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	03/14/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48923 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet a resident medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment that described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 residents (Resident #49) reviewed for care plans. The facility failed to ensure Resident #49's Dementia and Hypertension diagnoses and medications were addressed in her comprehensive care plan. This failure could place residents at risk of not receiving appropriate care. The findings included: Record review of Resident #49's face sheet last captured 03/14/2025 reflected Resident #49 was a [AGE] year-old female originally admitted on [DATE] and readmitted [DATE]. Her medical diagnoses included Dementia (group of thinking and social symptoms that interferes with daily functioning) and Essential Hypertension (high blood pressure). Record review of Resident #49's quarterly MDS assessment, dated 02/10/25, revealed a BIMS score of 05 indicating severely impaired cognition. She was totally dependent on staff for all efforts for ADLs including eating, oral hygiene, toileting, showering or bathing self, dressing and personal hygiene. Further review revealed Resident #49 needed extensive assistance with ADL care with two staff assistance and the resident was incontinent of bowel and continent of bladder with indwelling Foley Catheter. Record review of Resident #49's care plan dated 2/10/25 revealed the resident had ADL (activity of daily living) self-care performance deficit related to limited impairment to upper and lower extremities with interventions including resident needed extensive assist with two-person assistance with incontinent care. and totally dependent on staff for all efforts for ADLs including eating, oral hygiene, toileting, showering or bathing self, dressing and personal hygiene . Record review of Resident #49's order summary, dated 3/1/25, revealed Physician Orders which included the following: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Catapres TTS-3 Patch Weekly 0.3 MG/24Hr (Clonidine Hcl) Apply 1 patch trans dermally one time a day every Tuesday for with an order date of 12/26/2024 and a start date of 12/31/2024 - Hydrochlorothiazide oral tablet 25mg, Give 25mg via peg-tube (a tube that is passed through the abdominal wall to the stomach for delivering nutrition or medication) one time a day for HTN with order date 12/26/24. - Lisinopril tablet 20 mg, Give 2 tablet via G-tube one time a day for HTN hold for SBP < 110, HR less than 60. Record review of Resident #49's Comprehensive Care Plan initiated 2/20/2024 revealed there were no focus areas addressing the resident's diagnoses of Dementia and Hypertension and no focus areas which indicated her medications including Catapres hypertension patch, hydrochlorothiazide and Lisinopril. In an interview with LVN-MDS D on 03/13/25 at 2:47 PM, LVN-MDS D said she had been working as the MDS nurse for 3 years, and she completed care plans. MDS D said that Resident #49's Comprehensive Care Plan did not address their diagnoses of HTN and Dementia, and did not address their active orders for hypertension medications, but it should have . LVN MDS-D stated these diagnoses and medications were ordered/documented prior to her Care Plan being completed, so should have been included on her Comprehensive Care Plan. LVN MDS-D stated these diagnoses and medications should automatically trigger a Care Area Assessment (CAA) area and she did not know why they were not triggered or why they were missed. LVN MDS-D stated she was responsible for the quarterly and annual assessments of the Comprehensive Care Plan. LVN MDS-D further stated it was important for these diagnoses and medications to be addressed in the Care Plan, so staff had the information needed to meet the resident's specific care needs. Interview with the DON, on 03/13/2025 at 5:05 p.m. revealed the Comprehensive Care Plans needed to address and include all of the residents' nursing, mental and psychosocial needs, and contain the interventions and services the resident would need to meet these needs. The DON said she would be assessing and in-servicing staff to ensure the resident needs were being met to include completion of assessments and Care Plans. Record review of the facility's policy dated 1/20/2021, titled Comprehensive Care Planning, revealed .The interdisciplinary team will continue to develop the plan in conjunction with the RAI (MDS3.0) and CAAS, completing and conducting comprehensive Care Plan Meeting and Reviews by day 21 after admission. The Care Plan is revised every quarter, significant change of condition, annual or as the resident condition changes on an individualized basis. The Care Plan process is an ongoing review process: Procedure: 3. The comprehensive care plan is developed within 21 days of admission .5. The interdisciplinary team will review the healthcare practitioner's notes and orders (e.g., dietary needs, medications, routine treatments) and implement a Comprehensive Care Plan to meet the residents' immediate care needs including but not limited to: a. Initial goals based on an admission include GG section discharge goals. b. Physician orders. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. Specific Care plan on the main reason for Admission to the community, i.e.: Dementia

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and treatment consistent with professional standards of practice to prevent pressure ulcers for one (Resident #49) of eight residents reviewed for pressure ulcers. 1. The facility failed to ensure Resident #49 was repositioned every two hours as indicated in Resident #49's physician orders on 3/11/2025 at 1:24 p.m. and 3/12/2025 at 11:49 a.m. 2. The facility failed to ensure Resident #49 was repositioned every frequently and as necessary as indicated in Resident #49's care plan. These failures could place residents at risk for worsening pressure ulcers, new pressure ulcers, or infection. Findings included: Record review of Resident #49's face sheet dated 03/12/2025 reflected Resident #49 was a [AGE] year-old female originally admitted on [DATE] and readmitted [DATE]. Her medical diagnoses included compression of brain (commonly occurring as a traumatic brain injury where the brain tissue is acutely or chronically compressed), other speech and language deficits, cognitive communication deficit, Type 2 Diabetes Mellitus (high glucose in the blood), Post-Traumatic Hydrocephalus (PTH is a condition where there is a buildup of excess fluid in the brain after a traumatic brain injury, potentially causing increased pressure and brain damage), Dementia (group of thinking and social symptoms that interferes with daily functioning), gastrostomy status (tube inserted through the belly that brings nutrition directly to the stomach), dysphagia (swallowing difficulties), hemiplegia and hemiparesis (a condition that causes partial or total paralysis of one side of the body), following cerebral infarction affecting left non-dominant side cerebral infarction (a medical condition