STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455900	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Mount Pleasant	1606 Memorial Ave Mount Pleasant, TX 75455

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 16 (Resident #2) residents review for dignity and respect. The facility failed ensure Resident #2 was treated with dignity and respect by LVN A on 11/12/25 when LVN A told Resident #2 to sit his ass down. These failures could place residents at risk of a diminished quality of life, loss of dignity and self-worth.Findings included: 1. Record review of the face sheet dated 11/13/25 indicated Resident #2 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, disorganized schizophrenia (a subtype of schizophrenia characterized by disorganized thinking, speech, and behavior), and anxiety disorder. Record review of the MDS dated [DATE] indicated Resident #2 sometimes understood others and was sometimes understood by others. The MDS indicated Resident #2 was not able to complete the BIMS assessment. The MDS indicated Resident #2 had not had any physical behaviors or verbal behaviors directed toward others during the 7-day look back period. Record review of the care plan last revised on 11/11/25 indicated Resident #2 had anxiety related to cognitive deficit and Schizophrenia as evidenced by constant wandering and exit seeking. During an observation and interview attempt on 11/13/25 at 12:50 p.m. Resident #2 was observed wandering around the men's secured unit. The surveyor attempted to interview Resident #2, but he just smiled and agreed to everything the surveyor said. During an interview on 11/13/25 at 1:01 p.m. COTA B said she was exiting the shower with CNA C and another resident. COTA B said she observed LVN A walking with Resident #3. COTA B said when LVN A and Resident #3 walked past Resident #2 that Resident #3 accidentally bumped into Resident #2. COTA B said Resident #2 became agitated and started yelling and acting like he was going to hit Resident #3. COTA B said LVN A got in between Resident #2 and Resident #3. COTA B said LVN A began yelling at Resident #2 telling him he was not going to hit her people, and he needed to go sit his ass down. During an interview on 11/13/25 at 1:11 p. m. the Administrator said she did not have an official disciplinary action for LVN A regarding the incident on 11/12/25 with Resident #2. The Administrator said LVN A had been suspended and would be terminated if for nothing more than in her statement confirming she told Resident #2 to sit his ass down. During an interview on 11/15/25 at 1:47 p.m. LVN A said on 11/12/25 during an altercation between Resident #3 and Resident #2 she got in between the residents to intervene. LVN A said she got Resident #2's attention and got him to sit down. LVN A said she told Resident #2 to sit his ass down in his chair before she got into trouble. Record review of the facility's Resident Rights policy last revised December 2016 indicated, Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to.b. be treated with respect, kindness, and dignity.

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
	455900	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Mount Pleasant	1606 Memorial Ave Mount Pleasant, TX 75455

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete an accurate MDS assessment to reflect residents' status for 1 of 16 residents reviewed for assessments. (Resident #4) The facility failed to ensure Resident #4's MDS dated [DATE] documented the presence of a pressure ulcer that she re-admitted to the facility with on 10/16/25. This failure could place residents at risk for inaccurate assessments and not receiving needed services.Findings included:1. Record review of the face sheet dated 11/12/25 indicated Resident #4 was re-admitted to the facility on [DATE] with diagnoses including diabetes, schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia with symptoms of mood disorder like bipolar disorder or depression), hypertension (elevated blood pressure), and lack of coordination. Record review of the MDS dated [DATE] indicated Resident #4 usually understood others and was usually understood by others. The MDS indicated Resident #4 was unable to complete the BIMS assessment. The MDS indicated Resident #4 did not have a pressure ulcer. Record review of the nursing progress note dated 10/16/25 indicated, [Resident #4] returned from hospital via wheelchair accompanied by staff.Perineum (the region of the body between the pubic arch (a bony structure in the pelvis) and the tail bone) and scalp assessed, no redness, open areas, or skin breakdown observed on scalp. [Resident #4] does have an existing wound to buttocks dressing changed per wound care orders. During an interview on 11/12/25 at 11:14 a.m. the Treatment Nurse said the MDS Nurse was responsible for completing the MDS and the Care Plans. The Treatment Nurse said she did not know why the MDS dated [DATE] did not indicate Resident #4 had a pressure ulcer. The Treatment Nurse said when Resident #4 admitted to the facility on [DATE] she just had redness to her bottom that they were treating with barrier cream. The Treatment Nurse said when Resident #4 re-admitted to the facility on [DATE] she had a pressure ulcer to her bottom that was opened. The Treatment Nurse said she reported the pressure ulcer to the MDS Nurse in the morning meeting after Resident #4 had re-admitted to the facility on [DATE]. During an interview on 11/14/25 at 12:42 p.m. the MDS Nurse was she was responsible for completing all MDSs. The MDS Nurse said when she was completing an MDS regarding wounds she obtained the information to enter into the MDS from the weekly wound report, skin assessments, and weekly IDT meeting. The MDS Nurse said she had just missed the wound on Resident #4 when she re-admitted to the facility on [DATE]. The MDS Nurse said the importance of ensuring the MDS was completed accurately was to accurately depict the residents and to trigger all care needed on the care plan. During an interview on 11/12/25 at 3:00 p.m. the DON said the MDS Nurse was responsible for completing the MDS. Record review of the facility MDS Completion Accuracy and Timeliness policy last revised 11/15/23 indicated, The purpose of this policy is to ensure accuracy and timeliness of MDS completion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455900	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Mount Pleasant	1606 Memorial Ave Mount Pleasant, TX 75455

