STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675910	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Hogan Park	3203 Sage St Midland, TX 79705

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 51011 Based on observation, interview, and record review, the facility failed to ensure personal privacy was provided for 2 (#23 and #37) of 3 residents reviewed for dignity. The facility failed to ensure staff treated Resident #23 with respect and dignity while performing wound care ensuring the door was closed and without the privacy curtain being closed all the way on 01/15/2025. CNA A did not close the window blind while providing incontinent care for Resident #37 on 01/16/2025. These failures could place residents at risk for diminished quality of life and loss of dignity and self-worth. The findings included: Record Review of Resident #23's face sheet revealed a [AGE] year-old male, who was admitted to the facility on [DATE] with a pertinent diagnoses of spinal stenosis-cervical region (narrowing of the spinal canal, compressing the nerves traveling through the lower back into the legs), functional quadriplegia (a condition that causes a person to be completely unable to move due to a severe disability or frailty), Diabetes Mellitus (chronic condition that occurs when the body does not produce enough insulin or cells do not respond to insulin properly), muscle wasting and atrophy [shrinking of muscle or nerve tissue], major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), neuromuscular dysfunction of bladder (a condition that causes bladder control problems due to nerve damage) and neurogenic bowel (a condition that causes bowel control problems due to nerve damage). Record Review of Resident #23's MDS dated [DATE] revealed Resident #23 with the BIMS of 00 indicating severe cognitive impairment). Record review of Resident #23's care plan revised 12/09/24 reflected the resident has stage 3 pressure injuries to left lateral ankle, coccyx, stage 4 pressure injury to right hip, and potential/actual impairment to skin integrity of the right outer ankle related to trauma. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #23's physician orders dated 01/16/2025 revealed: Stage 3 pressure area to coccyx: cleanse with wound cleanser and 4x4 gauze, pat dry with 4x4 gauze, apply calcium alginate with honey (or equivalent to) to wound bed then secure with foam dressing every day shift every other day for Wound Healing. Stage 3 pressure area to left lateral ankle: cleanse with wound cleanser and 4x4 gauze, pat dry with 4x4 gauze, apply BETADINE to wound honey strip cut to wound size then secure with foam or dry dressing every day shift every other day for Wound Healing. Stage 3 pressure area to right outer ankle: cleanse with wound cleanser and 4x4 gauze, pat dry with 4x4 gauze, apply betadine to wound honey strip cut to wound size then secure with foam or dry dressing every day shift every other day for Wound Healing. STAGE 4 pressure injury to the right hip: cleanse with wound cleanser and 4x4s, pat dry with 4x4s, apply calcium alginate with honey (or equivalent to) to wound bed then secure with silicone super absorbent dressing every day shift every other day for Wound Healing Observation on 01/15/25 at 9:21 a.m. revealed the Wound Care nurse was unable to close the privacy curtain while providing wound care for Resident #23. Resident #23 was in the bed closest to the door. Resident #23's privacy curtain was not long enough to provide privacy from his roommate and the door to the hall (in case it was opened). The Wound Care nurse pulled the curtain as far as she could to allow privacy for Resident #23 from his roommate. The curtain ended at the foot of Resident #23's bed. Observation on 01/15/2025 at 10:08 a.m. revealed the Wound Care nurse opened the door half-way, took her gown off, went to a cart outside the door, retrieved gloves from the cart, put the gloves on, gathered the trash in the room, rolled Resident #23 to his right side, placed a pillow behind Resident #23's back and under his legs, and adjusted the pillows under Resident #23's head. These actions were performed by the Wound Care nurse while the door is half-way open and Resident #23 was lying in bed with only a shirt and brief on, legs bare. Then, the Wound Care Nurse covered Resident #23 with his blankets. During an interview with the Wound Care nurse on 01/15/2025 at 10:15 a.m. she stated the privacy curtain was not acceptable and she will report it. During an interview with Resident #23 on 01/16/2025 at 03:56 p.m. Resident #23 answered sometimes when asked if it bothers him when his brief and legs are showing with the door open. Resident #23 again answered sometimes when asked if it bothers him that the curtain does not close all the way to provide privacy from the door if opened, during care. Record review of Resident #37's admission record dated 01/16/25 indicated she was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease and muscle weakness. She was [AGE] years of age. Record review of Resident #37's care plan dated 08/15/2024 indicated in part: Focus: Resident has an ADL self-care performance deficit related to disease processes. Disease Process. Goal: The resident will maintain current level of function through the review date. Interventions/Tasks: Personal hygiene: The resident requires extensive assistance by 1 staff with personal hygiene and oral care. Toilet use: The resident is not toileted. