STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676116	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Westwood	8702 Course Drive Houston, TX 77099

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0690 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 observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #1) reviewed for incontinent care. The facility failed to ensure Resident #1's supra pubic Foley catheter was placed below the bladder during wound care by LVN A and CNA A.These failures could place residents at risk for pain, infection, injury, and hospitalization.Findings include:Record review of Resident #1's face sheet reflected, the date of admission was 11/20/21 and was readmitted on [DATE]. Resident #1 had diagnoses which included history of recurrent, mild, neuromuscular dysfunction of bladder, (the nerves controlling your bladder are damaged and can no longer coordinate properly with the bladder muscles), constipation (bowel movements that are infrequent, hard, dry or difficult to pass), bacterial infection, unspecified, cognitive communication deficit, , need for assistance with personal care.Record review of Resident #1's quarterly MDS assessment, dated 10/20/2025, Section C (Cognitive Patterns) reflected a BIMS score was 04 which indicated resident was severely impaired cognitively. Section H (Bladder and Bowel) reflected the resident had an indwelling catheter. Resident #1's functional status revealed he was dependent with supervision of staff with bed mobility, transfer, and toilet use. Further review revealed Resident #1 had a supra pubic Foley catheter. Record Review of Resident's #1's care plan dated 9/28/2025 reflected I have ADL self-care performance deficit and totally dependent on staff for all ADLs and requires assistance with activities of daily living due to decreased physical and functional mobility secondary to weakness and multiple medical comorbidities.I will remain clean, dry, without odor and comfortable every shift on a daily basis, with all needs to be anticipated and met by staff through the next 90 days. Record review of Resident #1's physician order, dated 10/27/2025, read in part .check supra pubic Foley catheter every shift and keep catheter from kinks and drainage bag lower than bladder at all times. Observation of Resident #1 on 11/5/25 at 11:55 AM, CNA A and another staff transferred Resident #1 on the shower bed via Hoyer lift to his bed . CNA A placed Resident #1's supra pubic Foley catheter on the bed with 40cc of urine and some urine along the catheter tubing. At 11:59 AM, LVN A came in Resident #1's room to perform Resident #1's pressure ulcer treatment to sacral, ischium, bottom and upper back, Resident #1's supra pubic remained on the bed during treatment. Interview with LVN A on 11/05/25 at 12:25PM, about the suprapubic F/C left on Resident #1's bed during pressure ulcer treatment, LVN A said she did not realized that the F/C bag was not hung at the bedside. LVN A said the F/C should be hung below Resident #1's bladder to prevent back flow of urine to bladder. Interview with CNA A on 11/05/25 at 1:41PM, regarding F/C left on the bed during pressure ulcer treatment, CNA A said he forgot, he was nervous and knew the F/C should be below the bladder to prevent urine flowing back in the bladder, which could cause a UTI. CNA A said he had in-service on Foley catheter care. Interview with the DON on 11/5/25 at 5:22 PM, she said the F/C should be hung below Resident #1's bladder and this is to prevent back flow of urine to bladder which could result in Resident #1 acquiring a UTI. The DON said she would be monitoring the CNAs randomly now. The DON said she does have monthly in -services on F/C and incontinent care. Record review of the facility's policy for Catheters and Care: Indwelling, straight, supra-pubic, and External Urinary, revised date of 4/2021 reflected: RN/LVN to insert catheter using following procedure.6. Secure urinary drainage bag below the level of the bladder and keep off the floor. Coil extra tubing and secure.

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review 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 of 2 residents (Resident #1) reviewed for infection control. The facility failed to ensure LVN A used the required PPE for Resident #1, who was on enhanced barrier precautions while performing pressure ulcer treatment on 11/5/25. These failures could place residents at risk of cross-contamination and development of infection.Finding include:Record review of Resident #1's face sheet reflected, the date of admission was 11/20/21 and was readmitted on [DATE]. Resident #1 had diagnoses which included history of neuromuscular dysfunction of bladder, (the nerves controlling your bladder are damaged and can no longer coordinate properly with the bladder muscles), constipation (bowel movements that are infrequent, hard ,dry or difficult to pass), , orthostatic hypotension (sudden drop blood pressure), bacterial infection, unspecified, cognitive communication deficit need for assistance with personal care.Record review of Resident #1's quarterly MDS assessment, dated 10/20/2025, Section C (Cognitive Patterns) reflected BIMS score was 04 which indicated severely impaired cognitively. Section H (Bladder and Bowel) reflected the resident had an indwelling catheter. Resident #1's functional status revealed he was dependent with supervision of staff with bed mobility, transfer, and toilet use. Further review revealed Resident #1 had a supra pubic Foley catheter. Record Review of Resident's #1's care plan dated 9/28/2025 reflected I have ADL self-care performance deficit and totally dependent on staff for all ADLs and requires assistance with activities of daily living due to decreased physical and functional mobility secondary to weakness and multiple medical comorbidities.I will remain clean, dry, without odor and comfortable every shift on a daily basis, with all needs to be anticipated and met by staff through the next 90 days.Observation on 11/5/25 at 11:59 AM, revealed Resident #1 lying in bed, a EBP sign was posted inside the room. LVN A entered Resident #1's room without donning PPE and performed pressure ulcer treatment to Resident #1. Interview with the LVN A on 11/5/25 at 12:30 PM revealed she forgot to don PPE. LVN A said she realized she should have donned PPE to protect the resident and herself for infection. She knew not donning PPE could cause infection. LVN A said she would be more careful. In an interview with the DON on 11/5/25 at 5:15 PM, she stated any resident who had wounds, contact isolation, Gastrostomy tube feeding, or Foley catheter was placed on Enhanced Barrier precautions to help reduce the spread of MDRO's. She stated signage was posted inside the head of Resident #1's bed, which explained what PPE was to be worn and for what task the PPE was to be worn for. She stated any contact with a resident with pressure ulcer required the use of gown and gloves. She stated the staff received training on the use of Enhanced Barrier Precautions. Record review of the facility's policy revised, 04/01/2024, on Enhanced Barrier Precautions, reflected the following: Policy Statement: Enhanced barrier precautions (EBPs) are a CDC guidance to reduce the transmission of multi-drug resistant organisms (MDRO) in health care 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.Record review of CDC guidelines reflected: https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html: Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning Personal protective equipment upon room entry and properly discarding before exiting the patient room is done to contain pathogens.