

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/21/2025
NAME OF PROVIDER OR SUPPLIER  Focused Care at Summer Place		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0557</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 be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure residents had the right to retain and use personal possessions for 1 of 5 residents (Resident #2) reviewed for personal property.</p> <p>LVN B took Resident #2's personal cell phone away from her on 11/9/2024 and it was out of Resident #2's possession until the next shift arrived.</p> <p>This failure could place residents at risk of being deprived of their ability to use personal cell phone.</p> <p>Findings included:</p> <p>Record review of the undated face sheet indicated Resident #2 was an [AGE] year-old female that admitted [DATE] with diagnoses that including: Metabolic encephalopathy (problems with a patient's metabolism causes brain dysfunction with causes ranging from low blood sugar to excess fluid in the brain. Symptoms may cause confusion or coma.), Dementia (conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), and Generalized Anxiety Disorder (excessive and uncontrollable worry about events or activities that interferes with daily functioning).</p> <p>Record review of the quarterly MDS dated [DATE] indicated Resident #2 was usually understood by others, usually understood others, had highly impaired hearing and used hearing aids. The MDS indicated she had a BIMS score of 13 indicating her cognition was intact. Resident #2 required partial/moderate assistance for rolling left and right and chair/bed-to-chair transfer.</p> <p>Record review of the undated care plan indicated Resident #2 had impaired thought processes related to metabolic encephalopathy, dementia, and Altered Mental Status. The care plan indicated she required extensive assistance for bed mobility and total assistance for transfer.</p> <p>The PIR (Provider Investigation Report) dated 11/9/24 indicated Resident #2 reported LVN B had taken her phone to prevent her from calling her family member and the police. Resident #2 had requested BioFreeze (a cooling ointment that relieves pain) to be applied to her legs. LVN B refused and stated the BioFreeze had been applied twice and Resident #2 was not scheduled to receive the next application until 8:00 AM. Resident #2 began yelling at LVN B stating I am calling the cops. As LVN B was leaving the room she removed Resident #2's cell phone. LVN B was suspended pending investigation.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/19/25 at 8:29 a.m., the Administrator said LVN B purposely took Resident #2's phone to prevent her from calling the police or her Family Member N. She said LVN B had told the prior DON that was why she had taken it.</p> <p>During an interview on 5/19/25 at 9:17 a.m., Resident #2 was sitting up on her bed. She said that LVN B had taken her phone away from her because she said she was going to Call the cops. She said she was without her phone for a few hours until the next shift came to work. She said she was not able to call her family and it was disrespectful for the nurse to take her phone. She said she was not upset about it now because the facility took care of the situation.</p> <p>During an attempted telephone interview on 5/20/25 at 10:00 a.m., and 10:30 a.m., the prior DON, RN W did not answer and did not return the surveyors calls.</p> <p>During an interview on 5/20/25 at 8:06 a.m., LVN B said Resident #2 was in her room and did not have her hearing aids in. She said Resident #2 had a UTI at the time and was confused. She said it was a long time ago and was hard to remember but she thought Resident #2 wanted some cream or something. She said Resident #2 had dropped her phone on the floor. LVN B said she picked up the Resident #2's phone and before she could hand it back to her, she realized a resident across the hall was falling. LVN B said she put Resident #2's phone in her pocket and hurriedly left the room to assist the other resident. She said she forgot she had Resident #2's phone in her pocket and did not realize it until it was time for her to go home so she gave the phone to the oncoming nurse. She said she did not intend to take the phone from Resident #2, she just forgot she had it. She said they were not allowed to take a resident's phones and she lost her job over it.</p> <p>During an interview on 5/20/25 at 9:13 a.m., MA M said staff could not take away a resident's phone because it was their personal property.</p> <p>During an interview on 5/20/25 at 9:15 a.m., LVN D said staff could not take a resident's phone, it was their personal property, and it was really bad to do that.</p> <p>During an interview on 5/20/25 at 9:24 a.m., LVN E said staff could never take a resident's personal property. She said it was against their rights. She said she would never do that and could get in big trouble for doing that.</p> <p>During an interview on 5/20/25 at 9:27 AM, CNA F said Oh no! Staff could never ever take a resident's phone, that was their personal property! She said it might be theft to take a resident's phone or to restrict their use of their personal phone.</p> <p>During an interview on 5/20/25 at 9:45 a.m., ADON L said staff absolutely could not take a resident's phone. She said that would be a violation of resident rights and misappropriation of property.