STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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** 38644 47072 Based on interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan consistent with the resident rights and that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and failed to describe services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required for one of twelve residents (Resident #43) reviewed for care plans. -The facility failed to care plan for Resident #43 received hospice care services, or the hospice care services he was provided. These failures placed residents at risk of not receiving required medical and end of life care in a timely manner, of a full understanding of the care needs. Findings Included: Resident #43 Record review of Resident #43' face sheet dated 3/27/2024 revealed a [AGE] year-old resident admitted on [DATE]. The face sheet documented his diagnoses included senile degeneration of the brain (various conditions involving progressive brain degeneration), generalized anxiety disorder (condition with exaggerated tension, worrying, and nervousness about daily life events), hypertension (high blood pressure), GERD (Gastroesophageal Reflux Disease, chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, the tube connecting the mouth and stomach), pressure ulcer (injury to the skin and the tissue below the skin due to pressure on the skin for a long time), contractures (abnormal shortening of muscle tissue), muscle wasting (loss of muscle leading to its shrinking and weakening) and atrophy (progressive and degeneration or shrinkage of muscles or nerve tissues), lack of coordination, amputation (removal of a limb, completely or partially as a preventative measure) of the left leg below the knee, colostomy (surgical process that creates an opening for the colon through the abdomen) status, and type 2 diabetes mellitus (condition resulting from insufficient production of insulin, causing high blood sugar). Per the face sheet, Resident #43 had a hospice care provider. (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
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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	Record review of Resident #43's admission MDS assessment dated [DATE] with an ARD of 2/20/2024 revealed a BIMS score of 13 indicating minimal cognitive impairment. The MDS documented that he had an impairment of one lower extremity, and he used a wheelchair for mobility. Per the MDS, Resident #43 required assistance with all ADL's except eating. The MDS revealed he had an indwelling catheter and an ostomy. The MDS documented he had one unhealed stage 4 pressure wound that was present at admission. Per the MDS, Resident #43 utilized a pressure reducing device for his bed, he received pressure wound care, and had received surgical wound care. The MDS revealed he received hospice care services. Record review of Resident #43's undated care plan revealed a focus on his penchant to remove his colostomy bag several times daily with interventions including monitoring for the behaviors, attempting to determine the cause, and documenting potential causes. The care plan documented a focus on his stage four pressure ulcer of the sacrum with interventions to include treatment administration as ordered, monitor the wound for healing daily, monitor his dressing every shift, monitor and any changes of his skin condition, and use of a low-pressure mattress. The care plan included a focus on Resident #43 colostomy with interventions to include changing it daily as needed and monitor and/or obtain lab work as needed. The care plan did not include any focus on his hospice care services. Record review of physician's orders report dated 3/27/2024 revealed an order dated 3/6/2024 to admit Resident #43 to a local hospice care provider. Record review of Resident #43 wound care physician's report dated 2/12/2024 revealed he had wounds of the left below the knee amputation site, right forefoot, and sacrum. Per the report, Resident #43 was receiving hospice care services. Record review of Resident #43 wound care physician's report dated 3/25/2024 revealed he had a wound of his sacrum. Per the report, Resident #43 was receiving hospice care services. In an interview on 3/28/2024 at 1:49 PM with Resident #43, he said he was receiving hospice care services. Resident #43 said he had no concerns with the care. Resident #43 said the hospice care provider came routinely to provide care. In an interview on 3/27/2024 at 12:49 PM with the WCN, she said Resident #43 was receiving hospice care services. In an interview on 3/27/2024 at 2:08 PM with the DON, she said Resident #43 was receiving hospice care services. The DON said if a resident was receiving hospice care services, that should be documented in the resident's care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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	In an interview on 3/28/2024 at 8:28 AM with the MDS Nurse, she said she had been employed since September 6, 2022. The MDS Nurse said her duties included completing the residents' MDS assessments, ensuring the residents' PASRR was complete and correct, and ensuring residents' care plans were updated and correct. The MDS nurse said the purpose of a care plan was to inform the nursing and CNA staff how to care for a resident. The MDS Nurse said the care plan also informed staff of resident idiosyncrasies that could present such as refusing care, sitting on the ground, or becoming combative. The MDS nurse said a resident receiving hospice care services should have a focus on his/her care plan related to those services. The MDS Nurse said Resident #43 should have had a focus in his care plan related to his hospice care services. The MDS nurse said she did not know why she had missed Resident #43's hospice care plan focus, but it could have been because there were numerous residents admitted at the time he was. The MDS Nurse said if a resident's care plan was incorrect the staff may not know what care the staff needed. The MDS Nurse said staff may not know who to call for Resident #43's care needs because his care plan did not include a focus on his hospice care services. In an interview on 3/28/2024 at 1:59 PM with the DON, she said a care plan allowed staff to know how to care for a resident, the resident's goals, and any interventions. The DON said if a resident receiving hospice care services did not have a focus in his/her care plan, the staff may not know how to care for him/her. The DON said she did not think the nurses would not know how to care for a resident receiving hospice care services because the physician's orders would be in the EHR. The DON said care plans for all residents were important, but the nurses would know a resident was receiving hospice care services because the hospice care providers entered orders for the residents and the nurses followed the orders. The DON said the expectation was to update care plans as soon as possible. Record review of the facility's Comprehensive Care Plan policy dated 4/25/2021 revealed a policy statement which read in part .Every resident will have an individualized interdisciplinary plan of care in place .The Care Plan process is an ongoing review process . The policy documented the comprehensive care plan was to be developed within twenty-one days of admission and after each care plan review. Per the policy, the care plan would include physician's orders, advanced directives, and pain management. The care plan revealed the policy would be updated with any updated information as needed. 47572