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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455900	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Mount Pleasant	1606 Memorial Ave Mount Pleasant, TX 75455

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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights for 3 of 16 (Resident #4, Resident #5, and Resident #6) residents reviewed for care plans, The facility failed to ensure Resident #4's pressure ulcer to her buttock was care planned from her re-admission on [DATE] until 11/11/25. The facility failed to ensure Resident #5's wander guard status was properly care planned with the care plan indicating Resident #5 had a wander guard in place and observations and interviews indicating Resident #5 did not have a wander guard. The facility failed to ensure Resident #6's secured unit status was properly care planned with the care plan indicating Resident #6 resided on the secured unit and a social services note dated 5/6/25 indicating she had been moved off the secured unit. This failure could place the residents at increased risk of not having their individual needs met and a decreased quality of life. Findings Included:1. Record review of the face sheet dated 11/12/25 indicated Resident #4 was re-admitted to the facility on [DATE] with diagnoses including diabetes, schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia with symptoms of mood disorder like bipolar disorder or depression), hypertension (elevated blood pressure), and lack of coordination. Record review of the MDS dated [DATE] indicated Resident #4 usually understood others and was usually understood by others. The MDS indicated Resident #4 was unable to complete the BIMS assessment. The MDS indicated Resident #4 did not have a pressure ulcer. Record review of the nursing progress note dated 10/16/25 indicated, [Resident #4] returned from hospital via wheelchair accompanied by staff.Perineum (the region of the body between the pubic arch (a bony structure in the pelvis) and the tail bone) and scalp assessed, no redness, open areas, or skin breakdown observed on scalp. [Resident #4] does have an existing wound to buttocks dressing changed per wound care orders. Record review of the care plan last revised 11/11/25 indicated Resident #4 was at risk for skin Breakdown related to thin, fragile skin with poor turgor (the elasticity or firmness of the skin) and decreased mobility. The care plan indicated Resident #4 had a surgical incision to abdominal midline with staples intact. The care plan indicated on 11/11/25 it was initiated that Resident #4 had a pressure ulcer to her coccyx (small bone at the base of the spine) and bilateral buttocks with interventions including encourage good nutrition and hydration in order to promote healthier skin, identify/document potential causative factors and eliminate/resolve where possible, monitor/document location, size and treatment of skin injury, and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. During an interview on 11/12/25 at 11:14 am the Treatment Nurse said she had been the treatment nurse at the facility for approximately 1 year. The Treatment Nurse said Resident #4 had a wound on her bottom when she admitted to the facility. The Treatment Nurse said the MDS Nurse was responsible for completing the MDS and the Care Plans. The Treatment Nurse said when Resident #4 admitted to the facility on [DATE] she just had redness to her bottom that they were treating with barrier cream. The Treatment Nurse said when Resident #4 re-admitted to the facility on [DATE] she had a pressure ulcer to her bottom that was opened. The Treatment Nurse said she reported the pressure ulcer to the MDS Nurse in the morning meeting after Resident #4 had re-admitted to the facility on [DATE]. The Treatment Nurse said a care plan regarding a wound should be initiated as soon as the wound was found. The Treatment Nurse said she did not know why Resident #4's care plan regarding her wounds was not initiated until 11/11/25. The Treatment Nurse said the importance in a resident's care plan being updated when a wound was discovered was continuance of care. 2. Record review of the face sheet dated 11/13/25 indicated Resident #5 re-admitted to the facility on [DATE] with diagnoses including difficulty walking, muscle weakness, lack of coordination, right BKA, and hypertension. Record review of the MDS dated [DATE] indicated Resident #5 usually understood others and was usually understood by others. The MDS indicated Resident #5 had a BIMS of 09 and was moderately cognitively impaired. The MDS indicated Resident #5 used a wheelchair for mobility and required partial/moderate assistance with transfers. Record review of the care plan last revised 2/28/25 indicated Resident #5 had a history of elopement risk and was at risk for possible injury related to impaired safety awareness and intermittent confusion with interventions including wander guard (a safety system used in facilities to prevent residents at risk of wandering from leaving designated areas) placed for resident's safety, bracelet will alert staff if and when resident attempts to exit doors of facility. During an observation on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455900	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Mount Pleasant	1606 Memorial Ave Mount Pleasant, TX 75455