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #37's quarterly MDS assessment dated [DATE] indicated in part: BIMS = 13 indicating the resident's mental status was cognitively intact. Bladder and Bowel was: Urinary Continence Always incontinent (no episodes of continent voiding). Bowel Continence - Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement). During an observation on 01/16/25 at 4:08 PM CNA A performed incontinent care for Resident #37. CNA A entered the resident's room and explained to the resident what she was going to do and then closed the door and pulled the privacy curtain. CNA A then performed the incontinent care by uncovering Resident #37 and cleansed her vaginal and rectal area. During the personal care the window blind was not closed. The window faced an area where people would walk by as there was a convenience store next to the facility and the resident's bed was by the window. During an interview on 01/16/25 at 4:13 PM Resident #37 said the staff usually closed the window blinds to provide privacy but did not know why the staff had not this time. The resident said she would not like to be seen by people passing by while her private parts were exposed as that would be embarrassing to her. During an interview on 01/16/25 at 4:14 PM CNA A acknowledged that she should have closed the window blinds but had not thought about that. CNA A said she closed the privacy curtain and closed the door, but she probably got nervous and forgot to close the blind. The CNA said not closing the window blind could expose the resident to passersby and embarrass Resident #37 and violate her privacy rights. During an interview on 01/16/25 at 4:26 PM the DON said her expectations was for staff to provide privacy for residents when providing some type of personal care to prevent exposure of the resident. The DON was made aware of the observation of the wound care and incontinent care and how the staff did not fully provide privacy during the care for Residents #23 and #37. The DON acknowledged that the staff should have provided full privacy to prevent violation of the privacy and dignity rights. During an interview on 01/16/25 at 4:38 PM the Administrator was made aware of the observations listed above. The Administrator said he acknowledged that the nursing staff should have provided privacy during the patient care and would provide a policy of privacy. Record review of the facility's document titled Nursing services-competency evaluation dated 06/13 indicated in part: Prepare work area. Provide privacy (Pull curtain, close door/blinds).

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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. 45411 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services. - The facility failed to ensure that prepared food stored in the refrigerator was labeled and dated. - The facility failed to ensure that lids were sealed on spices kept in the dry storage room. - The facility failed to ensure that food stored in the refrigerator and dry storage room was in sealed containers. - The facility failed to ensure the overall cleanliness and sanitation of the kitchen and its storage areas. The findings included: Observation of the kitchen on 01/14/25 from 9:28 AM -10:32 AM revealed the following: - juice machine spigot/holder with red liquid collecting in bottom of holder and red buildup at mouth of holder that was sticky to touch - floors visibly dirty throughout kitchen and dry storage area (food and other debris noted on the floor in all areas); - one large metal bowl with clear plastic wrap cover containing yellow food noted in refrigerator with no label or date; - one package of pre-sliced yellow cheese noted in refrigerator; plastic package was torn open and discoloration and hardening of the edges of the 7 slices of cheese in package; - five 16-ounce bottles of spices (nutmeg received 1/18/24, ground oregano received 2/19/24, ground oregano received 11/20/24, ground allspice received 2/6/23, poultry seasoning received 2/6/23) noted on metal shelf in dry storage with lids open; - large clear plastic storage container labeled flour