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47572 Based on interviews and record reviews, the facility failed to ensure comprehensive care plans were reviewed and revised by the Interdisciplinary Team after each assessment for one of twelve residents (Resident #58) reviewed for care plans. - The facility did not develop and implement a comprehensive person-centered care plan to address Resident #58' needs within 21 days of admission. - Resident #58's comprehensive person-centered care plan initiated on 01/25/2024 was not signed. These failures placed residents at risk for not receiving care and services to meet their medical, physical, and psychosocial needs. Findings Included: A review of Resident #58's face sheet revealed he was a [AGE] year-old-male admitted to the facility on [DATE] and diagnosed with other secondary Hypertension, Type 2 Diabetes Mellitus without complications, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Hyperlipidemia - unspecified, Chronic Kidney Disease - unspecified, Chronic Obstructive Pulmonary Disease (diseases that cause airflow blockage and breathing-related problems) - unspecified, Mood Disorder Due to known physiological condition - unspecified, unspecified Dementia - unspecified severity - without behavioral disturbance - Psychotic Disturbance - mood disturbance - and Anxiety, Cerebral Infarction (the brain tissue has not received enough blood - stroke) - unspecified, muscle weakness - generalized, other abnormalities of gait and mobility, other lack of coordination, Cognitive communication deficit, other Frontotemporal Neurocognitive Disorder (group of brain diseases that mainly affect the frontal and temporal lobes of the brain), Muscle Wasting And Atrophy (when muscles waste away) - not elsewhere classified - multiple sites. A review of Resident #58's comprehensive person-centered care plan showed that it was initiated on 01/25/2024, 40 days after his admission. The plan was not signed by any entity, the resident himself, or his representative. In an interview on 3/28/2024 at 8:28 AM with the MDS Nurse, she said she had been employed since September 6, 2022. The MDS Nurse said her duties included completing the residents' MDS assessments, ensuring the residents' PASRR was complete and correct, and ensuring residents' care plans were updated and correct. The MDS nurse said the purpose of a care plan was to inform the nursing and CNA staff how to care for a resident. The MDS Nurse said the care plan also informed staff of resident idiosyncrasies that could present such as refusing care, sitting on the ground, or becoming combative. The MDS Nurse said if a resident's care plan was incorrect the staff may not know what care the staff needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/28/2024 at 11:12 AM, the MDS nurse said she did not remember to do Resident #58's care plan by day 21 after admission. She said she may have had 5 to 6 admissions and/or Care Plans to do every day, and that she missed doing a care plan. She said she did not have any excuses. She said the residents' quality of care could be affected if there had not been a comprehensive person-centered care plan in place for the residents. In an interview on 3/28/2024 at 1:59 PM with the DON, she said a care plan allowed staff to know how to care for a resident, the resident's goals, and any interventions. The DON said if a resident receiving hospice care services did not have a focus in his/her care plan, the staff may not know how to care for him/her. Record review of the facility's Comprehensive Care Plan policy dated 4/25/2021 revealed a policy statement which read in part .Every resident will have an individualized interdisciplinary plan of care in place .The Care Plan process is an ongoing review process . The policy documented the comprehensive care plan was to be developed within twenty-one days of admission and after each care plan review. Per the policy, the care plan would include physician's orders, advanced directives, and pain management. The care plan revealed the policy would be updated with any updated information as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on observations, interviews, and record review the facility failed to ensure residents who are incontinent of urine received appropriate treatment and services to prevent urinary tract infections for 1 out of 5 residents (Resident #222) reviewed for incontinent care. - CNA B did not separate Resident #22's labia to clean and wiped from back to front during incontinent care. This deficient practice could place residents at-risk for infection due to improper care practices and decreased quality of life. Findings included: Record review of Resident #22's face sheet dated 03/27/24 revealed an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #22 diagnoses which included hypertension (a condition which the blood vessels have persistently raised pressure), neuropathy (nerve problem that cause pain, numbness, tingling swelling in different parts of the body), and heart failure (heart muscle cannot pump enough blood to meet the needs for the body). Record review of Resident #22's significant MDS dated [DATE] read in part . Resident #22's BIMS score of 11 which indicated moderately impaired cognition. Resident #22 functional status revealed resident needed extensive assistance with all ADLs . Record review of Resident #22's care plan initiated date 03/27/24 read in part .Resident #22 had ADL self-care performance deficit related to disease processes, confusion, and musculoskeletal impairment. Interventions: for shower revision date 03/27/24 . read the resident is totally dependent on 1 staff to provide showers on Monday, Wednesday, and Friday, initiated date 03/27/24 . resident requires extensive assistance of 1 staff for toilet use . During an observation on 03/26/24 at 10:31 a.m., incontinent care was provided for Resident #22 by CNA CC and assisted by CNA N. During incontinent care, CNA CC did not separate Resident # 22's labia, and she wiped the resident from back to front. During an interview on 03/26/24 at 10:56 a.m., CNA N said CNA CC did not separate Resident #22's labia. CNA CC should have separated the labia and cleaned it