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	01/13/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of resident property for 1 of 6 residents reviewed for misappropriation of resident property. (Resident #1) The facility to failed keep Resident #1 free of misappropriation of property when RN A took a discontinued medication, 60 tablets of Meloxicam 7.5 milligrams, from the facility. This failure could place residents at risk for decreased quality of life, misappropriation of property, and dignity.Findings Included: Record review of face sheet dated 01/13/26 indicated Resident #1 was [AGE] years old and was initially admitted to the facility on [DATE] with diagnoses of senile degeneration of the brain (significant age-related cognitive decline), difficulty in walking, and a cognitive communication deficit.Record review of an Order Summary Report dated 01/13/26 for Resident #1 indicated an order for Meloxicam (a prescription nonsteroidal anti-inflammatory drug (NSAID) used primarily to relieve pain, swelling, and stiffness caused by various forms of arthritis, including osteoarthritis, rheumatoid arthritis, and juvenile rheumatoid arthritis. It is not a narcotic or an opioid) Oral Tablet 7.5 milligrams with a start date of 01/28/25 and an end date of 10/25/25. There were no current orders for Meloxicam.Record review of a significant change MDS assessment dated [DATE] indicated Resident #1 was usually understood and usually understood others. The MDS indicated a BIMS of 03 which indicated severe cognitive impairment.Record review of a care plan last revised on 12/30/25 for Resident #1 had potential for pain related to inability to detect/notify staff of pain in a timely manner. There was an intervention to administer pain medications as order.Record review of the Medication Administration Records for Resident #1 for October 2025, November 2025, December 2025, and January 2026 indicated Resident #1 had not received a dose of Meloxicam since 10/27/25.Record review of a police report dated 01/09/26 indicated that on 01/01/26, RN A was in possession of 60 Meloxicam 7.5 milligram pills belonging to Resident #1. The police reported indicated the incident type was criminal.Record review of a Provider Investigation Report dated 01/09/26 indicated on 01/01/26 at 3:30 p.m. RN A was pulled over by the police for a routine traffic stop. The report indicated RN A was the perpetrator. The report indicated the DCO was contacted by a police officer to notify him that RN A was found in possession of a resident's medication while on a traffic stop. The report indicated Resident #1 was not affected by the incident. The report indicated a medication count at the facility confirmed that no other medications were missing from the facility. The report indicated RN A confirmed she had the medication in her presence. The report indicated, .She stated it was a misunderstanding and accident that she picked it up. The medication was not under current physician order. No resident went without prescribed medication. Nurse did not deny that it was in her possession. The police drew up a report and plan to pursue charges as appropriate. The facility investigation findings were confirmed. The report indicated staff were educated regarding medication administration and storage. The report indicated that RN A was removed from her assignment due to mismanagement of prescribed medication. The report was (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: 455900	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signed by the EDO.Record review of an email to the EDO from RN A dated 01/06/26 at 10:22 a.m. indicated, During a very busy shift, the medication aide and I.were administering residents medications at the nurses station. I got called down to a residents room, I placed blister-pack medications underneath some paper at the nurse station, which was a lapse in protocol. When I later gathered by belongings to leave, I inadvertently picked up the papers with the blister packs underneath and placed them into my bag without realizing the medications were included. I was unaware that the mediations were in my possession until I was stopped by law enforcement for an unrelated matter, at which time a search revealed the blister packs. There was no intent to remove, conceal, divert, or misuse medications. I acknowledge this breach of protocol and understand the importance of strict adherence to medication handling procedures.Record review of a Termination Recommendation form dated 01/02/26 indicated RN A was terminated for unsatisfactory performance, violation of company policy, and misappropriation. The form indicated RN A misappropriated medication in overflow for resident use, she did not deny fault.the police report confirms her fault. The form indicated RN A was suspended on 01/01/26.During an interview on 01/13/26 at 10:47 a.m., Resident #1 was non-verbal and did not answer any questions when asked.During an interview on 1/13/26 at 11:04 p.m., Medication Aide B said she got a call at home on [DATE] that RN A was stopped, and the police had found pills in her car. She said it was RN A's husband that called her. She said RN A was found with Meloxicam. She said she talked to RN A that evening and RN A told her it was a mistake. She said on a previous shift there had been two cards of Meloxicam for Resident #1 on the medication cart. She said both cards were full and contained 60 pills total. She said she took the two cards to RN A and told her that Resident #1 was no longer on the medication. She said RN A checked Resident #1's electronic medical record and confirmed the resident was no longer on the medications. She said RN A took the cards and laid them beside her, near her computer. She said she did not know what RN A did with them after that. She said RN A told her that when she got off work she was in a hurry, and the pills must have been scooped up with her personal items. Medication Aide B said she believed that was what happened. She said she had never seen RN A take anything she should not have taken. She said she did not know RN A well enough to say if she would take them or not. She said she would like to believe RN A did not take them purposely. She said, normally when she found discontinued medications on the medication cart, she took them to the nurse to verify there was no longer an order for the medication and then she put them in the discontinued box locked in the medication room. She said this time that was not what happened because RN A