noted on shelf in dry storage with flour covering the lid of the container and surrounding storage containers; - large clear plastic storage container labeled pasta noted on shelf in dry storage with loose pasta noted in the bottom of the container; the container did not have a lid; - white tile on wall to either side of stove with visible brown droplet stains that were greasy to touch; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- food debris, greasy/gritty stains, and dust build-up noted under the stove which was being held level by wooden shims under the front feet; wooden shims were heavily stained; - 3 basin sink area noted to have mildew odor coming from under the sink where chemical/soap container the fed the sinks was stored; - mildew odor noted in area under dishwasher; - black fuzzy debris noted to wall behind dish drying racks; - ceiling mounted outlet next to steam table and plate rack with build-up of black/dark brown substance and visible dust and dirt on top; substance was gritty and greasy to touch. In an interview on 01/14/25 at 10:35 AM, the Dietary Manager stated that the kitchen was only allowed one cook and one dietary aid per shift to cook, clean, serve, and wash dishes and they had trouble keeping up with deep cleaning. He stated that the kitchen could only be spot cleaned (cleaning up spills or washing dishes) while food was being prepared and served so the staff had to wait until after the evening meal or come in overnight to deep clean. He stated that he did not have staff to work overnight and that he had come in himself to clean on several occasions. He stated that he had requested additional staff and was told no by the corporate office. He stated that all the dietary staff had been trained on labeling/dating/storing food by him when he started in the position of Dietary Manager, and he had no explanation for the unlabeled and open items in the refrigerator or the open lids on containers in the dry storage. In an interview on 01/16/25 at 4:29 PM, the Interim Administrator stated he was aware of the issues in the kitchen regarding sanitation. He stated that the kitchen was not clean. He stated that all facility staffing was done per the corporate staffing formula, and it was not likely to be changed to allow for cleaning staff. He stated that due to his being interim, he would bring it up with the regular Administrator when she returned. In an interview on 01/16/25 at 4:57 PM, Maintenance Director stated that cleaning was the responsibility of the food services staff, but he was aware that the kitchen needed to be deep cleaned per the facility schedule. He stated he was not aware of the mildew smell coming from the 3 basin sink and dishwasher areas. In an interview on 01/16/25 at 5:11 PM, the DON stated she was aware that the kitchen was not clean or sanitary. She stated that the facility's kitchen was not under her oversight but there were ongoing issues since before she started as DON in October of 2024. Review of facility policy titled Food Safety in Receiving and Storage, dated 04/2022, revealed, in part: Food is stored in its original packaging as long as the packaging is clean, dry, and intact.Food that is repackaged is placed in a leak-proof, pest-proof, non-absorbant, sanitary container with a tight-fitting lid. The container/lid is labeled with the name of contents and dated with the date it was transferred to the container. Dry bulk foods (i.e. flour, sugar) are stored in seamless metal or plastic containers with tight covers, or bins that are easily sanitized.Containers are cleaned regularly. Storeroom floors will be swept and mopped daily. Review of facility policy titled Kitchen Cleaning Schedule, revised 11/2023, revealed, in part: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Food and Nutrition Services Personnel will be responsible for maintaining the cleanliness and sanitation of kitchen.The Director of Food & Nutrition Services is responsible for utilizing the kitchen cleaning schedule template and assigning tasks to staff on a daily, monthly, and annual basis. Review of Food Code 2022 Recommendations of the United States Public Health Service Food and Drug Administration revision date 01/18/2023 revealed, in part: 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the food in packages, covered containers, or wrappings 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 45411 Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly for 3 of 6 dumpsters reviewed for food and nutrition services. - The facility failed to ensure that 2 of 6 dumpsters were placed on a concrete slab. - The facility failed to ensure that the area surrounding the dumpsters was free of garbage and other debris. - The facility failed to ensure dumpster doors for 3 of 6 dumpsters were when no staff