properly, which would have prevented Resident #22 from getting an infection (UTI). CNA N said CNA CC cleaned Resident #22 from back to front, and CNA CC could have contaminated the peri area with the bacteria from the rectum. CNA N said she had an in-service on peri care last week and a skills check-off on incontinent care too. CNA N said the nurse monitors the aides when the nurse makes rounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/26/24 at 12:00 p.m., CNA CC said she did not separate Resident #22's labia and cleaned the area three times. CNA CC said that if the labia was not cleaned properly, Resident #22 could get an infection. CNA CC said she made a mistake when she cleaned Resident #22 from back to front, which could have caused Resident #22 to get an infection. CNA CC said she had an in-service on incontinent care last week, and she had a skills check- off which included incontinent care. CNA CC said the nurse monitored the aide when the nurse made rounds. During an interview on 03/28/24 at 9:40 a.m., RN A said CNA CC should have separated Resident #22's labia and cleaned it three times: side, side, and then the middle part last. RN A said if Resident #22's labia was not cleaned properly, Resident #22 could get an infection. RN A said CNA CC should not have cleaned Resident # 22 from back to front to prevent contaminating Resident #22's private area with any bacteria from the rectum. RN A said he had a skills check-off, including incontinent care. During an interview on 03/27/24 at 3:45 p.m., the DON said CNA CC should not have wiped Resident # 22 from back to front because of contamination, an infection control issue. The DON said Resident #22's labia were supposed to be spread apart, and CNA CC should have cleaned each side and then the center. The DON said if Resident #22's labia was not appropriately cleaned, Resident #22 could get infection. Record review of the facility policy on perineal care effective date 10/01/21 read in part . to provide cleanliness and comfort to the resident, to prevent infection . steps in procedure #8b .wash perineal area, wiping from front to back #8d (1) . separate labia and wash area downward from front to back . 47572

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on observations, interviews, and record review, the facility failed to ensure that the medication error rate was not five percent (%) or greater. The facility had a medication error rate of 10% based on 3 errors out of 28 opportunities, which involved 2 of 6 residents (Residents #34 and #27) reviewed for medication errors. MA I administered the wrong medication to Resident #34 according to Physician orders. MA JJ administered the wrong medication to Resident #27 and did not administer Vitamin D 50,000 units to Resident #27 as ordered by the Physician. These failures could place residents at risk of inadequate therapeutic outcomes, increased negative side effects, and a decline in health. Findings included: 1.Record review of Resident #34's face sheet dated 3/28/24 revealed a [AGE] year-old male admitted on [DATE]. His diagnoses included hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild or partial weakness or loss of strength on one side of the body) affecting the right dominant side, cognitive communication deficit, type 2 diabetes, hyperlipidemia (elevated cholesterol), and hypertensive heart disease (a serious condition caused by chronic high blood pressure that affects the heart and blood vessels). Record review of Resident #34's quarterly MDS assessment dated [DATE] revealed a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. He required supervision to maximum assistance from staff with ADL care. Record review of Resident #34's order summary report for March 2024 revealed an order for Allergy Relief oral tablet 10 mg (Loratadine) give 1 tablet by mouth one time a day for allergies, order date 2/29/24. Observation on 3/28/24 at 8:21 a.m. with MA I revealed she prepared Resident #34's morning medication which included Cetirizine 10 mg (an allergy relief medication) - 1 tablet, Spironolactone 25 mg - 1 tablet, Memantine 10 mg - 1 tablet, Losartan 100 mg - 1 tablet, Duloxetine 20 mg DR - 1 capsule, Amlodipine 10 mg - 1 tablet, Vitamin B12 500 mcg - 2 tablets, and Lactulose 30 mL. She entered the room and administered the medications to Resident #34. She did not prepare and administer Loratadine as prescribed by the physician. In an observation and interview on 3/28/24 at 8:29 a.m. MA I said Cetirizine was in the same drug family and had the same dose as Loratadine and thought it was the same medication. She said if the name of medication did not match the order, she should ask the nurse. She said she normally gave the Cetirizine instead of Loratadine and previously confirmed with a nurse. She said when administering medication she checked the name of the medicine, dosage, and name of patient on the eMAR to make sure it matched the medication bottle. MA I looked in her medication cart and confirmed that she had Loratadine 10 mg available on her cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/28/24 at 12:51 p.m. the DON said nursing staff should compare the MD order to the medication to ensure the proper medication was given. She said staff should verify the right medication, dose, time, and patient to prevent medication error. In an interview on 3/28/24 at 4:08 p.m. the Administrator said Cetirizine and Loratadine were different antihistamines and she expected nursing staff to follow the MD orders. 2.Record review of Resident #27's face sheet dated 3/28/24 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included vitamin D deficiency, mild cognitive impairment, and congestive heart failure. Record review of Resident #27's quarterly MDS assessment dated [DATE] revealed a BIMS score of 6 out of 15 which indicated severe cognitive impairment. She required assistance from staff with ADL care. Record review of Resident #37's order summary report for March 2024 revealed orders for Ergocalciferol capsule (Vitamin D) 50,000 units give 1 capsule by mouth one time a day every Wednesday for supplement, order date 9/28/23; Multiple Vitamin give 1 tablet by mouth one time a day for supplementation - wound healing, order date 9/28/23. Record review of Resident #37's Medication Administration Record for March 2024 revealed a 4 was documented on 3/27/24 at the 9:00 a.m. administration time by MA JJ for Ergocalciferol 50,000 units. A 4 indicated vitals outside of parameters for administration. In an observation on 3/27/24 at 8:30 a.m. with MA JJ revealed she prepared and administered Resident #37's morning medication which included Multivitamin with mineral - 1 tablet, ascorbic acid 500 mg - 1 tablet, ferrous sulfate 325 mg - 1 tablet, docusate 100 mg - 1 tablet, zinc 50 mg - 1 tablet, and Eliquis 5 mg - 1 tablet. MA JJ did not administer Ergocalciferol to Resident #37 and administered multivitamin