told her that she would handle it.During an interview on 01/13/26 at 12:43 p.m., the EDO said that RN A had been terminated. She said RN A had not been back in the building since 01/01/26. She said she did not handle the referral, but the information had been sent to corporate, and RN A would be referred to the state board.During an interview on 01/13/26 at 1:39 p.m., the DCO said on 01/01/26 he was notified by the police directly that they had searched RN A's car. He said the police told him they found medication belonging to Resident #1 in her car. He said the medication was a discontinued medication. He said he was told that RN A and Medication Aide B were cleaning out the cart. He said the process was there was a box in the locked medication room for discontinued medications. He said the nurse should have placed the medications in the discontinued box. He said he checked the box every week. He said he has now increased monitoring of medications. He said what was told to him was that RN A had sat the medications on down and when she was ready to pick up her personal items to leave, she accidentally picked up the medications too. He said the police told him there were two cards of the Meloxicam and none were missing from the cards. He said since the incident they had increased spot checking the medications. He said they had scheduled extra visits from the pharmacy (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455900	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	company to audit all medication. He said after the incident he immediately audited medications, and everything checked out fine. He said they are also using a form to keep up with medication counts. He said he would have expected the nurse to have immediately put the discontinued medications in the medication room in the discontinued box. He said there was no reason for a medication to be left out anywhere. He said they have completed in-services on medication administration and had scheduled frequent meetings with staff on all high points on how the building needed to be run. He said a nurse taking a medication could place a resident at risk for pain, alteration in vitals, and wellbeing. He said staff taking a medication was just not tolerated. He said RN A had been terminated and would be referred by corporate staff to the state board.During an interview on 01/13/26 at 2:12 p.m., the EDO said RN A called her on 01/01/26 and said that her husband had just been arrested and said, we had stuff in the car and I am afraid it is going to come back on me. She said at that point she was thinking it was drugs but not medications from the facility. She said the police had called the DCO and told him about the medication and which resident it belonged to. She said she did not know anything further until she had the police report. She said RN A ended up having 2 full cards containing a total of 60 pills of Meloxicam. She said then RN A sent her the emailed statement where she admitted to taking the medication and it was accidental. She said it could not have been accidental because it was in a small laptop case. She said there was no way RN A did not know she took the medication. She said there was no way RN A accidentally scooped up the medications. She said it was a discontinued medication, and it did not affect the resident. She said once Medication Aide B handed RN A the discontinued medication it should have been immediately secured. She said it should never have been left out for just anyone to access. She said immediately they counted every other medication in the facility. She said they had the pharmacist come to check all locked storage areas. She said now she expected all discontinued medications to come off the cart immediately, so that there is not an accidental use of the medication. She said previously it was not done daily. She said after this incident this will be done daily. She said the police told her that because it was not a controlled substance and the resident had not been using the medication they would not press charges. She said the facility had requested to press charges against RN A. She said there was now a warrant for her arrest because they chose to press charges. She said a staff member taking a resident's medication could cause them to not have the medications they need, could delay care, and affect their condition negatively.During an interview on 01/14/26 at 7:50 a.m., RN A said she and Medication Aide B were busy at work. She said Medication Aide B asked her about Resident #1's Meloxicam and if the resident still needed it or not. She said she was at the computer at the time. She said the medication had been discontinued. She said Medication Aide B handed her the medication. She said she then got called away from the computer. She said she laid the two cards beside the computer and covered them with some papers. She said at the end of the day she picked up her personal items and placed them in her bag. She said she did not know the medication was in her bag until the police searched her car. She said she was not arrested. She said Resident #1 had not missed any medications because the medications had been discontinued. She said she could not remember when the medication had been discontinued. She said as soon as she determined that the medication had been discontinued, she should have immediately locked them in the medication room in the discontinued box.Record review of an Abuse facility policy last revised on 01/27/20, The purpose of this policy is to ensure that each resident has the right to be free from any type of Abuse, Neglect, Intimidation, Involuntary Seclusion/Confinement, and or Misappropriation of property. The facility staff will adhere to the policies and procedures and will follow guidelines in the written policy and procedure.Residents will not be subjected to abuse by (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455900	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Mount Pleasant		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anyone, including, but not limited to community staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, or legal guardians, care taker, friends, or other individuals.Record review of a Storage of Medications facility policy last revised April 2007 indicated, .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.The facility shall no use discontinued, outdated, or deteriorated drugs or biological. All such drugs shell be returned to the dispensing pharmacy or destroyed.