where blood flow to the brain is disrupted, causing brain tissue to die due to a lack of oxygen and nutrients), Essential Hypertension (high blood pressure) and neuromuscular dysfunction of bladder with indwelling Foley catheter. Record review of Resident #49's quarterly MDS assessment, dated 02/10/25, revealed a BIMS score of 05 indicating severely impaired cognition. Further review revealed Resident #49 needed extensive assistance with ADL care with one staff assistance. Section GG of Resident #49's MDS indicated Resident #49 was dependent (required assistance and was unable to help with activities) with all ADLs and was unable to roll to the left or right. Section M of Resident #49's MDS assessment indicated Resident #49 was at risk for developing pressure ulcers. Record review of Resident #49's care plan with a revision date of 02/10/2025 revealed Resident #49 had the potential to develop pressure ulcers and interventions included to reposition the resident frequently or more often as needed. Record review of Resident #49's weekly wound evaluation and summary report dated 3/6/2025 revealed Resident #49 had no wound on her sacrum (area at the base of the spine). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #49's skin assessment progress notes dated 3/13/25 reflected open to sacral and coccyx measurement was 5cm (Length) x 0.3cm (width). Record review of Resident #49's physician order dated 3/01/2025 revealed Resident #49 should be repositioned every two hours . In an observation on 3/11/2025 at 9:39 a.m., Resident #49 was observed lying flat on her back with one pillow under her head. No other pillows or wedges (foam wedge used for positioning) were observed in Resident #49's room. Resident #49 was unable to answer questions appropriately. In an observation on 3/11/2025 at 10:46 a.m., Resident #49 was observed lying flat on her back with one pillow under her head. No other pillows or wedges (foam wedge used for positioning) were observed in Resident #49's room. Resident #49 was unable to answer questions appropriately. In an observation on 3/11/2025 at 1:24 p.m., Resident #49 was observed in the same position on her back with one pillow under her head. No other pillows or wedges were observed in Resident #49's room. In an observation on 3/11/2025 at 4:45 p.m., Resident #49 was observed lying flat on her back with one pillow under her head. No other pillows or wedges (foam wedge used for positioning) were observed in Resident #49's room. Resident #49 was unable to answer questions appropriately. In an observation on 3/12/2025 at 9:35 a.m., Resident #49 was observed in the same position on her back with one pillow under her head. No other pillows or wedges were observed in Resident #49's room. In an observation on 3/12/2025 at 11:49 a.m., Resident #49 was observed in the same position on her back with one pillow under her head. No other pillows or wedges were observed in Resident #49's room. In an observation of incontinent and Foley catheter care on 03/12/25 at 1:30 PM with CNA H, Resident #49 was lying in bed on her back. While cleaning in-between Resident #49's buttocks with the wet wipes. Resident #49 was grimacing and said ouch, ouch. CNA H then applied Zinc Oxide 20 % cream, a skin protectant. In an observation on 3/12/2025 at 3:00 p.m., Resident #49 was observed in the same position on her back with one pillow under her head. No other pillows or wedges were observed in Resident #49's room. In an interview with C.NA H on 3/12/25 at 3:05PM regarding turning and repositioning Resident #49, CNA H said pressure sores were prevented by rotating or turning the resident every two hours. CNA H stated some residents had extra pillows, and some residents had wedges to use for turning. CNA H stated that if a resident was not turned then sores could develop. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/12/25 at 6:23 PM of a skin assessment with Wound Care Nurse revealed Resident #49 was lying on her back in bed. LVN repositioned Resident #49 to her left side and used the wet wipes to clean in-between the buttocks, where the sacral (bone or region at base of spine)and coccyx (tailbone) met, with resident grimacing and hitting the bed. Resident #49 had an open area between sacral and coccyx area about 5cm (length) by 0.2cm (wide) and the Wound Care Nurse was asked to measure the open area. She said the wound doctor does the wound measuring. In an interview with the Wound Care Nurse on 3/12/25 at 6:35 PM, she said she was not aware that Resident #49 had an open area in-between her buttocks and she was going to call the doctor and resident's responsible party to notify them. In an interview on 3/13/2025 at 10:10 a.m., the Wound Care Nurse reported if a resident was bedridden then they were repositioned every one to two hours. The Wound Care Nurse reported they used pillows to help reposition residents, and the nurse was responsible for ensuring residents were repositioned. The Wound Care Nurse stated if residents were not repositioned then it could cause skin breakdown (wounds). The Wound Care Nurse stated Resident #49 was on an air mattress and stated Resident #49 was repositioned every one to two hours . In an interview on 3/13/2025 at 11:55 a.m., the DON reported that dependent (requires assistance) residents should be turned every one and a half to two hours and more frequently if they were in pain. The DON stated pillows or wedges were used for repositioning the residents. The DON reported Resident #49 should still be repositioned every one to two hours. Record review of facility's policy titled, Skin Management Policy, with a revision date of 2/01/2014, revealed If new skin alterations of any type are identified .physician orders are obtained. The patient is reviewed by the interdisciplinary team and a plan of care is initiated. A policy specific to repositioning residents for pressure ulcer prevention was not received at the time of exit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 3 residents (Resident #45) reviewed for incontinent care. The facility failed to ensure CNA O did not place the foley catheter bag on Resident #45's bed during wound care. This failure could place residents at risk for pain, infection, injury, and hospitalization . Findings included: Record review of Resident #45's sheet dated 03/14/25 revealed a [AGE] year-old female was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #45 had diagnoses which included: hypertension (force of blood pushing against artery walls consistently too high pressure), respiratory failure (a serious condition that makes it difficult for a person to breathe without help) and pressure ulcer of right hip (injuries to the skin and the tissue below the skin that are due to pressure on the skin). Record review of Resident #45's Quarterly MDS assessment dated [DATE] revealed Resident had memory problem which indicated severely impaired cognition. Resident #45 was dependent on staff for all ADLs with two staff assistance. Further review revealed the resident was incontinent of bowel and she had an indwelling catheter. Record review of Resident # 45's care plan revised on 04/04/24 revealed Resident #45 had an Indwelling Catheter for dx: neurogenic bladder (lacks bladder control due to brain, spinal cord or nerve problem) and multiple pressure ulcers. Interventions: staff to ensure to position catheter bag and tubing below the level of the bladder and with a privacy bag. Record review of Resident #45's order summary report for March 2025 read in part . urinary catheter 20 FR(measurement for the size of catheter), 30CC . diagnosis: neuromuscular dysfunction of bladder: ordered date 02/27/24 . During an observation on 03/12/25 at 9:45 a.m., Resident #45's wound care treatment was provided by the Wound care nurse and CNA O. CNA O placed Resident #45's foley catheter bag on the bed at the same level of the resident's bladder from 9:45 a.m. to 10:00 a.m. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/25 at 10:18 a.m., the Wound care nurse said they typically put the Foley bag on Resident #45's bed so the Foley would not pull out when they turned the resident. The Wound care nurse said since the Foley was on the same level as Resident #45's, bladder and urine would back up, the resident could get an infection. The Wound care nurse said the charge nurse on the floor monitored the aides during rounding. The Wound care nurse said she had in-service and skills check-off training on how to work with a resident with a Foley, and she said she could not recall what was taught during the training. The Wound care nurse said the ADON and DON monitored the nurses during random rounding. During an interview on 03/12/25 at 10:59 a.m., CNA O said she placed Resident #45's Foley bag on the bed because they were about to turn the resident to the right for wound care. CNA O said Resident #45's Foley bag was at the same level as the bladder, and the urine would back up to the resident's bladder. CNA O said she had training on Foley care and was educated to place the Foley bag on the side of the bed, to which the resident would be turned, and hang the Foley bag below the bladder. CNA O said when the urine flows back into Resident #45, it could cause an infection for the resident. She said the charge nurse monitored the aides during rounding. During an interview on 03/12/25 at 1:22 p.m., the DON said Resident #45's foley bag should always be placed below Resident #45's bladder when CNA O turned her or during care so the urine would flow through gravity. The DON said if Resident #45's Foley bag was placed on the bed, which was the same level as the bladder, the urine could flow back and could cause a UTI for Resident #45. She said the Wound care nurse and CNA O had training on Foley care, and the bag should be below the bladder. The DON said the nurse monitors the aides during rounding, and the ADON and DON monitor the nurses during random rounding. Record review of the facility policy indwelling catheter dated 04/20/21 read in part . it is the policy of this community that the resident with a urinary catheter will be provided services in a safe and appropriate manner to minimize the risk of urinary tract complications . procedure indwelling catheter #6 .secure urinary drainage bag below the level of the bladder .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observation, interview and record review the facility failed to ensure based on a resident's comprehensive assessment, a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 3 (Residents # 32, #37 and #49) of 4 residents reviewed for g-tube medication administration . RN A failed to ensure Resident #32's GT (g-tube, a surgically placed device including a tube that leads from the outside of the body to the stomach to provide nutrition or medication) medications and water were administered by gravity, not by pushing the water via Resident #32's g-tube. RN A failed to ensure Resident #49's GT medications and water were administered by gravity, not by pushing the water via Resident #49's g-tube. LVN A did not check Resident #37's feeding bag for dates on 03/14/2025 during her shift. This failure could place residents at risk of abdominal discomfort, tube dislodgement, and tube occlusion (blockage) and possible infection. Findings include: Record review of Resident #32's Admission Record dated 03/14/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #32's quarterly MDS Assessment, dated 02/25/25, ref lected his diagnoses included cerebral arteriosclerosis (a narrowing of arteries due to fatty buildup and limits supply of blood to the brain), aphasia (language disorder) following cerebral infarction (stroke), gastrostomy status (tube inserted through the belly that brings nutrition directly to the stomach), dysphagia (swallowing difficulties). Resident #32's BIMS score was 00 which indicated severe cognitive impairment. The MDS further reflected Section K - Swallowing/Nutritional Status indicated the resident's nutritional approach was a feeding tube. Record review of Resident #32's care plan, revised date 03/03/25, reflected: Feeding Tube: Resident requires the use of a feeding tube and is at risk for aspirations, weight loss, and dehydration. Goal: Resident will maintain adequate nutritional and hydration status as evidenced by weight being stable, no signs or symptoms of malnutrition, or dehydration through review date. Interventions: Check for tube placement and monitor gastric contents 'residual volume' (amount of liquid drained from a stomach following administration of enteral feed) per facility protocol. Hold tube feedings and notify physician if residual volume is greater than threshold as dictated by the physician. Record review of Resident #32's physician order, dated 03/01/2025, reflected: Enteral Feed Order every shift Check gastric residual volume. Hold feeding and notify physician for residual greater than 150cc. Flush with 30ml of water and reconnect feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #32's physician order, dated 03/01/25, reflected: Enteral Feed Order every shift Flush enteral tube with 30ml water pre/post medication administration and 5-10 ml water between each medication. Observation on 03/12/25 at 9:09 AM revealed RN A stood outside Resident #32's door. She was preparing to provide Resident #32's medications. RN A performed hand hygiene and donned a pair of gloves. RN A disconnected Resident #32 from his g-tube feeding and checked the residual with the syringe. RN A proceeded to flush with 30 cc of water with a syringe by pushing down the plunger on the GT , then administered medications and flushed with water by pushing water through the syringe. RN A connected the resident back to the g-tube and turned-on the feeding pump. Record review of Resident #49's face sheet last captured 03/12/2025 Resident #49 was a [AGE] year-old female originally admitted on [DATE] and readmitted [DATE]. Her medical diagnoses included compression of brain (brain tissue that is acutely or chronically compressed commonly due to traumatic brain injury), other speech and language deficits, cognitive communication deficit, Type 2 Diabetes Mellitus (high glucose in the blood), Post-Traumatic Hydrocephalus, (PTH- is a condition where there is a buildup of excess