at 11:28 AM LVN A said if the cart was left unlocked and unattended it could lead to unauthorized people having access to it or any residents getting into it. The LVN said she stepped away and forgot to lock it. The cart was inspected with LVN A present and several over the counter and prescription medications were located in the cart.</p> <p>During an interview on 04/09/24 at 11:33 AM the ADON said it was each nurses responsibility to make sure their carts were locked if they were not using or stepped away. The ADON said the nurse probably got distracted and forgot to lock it when she stepped away. The ADON said she would have a serious talk with the nurse that left it unlocked.</p> <p>During an interview on 04/11/24 at 05:06 PM the Administrator said it was her expectation for the medication carts to be locked if the facility staff was not present at the cart. The Administrator was made aware of the unlocked, unattended medication cart observation. The Administrator said if the cart was left unlocked and unattended then unauthorized people could get into the cart. The Administrator said the failure probably occurred because the nurse walked away from the cart and forgot to lock it.</p> <p>Record review of the facility's policy, dated August 2020, titled, Administration procedures for all medications indicated in part: Nursing policies developed by the facility may supersede the procedures outlined in this policy. Security all medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/aide.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45399</p> <p>Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen.</p> <p>The facility failed to:</p> <p>Provide a clean kitchen.</p> <p>Ensure food items in the freezer were labeled and dated.</p> <p>Ensure food items in dry pantry were sealed appropriately.</p> <p>This deficient practice could affect residents who receive meals prepared from the kitchen and served by facility staff at risk for food borne illness and cross contamination.</p> <p>Findings included:</p> <p>Observation and interviews on 04/09/24 between 9:00 a.m. and 10:30 a.m. findings revealed:</p> <p>Water was pooled in front of the three-compartment sink.</p> <p>Walk through of dry pantry showed 1-12-ounce bag of dry gravy, opened and spilling on floor.</p> <p>Brown grime up along the walls and under the storage shelves.</p> <p>Buildup of grime on equipment.</p> <p>Stainless steel freezer doors and handles, rolling carts, and kitchen floors were visibly dirty.</p> <p>The wall behind the dishwasher was covered in black grime.</p> <p>The freezer had 2 opened, unlabeled, undated 32-ounce bags of frozen white nuggets.</p> <p>Interview on 4/09/24 at 10:50 AM the DM stated that the kitchen was a work in progress, she stated that she has been manager for a short time and was trying to clean up the kitchen. She stated that she was retraining staff to keep everything clean, but some staff do not do their assigned tasks. She agreed the kitchen was not up to cleanliness standards for a kitchen. DM stated that staff was responsible for cleaning the kitchen and that it was ultimately her responsibility to ensure it was done. There was grime on everything, and it was on my list of things to do. The black grime behind the dishwasher would not come off after scraping, so the Administrator was informed.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 04/11/24 at 11:00 AM with the Administrator stated that she was aware of the grime in the kitchen, she was aware staff attempted to scrape it off the wall unsuccessfully. Administrator stated that she was currently working on replacing the wall completely.</p> <p>Review of Kitchen Cleaning schedule policy dated 11/2023 revealed: Food and nutrition services personnel will be responsible for maintaining the cleanliness and sanitation of the kitchen. The director of Food and nutrition services stated it was her responsibility for utilizing the kitchen cleaning schedule and assigning tasks on a daily, monthly, and annual basis. DM stated it was her responsibility of the employee to follow the cleaning schedule.</p> <p>Review of a blank, undated Weekly Kitchen Schedule revealed: base boards, refrigerator, freezer, walls, and dry storage was to be cleaned daily.</p> <p>Review of the facility's policy and procedure on Food Safety in Receiving and Storage, revised 12/2023, revealed in part,</p> <p>Foods will be received and stored by methods to minimize contamination and bacterial growth. Foods will be stored in its original packaging if the packaging is clean, dry, intact. Foods may remain in the shipped box, any food removed from the shipped box must be labeled and dated. Storeroom floors will be swept and mopped daily.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>45411</p> <p>Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 1 facility reviewed for environment.</p> <p>The facility failed to ensure that wastewater was not discharged on to the ground outside the main entrance into the parking lot on 04/09/24 and 04/10/24.</p> <p>This failure could place the residents, staff, and the public in danger of contracting illness and disease from vector borne transmission of infectious bacteria and viruses.