with minerals instead of multiple vitamin as ordered by the MD. In an interview on 3/27/24 at 8:35 a.m. MA JJ said she would check with the nurse on the availability of Vitamin D 50,000 units (Ergocaliferol). She said Resident #37's physician order did not say to administer multivitamin with minerals. She said she had a bottle on the medication cart without minerals but said she was not sure which one to give. She said when the order indicated to give multiple vitamin for supplementation, she gave the one with the minerals. In an interview on 3/28/24 at 8:37 am MA JJ said she was unable to administer the Vitamin D 50,000 units to Resident #37 (on 3/27/24) because the pharmacy did not deliver it. She said the medication was ordered from the pharmacy but had not arrived yet. She said she normally reordered a medication 72 hours in advance so the medication would not run out. In a continued interview on 3/28/24 at 8:53 a.m. MA JJ said she documented 4 - vitals outside of parameters on Resident #37's MAR because there was no other exception that matched the reason it was not given. She said the reason Vitamin D was not given was because it was not available. She said Resident #37's vitals were fine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/28/24 at 12:41 p.m. DON said the dietitian told her the multiple vitamins and multiple vitamins with minerals were equivalent, but the medication aides had to follow the MD orders. She said medications were expected to be available for residents so that the nurse could provide the medication for their condition. She said she audited the carts weekly for medication availability and the medication aides should notify her or WCN if a medication needed to be reordered. In an observation and interview on 3/28/24 at 1:12 p.m. of the medication aide cart for 600 hall with the DON revealed she retrieved the multiple vitamin without minerals bottle and said that was the medication that matched Resident #37's physician order and the one that should have been administered. Record review of the facility's Oral Medication Administration policy revised 8/2020 read in part, .Procedures . 2. Review and confirm medication orders for each individual resident on the MAR prior to administering medications to each resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on observations, interviews, and record review, the facility failed to ensure that drugs and biologicals were stored in locked compartments and accessed only by authorized personnel for 2 of 6 residents (#64 and #21) reviewed for medication storage. Resident #64 had two boxes of Salonpas patches (temporary relief of minor aches) at the bedside and did not have a MD order to self-administer. Resident #21 had Nystatin powder (used to treat fungal infections) on the tv stand that CNAs applied during brief changes. These failures could place residents at risk of loss of their medications, inadequate therapeutic outcomes, or decline in health. Findings included: Resident #64 Record review of Resident #64's face sheet dated 3/28/24 revealed a [AGE] year-old female readmitted on [DATE]. Her diagnoses included sickle cell disease with crisis (genetic disorder that affects red blood cells), unspecified dementia, and blindness to right eye. Record review of Resident #64's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15 which indicated severe cognitive impairment. She required supervision or touch assistance with ADL care. Record review of Resident #64's care plan dated 1/30/24 revealed she was on pain management therapy for systematic anti-inflammatory response syndrome. Interventions were to administer analgesic medications as ordered by the physician. The care plan did not indicate that Resident #64 self-administered medications. Record review of Resident 64's Order Summary Report for March 2024 revealed orders for 1. Salonpas pain relief patch apply to bilateral LE (lower extremity) one time a day for pain apply to lateral lower leg, lateral thigh bilateral legs, and remove per schedule 12 hours on 12 hours off, order date 3/21/24. 2. Salonpas pain relief patch apply to left hip one time a day for pain and remove per schedule, order date 1/20/24. There was no order for the resident to self-administer the medication. In an observation and interview on 3/26/24 at 9:31 a.m. of Resident #64 in her room revealed 2 boxes of Salonpas at the bedside. Resident #64 said she had sickle cell disease and was often in pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 3/28/24 at 9:45 a.m. Resident #64 said she was not hiding it from the facility, she had Salonpas patches in her room and was applying them. She said she put the Salonpas patches on her lower left leg due to pain but did not have one on now. She said she kept the same patch on for approximately 2-3 days until it came off. She said the instructions for the patches were on the box. Observation of the instructions on the Salonpas box revealed to apply the patch every 8 hours. Resident #64 said the facility applied the patch to her hip. In an interview on 3/28/24 at 9:54 a.m. MA JJ said she applied Resident #64's Salonpas to her left hip. She said she did not apply the patches to the leg because directions were not easily visible on the eMAR. She said she did not know she was supposed to apply patches to the legs until this State Surveyor asked about it. She said she signed off on both Salonpas orders in the eMAR but thought it was the same instructions. She said the resident was not supposed to have patches in her room and said she did not administer her own medications. In an observation and interview on 3/28/24 at 11:10 a.m. LPN K said she had not seen Salonpas patches in Resident #64's room. LPN K entered Resident #64's room and the resident told LPN K that she applied the patches to both of her legs. Resident #64 said she brought them from home. LPN K told Resident #64 that she could not leave the Salonpas patches at the bedside and she would have to administer a self-administration assessment. LPN K removed the 2 boxes of Salonpas from Resident #64's bedside. In an interview on 3/28/24 at 12:55 p.m. the DON said Resident #64 was not supposed to administer her own medications and the medication aide should. She said the MA should follow the orders on the MAR. The DON said the Salonpas instructions indicated to apply for 8 hours. She said if Resident #64 applied patches on her own she would need supervision to ensure the patch was removed. She said skin breakdown could occur if the patch stayed on too long. She said Resident #64 did not have a self-administration assessment. Resident #21 Record review of Resident #21's face sheet dated 3/28/24 revealed a [AGE] year-old female readmitted on [DATE]. Her diagnosis included heart failure, type 2 diabetes, kidney disease, and need for assistance with personal care. Record review of Resident #21's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated intact cognition. She was dependent on staff for toileting hygiene. Record review of Resident #21's care plan dated 1/29/24 revealed she was at risk for frequent infections, pressure/venous/statis ulcers, cognitive/physical impairment/skin desensitized to pain, or pressure related to diabetes mellitus. Interventions were to check all of body for breaks in skin and treat promptly as ordered by the doctor. In an observation and interview on 3/26/24 at 9:49 a.m. in Resident #21's room revealed there was a prescription box of Nystatin 100,000 unit/gm powder on her tv stand. The pharmacy label was dated 1/1/24 and had Resident #21's name on it. The directions were to apply to groin topically two times a day for rash. She said the powder arrived yesterday (3/25/24) and the facility gave the Nystatin to the CNAs to apply to the resident twice per day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/26/24 at 12:52 p.m. Resident #21 said CNA Y went in her room and applied the Nystatin powder. In an observation and interview on 3/27/24 at 11:09 a.m. in Resident #21's room revealed the prescription Nystatin powder was on the tv stand. Resident #21 said CNA N applied the powder under her belly. In an interview on 3/27/24 at 4:19 p.m. CNA N said when she changed Resident #21, she cleaned her and applied A&D ointment. She said she did apply the Nystatin powder under the resident's belly. She said she applied the powder one time in the morning and then again around 3:15 p.m. She said she would apply the Nystatin powder again during her shift. She said Resident #21 told her the nurse gave it to her (the resident) for the aides to put on, and she took her word for it. She said Nystatin powder was a prescribed medication and the nurses were aware the aides were applying the powder. She said Resident #21 told her where to apply the powder and the affected area looked better. In an interview on 3/28/24 at 11:04 a.m. LPN K said she did not give the CNAs the Nystatin powder and did not tell them to apply it to Resident #21. She said the aides did not tell her they were applying the Nystatin powder to the resident. She said she did not apply the Nystatin powder to Resident #21 yesterday because she got busy. She said she would have to check with the DON to see if the aides were able to administer Nystatin powder to the resident. She said the Nystatin powder was prescribed from the pharmacy and if there was an MD order for the medication the nurse would have to apply it. In an interview on 3/28/24 at 1:00 p.m. the DON said the nurse should apply the nystatin powder to Resident #21. She said the aides could not apply it because a licensed nurse had to administer prescribed topical medications. She said licensed nurses had to observe the condition of skin. In an interview on 3/28/24 at 4:08 p.m. the Administrator said she was recently educated by the Regional Nurse that Nystatin powder had to be applied by the nurse. She said no resident, to her knowledge, self-administered medication. She said if a resident wanted to self-administer, the facility would follow the policy and the resident would be educated. She said residents were unable to have medication in their room due to safety. She said the facility wanted to make sure the medication was applied correctly and to the right area during the right time frame. She said there could be a potential negative outcome if medication were in the room. Record review of the facility's Self-Administration of Medications policy dated 12/2016 read in part, . Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so .8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents .9. Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 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. 47072 Based on observations, interviews, and record reviews, the facility failed to store and serve food under sanitary conditions per professional standards for food service safety for one out of one kitchen and dining. -The facility failed to follow proper sanitation and food handling practices. -The facility failed to keep clean the ice machine used to distribute ice to the residents. -The DFS, FSA SS, and FSA TT did not follow proper sanitization procedures. -FSM QQ, FSA SS, and FSA TT did not follow proper food handler procedures. These deficient practices could put all 65 residents who received meals from the facility kitchen at risk of foodborne illnesses. Findings included: 1. Observation on 03/26/24 at 8:15 AM showed two staff members, the DFS and FSM QQ, in the kitchen without hairnets. The DFS was pouring juice from the Fountain System into different pitchers. FSM QQ was observed cleaning the kitchen counter. In an interview on 03/26/2024 at 8:16 AM, the DFS said she left her hairnet in her office and that FSM QQ's hairnet just fell off her head. Observation on 03/26/2024 at 11:37 AM showed FSA SS in the kitchen transporting food tray without a beard net. Observation on 03/27/2024 at 1:29 PM showed FSA RR in the kitchen with no hair net. In an interview on 03/27/2024 at 1:30 PM, FSA RR said she would wear a hair net before entering the kitchen. She said she forgot to wear it earlier. She said she would usually wear a hair net before entering the kitchen and proceed to wash her hands. In an interview on 03/27/2024 at 1:34 PM, the DFS said staff should wear a hair net before entering the kitchen and wash their hands immediately afterward. She said the hair net container was outside by the kitchen door for that purpose. If staff did not wear hair nets, hair could get in the food and cause sickness to the residents. 2. An observation on 03/26/2024 from 8:33 AM to 9:01 AM showed that FSA TT removed sanitized dishes from the dishwasher machine and placed them on a rack. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 03/26/2024 at 8:35 AM, FSA TT said she did not take the water temperature and PPM measurements this morning. She said she would do it when she finished sanitizing the dishes. She said she was not working on 03/24/2024 and 03/25/2024 and did not know why the log was not completed for those days. She said she and the other staff always make the logs when they finish washing the dishes. She said she would use the PPM testing trips to measure the water PPM after sanitizing the dishes. She said she was taught to check the ppm after sanitizing the dishes. She said she did not know if she had to check it before or during sanitizing. She said she started working as the dishwasher staff about two years ago and had always checked the water temperature and the PPM after the sanitizing process was completed. A review of the dishwasher machine water temperature log and PPM showed no records for the dishwasher water temperature and PPM for 03/24/2024, 03/25/2024, and the morning of 03/26/2024. 