STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676210	A. Building B. Wing	04/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Summer Place	2485 S Major Dr Beaumont, TX 77707

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32217 Based on interview and record review, the facility failed to report an incident of possible injury of unknown origin or neglect immediately, but no later 2 hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse to the State Agency in accordance with State law for 1 of 5 residents (Resident #1) reviewed for incidents. The facility failed to report to State Agency when Resident #1 was located in the visitor bathroom, deceased and a possible head injury, on [DATE]. This failure to report could place the residents at risk for unreported allegations of neglect and injuries of unknow origin not being investigated due to not reporting. Findings included: Record review of Resident #1's physician's orders dated [DATE] indicated Resident #1 was admitted on [DATE], was an [AGE] year-old female, and had diagnoses of cerebral infarction (a condition where part of the brain is damaged or dies due to a lack of blood supply), altered mental status, and diabetes. Record review of Resident #1's Quarterly MDS dated [DATE] indicated she had a BIMS of 04, indicating severe mental impairment. She was occasionally incontinent of bowel and bladder. Resident #1 required setup or clean-up assistance with toileting hygiene. (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity). Additional active diagnoses included lack of coordination, history of falling, and abnormalities of gait and mobility. Record review of Resident #1's care plan initiated [DATE] indicated the resident required supervision assistance by 1 staff for toileting and the resident used the community restroom at times. Resident #1 had a history of falls and unsteady gait. Resident #1 ambulated with a rolling walker freely from her room to the dining and common areas throughout the day. Interventions for Resident #1 included for staff to anticipate her needs, assure areas were free of clutter, encourage the resident to ask for assistance of staff, and ensure call light was in reach and answer promptly. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nurse note documented by LVN A on [DATE] at 9:12 a.m. indicated Resident #1 was located on the community restroom floor in a sitting position, unresponsive and with a head injury. Record review of an incident report regarding Resident #1 documented on [DATE] at 9:10 a.m. indicated LVN A was called to the hallway of the visitor bathroom and was told that this resident was found on the floor of the bathroom in a sitting position in front of the commode with no clothes on and her head was bent over in between both her legs face down on the floor. The report indicated the resident was noted with a hematoma to the right forehead. There was stool noted on her hands and on the floor in front of her and behind her. There was no verbal response from the resident. During an interview on [DATE] at 3:05 p.m., LVN A said Resident #1 had a routine of being either in her room doing puzzles, or in dining room for meals or activities. She said she would use the public restroom. She said on the morning of the incident, when Resident #1 was not in her room or the dining room, she began looking for her around 8:30 a.m. so she could check her blood glucose. LVN A said she had not seen Resident #1 since beginning her shift at 6:00 a.m. During an interview on [DATE] at 5:00 p.m., MA C said her shift began at 6:00 a.m. She said she looked for Resident #1 in her room at around 6:30 a.m. to give her morning medications to her. She said she was not in her room and the roommate told her she thought she was in the dining room. MA C said she had completed her medication pass at around 8:00 a.m. except for Resident #1's medications. She said she was not in dining room or her room. MA C said she knew Resident #1 frequented the public restroom and decided to check. She said when she found the bathroom door to be locked, she had housekeeper unlock the door and Resident #1 was found on floor in a sitting position with her head to the floor. A statement signed and dated [DATE] at 11:11 a.m. indicated CNA G worked [DATE], the early morning hours of the day of the incident. CNA G indicated in her statement she observed Resident #1 in her room sitting in bed working a crossword puzzle around 6:03 a.m. Attempts to contact and interview CNA G were made on [DATE] at 2:15 p.m. The CNA's number was not a working number and the facility did not have any other contact numbers available. During an interview on [DATE] at 10:30 a.m., the ADON said Resident #1 would walk around from room to dining room to public bathroom and to front common area freely without assistance. She said her gait was not unsteady. During an interview on [DATE] at 10:40 a.m., LVN F said she worked every weekend. She said Resident #1 used her walker to ambulate throughout facility. She liked doing crossword puzzles and would usually work them in her room or the dining room. She said sometimes on weekends, Resident #1 would sit in the lounge area next to the nurse's station and would watch television or work her puzzles. During an interview on [DATE] at 1:15 p.m., the Administrator said at approximately 9:00 a.m., they were made aware of Resident #1 being discovered unresponsive in the public restroom. She said Resident #1 had removed her clothing and feces and urine were on floor. Resident #1 had a hematoma to her forehead. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:45 p.m., the DON said on [DATE] Resident #1 was found in the community restroom around 8:,d+[DATE]:40 a.m. She said CNA E called her to the restroom and Resident #1 was slumped on the floor with her head touching the floor and had a hematoma to her right forehead. She said she also had small amount of blood to lips and appeared to have hit her mouth on the floor. She said she quickly assessed Resident #1 and placed her in a lying position on the floor. She was unresponsive, did not have a pulse, and was not breathing. She initiated CPR while other staff retrieved the crash cart and AED. The DON said first responders were at facility within ,d+[DATE] minutes and had said Resident #1 had expired. DON said local police were also called and the police called the local Justice of the Peace and after speaking with him, Resident was declared expired. During a phone interview on [DATE] at 2:49 p.m., CNA E said she arrived to work at 7:00 a.m. She said she noticed Resident #1 was not in her room and was not in the dining room for breakfast. She said Resident #1 had to be reminded often to use her call light for assistance. She said Resident #1 was able to get herself in and out of bed and would get her walker and ambulate to the restroom in her room, and would ambulate freely to the dining room using her walker. She said the resident would do this frequently throughout the day. During an interview on [DATE] at 9:00 a.m., Resident #2 said she was the roommate to Resident #1. She said Resident #1 would often get in and out of her bed at all hours and would ambulate with her walker to the restroom in their room. She said Resident #1 had told her that she liked using the public restroom better because she felt like the toilet paper was softer. She said she would remind Resident #1 to use her call light for assistance but she would not listen. Resident #2 said Resident #1 would usually ambulate to the public restroom during the daytime and take herself without assistance since she could get out of bed herself. She said on the morning of the incident around ,d+[DATE]:30 a.m., Resident #1 left the room while she (Resident #2) was in their bathroom in the room. During an interview on [DATE] at 11:30 a.m., the Administrator said she was the Abuse Coordinator for reporting to the state. She said incident was not reported because she felt it was not a suspicious death and she was going by the state guidelines. The Administrator said the facility policy said to report to state office in the event the incident was suspicious. She said due to resident routinely visiting the public restroom, she felt the incident was not suspicious in nature. The Administrator said an investigation had been initiated and statements from nursing staff had been obtained. She said an in-service as scheduled on [DATE] regarding abuse/neglect, making rounds every two hours, and providing ADLs (activities of daily living). Record review of the policy titled Abuse dated [DATE] indicated . All events that involve a suspicious serious bodily injury of unknown origin must be reported immediately or no later than 2 hours of alleged violation. If the allegation does not involve abuse and the event does not result in serious bodily injury, the allegation should be reported within 24 hours.