</p> <p>Findings included:</p> <p>Observations on 04/09/24, at 2:30 pm and again on 04/10/24, at 9:30 am revealed the main entrance parking lot had grey colored water streaming from a drain clean out located at the end of A Hall. There was pile of soiled toilet tissue next to the drain clean out. The stream of grey water ran from clean out location to end parking lot, pooling in areas next to exit on A hall.</p> <p>Observation on 04/10/24 at 8:30 am revealed the Maintenance Director outside the building at the end of A Hall with a shovel filling in a hole at the foundation of the building where the drain clean out was located. During this observation the ground was noted to be wet but there was no grey water pooling observed. There was still grey water pooled in the parking lot from the previous day.</p> <p>Observation 04/10/24 at 12:38 pm revealed grey water pooling and flowing from drain clean out location at foundation of building next to door at the end of A Hall. Soiled toilet paper and grey water coming from the clean out were observed flowing into parking lot and to west side of building into the field to the south of the facility. Large accumulation of grey water was noted at west end of the parking lot.</p> <p>In an interview with the Regional Maintenance Director on 04/10/24, at 9:30 a.m. he said the facility maintenance director was responsible for building and grounds maintenance. He said it was wastewater drainage, which included bodily solids, bodily waste, and paper solids on the ground around the drain clean out and streaming down the parking lot. He said he was not aware of the problem since he had just become the regional maintenance director on 04/10/2024. He stated he was aware the facility had plumbing issues due to the age of the building but wasn't aware that there was an active sewage leak. He agreed the presence of the wastewater on the ground from the drain clean out was a hazard to the residents, could cause sickness and could contaminate the ground water.</p> <p>In an interview with the Administrator-1 on 04/10/24, at 10:30 a.m. she said she was not aware of the problem with drain clean out off A hall but had been attempting to get plumbers to come and make repairs to the facilities aging plumbing system.</p> <p>Record review of Infection Control Policy dated 10/25/2022 revealed, in part:</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.2. The objectives of our infection control policies and practices are to .c. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the public.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>45411</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for one of one facility reviewed.</p> <p>The facility failed to ensure the facility was free of rodents.</p> <p>This failure could place the residents at risk of unsanitary and unsafe conditions.</p> <p>Findings included:</p> <p>During a confidential group interview on 4/10/24 at 11:48 am with nine residents, it was stated that the facility changed to a new pest control company in February 2024. All nine residents agreed that the new company had done very well in getting rid of the bugs in the facility but there was still a problem with mice. All residents present for the meeting agreed that the facility continued to have a problem with mice and two of the residents stated that they each have a pet mouse that they have named in their room (they did not live in the same room) that would get on their beds and let them feed them from their hand and pet them. All residents present denied any injuries - bites, scratches - from any rodents in the facility.</p> <p>During observation on 4/10/24 at 12:10 pm of a supply closet on E Hall (not inside the locked unit), a dead rat was observed in the air vent above the shelving holding medical supplies such as briefs, wipes, gloves, and hand sanitizer.</p> <p>In an interview on 4/10/24 at 12:14 pm the Regional Maintenance Director stated it was his first day of work for the facility. He stated he was not aware of the dead rat prior to finding it.</p> <p>In an interview on 4/11/24 at 1:45 pm the Administrator stated she did not know about the dead rat in the vent but was aware there was an issue with rodents in the building. She stated that in February of 2024 the facility had changed pest control vendors due to issues with the previous vendor only treating for insects. She stated that the new vendor treated the facility once a week for rodents specifically in addition to insects.</p> <p>In a joint interview on 4/11/24 at 5:10 PM with the DON and the Administrator, the DON stated there had been an issue with some of the residents feeding the mice and treating them like pets so getting rid of the mice had been difficult. She stated that several of the residents would allow the mice on their beds and feed them crackers or cookies or intentionally leave food out in their rooms to lure the mice in. The Administrator stated that the new pest control company had helped to reduce the number of rodents, but they just started using them two months ago and there were still some issues. Both the Administrator and the DON stated they had spoken to residents numerous times in groups and individually about not feeding the mice because they were not pets and posed serious health risks.</p> <p>Record review of Infection Control Policy dated 10/25/2022 revealed, in part:</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>.2. The objectives of our infection control policies and practices are to .c. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the public.</p>		