fluid in the brain after a traumatic brain injury, potentially causing increased pressure and brain damage), Dementia (group of thinking and social symptoms that interferes with daily functioning), gastrostomy status (tube inserted through the belly that brings nutrition directly to the stomach), dysphagia (swallowing difficulties), hemiplegia and hemiparesis (a condition that causes partial or total paralysis of one side of the body), following cerebral infarction affecting left non-dominant side cerebral infarction (a medical condition where blood flow to the brain is disrupted, causing brain tissue to die due to a lack of oxygen and nutrients), Essential Hypertension (high blood pressure) and neuromuscular dysfunction of bladder with indwelling Foley catheter. Record review of Resident #49's quarterly MDS assessment, dated 02/10/25, revealed a BIMS score of 05 indicating severely impaired cognition. She was totally dependent on staff for all efforts for ADLs including eating. Record review of Resident #49's physician order, dated 03/01/2025, reflected: Enteral Feed Order every shift Check gastric residual volume. Hold feeding and notify physician for residual greater than 150cc. Flush with 30ml of water and reconnect feeding tube. Observation on 03/12/25 at 9:09 AM revealed RN A stood outside Resident #49's door. She was preparing to provide Resident #49's medications. RN A performed hand hygiene and donned a pair of gloves. RN A disconnected Resident #49 from his g-tube feeding, checked residual with the syringe, then she proceeded to flush with 30 cc of water with a syringe by pushing down GT plunger. Then she administered medications and flushed with water by pushing water through the syringe. RN A connected the resident back to the g-tube and turned-on the feeding pump. Interview on 03/12/25 at 12:05 PM with RN A, revealed she always checked for placement and residual before giving medications. She stated she was pushing down the water with the syringe. She stated she was pushing but not hard. She stated pushing down water instead of using gravity could cause stoma (opening in the abdomen) problems, or cause pressure or bleeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/13/25 at 5:55 PM with the ADON revealed the expectation when administering medication was nurses should be following the physician order, checking for placement, residual, each medication should be given in separate cups and flush with water in between medications. She stated pushing fluid instead of using gravity could cause discomfort to the resident. Interview on 03/13/25 at 6:07 PM with the DON revealed the expectation when administering medication was nurses should be following the physician order and checking for placement and residual. She stated when administering medication or water it should always be via gravity to prevent aspiration pneumonia. Record review of Resident #37's face sheet reflected she was a [AGE] year-old, she was originally admitted on [DATE] and most recently readmitted on [DATE]. Her medical diagnoses included cerebral infarction (stroke), Parkinson's Disease (movement disorder of the nervous system that worsens over time), hypertension (high blood pressure) , muscle wasting, cognitive communication deficit, and nontraumatic subarachnoid hemorrhage (bleeding in the brain with symptoms including paralysis and impairments of nerve and brain function). Record review of Resident #37's care plan last updated 1/23/25, reflected Resident #37 required tube feeding related to Dysphagia with interventions including checking for tube placement and gastric contents or residual volume per facility protocol and record and providing local care to the g-tube site as ordered. Record review of Resident #37's Physician Orders, reflected she had orders for Jevity feeding 1.5 at 45 ML/HR for 20 hours and turn off from 8:00am to 12:00pm starting 04/24/24. Record review of Resident #37's MAR/TAR for March 2025, reflected LVN A documented turning off Resident #37's feeding machine on 3/14/25 at 8:00am . Observation of Resident #37 and interview on 03/14/2025 at 11:04am with the ADON, revealed the feeding bag had no label. The ADON said that the bag should have a labelled and have been dated and initialed by the nurse, and she would talk to the nurse about it. She said if nurses don't document something you cannot prove that they did it. In an interview with LVN A on 3/14/2025 at 12:01pm, she said she did not change Resident #37's feeding bag but did turn it off per Physician Orders. She said she did not notice there was no label on the bag, but she should have checked it for a label and created a label if the feeding bag did not have one. She said that labelling the feeding bag is important so nurses could identify what the resident is receiving and if they're getting the right rate. The bag could have been there for days, and no one would know it was an old feeding. A risk to residents would be infection or abdominal issues if the feeding was sour. Record review of Enteral Tube Medication Administration Policy # 9.12, Effective Date 09-2018 with Revision Date 08-2020, reflected the policy read in part: Medications will be administered in a safe and effective manner. The guidelines in this policy detail how to administer medication with an enteral tube. Nursing policies developed by the facility may supersede the procedures outlined in this policy. (continued on next page)

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Focused Care at Westwood	8702 Course Drive Houston, TX 77099

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12. With gloves on, check for proper tube placement in accordance with facility policy. 13. Check gastric content for residual feeding. Return residual volumes to the stomach. Report any residual above 100 ml. 14. If a pump is being used for feedings, turn it off. 15. Remove the plunger from the 60 ml syringe and connect the syringe to the clamped tubing using the appropriate port. 16. Administer each medication separately and flush the tubing between each medication. a. Place 15 ml (or the prescribed amount) of water in the syringe and flush the tubing using gravity flow. b. Pour dissolved/diluted medication in the syringe and unclamp tubing, allowing medication to flow by gravity. c. Flush the tube with 15 ml (or the prescribed amount) of water between each medication. Pinch the tubing below the syringe tip when each volume of liquid clears the syringe to avoid excessive air entering the stomach, as this can cause discomfort or emesis. d. Clamp tubing and detach the syringe.