</p> <p>During an attempted telephone interview on 5/20/25 at 10:00 a.m., and 10:30 a.m., the prior DON, RN W did not answer and did not return the surveyors call.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/21/25 at 8:42 a.m., the DON said taking a resident's phone was disregarding the resident's rights by taking their personal property. She said it could be misappropriation of property. The risk to the resident could be mental issues, or the resident feeling unsafe which could open a window to abuse and a whole list of things you were not supposed to do. She said LVN B was fired after she took the phone from Resident #2.</p> <p>During an interview on 5/21/25 at 10:00 a.m., the Administrator said she believed LVN B took Resident #2's phone purposely. She said LVN B told the prior DON she had taken the phone to keep Resident #2 from calling the police. The ADM said it was misappropriation. The risk to the resident was anxiety, stress, and could put her in a vulnerable place by taking her only means of communication because she was bedbound. She said psychologically, it was not good for the resident.</p> <p>Record review of an Employee Termination Form dated 11/12/24 indicated LVN B was terminated for insubordination and not eligible for rehire.</p> <p>Record review of Staff Development/In-service Attendance Sheets indicated LVN B was in-serviced on Resident Rights on 2/5/24 and 3/11/24.</p> <p>Record review of a Resident Rights policy, provided by the ADM, with a revised date of December 2016 indicated:</p> <p>Policy Statement.</p> <p>Employees shall treat all residents with kindness, respect, and dignity.</p> <p>Policy Interpretation and Implementation.</p> <p>1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <ul style="list-style-type: none"> <li>a. a dignified existence;</li> <li>b. be treated with respect, kindness, and dignity;</li> <li>c. be free from abuse, neglect, misappropriation of property, and exploitation .</li> <li>f. communication with and access to people and services, both inside and outside the facility .</li> <li>g. exercise his or her rights as a resident of the facility and as a resident or citizen of the United States;</li> <li>h. be supported by the facility in exercising his or her rights;</li> <li>i. exercise his or her rights without interference, coercion, discrimination or reprisal from the facility .</li> </ul> <p>Record review of a Quality of Life-Dignity Policy, provided by the Administrator, with a revised date of August 2009 indicated:</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Policy Statement.</p> <p>Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.</p> <p>Policy Interpretation and Implementation</p> <p>1.Residents shall be treated with dignity and respect at all times.</p> <p>2.'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .</p> <p>6.Residents' private space and property shall be respected at all times .</p> <p>b. Staff will not handle or move a resident's personal belongings (including radios and televisions) without the resident's permission .</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide assistive devices to prevent accidents for 1 of 6 residents (Resident #1) reviewed for accidents.</p> <p>The facility failed to ensure CNA A utilized a mechanical lift and had assistance from another staff member during a bed to wheelchair transfer on 05/05/25 which resulted in Resident #1 having complaint of pain to the right ankle. An x-ray was conducted on 05/05/25 with the results of evidence of acute fracture of the right distal tibia (bone in the lower leg).</p> <p>The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 05/05/25 and ended on 05/07/25. The facility had corrected the noncompliance before the investigation began.</p> <p>This failure could place residents at risk for falls resulting in injury, pain, and hospitalization.</p> <p>Findings included:</p> <p>Record review of a face sheet dated 05/19/25 indicated Resident #1 was a [AGE] year-old male admitted on [DATE]. His diagnoses included diagnoses included a wedge compression fracture of 4th lumbar (L4) vertebrae (one side of the 4th bone in the lower back collapsed) onset date 01/09/24.</p> <p>Record review of an MDS OBRA assessment dated [DATE] indicated Resident #1 had moderately impaired cognitive skills. He required partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort for chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer.</p> <p>Record review of an MDS OSA assessment dated [DATE] indicated Resident #1 had moderately impaired cognitive skills. He required extensive assistance when resident was involved in activity, staff provide weight-bearing support with two+ persons physical assist.</p> <p>Record review of a care plan initiated on 12/22/21 indicated Resident #1 required the use of mechanical lift with total assistance by 2 staff to move between surfaces every 2 hours and as necessary.</p> <p>Record review of the [NAME] (electronic care task utilized by care staff) printed 05/20/25 indicated Resident #1 had special instructions to use the mechanical lift with 2 staff for all transfers every shift for chronic L4-L5 fracture.</p> <p>Record review of Resident #1's progress notes indicated:</p> <p>*an entry dated 05/05/2025 at 06:30 a.m. indicated CNA A reported that upon transfer from bed to wheelchair Resident#1 complained of right leg pain. The nurse went to assess the resident's leg. The resident was asked where he hurt, and he said his right ankle had pain. There was no swelling at the ankle no bruising was noted at this time. Will notify the oncoming nurse.