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 6 (Resident #1) residents reviewed for quality of care. The facility failed to ensure Resident #1 had a skin assessment performed weekly on the weeks of 10/6/25, 10/13/25, 10/20/25, and 10/27/25 per facility policy. These failures could result in skin issues on residents being missed, skin issues deteriorating without being monitored, and decreased quality of life. Findings Included: 1. Record review of the face sheet dated 11/12/25 indicated Resident #1 admitted to the facility on [DATE] with diagnoses including cerebral infarction (a type of stroke caused by the blood vessels supplying the brain being blocked), Atrial Fibrillation (an irregular heartbeat where the upper chambers of the heart beat chaotically and very fast), COPD, and hypertension (elevated blood pressure). Record review of the MDS dated [DATE] indicated Resident #1 usually understood others and was usually understood by others. The MDS indicated Resident #1 had a BIMS of 10 and was moderately cognitively impaired. The MDS indicated Resident #1 was at risk for developing pressure ulcers. Record review of the care plan revised 8/21/25 indicated Resident #1 was at risk for skin breakdown related to thin, fragile skin, incontinence and ambulating with decreased sense of safety. Record review of the weekly skin assessments for October 2025 indicated Resident #1 had a skin assessment on 10/1/25. The skin assessment dated [DATE] indicated Resident #1 did not have any skin issues. Record review of the weekly skin assessment for October 2025 indicated Resident #1 did not have weekly skin assessments in the weeks of 10/6/25, 10/13/25, 10/20/25, and 10/27/25. Record review of the weekly skin assessment dated [DATE] indicated Resident #1 did not have any skin issues. During an interview on 11/12/25 at 1:38 p.m. the Treatment Nurse said skin assessments were to be performed weekly, and all skin issues should be on the weekly skin assessments. The Treatment Nurse said the importance of weekly skin assessments was to assess the skin for an issue. During an interview on 11/12/25 at 2:47 p.m. the DON said skin assessments should be performed weekly, and he would look at his soft file to see if he had skin assessments on Resident #1 for the missing dates in October 2025. During an interview on 11/12/25 at 3:00 p.m. the DON brought the surveyor shower sheets for Resident #1 for the missing dates that were filled out by the CNAs where they could mark on the image of a body if they saw any skin issues. The DON showed the surveyor where a nurse signed off on the shower sheets. The DON said that the nurses were not usually there when a shower was given to assess the skin themselves. The DON said he understood it was out of the CNAs' scope of practice to assess. The DON said the weekly skin assessment should be performed by a nurse. Record review of the facility's Skin Management Policy last revised 10/6/22 indicated, The purpose of this procedure is for prevention and treatment of skin breakdown such as pressure injuries, diabetic ulcers, arterial ulcers, and skin wounds.Skin assessments will be documented at a minimum of every 7 days on a Weekly Skin Assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455900	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Mount Pleasant	1606 Memorial Ave Mount Pleasant, TX 75455

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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455900	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Mount Pleasant	1606 Memorial Ave Mount Pleasant, TX 75455