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 Based on observations, interviews, and record review the facility failed to ensure pain management was provided to residents who required such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices goals and preferences for 1 of 3 (Resident #49) residents reviewed for pain management. -CNA H failed to stop performing incontinent care while Resident #49 was in pain. -CNA H failed to notify the Wound Care Nurse of Resident #49's pain in a timely manner after incontinent care. These failures could place resident at risk for increased pain causing undue suffering. Findings included: Record review of Resident #49's face sheet, reflected she was a [AGE] year-old female originally admitted on [DATE] and readmitted [DATE]. Her medical diagnoses included compression of brain (brain tissue being acutely or chronically compressed commonly due to a traumatic brain injury), other speech and language deficits, cognitive communication deficit, Type 2 Diabetes Mellitus (high glucose in the blood) Post-Traumatic Hydrocephalus, (PTH- is a condition where there is a buildup of excess fluid in the brain after a traumatic brain injury, potentially causing increased pressure and brain damage), Dementia (group of thinking and social symptoms that interferes with daily functioning), gastrostomy status (tube inserted through the belly that brings nutrition directly to the stomach), dysphagia (swallowing difficulties), hemiplegia and hemiparesis (a condition that causes partial or total paralysis of one side of the body), following cerebral infarction affecting left non-dominant side cerebral infarction (a medical condition where blood flow to the brain is disrupted, causing brain tissue to die due to a lack of oxygen and nutrients), Essential Hypertension (high blood pressure) and neuromuscular dysfunction of bladder with indwelling Foley catheter. Record review of Resident #49's quarterly MDS assessment, dated 02/10/25, revealed a BIMS score of 05 indicating severely impaired cognition. Further review revealed Resident #49 needed extensive assistance with ADL care with one staff assistance. Section GG of Resident #49's MDS indicated Resident #49 was dependent (required assistance and was unable to help with activities) with all ADLs and was unable to roll to the left or right. Section M of Resident #49's MDS assessment indicated Resident #49 was at risk for developing pressure ulcers. Record review of Resident #49's care plan with a revision date of 02/10/2025 revealed Resident #49 had the potential to develop pressure ulcers and interventions included to reposition the resident frequently or more often as needed. Resident #49 was also care-planned for potential pain due to brain injury and stroke, with interventions including assess characteristics of pain, administering pain medications as ordered, discussing with resident regarding factors of pain and what can reduce it, and discuss with physician that for maximum pain to give medications as ordered and as needed. Record review of Resident #49's Physician Orders, she had orders for pain monitoring starting 12/16/2024 and document interventions such as applying heat or cold or re-positioning. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #49's weekly wound evaluation and summary report dated 3/6/2025 revealed Resident #49 had no wound on her sacrum. Record review of Resident #49's MAR dated 3/1/25 through 3/13/25 for monitoring pain every shift (day, evening and night) documented zero every shift, indicating no pain. Record review of Resident #49's skin assessment progress notes dated 3/13/25 reflected an open skin area to the sacral and coccyx bone area measurement was 5cm (Length) x 0.3cm (width). Observation of incontinent and Foley catheter care on 03/12/25 at 1:30 PM with CNA H revealed Resident #49 was lying in bed on her back. CNA H entered Resident #49's room then began cleaning in between Resident #49's buttock with the wet wipes . At the same time CNA H was wiping, Resident #49 was grimacing and said ouch, ouch. CNA H applied Zinc Oxide 20 % cream which was a skin protectant. Resident had an open area between her buttocks measuring about 5 cm. In an interview with CNA H on 3/12/25 at 2:10 PM, she said she had been working with the facility for 1 year and she had an in-services on reporting to her charge nurse when a resident was is in pain. She stated that she failed to notify the Wound Care Nurse of Resident #49's pain in a timely manner. Observation on 3/12/25 at 6:23 PM of a skin assessment with Wound Care Nurse revealed Resident #49 was lying on her back in bed. Resident #49 had a large bowel movement. Wound Care Nurse repositioned Resident #49 to the left side, and used the wet wipes to clean in-between the buttocks, where the sacral and coccyx bones meet. Resident #49 was grimacing and hitting the bed. The Wound Care Nurse did not assess Resident pain level . In an interview with Wound Care Nurse on 3/12/25 at 6:35 PM, she said she was not aware of the open area on Resident #49's buttock and that she was grimacing during incontinent care. The nurse said she did assess Resident #49 afterward, and the resident was still grimacing. When the nurse asked if she was in pain, she said Resident #49 told her she was not in pain but that it burned. The nurse said if someone looks like they're in pain, she will assess and provide pain treatment. If they're in pain during care she said she would stop and ask them. The Wound Care Nurse said she told the doctor about the burning pain, and the resident had a standing order for pain and doctor didn't give anything new. The nurse's expectation for nurses and aides are that they would tell her or nurses on the floor when they find something new. During an interview on 3/12/25 at 6:42 PM the DON said the Wound Care Nurse was supposed to measure the open area and notify the wound doctor and RP of any changes. The DON said she would in-service on notification. In an interview with the DON on 3/13/25 at 12:52 PM she stated CNA H and Wound Care Nurse should have stopped incontinent care when Resident #49 was in pain. The DON stated nurses were instructed to monitor for pain every shift. She stated the negative effects for not monitoring residents' pain would be the pain would be unmanaged.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on interviews and record reviews, the facility failed to ensure that residents were free of significant medication errors for for 1 of 3 (Resident #49) residents reviewed for pharmacy services. The facility failed to ensure Resident #49 was free of significant medication errors when Resident #49 was reviewed for pain management in that: -CNA H failed to stop performing incontinent care while Resident #49 was in pain. -CNA H failed to notify the Wound Care Nurse of Resident #49's pain in a timely manner after incontinent care. These failures could place resident at risk for increased pain causing undue suffering. Findings included: Record review of Resident #49's face sheet, reflected she was a [AGE] year-old female originally admitted on [DATE] and readmitted [DATE]. Her medical diagnoses included compression of brain (brain tissue being acutely or chronically compressed commonly due to a traumatic brain injury), other speech and language deficits, cognitive communication deficit, Type 2 Diabetes Mellitus (high glucose in the blood) Post-Traumatic Hydrocephalus, (PTH- is a condition where there is a buildup of excess fluid in the brain after a traumatic brain injury, potentially causing increased pressure and brain damage), Dementia (group of thinking and social symptoms that interferes with daily functioning), gastrostomy