3. On 03/26/2024, at 8:57 AM, a pair of eyeglasses was observed in the dry storage on top of a bag of brown sugar. In an interview on 03/26/2024 at 8:59 AM, the DFS said the glasses belonged to FSA SS and should not have been there. 4. Observation of the meal service on 03/26/2024 from 12:01 PM to 12:33 PM showed FSM QQ fixing a salad on a plate with her bare hands, then handing it to the DFS. The DFS placed the plate on the kitchen table inside the kitchen. Further observation showed FSA TT holding the residents' cups by the rim, not the body. In an interview on 03/26/2024 at 12:05 PM, the DFS said she was preparing a chef salad for a resident. This State Surveyor informed the DFS that FSM QQ used her bare hands to fix the salad. The DFS threw the salad in the trash and requested a new one. She said the staff was not wearing gloves because the dietitian told them to stop wearing gloves in the service line. 5. Observation on 03/27/2024 at 9:43 AM showed FSA SS transferring sanitized silverware from the sanitizing tray to a container with his bare hands touching all parts of the silverware. Further observation showed FSA SS scratching his head and touching the temperature log, and then, he transferred the sanitized silverware from the sanitizing tray to a container. In an interview on 03/27/2024 at 9:45 AM, FSA SS said he did not take the water temperature or check the PPM this morning and would do it after he had cleaned and sanitized the dishes. He said the DPO recorded the values for this morning, not him. When asked what the purpose of taking the temperature after washing and sanitizing the dishes was, he said he did not know, and that was what the DFS had taught him. A review of the dishwasher water temperature and PPM logbook showed the water temperature was 100 F and PPM 150 for the morning of 03/27/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the DFS on 03/27/2024 at 10:06 AM, she said that she did not teach the staff to measure the water temperature and check the ppm after sanitizing. She said she taught them to do it before and during the process. She said she conducted in-services with the staff on 03/26/2024 on the sanitizing process and went over the process with FSA SS in the morning of 03/27/2024 before he started cleaning the dishes. She added that she would ask the staff to sanitize the silverware again because they were not handled in a manner that prevented cross-contamination. She said she wrote the missing information for 03/24/2024 and 03/25/204 because she realized the staff did not do it. She said she did not know what the measurements were for those days. She said she wrote those numbers because that was the number it had always been. 5. Observation of the meal service on 03/27/2024 at 12:01 PM showed FSA SS scratching his head, touching his clothes, and pulling his pants while passing the food trays. In an interview on 03/27/2024 at 12:10 PM, the DFS said that staff members who do not follow proper sanitization procedures can cause cross-contamination and pass on whatever they have to somebody else. She said the residents could get sick or die depending on what the staff passes on to them. In an interview on 03/27/2024 at 12:12 PM, FSA SS said he could cause cross-contamination and get the residents sick. He said he knew he had to wash his hands whenever he touched any body parts. He said he should have stopped and washed his hands after scratching his head or touching his body. He said he did not wash his hands because he did not think him scratching his head and touching any parts of his body without washing his hands was a big deal. 6. Observation on 03/26/2024 at 12:35 PM showed the water fountain located in hall 300 was dirty with a white/yellowish stain. Observation on 03/28/2024 at 8:54 AM showed CNA U filling up the residents' water pitcher from the ice machine. In an interview on 03/28/2024 at 8:55 AM, CNA U said a guy would come and service the machine about a month ago and change the filter. She said the housekeeper would come to clean the machine when she was done getting water. She said she did not verify if the machine was clean before she got the water but thought it had already been cleaned from yesterday. She said the nozzles were clean enough. She said that she would get the housekeeper to clean the machine when she was done distributing the water to the residents. She said the resident would get sick from bacteria if the ice machine was not clean. In an interview on 03/28/2024 at 1:46 PM, the Admin said that the ice machine is deep cleaned quarterly by a company. She added that the housekeeper also cleans it every day. She said anyone can wipe the machine down if there are spots or stains. In an interview on 03/28/2024 at 1:52 PM, the DPO said the ice machine was the only one the resident used to drink out of. He said there was only one in the hallway. He said the machine did not belong to the facility. He said the company always deep-cleaned it, but it always looked dirty. He said the white and yellowish stains were calcium buildup, and they could not remove it. He said the facility did not keep a cleaning log for the ice machine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 03/28/2024 at 2:02 PM, HK BBB said she had just started working at the facility on 03/19/24 and that today would be her first time cleaning the ice machine. IAW FDA Food Code 2022 Chapter 2-103.11, The PERSON IN CHARGE shall ensure that: (N) EMPLOYEES are preventing cross-contamination of READY-TO-EAT FOOD with bare hands by properly using suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT. IAW FDA Code 2022 Chapter 2-401.11, . Insanitary personal practices such as scratching the head, placing the fingers in or about the mouth or nose, and indiscriminate and uncovered sneezing or coughing may result in food contamination . IAW FDA Food Code 2022 Chapter 2-301.14, (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (I) After engaging in other activities that contaminate the hands. According to the TAC 483.60(i)(1)-(2), . Employees should never use bare hand contact with any foods, ready to eat or otherwise. Since the skin carries microorganisms, it is critical that staff involved in food preparation and services consistently utilize good hygienic practices and techniques. According to the facility's Food Preparation and Service Policy revised on 10/2017, 5. Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of food-borne illness. 