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	12/04/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of eleven residents reviewed for quality of care. The facility failed to thoroughly document measurements of two skin openings on Resident #1's bilateral (both sides) buttocks and notify the MD or NP regarding two skin openings that were present on admission. This failure could place residents at risk of not receiving necessary medical care and deterioration of the skin.Findings included: Review of Resident #1's face sheet revealed a [AGE] year-old man admitted on [DATE] with diagnoses of Type 2 Diabetes Mellitus (where your body does not make enough insulin or cannot use insulin properly leading to high blood sugar), Chronic Obstructive Pulmonary Disease (COPD - a progressive lung disease that blocks airflow, making breathing difficult), and Acute and Chronic Respiratory Failure (when lungs cannot get enough oxygen or remove enough carbon dioxide). Review of Resident #1's MDS Resident Assessment and Care Screening dated 11/15/2025 revealed the following:*a BIMS score of 10 which indicated moderate cognitive impairment. *Under the skin condition section; Is the resident at risk of pressure ulcers/injuries; A 1 was entered which indicated Yes. *Under other ulcers, wounds, and skin problems section; under other problems listed as open lesions, surgical wounds, burns, skin tears, moisture associated skin damage; the box next to none of the above were present was checked. Review of Resident #1's care plan dated 11/14/2025 revealed I am at risk for frequent infections, pressure/venous/statis ulcers (types of wounds), hyper/hypoglycemia (high and low blood sugar), renal (kidney) failure, cognitive/physical impairment, skin desensitized to pain or pressure related to diabetes mellitus.monitor/document/report PRN s/sx of hyperglycemia.poor wound healing. Review of Resident #1's weekly skin assessments from 11/13/2025 to 11/30/2025 revealed all five documented the exact same information. They stated there was moisture associated skin damage; redness, excoriation (scratching, scraping, or wearing off the skin), and small open area on sacrum; Does the resident have a pressure, venous, arterial, diabetic, or surgical wound? (types of wounds); No. Review of Resident #1's nursing progress notes from 11/13/2025 to 12/03/2025 revealed no notes regarding skin integrity or notification of skin integrity to MD, NP, or family. During an observation on 12/03/2025 at 09:31 a.m., revealed Resident #1 in his room on his bed. He stated he did not really have any concerns. He stated he had some pain (generalized pain due to cancer) and therefore he completed physical therapy in bed. He stated his bottom was sore and they put cream on his bottom. He stated, I wish they would do more (for his bottom). He stated they were good at taking care of stuff. At this point, an observation was made of Resident #1's bottom. There was a small circular skin opening on one side of his buttocks and what appeared to be another opening, a small slit on the other buttock. Review of Resident #1's weekly skin assessment, dated 12/03/2025, after surveyor intervention was documented by the ADON and revealed Bilateral Buttocks -Left buttock mostly red blanchable chaffed and right buttocks mostly red blanchable and chaffed.left buttock has an area that is that is opened 1 x 1 right buttock area that is opened 0.5 x 0.1 areas looks more like excoriation. Review of Resident #'1s nursing progress notes, dated 12/03/2025 at 2:09 p.m., after surveyor intervention revealed This nurse notified np of opened area to bital (bilateral) buttocks received a order to clean with wound cleanser apply collagen cover with hydrocolloid change every three days resident is his own rp and was notified site was cleaned and treat (treatment) applied.Review of Resident #1's physician orders, dated 12/04/2025 revealed no orders for impaired skin integrity up to 12/03/2025, after surveyor intervention revealed excoriation to the left buttocks - cleanse with wound cleanser, pat dry, apply collage to opened area, cover with hydrocolloid dressing one time a day with a start date of 12/03/2025 and excoriation to the right buttocks - cleanse with wound cleanser, pat dry, apply collage to opened area, cover with hydrocolloid dressing one time a day with a start date of 12/03/2025. During an interview on 12/03/2024 at 09:59 a.m., the ADON stated she was the ADON and treatment nurse. She handled all major wounds. She stated the floor nurses care for excoriation, skin tears, and moisture associated skin damage. She stated if there was any opening to the skin, she would put her eyes on the skin issues to determine what we got and what we are dealing with. She said I normally would refer them to the wound care NP.to have another set of eyes. Unless they are hospice, I ask hospice for their eyes. The ADON stated the floor nurses completed weekly skin assessments. She stated the assessments should include measurements, how it looks, if it is getting worse or better. The ADON stated