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*an entry dated 05/05/2025 at 06:42 a.m. indicated while CNA A assisted Resident #1 with transfer from bed to wheelchair the resident's right ankle was twisted. The resident complained of pain in the ankle and was medicated with prn dose of Tylenol 325mg. The physician's office was made aware and an order for an x-ray was given.</p> <p>Record review of an x-ray report dated 05/05/25 indicated Resident #1 had evidence of an acute fracture of the right distal tibia (bone in the lower leg) and osteopenia (a condition of lower-than-normal bone mineral density that may lead to a condition in which bones become weak and brittle).</p> <p>Record review of the facility's investigation report dated 05/12/25 indicated on 05/06/25 during the morning meeting discussion on incidents it was noted that Resident #1's x-ray results showed an acute nondisplaced fracture of the right distal 3rd of the tibia. Resident #1 was transported via ambulance via stretcher to the local hospital related to a right ankle fracture. The Administrator's questions led to CNA A admitting to the DON that on 05/05/25 he did not use the Mechanical lift nor get assistance from another staff which Resident #1 required.</p> <p>During an interview on 05/20/25 at 10:30 a.m., the Administrator said CNA A was transferring Resident #1 without using the mechanical lift and a second staff on 05/05/25. She said Resident #1's right foot was turned and complained of pain afterwards. She said the physician was notified and an order was received to obtain an x-ray, but the resident refused because he wanted to go to dialysis first. She said when Resident #1 returned to the facility an x-ray was done. She said the result was received and the resident had a fracture of the lower leg. She said CNA A admitted he did not use the mechanical lift or have a second staff member with him to transfer Resident #1. She said he had been suspended and was terminated. She said all staff were trained upon hire and yearly on how to access the [NAME] in the kiosk (a small wall mounted computer used for providing resident information and staff to document care) to determine what care and how many staff were needed for care for each resident.</p> <p>During an observation and interview on 05/20/25 at 04:15 p.m., Resident #1 was in the bed. He was clean, neatly groomed, and had no offensive odors. He was wearing an orthopedic boot to his right lower leg. He said the male CNA who transferred him to the wheelchair stronged him - indicated by making a hugging gesture. He said he did not use a gait belt or a Mechanical lift. He said CNA A always stronged him and everyone else used a Mechanical lift. He said he wished it did not happen. He said he did not ask him not to use the Mechanical lift. He said everyone else transferred him with the Mechanical lift.</p> <p>The surveyor attempted to contact CNA A for an interview on 05/19/25 01:29 p.m. He did not respond.</p> <p>On 05/21/25, the surveyor confirmed the facility implemented appropriate measures to ensure the safety of residents after the incident on 05/05/25-05/07/25 involving Resident #1 by the following:</p> <p>Record review of CNA A's Disciplinary Action form dated 05/06/25 indicated he was suspended starting on 05/07/25 through 05/12/25. CNA A was then terminated.</p> <p>Record review of Proficiency Trainings provided to staff upon hire and annually which included training on the Point of Care to access the [NAME], and Mechanical Lift Transfers for CNA S hired on 05/13/25 and LVN X hired on 05/15/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of In-Services on 05/06/25 after the incident on 05/05/25 included:</p> <p>Pain to be Reported was received by AD, MR, Transportation, RA, DOR, LVN D, LVN E, CNA F, CNA G, LVN H, LVN J, LVN K, MA M, CNA O, CNA P, CNA Q, CNA R, CNA S, LVN T, CNA U, and CNA V.</p> <p>Falls was received by AD, MR, Transportation, RA, DOR, LVN D, LVN E, CNA F, CNA G, LVN H, LVN J, LVN K, MA M, CNA O, CNA P, CNA Q, CNA R, CNA S, LVN T, CNA U, and CNA V.</p> <p>ANE was received by AD, MR, Transportation, RA, DOR, LVN D, LVN E, CNA F, CNA G, LVN H, LVN J, LVN K, MA M, CNA O, CNA P, CNA Q, CNA R, CNA S, LVN T, CNA U, and CNA V.</p> <p>Resident Rights was received by AD, MR, Transportation, RA, DOR, LVN D, LVN E, CNA F, CNA G, LVN H, LVN J, LVN K, MA M, CNA O, CNA P, CNA Q, CNA R, CNA S, LVN T, CNA U, and CNA V.</p> <p>ACCURATELY CODING ADLs WHEN DOCUMENTING ADL's, RN's, LVN's and RCP's can check several areas of resident chart when needing information refer to resident's: care profile/special instructions, [NAME], care plan, and POC instructions to ensure documentation is accurate was received by RA, LVN D, LVN E, CNA F, CNA G, LVN H, LVN J, LVN K, MA M, CNA O, CNA P, CNA Q, CNA R, CNA S, LVN T, CNA U, and CNA V.</p> <p>Observations of staff with mechanical lift transfers of Resident #1 on 05/19/25 at 02:34 p.m. and on 05/20/25 at 08:38 a.m. and Resident #3 on 05/21/25 at 08:38 a.m. indicated no observed concerns with transfer assistance.