7. Food and nutrition services staff shall wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food. A review of the facility's Food Preparation and Service with revised date 10/2017 parts 6 read, Bare hand contact with food is prohibited. Gloves must be worn when handling food directly. However, gloves can also become contaminated and/or soiled and must be changed between tasks. Disposable gloves are single-use items and shall be discarded after each use. A review of the facility's Sanitization Policy revised on 10/2008 part 8 read, Dishwashing machines must be operated using the following specifications: High-Temperature Dishwasher (Heat Sanitization) a. Wash temperature (150 - I65 F) for at least forty-five (45) seconds: b. Rinse temperature (165 - I80 F) for at least twelve (12) seconds. Low-Temperature Dishwasher (Chemical Sanitization) a. Wash temperature (120 F); b. Final rinse with 50 parts per million (ppm) hypochlorite (chlorine) for at least 10 seconds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47572 Based on interviews and record review the facility failed to ensure professional staff were licensed, certified, or registered in accordance with applicable State laws for one of seventeen staff (CNA O) reviewed for staff qualifications. The facility failed to ensure CNA O was appropriately certified to practice and provide CNA care in the State of Texas. This failure could place residents at risk of not receiving care and services from staff who were properly trained. The findings included: Interview on [DATE] at 12:39 PM with CNA O, she said she had last worked at the facility on [DATE]. CNA O said she worked on an as needed basis, and she had not worked many hours at the facility recently. CNA O said she believed her CNA license was current. CNA O said she sent her license renewal paperwork to the State in January of 2024 when she learned it was expired. CNA O said she learned the license was expired when the facility staff informed her. CNA O said she could not recall who had informed her. CNA O said she had not received any information from the State that her license was current. CNA O said she was instructed by the facility to check the State's website to determine if her license was valid, but she had not done so. CNA O was informed that per the State's license verification website, her license had been expired since [DATE]. CNA O said she had worked at the facility many times since [DATE]. CNA O said she was first licensed as a CNA on [DATE]. Interview on [DATE] at 12:53 PM she said she had spoken with the corporate HR department regarding CNA O's expired license. The Admin said the corporate office did not have CNA O on the list of expired license's. The ADMIN said the corporate office also said that the State had provided an extension on licensing as the State had changed licensing systems and was now exclusively online, and there had been delays with the new system. The Admin said the extension was through [DATE]. Interview on [DATE] at 1:18 PM with the Admin, she said based on the language of the State's CNA license extension, CNA O's license would not have been valid. The Admin said the facility's corporate informed the staff if his/her license was expired, but the State did so as well. The Admin said because CNA O did not have an active license and was able to work with residents, she may not have known updated expectations for her license. The Admin said CNA O received her initial CNA training, and the facility also provided continuous training to the CNA's. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Telephone interview on [DATE] at 1:25 PM with the Corporate HR Designee, she said she did not complete the staff EMR review for the facility on [DATE]. The Corporate HR Designee said the corporate talent acquisition group completed the background checks and EMR checks. The Corporate HR Designee said based on the state's CNA license extension policy granting CNA's with an active license on [DATE] an extension until [DATE], CNA O's license did not qualify. The Corporate HR Designee said CNA O's license would have been expired. The Corporate HR Designee said she believed that all CNA's licenses had been extended until [DATE]. The Corporate HR Designee said she believed the misconception was either miscommunication or misunderstanding the State's CNA license extension by the corporate head nurses. The Corporate HR Designee said the corporate head nurses had provided information to the facilities and corporate staff related to the State's CNA license extension. The Corporate HR Designee said if CNA O had been involved in an incident at the facility, the facility and corporation would have been liable for allowing an unlicensed employee access to the residents. Record review of CNA O's timecard statements from [DATE] through [DATE] revealed she worked a total of 647.62 hours during that time. The statement documented she worked a total of 7.15 hours in [DATE], on [DATE]. Record review of CNA O's license verification report dated [DATE] revealed her license had expired on [DATE]. CNA O's identification was verified utilizing her social security number. Record review of the facility's undated staff roster, provided by the facility on [DATE], revealed CNA O was listed as an active Resident Care Provider. Record review of the facility's EMR review completed on [DATE] at 2:46 PM revealed CNA O's license was expired. The review documented the license expired on [DATE]. Record review of the State's website on [DATE] at 1:09 PM revealed the state had approved all CNA's with a license active on [DATE] an extension on their license until [DATE]. (Note CNA O's license expired on [DATE] and was outside this extension). Record Review of the facility's undated Focused Post Acute Care Partners job description for CNA's revealed the facility's CNA's would be responsible for assisting residents with ADL's. The job description documented the qualifications for the position included a high school diploma or GED, and that CNA's must have a current nurse aide certification in the State.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on observations, interviews, and record review the facility failed to ensure clinical records were maintained in accordance with accepted professional standards and practices, were complete, and accurately documented for 1 (Resident #37) of 4 residents reviewed for clinical records. The facility failed to input treatment orders and document administration of those orders into the electronic health record for Resident #37's stage 3 pressure injury to right ischium, stage 3 pressure injury to right posterior thigh, and stage 3 pressure injury to left posterior thigh. These failures could place residents at risk for additional skin breakdown and inadequate care. Findings included: Record review of Resident # 37 face sheet dated 3/27/24 revealed a [AGE] year-old female admitted on [DATE]. Her diagnoses included type 2 diabetes, end stage renal disease, morbid obesity, bipolar disorder, and heart failure. Record review of Resident # 37's admission MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 which indicated no cognitive impairment. She was dependent on staff for toileting hygiene and shower/baths. She was at risk of developing pressure ulcers/injuries. She did not have unhealed pressure ulcers/injuries. She had moisture associated skin damage. Record review of Resident # 37 care plan dated 3/8/24 revealed she had a