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 3 residents (Resident #1) reviewed for treatment and services related to indwelling catheters. The facility failed to ensure Resident #1's Foley catheter drainage bag was kept off the floor on 10/21/25. These failures could place residents at risk for urinary tract infections, injuries, and a decreased quality of life.The findings included: Record review the face sheet, dated 10/22/25, reflected Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of senile degeneration of the brain (progressive deterioration of brain tissue and function that occurs with aging), neuromuscular dysfunction of the bladder (nerve damage that affects bladder control), benign prostatic hyperplasia (enlargement of the prostate gland), and retention of urine (inability to completely empty the bladder). Record review of the admission MDS assessment, dated 09/29/25, reflected Resident #1 had clear speech, was understood by others, and was usually able to understand others. Resident #1 had a BIMS score of 11, which indicated moderately impaired cognition. Resident #1 had no behaviors or refusal of care during the look-back period. The MDS reflected Resident #1 had an indwelling catheter with an active urinary tract infection during the last 30 days (look-back period). Record review of the comprehensive care plan, initiated 10/02/25, reflected Resident #1 used a Foley catheter related to a neurogenic bladder and retention. The interventions included: position drainage bag below the level of the bladder and away from entrance door, check tubing for kinds, monitor intake and output, monitor pain/discomfort, and monitor for signs and symptoms of UTI. Record review of the progress notes, dated 10/14/25 reflected Resident #1 had a functional decline and altered mental status. Orders were given for urinalysis. Record review of the lab results, reported on 10/16/25, reflected Resident #1 had a positive urinalysis, which grew Escherichia coli (Gram-Negative bacteria) and Candida glabrata (yeast). Record review of the McGeer Criteria for Infection, dated 10/18/25, reflected Resident #1 had leukocytosis (high white blood cell count) and a functional decline. The assessment reflected that he was prescribed antibiotics for a urinary tract infection with an indwelling catheter. The assessment revealed Resident #1 did meet the criteria for antibiotic use. Record review of the 72 Hour Antibiotic Review, dated 10/18/25, reflected a one-time dose of antibiotic was given on 10/18/25 for a urinary tract infection. Record review of the order recap report, dated between 10/01/25 and 10/31/25, reflected Resident #1 had the following orders:1. Monitor for signs and symptoms of sepsis development throughout the antibiotic course and 72 hours after., which started on 10/18/25 and ended on 10/23/25.2. Fosfomycin (antibiotic) 3 GM - Give 1 packet by mouth one time only for UTI which started and ended on 10/18/25. Record review of the MAR, dated October 2025, reflected Resident #1 was given an antibiotic for a UTI on 10/18/25. During an observation on 10/21/25 at 9:42 AM, Resident #1's foley catheter drainage bag was laying on the ground under his bed. Resident #1 stated he did not know the bag was on the ground. During an interview on 10/22/25 at 12:48 PM, RN A stated everyone was responsible for monitoring to ensure the Foley catheter drainage bags were kept off the floor. RN A stated she did not notice that Resident #1's Foley catheter drainage bag was on the ground. RN A stated she checked the Foley catheter drainage bag at least two times a day during rounds. RN A stated she also checked as needed for any issues. RN A stated if the catheter drainage bag was kept on the ground it would have placed Resident #1 at risk of injury if it was stepped on or accidentally pulled out. During an interview on 10/22/25 at 1:59 PM, the DCO stated Resident #1's Foley catheter drainage bag should not have been kept on the floor. The DCO stated everyone was responsible for monitoring to ensure that Foley catheter drainage bags were kept off the ground. The DCO stated he was new to the position, but he would have provided in-service education for the staff. The DCO stated it was important to keep Foley catheter drainage bags off the floor to prevent urinary tract infections, maintain infection control practices, and prevent injuries. During an interview on 10/22/25 at 2:13 PM, the Administrator stated Foley catheter drainage bags should have been secured to the bed and kept off the ground. The Administrator stated all staff was responsible for monitoring to ensure Foley catheter drainage bags were kept off the ground. The Administrator stated the nursing direct care staff should be monitoring the Foley catheter routinely. The Administrator stated it was important to ensure the Foley catheter drainage bag was kept off the ground to prevent the spread of infection to others or prevent Resident #1 from obtaining a urinary tract infection. Record review of the Catheters-Insertion and Care; Indwelling, Straight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455900	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Mount Pleasant	1606 Memorial Ave Mount Pleasant, TX 75455

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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455900	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Mount Pleasant	1606 Memorial Ave Mount Pleasant, TX 75455