status (tube inserted through the belly that brings nutrition directly to the stomach), dysphagia (swallowing difficulties), hemiplegia and hemiparesis (a condition that causes partial or total paralysis of one side of the body), following cerebral infarction affecting left non-dominant side cerebral infarction (a medical condition where blood flow to the brain is disrupted, causing brain tissue to die due to a lack of oxygen and nutrients), Essential Hypertension (high blood pressure) and neuromuscular dysfunction of bladder with indwelling Foley catheter. Record review of Resident #49's quarterly MDS assessment, dated 02/10/25, revealed a BIMS score of 05 indicating severely impaired cognition. Further review revealed Resident #49 needed extensive assistance with ADL care with one staff assistance. Section GG of Resident #49's MDS indicated Resident #49 was dependent (required assistance and was unable to help with activities) with all ADLs and was unable to roll to the left or right. Section M of Resident #49's MDS assessment indicated Resident #49 was at risk for developing pressure ulcers. Record review of Resident #49's care plan with a revision date of 02/10/2025 revealed Resident #49 had the potential to develop pressure ulcers and interventions included to reposition the resident frequently or more often as needed. Resident #49 was also care-planned for potential pain due to brain injury and stroke, with interventions including assess characteristics of pain, administering pain medications as ordered, discussing with resident regarding factors of pain and what can reduce it, and discuss with physician that for maximum pain to give medications as ordered and as needed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #49's Physician Orders, she had orders for pain monitoring starting 12/16/2024 and document interventions such as applying heat or cold or re-positioning. Record review of Resident #49's weekly wound evaluation and summary report dated 3/6/2025 revealed Resident #49 had no wound on her sacrum. Record review of Resident #49's MAR dated 3/1/25 through 3/13/25 for monitoring pain every shift (day, evening and night) documented zero every shift, indicating no pain. Record review of Resident #49's skin assessment progress notes dated 3/13/25 reflected an open skin area to the sacral and coccyx bone area measurement was 5cm (Length) x 0.3cm (width). Observation of incontinent and Foley catheter care on 03/12/25 at 1:30 PM with CNA H revealed Resident #49 was lying in bed on her back. CNA H entered Resident #49's room then began cleaning in between Resident #49's buttock with the wet wipes . At the same time CNA H was wiping, Resident #49 was grimacing and said ouch, ouch. CNA H applied Zinc Oxide 20 % cream which was a skin protectant. Resident had an open area between her buttocks measuring about 5 cm. In an interview with CNA H on 3/12/25 at 2:10PM, she said she has been working with the facility for 1 year and she had in-services on reporting to her charge nurse when a resident is in pain. Observation on 3/12/25 at 6:23 PM of a skin assessment with Wound Care Nurse revealed Resident #49 was lying on her back in bed. Resident #49 had a large bowel movement. Wound Care Nurse repositioned Resident #49 to the left side, and used the wet wipes to clean in-between the buttocks, where the sacral and coccyx bones meet. Resident #49 was grimacing and hitting the bed. The Wound Care Nurse did not assess Resident pain level . In an interview with Wound Care Nurse on 3/12/25 at 6:35 PM, she said she was not aware of the open area on Resident #49's buttock and that she was grimacing during incontinent care. The nurse said she did assess Resident #49 afterward, and the resident was still grimacing. When the nurse asked if she was in pain, she said Resident #49 told her she was not in pain but that it burned. The nurse said if someone looks like they're in pain, she will assess and provide pain treatment. If they're in pain during care she said she would stop and ask them. The Wound Care Nurse said she told the doctor about the burning pain, and the resident had a standing order for pain and doctor didn't give anything new. The nurse's expectation for nurses and aides are that they would tell her or nurses on the floor when they find something new. During an interview on 3/12/25 at 6:42 PM the DON said the Wound Care Nurse was supposed to measure the open area and notify the wound doctor and RP of any changes. The DON said she would in-service on notification. In an interview with the DON on 3/13/25 at 12:52 PM she stated CNA H and Wound Care Nurse should have stopped incontinent care when Resident #49 was in pain. The DON stated nurses were instructed to monitor for pain every shift. She stated the negative effects for not monitoring residents' pain would be the pain would be unmanaged.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36918 Based on observation, interview, and record review the facility failed to store, prepare, distributed, and serve food in accordance with professional standards for food service safety for the facility's only kitchen, reviewed for food and nutrition services. The facility failed to ensure staff did not store their personal items on the left second shelf of the walk-in cooler, including:. 1. Jumex mango energy drink can. 2. Red bull watermelon drink can 3. Coffee mate coconut liquid creme 32fl oz 4. A black and white with yellow brown flower lunch bag with 2 bottles of water, and one of the bottled water was open. The facility failed to ensure staff did not store three gray crates on the floor by Dishwasher A. These failures could place residents at risk for cross contamination and air-borne illnesses. Findings include: During an observation on 03/11/25 at 8:21 a.m., the following items were on the left second shelf of the walk-in cooler: a Jumex mango energy drink can, a Red Bull watermelon drink can, a Coffee-mate coconut liquid creme 32fl oz, and a black-and-white with yellow-brown flowers lunch bag with two bottles of water, one of which was open. They were staff personal items stored on the left second shelf of the walk-in cooler. During an interview on 03/12/25 at 8:24 a.m., the DM said the items in the cooler belonged to staff and should not be kept in the walk-ing cooler because it was cross-contamination. The DM said he was responsible for monitoring the staff and ensuring that only the items bought by the facility were stored in the walk-ing cooler. He said the kitchen staff had in-service on infection control and storage. During an observation on 03/11/25 at 8:26 a.m., three gray dish crates were on the floor by the dish washer and the three-compartment sink and the floor was wet. Dish washer A picked up the three crates and placed them on top of the clean stacked crates which were stored off the floor. During an observation and interview on 03/11/25 at 8:28 a.m., the DM said he saw the three crates were on the wet floor between the washing machine, and the three-compartment sink. The DM said the dish crates should not have been placed on the floor because of infection (cross - contamination). He said he monitors the staff throughout the shift. The DM stated if clean plates were placed in the dirty crates, the residents could get sick if the residents ate from the plates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/11/25 at 8:49 a.m., Dishwasher A said he placed the three crates on the floor, removed them, and placed them on top of the clean crates. Dishwasher A said he should not have put the crates on the floor because of infection control. Dishwasher A said if a resident ate off any plate that came in contact, the resident could become sick because the germs from the crates could be transferred to the plate. Dishwasher A said he had infection control training and in service, and the dietary manager monitors the kitchen staff throughout the shift. During an interview on 03/11/25 at 3:25 p.m., the Administrator said none of the kitchen equipment, including crates, should be placed on the floor. The crates are not supposed to be picked up and placed on a clean surface because of infection control (cross-contamination). The Administrator said the staff should not place their personal belongings in the walk-in cooler because it would cause cross-contamination. Record review of the facility food receiving and storage dated 2001 MED - PASS, Inc. (Revised October 2017) read in part . foods shall be received and stored in a manner that complies with safe food handing practices . policy interpretation and implementation .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 44669 Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 1 of 1 refrigerator reviewed for food safety. The refrigerator located on the 400 hall contained undated and unlabeled perishable food items. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings include: Observations/Interview on 03/12/2025 at 02:12 p.m. revealed within refrigerator located on hall-400 behind locked code accessed glassed wooden door designated for resident's food brought from the outside contained: 1. Undated bag of plastic containers containing green vegetables and soup. 2. Unlabeled/undated bagged and boxed chicken and other unidentifiable food items. 3. Unlabeled/undated bagged containers of supplement shakes, and protein drinks. 4. Unlabeled/undated clear wrapped cup of sugar. 5. Unlabeled/undated bagged drink container not labeled or dated. 6. Unlabeled/undated bagged oranges not labeled or dated. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant Director of Nursing (ADON) A stated that the food in a brown plastic bag with containers of green vegetables and broth like soup labeled with Resident #74's name and not dated belonged to the Resident #47 whose wife had brought and left the food for the resident today. She stated that the wife had the code to the room and was supposed to inform nursing staff that the 2-bagged items with food were being stored so that the nursing staff could label, date, and ensure that the food sat leveled in the refrigerator. ADON A then pulled out a white paper bag sealed with a fast-food restaurant sticker. Inside contained a box with what appeared to be chicken and other unidentifiable food items. The food box was flimsy, worn and not labeled and not dated. ADON A then pulled at a white plastic bag with slight difficulty as the bag was frozen to back of refrigerator wall. Inside the bag contained 2-meal supplement shakes and 8-protein drinks. The bag nor the drinks were labeled or dated. She stated that possibly the nursing staff had stored the shakes/supplemental drinks there for medication pass usage. She stated that the bag being frozen to the back of the refrigerator indicated to her that the drinks had been in there for some time. On the door of the refrigerator ADON was observed removing a white syrofoam cup wrapped in clear plastic wrap resembling sugar, not labeled, or dated. She stated that the nursing staff probably stored the sugar for a resident. She was then observed removing a brown and black drink container not labeled or dated. She stated that the container probably belonged to a nursing staff. The ADON was than observed removing 3-oranges in a clear bag not labeled or dated. The ADON stated that she was unaware who the oranges belonged to. She stated that she would immediately discard the unlabeled and undated items. She stated that the refrigerator was for the storing of resident food items only. She stated that the nursing staff were responsible for monitoring the refrigerator and ensuring foods were leveled to avoid spillage and had not stayed in there too long. During an interview on 03/12/25 at 3:32 p.m., the Administrator said the facility had an area where the family could store food brought from home, and the family should tell the staff whenever the family brought food from home for residents. The Administrator said when the family notified the nurse, the nurse would date the food with the start date, discard date, and resident information. She said if the food was cooked, the facility kept the food for 24 hours. Record review of policy dated effective: 01/2018 and last revised: 03/2021 Section: Nutritional Management Department: Food & Nutrition Services. Policy: Food from Outside Sources. POLICY Residents may have outside sources of food brought in. The community will ensure that proper steps are taken so that the food remains safe. PROCEDURE 1. Community team members will educate residents and/or family members on food brought in from outside the community on: a. Proper Storage i. Cold items stored in resident refrigerator & discarded appropriately based on labeled dates and/or 3 days after opening to prevent food borne illness ii. Dry goods properly sealed to prevent pests & discarded appropriately based on labeled dates . If residents would like the Food & Nutrition Services Team to store their food item, the following conditions must be met: a. Food is unopened b. Resident Name is labeled on food product c. Receive date added d. Open date is added (once opened)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 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 including hand hygiene procedures to be followed by staff involved in direct resident contact for 1 (Resident #49) of 6 residents reviewed for infection control. -The facility failed to ensure CNA H utilized proper handwashing, infection control procedures , and completely cleaned Resident #49 when she did not open Resident #49's labia to clean or clean her buttocks and CNA H did not sanitize her hands between changing gloves during indwelling foley and incontinent care. - Wound Care Nurse failed to utilize handwashing, infection control procedure and completely clean Resident #49, during skin assessment, indwelling Foley and incontinent care when she did not open Resident #49's labia to clean and did not use sanitizer before donning gloves before providing incontinent care. These failures could affect residents, who were incontinent or had a catheter, and could place them at risk for urinary tract infections, discomfort, skin breakdown, and a decreased quality of life. Findings included: Record review of Resident #49's face sheet