stage 3 pressure injury to the right ischium. The interventions were to administer treatments as ordered and monitor for effectiveness, assess/monitor wound healing daily, and monitor dressing daily to ensure it is intact and adhering. Record review of Resident #37's nursing note dated 3/7/24 written by LPN D read in part, .Resident arrived at facility via stretcher with EMS. Resident is AAOx4, skin is warm and dry to touch . incontinent to bowel and bladder . Sacrum wound noted, left post thigh non pressure wound, redness noted underneath both breasts, under stomach and groin area (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident # 37's initial wound MD visit report dated 3/18/24 revealed she had 3 pressure wounds. Wound #1 was a stage 3 pressure injury on the right ischium, not healed. The measurements were 2.6 cm length x 2.5 cm width x 0.1 cm depth, with an area of 6.5 sq cm and a volume of 0.65 cubic cm. There was a moderate amount of serous drainage (a type of fluid that comes out of a wound with tissue damage) noted with no odor. The wound bed was 20% granulation (the development of new tissue and blood vessels in a wound during the healing process), 20% slough (necrotic tissue that needs to be removed from the wound for healing to take place), 60% epithelization (an essential component of wound healing used as a defining parameter of a successful wound closure). The wound order for the right ischium was to cleanse/irrigate wound with normal saline/water, apply calcium alginate, honey-based ointment and cover with dry dressing every day and as needed. Wound #2 was a stage 3 pressure injury to the right posterior thigh, not healed. Initial measurements were 3.6 cm length x 5.1 cm width x 0.1 cm depth. There was a moderate amount of serous drainage noted with no odor. Wound bed was 40% granulation, 20% slough, and 40% epithelization. The wound orders for Wound #2 were to cleanse/irrigate wound with NS/water, apply calcium alginate, honey-based ointment with dry dressing every day, and as needed. Wound #3 was a stage 3 pressure injury to the left posterior thigh. Measurements were 7.1 cm length x 3.6 cm width x 0.1 cm depth, light amount of serous drainage with no odor. Wound bed had 20% granulation, 20% slough, and 60% epithelialization. The wound orders for Wound #3 were to cleanse/irrigate wound with NS/water and apply 40% zinc oxide every shift and as needed. Record review of Resident # 37's Order Summary Report for March 2024 dated 3/26/24 at 1:48 p.m. revealed there were no active wound orders for her stage 3 pressure injury to the right ischium, stage 3 right posterior thigh, or stage 3 left posterior thigh. Record review of Resident # 37's MAR for March 2024 dated 3/26/24 at 2:08 p.m. revealed the wound treatments for the stage 3 right posterior thigh and stage 3 left posterior thigh ordered by the physician on 3/18/24 were not listed on there and had no record of administration. The treatment for the stage 3 pressure injury to right ischium was listed and indicated WCN administered the treatment daily from 3/9/24 - 3/25/24. Record review of Resident #37's Order Summary Report for March 2024 dated 3/27/24 at 10:34 a.m. revealed there were no active, completed, or discontinued wound orders for her stage 3 right posterior thigh or stage 3 left posterior thigh. There was a discontinued order for: Cleanse stage 3 wound to right ischium with NS, pat dry, apply Honey and calcium alginate, cover with border gauze dressing every day shift, order date 3/8/24. Record review of Resident #37's Order Audit Report dated 3/27/24 at 10:38 a.m. revealed the order for: Cleanse stage 3 wound to right ischium with NS, pat dry, apply Honey and calcium alginate, cover with border gauze dressing every day shift, order date 3/8/24 was created on 3/26/24 at 1:57 p.m. by WCN and discontinued on 3/26/24 at 11:01 p.m. by WCN with an effective discontinued date of 3/25/24. Record review of Resident #37's administration history for the treatment order: Cleanse stage 3 wound to right ischium with NS, pat dry, apply Honey and calcium alginate, cover with border gauze dressing every day shift, order date 3/8/24 revealed all entries were documented on the MAR as administered on 3/26/24 by WCN. In an interview on 3/26/24 at 4:46 p.m. Resident #37 said she had a wound on her butt and the facility only put cream on it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 3/27/24 at 11:01 a.m. of Resident #37's skin with WCN revealed there was excoriation on her back and inner thighs. The wound on the ischium was approximately 2.5 cm by 2.0 cm and had about 10% slough and 70% granulation tissue. In an interview on 3/28/24 at 12:19 p.m. the DON said the wound orders for Resident #37 were carried out by the WCN and her wounds were improving but said the WCN may not have put the wound orders in the system on time. She said there was an order in the electronic system for the stage 3 pressure injury to right ischium with an order date of 3/8/24 that was created by WCN on 3/26/24. She said the created date was the day the order was created and recently learned that an order could be back dated. She said she would conduct a one-to-one in-service with WCN on entering physician orders in a timely manner and charting/documenting immediately. She said all nurses were to enter MD orders in a timely manner and all must be documented and charted immediately. She said wound MD orders should be entered into the system in a timely manner and failure to do so would result in disciplinary action. She said failure to input orders timely could delay treatment and worsen the wound. In an interview on 3/28/24 at 2:24 p.m. the WCN said she put Resident #37's wound orders in late (on 3/26/24) because she got behind. She said she did the wound care but did not document that it was being done. She said it was in her mind to put the orders in the system, but she was too busy. She said it was important to document the order and administration so other nurses would know what to do if she was not in the facility. She said if the documentation was not in the system, it was considered not done. In an interview on 3/28/24 at 4:08 p.m. the Administrator said she expected wound orders to be entered into the system timely per the physician and get carried out. She said she understood staff got behind, but the expectation was for staff to document as things occurred. She said residents could have a delay in care if orders were not entered timely. Record review of the facility's Skin Management: Prevention and Treatment of Wounds dated 11/1/2019 read in part, .The purpose of this procedure is for prevention and treatment of skin breakdown such as pressure injuries, diabetic ulcers, arterial ulcers, and skin wounds . Procedure .4. Treatment: a licensed nurse will obtain orders from physician for new skin wounds and transcribe onto resident's treatment record for follow up .