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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure in accordance with accepted standards of practices, the medical records on each resident were accurately documented for 2 of 16 residents (Resident #4 and Resident #7) reviewed for accurate medical records. The facility failed to ensure Resident #4's wound assessment completed on 11/7/25 by the Treatment Nurse accurately reflected her pressure ulcer was worsening as the Wound Care NP had documented on 11/7/25. The facility failed to ensure Resident #7's wound assessment completed on 11/7/25 by the Treatment Nurse accurately reflected her pressure ulcer was worsening as the Wound Care NP had documented on 11/7/25. These failures could place residents receiving wound care at risk for confusion on whether a wound is improving or worsening. Findings included:1. Record review of the face sheet dated 11/12/25 indicated Resident #4 was re-admitted to the facility on [DATE] with diagnoses including diabetes, schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia with symptoms of mood disorder like bipolar disorder or depression), hypertension (elevated blood pressure), and lack of coordination. Record review of the MDS dated [DATE] indicated Resident #4 usually understood others and was usually understood by others. The MDS indicated Resident #4 was unable to complete the BIMS assessment. The MDS indicated Resident #4 did not have a pressure ulcer. Record review of the nursing progress note dated 10/16/25 indicated, [Resident #4] returned from hospital via wheelchair accompanied by staff.Perineum (the region of the body between the pubic arch (a bony structure in the pelvis) and the tail bone) and scalp assessed, no redness, open areas, or skin breakdown observed on scalp. [Resident #4] does have an existing wound to buttocks dressing changed per wound care orders. Record review of the care plan last revised 11/11/25 indicated Resident #4 was at risk for skin Breakdown related to thin, fragile skin with poor turgor (the elasticity or firmness of the skin) and decreased mobility. The care plan indicated Resident #4 had a surgical incision to abdominal midline with staples intact. The care plan indicated on 11/11/25 it was initiated that Resident #4 had a pressure ulcer to her coccyx (small bone at the base of the spine) and bilateral buttock. Record review of the wound assessment completed by the Treatment Nurse dated 11/7/25 indicated Resident #4 had a pressure ulcer to her coccyx/bilateral buttocks that was improving. Record review of the Wound Care NP's progress note dated 11/7/25 indicated Resident #4's wound to her coccyx/bilateral buttocks that was worsening. During an interview on 11/12/25 at 11:14 a.m. the Treatment Nurse said she had been the treatment nurse at the facility for approximately 1 year. The Treatment Nurse said Resident #4 had a wound on her bottom when she admitted to the facility. The Treatment Nurse said the wound had been improving but when Resident #4 had stopped eating the wound began to decline. The Treatment Nurse said Resident #4 received wound care daily and was seen by the Wound Care NP weekly. The Treatment Nurse said she made a mistake in the wound assessment dated [DATE] when she documented Resident #4's wound to her coccyx was improving after the Wound Care NP documented the wound was worsening. The Treatment Nurse said the importance of ensuring proper documentation was performed was continuance of care. 2. Record review of the face sheet dated 11/14/25 indicated Resident #7 was re-admitted to the facility on [DATE] with diagnoses including lack of coordination, diabetes, obesity, and pressure ulcers to the sacral region (triangular area of the lower back at the base of the spine) and right buttock. Record review of the MDS dated [DATE] indicated Resident #7 understood others and was understood by others. The MDS indicated Resident #7 had a BIMS of 10 and was moderately cognitively impaired. The MDS indicated Resident #7 had one or more unhealed pressure ulcers. Record review of the wound assessment completed by the Treatment Nurse dated 11/7/25 and signed 11/12/25 indicated the pressure ulcer to Resident #7's left ischium (a thick, irregularly shaped bone in the pelvis) was worsening. Record review of the audit report dated 11/14/25 indicated the wound assessment dated [DATE] had been audited on 11/12/25 by the Treatment Nurse from originally indicating on 11/7/25 the pressure ulcer to Resident #7's left ischium was worsening to improving. Record review of the Wound Care NP's progress note dated 11/7/25 indicated the pressure ulcer to Resident #7's left ischium was worsening. During an interview on 11/12/25 at 11:29 a.m. the Wound Care NP said he expected the nursing wound assessments that were completed on the same day as his assessments to accurately reflect what his assessment reflected regarding wound status of improving, stable, or worsening. During an interview on 11/12/25 at 3:00 p.m. the DON said he expected clinical documentation of wounds to reflect what the wound care physician documented on their notes. The