</p> <p>During an interview on 05/19/25 at 08:00 a.m. LVN J said she worked 6a-2p and 2p-10p shifts. She said CNAs were to check the kiosk for the [NAME] which provided information on how much assistance and how many staff were needed for care on residents such as eating, bathing, and transfers. She said she knew how to look up the information if a CNA had questions. She said Resident #1 had always required a Mechanical lift and 2 staff for transfers due to a compression fracture of a vertebrae in his spine. She said recently he had started working with restorative only for sitting to standing. She said the CNAs were not have him stand for transfers.</p> <p>During an interview on 05/19/25 at 01:15 p.m. CNA F said the kiosk had a [NAME] which would let him know what assistance and how many staff were needed for resident care.</p> <p>During in interview on 05/19/25 at 01:20 p.m. CNA G said she looked up the [NAME] on the kiosk to know what assistance and how many staff were needed for resident care.</p> <p>During an interview on 05/20/25 at 08:30 a.m. CNA O said she worked 6a-6p shift. She said she looked up the resident [NAME] on the kiosk so she would know if a resident needed assistance, what kind of assistance (staff or mechanical lift), and how many staff were needed. She said she worked with Resident #1 and he had always had to have a Mechanical lift and 2 staff for transfers.</p> <p>During an interview on 05/20/25 at 09:13 a.m., MA M said she worked the 6a-6p shift. She said to find the resident's information to know what assistance they needed staff would look on the [NAME] in the kiosk. She said as far as she knew all staff were trained on how to look up the [NAME] on the kiosk.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/20/25 at 01:32 p.m. CNA P and CNA Q said they worked the 6a-6p shift. They said they looked up what kind of assistance a resident needed on the [NAME] located in the kiosk. They said they would assist when Resident #1 needed to be transferred because he used a Mechanical lift and 2 staff with all transfers.</p> <p>During an interview on 05/21/25 at 12:12 p.m. CNA R said he worked 6a-6p shift. He said he received training regarding resident abuse, neglect, rights and resident [NAME] care levels. He verbalized understanding of the trainings and was able to give examples of resident [NAME] care levels and he would ask for assistance if required.</p> <p>During an interview on 05/21/25 at 12:14 p.m. CNA S said she worked 6a-6p shift. She said she received training regarding resident abuse, neglect, rights and resident [NAME] care levels. She verbalized understanding of the trainings and was able to give examples of resident [NAME] care levels and she would ask for assistance if required.</p> <p>During an interview on 05/21/25 at 12:16 p.m. LVN T said she worked whatever shift she was needed. She said she received training regarding resident abuse, neglect, rights and even received training on resident [NAME] care levels. She verbalized understanding of the trainings and was able to give examples of resident [NAME] care levels and she would assist if required.</p> <p>During an interview on 05/21/25 at 12:18 p.m. LVN D said she worked the 6a-2p shift. She said she received training regarding resident abuse, neglect, rights and also resident [NAME] care levels. She verbalized understanding of the trainings and was able to give examples of resident [NAME] care levels and she would assist if required.</p> <p>During an interview on 05/21/25 at 12:19 p.m. LVN E said he worked the 6a-2p and 2p-10p shifts. He said he received training regarding resident abuse, neglect, rights and also resident [NAME] care levels. He verbalized understanding of the trainings and was able to give examples of resident [NAME] care levels and he would assist if required.</p> <p>During an interview on 05/21/25 at 12:20 p.m. CNA U said she received training regarding resident abuse, neglect, rights and resident [NAME] care levels. She verbalized understanding of the trainings and was able to give examples of resident [NAME] care levels and she would ask for assistance if required.</p> <p>During an interview on 05/21/25 at 12:26 p.m. LVN K said she worked the 6a-6p shift. She said she received training regarding resident abuse, neglect, rights and also resident [NAME] care levels. She verbalized understanding of the trainings and was able to give examples of resident [NAME] care levels. She said she would assist if required. She said Resident #1 had always been a Mechanical lift and 2 staff for transfers because he had a compression fracture of a vertebrae in his back.</p> <p>During an interview on 05/21/25 at 12:28 p.m. CNA V said worked the 6a-6p shift. She said she received training regarding resident abuse, neglect, rights and resident [NAME] care levels. She verbalized understanding of the trainings and was able to give examples of resident [NAME] care levels and she would ask for assistance if required.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/21/25 at 12:30 p.m. LVN H said she received training regarding resident abuse, neglect, rights and also on resident [NAME] care levels. She verbalized understanding of the trainings and was able to give examples of resident [NAME] care levels. She said she would assist if required.</p> <p>The noncompliance was identified as PNC. The Immediate Jeopardy began on 05/05/25 and ended on 05/07/25. The facility had corrected the noncompliance before the investigation began.</p>		