last captured 03/12/2025 reflected Resident #49 was a [AGE] year-old female originally admitted on [DATE] and readmitted [DATE]. Her medical diagnoses included compression of brain (brain tissue is acutely or chronically compressed commonly use to traumatic brain injury), other speech and language deficits, cognitive communication deficit, Type 2 Diabetes Mellitus (high glucose in the blood) Post-Traumatic Hydrocephalus, (PTH- is a condition where there is a buildup of excess fluid in the brain after a traumatic brain injury, potentially causing increased pressure and brain damage), Dementia (group of thinking and social symptoms that interferes with daily functioning), gastrostomy status (tube inserted through the belly that brings nutrition directly to the stomach), dysphagia (swallowing difficulties), hemiplegia and hemiparesis (a condition that causes partial or total paralysis of one side of the body), following cerebral infarction affecting left non-dominant side cerebral infarction (a medical condition where blood flow to the brain is disrupted, causing brain tissue to die due to a lack of oxygen and nutrients), Essential Hypertension (high blood pressure) and neuromuscular dysfunction of bladder with indwelling Foley catheter. Record review of Resident #49's quarterly MDS assessment, dated 02/10/25, revealed a BIMS score of 05 indicating severely impaired cognition. Further review revealed Resident #49 needed extensive assistance with ADL care with one staff assistance and the resident was incontinent of bowel and continent of bladder with indwelling Foley Catheter. She was totally dependent on staff for all efforts for ADLs including eating, oral hygiene, toileting, showering or bathing self, dressing and personal hygiene. (continued on next page)

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	03/14/2025

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #49's care plan dated 2/10/25 revealed the resident had an ADL self-care performance deficit related to limited impairment to upper and lower extremities. Intervention: resident needed extensive assist with two-person assistance with incontinent care. Record review of Resident #49's order summary, dated 3/1/25, revealed Physician Orders which included the following: secure catheter with leg strap every shift. Record review of Resident #49's MAR dated 3/1/25 through 3/12/25 for secure catheter with leg strap every shift reflected it was initialed as done during day, evening and night shift. Observation of incontinent and Foley catheter care on 03/12/25 at 1:30 PM with CNA H revealed Resident #49 was lying in bed on her back. CNA H entered Resident #49's room without washing her hands. CNA H picked up wet wipes and clean gloves and placed both of those items on Resident # 49's bedside table and began to don her PPE . She pulled the resident's privacy curtain shut, donned clean gloves, and opened Resident #49's brief. The indwelling catheter was not secured with a strap to her leg, and the catheter was seen under her right thigh with 300 ml yellow urine measured. CNA H used wet wipes and cleaned the resident's groin and peri area. There was brownish discharge on the brief with a foul odor. CNA H did not open Resident #49's labia to clean. She then cleaned the indwelling catheter tubing but not starting from the insertion site. She did not clean around the resident's buttocks, outside of wiping in-between Resident #49's buttocks. Then she applied Zinc Oxide 20 % cream, a skin protectant. During incontinent care, CNA H changed gloves 3 times without washing hands or using hand sanitizer . In an interview with C.NA H on 3/12/25 at 2:10PM, she said the nurses always secure the indwelling catheter and she would let the nurse know that it was observed not secured during incontinent care. C.NA H said she did not remember to wash her hands before donning her gloves and during incontinent care. She said she has been working with the facility for 1 year and she had in-services today on indwelling catheters for males and she had not had any in-services for females with catheters. She knew not washing hands during incontinent care could cause cross contamination, and she had in-services for hand washing several weeks ago. Observation on 3/12/25 at 6:23 PM of a skin assessment with Wound Care Nurse revealed Resident #49 was lying on her back in bed. The Wound Care Nurse did not wash her hands. The Wound Care Nurse donned clean gloves, and opened Resident #49's brief with the indwelling catheter not secured under the resident's right thigh. Resident #49 had a large bowel movement. The Wound Care Nurse repositioned Resident #49 to the left side and used the wet wipes to clean in-between the buttocks, where the sacral and coccyx region met on the lower back. The Wound Care Nurse changed gloves 3 times and did not wash hands or use hand sanitizer before donning clean gloves . LVN did not open the labia to clean. In an interview with Wound Care Nurse on 3/12/25 at 6:35 PM, she said she had skills check off and in-services on incontinent care. She said the resident could get an infection and skin breakdown if not cleaned properly. During an interview on 3/12/25 at 6:42 PM the DON said C.NA H should have been separated Resident #49's labia and wiped both sides and the middle. If the aide could not see the rectal area she had to separate and wipe the left and right buttocks. She said there could be a negative outcome for Resident #49, such as UTI and skin breakdown. She said the ADON monitored the aides and ensured they provided care for the residents, while including the DON monitored the nurses, by making random checks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/25 at 10:57am with ADON RN O, she said she trained the aides on how to provide incontinence care, and other aides trained new aides on how to care for the residents. She said Resident #49's labia should have been correctly separated and cleaned on both sides and in the middle and indwelling catheter. RN O said if CNA H did not clean Resident #49 thoroughly, she could have gotten a UTI and rashes. She stated the buttocks should have been separated and wiped from front to back, and the buttocks themselves should have been wiped too . Record review of the facility's policy on perineal care, dated 10/01/21, read in part . to provide cleanliness and comfort to the resident, to prevent infection and skin irritation . steps in procedure . #8b1 . separate labia and wash . #8d . wash the rectal area thoroughly . Record review of the facility's policy on catheters, dated 04/20/21, read in part . it is the policy of this community that resident with a urinary catheter will be provided services in a safe and appropriate manner to minimize the risk of urinary tract infections . Record review of the facility's policy on Hand Hygiene dated 8/4/2021 read in part, You should always perform hand hygiene before applying and after removing personal protective equipment including gloves, gown and mask, with hand hygiene defined as hand washing using soap and water or the use of an alcohol-based hand rub to destroy harmful pathogens . on the hands.