were disposing of garbage . These failures could lead to an unsanitary environment and encourage the presence of pests. The findings included: Observation on 01/15/25 at 12:53 PM revealed a row of six commercial size dumpsters at the rear of the facility. Dumpster #1 was placed on dirt and a puddle was noted under the back corner with mud, loose garbage, and an odor coming from the water. Dumpster #1 did not sit flat and even - the rear, left corner of the dumpster was angled into the puddle. It could not be determined if the puddle had developed from the drain in the dumpster or recent snow. Dumpster #6 was placed on dirt and rocks. Dumpster #6 did not sit flat and even due to the rocks underneath. Three of six dumpsters (dumpsters #1, #2, and #6) had open lids at the time of the observation and no staff were observed in the area. In an interview on 01/16/25 at 4:29 PM, the Interim Administrator stated that he was not aware of the dumpsters not being on a slab since he was not the regular administrator. He stated he would need to look into what could be done with the city to fix the issue. In an interview on 01/16/25 at 4:57 PM, Maintenance Director stated he was not aware that two of the facility's six dumpsters were not placed on the proper surface and he would have to speak to the city's waste removal department about the slab under the dumpsters and their placement. He stated that the facility frequently had all 6 dumpsters full, and they could not be removed. Interview on 01/16/25 at 5:09 PM, the Interim Administrator stated that there was no facility policy or procedure regarding the proper placement of the dumpsters.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30057 Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 (#21) of 2 residents reviewed for infection control. The facility failed to ensure the Wound Care nurse used PPE during wound care for Residents #21 as the resident was on EBP precautions. These failures could place resident's risk for cross contamination and the spread of infection. Findings included: Record review of Resident #21's admission record dated 01/16/2025 indicated she was admitted to the facility on [DATE]. Diagnoses included dementia, muscle wasting and atrophy, and heart failure. She was [AGE] years of age. Record review of Resident #21's MDS dated [DATE] indicated in part: BIMS = 5 indicating resident had severe impairment. Section M - Skin conditions = Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Record review of Resident #21's care plan dated 10/30/2024 indicated in part: Problem: The resident has unstageable ulcer to coccyx r/t disease process, history of ulcers, immobility. Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date. Interventions: Resident requires supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Record review of Resident #21's Order Summary Report dated 01/16/2025 revealed in part: Cleanse with wound cleanser and 4x4s.Pat wound dry with 4x4s. Apply calcium alginate to the wound. Cover wound with dry dressing. Change daily and every 4 hours as needed if dressing comes off or becomes soiled. Effective 01/12/2025. During an observation on 01/14/2025 at 10:18 a.m. the Wound Care Nurse performed wound care. The Wound Care nurse entered the resident's room, washed her hands, and put gloves on. The Wound Care nurse performed the wound care as ordered. The Wound Care nurse did not put on any type of PPE except gloves during the process. There was an EBP posting above the bed of Resident #21. During an interview on 01/15/2025 at 9:08 a.m. the Wound Care nurse stated she forgot to put a gown on. The Wound Care nurse stated she is aware of the requirement and the facility's policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/2025 at 6:40 p.m. the DON/Infection Preventionist (IP) said EBP was to be used for any resident with any MDRO (Multi-Drug Resistant Organisms), residents with chronic indwelling devices, and residents with pressure ulcers. The DON/IP said if the staff were going to be performing high-contact care, such as wound care, then they should use the PPE. The DON/IP said if the staff did not wear the correct PPE such as the gown and gloves that could lead to possible cross contamination for resident #21 and other residents. Record Review of the facility's policy and procedure titled Enhanced Barrier Precautions (EBP) dated 04/01/2024 indicated in part: EBP require team members to wear a gown and gloves while performing high-contact care activities with residents who are infected or colonized with a targeted multi-drug resistant organism (MDRO), or who have open wound or indwelling medical device. Wounds generally include chronic wounds. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. High contact resident care activities include .wound care.