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	05/20/2026

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

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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 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** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #1) reviewed for infection control.The facility failed to ensure the ADON applied enhanced barrier precautions when she performed a skin assessment and provided incontinent care to Resident #1 on 5/18/2026 at 3:00 PM.The facility failed to ensure the CNA applied enhanced barrier precautions while assisting the ADON with positioning and holding Resident #1 on 5/18/2026 at 3:00 PM.These failures could place residents at risk of cross-contamination and infections leading to illness. Findings included: Record review of Resident #1's Face sheet, dated 5/20/2026, indicated a 38-year- old female admitted [DATE], diagnoses included chronic respiratory failure (a long-term condition where the lungs cannot maintain adequate oxygen levels to remove carbon dioxide effectively), obesity (a medical condition in which excess body fat has accumulated to such an extent that it can have negative effects on health), quadriplegia (a symptom of paralysis that affects all limbs and body from the neck down), bipolar disorder (a mental health condition characterized by significant mood swings), neuromuscular dysfunction of bladder (occurs when nerve damage disrupts communication between the brain, spinal cord and bladder, leading to urinary control problems) and tracheostomy status(a surgical procedure that creates an opening in the neck to facilitate breathing when the usual airway is obstructed or compromised). Record review of Resident #1's quarterly MDS assessment, dated 2/7/2026, indicated the resident was understood and understood others. Resident #1 had a BIMS score of 12 indicating she was moderately cognitively impairment. The MDS also indicated Resident #1 was dependent on bathing, dressing, and toileting. Resident #1's MDS indicated she had an indwelling catheter and tracheostomy. Record review of Resident #1's Care Plan, initiated on 12/27/2024, indicated the resident had enhanced barrier precautions related to foley catheter, tracheostomy, and open skin areas. The care plan, revised on 11/25/2025, indicated Resident #1 had a tracheostomy related to chronic respiratory failure and an indwelling catheter related to neurogenic bladder (a condition in which damage to brain, spinal cord, or nerves disrupts the normal electrical signals between the nervous system and bladder) and was at risk for infection and pain. Resident #1's Care plan also indicated she had potential for skin impairment or infection related to attempting to tattoo to arms. Resident #1 scrapes areas of skin then attempts to color it with pens and markers. During an observation on 5/18/2026 at 2:00 P.M., Resident #1 was lying in bed under the covers. Resident #1 was observed with a tracheostomy, indwelling catheter, and skin irritations on her left upper arm. During an observation on 5/18/2026 at 3:00 P.M., the ADON perform skin an assessment on Resident #1. The ADON did not wash her hands prior to placing gloves. The ADON did not put on PPE while assessing Resident #1's skin. The ADON cleansed Resident #1's skin with wipes to remove barrier ointment. The ADON did not use hand sanitizer between glove changes during the skin assessment. Resident #1 was observed to have red areas under the creases of her left breast and creases between her legs. The ADON reapplied barrier ointment to areas. The ADON changed Resident #1's brief during the encounter and covered her back up with blankets. Resident #1 had a container (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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	located inside her room with PPE and a yellow sign was above her bed indicating she was on EBP (enhanced barrier precautions). During an observation on 5/18/2026 at 3:00 P.M., CNA A entered Resident #1's room to assist the ADON with positioning Resident #1. CNA A washed her hands and applied gloves only. CNA A did not apply PPE prior to assisting with care for Resident #1. During an interview on 5/18/2026 at 3:25 P.M., CNA A said if Resident #1 was on EBP there would be a sign on the outside of her door. She said she did not have to wear PPE while providing Resident #1's care. CNA A said PPE was worn if the resident was coughing or if there was a feces smell, a bad wound or staph infection (a bacteria that can spread through cuts, scrapes and skin to skin contact). CNA A said if PPE were not worn with a resident who required PPE, it could cause germs to be transmitted to staff or another resident through cross-contamination. CNA A said the nurse was responsible for ensuring the PPE was worn and EBP were followed. CNA A said she was in-serviced on EBP and PPE but could not recall the date. During an interview on 5/18/2026 3:34 PM, the ADON said she washed her hands prior to entering Resident #1's room. The ADON said she should have worn PPE and realized it when CNA A washed her hands. The ADON said she should have stopped and put on PPE. The ADON said staff should wear PPE when a resident had a foley catheter, tracheostomy, or open wounds. The ADON said CNA A should also have worn PPE. The ADON said she was in-serviced and had in-serviced staff on PPE and EBP. The ADON could not recall the last in-service date. The ADON said not wearing proper PPE while providing care could result in transferring germs to the resident or could spread infection. She said she was responsible for ensuring PPE was worn and staff were educated. The ADON said she had not observed any bugs in Resident #1's room and stated Resident #1 picked at her skin. During an interview on 5/19/2026 at 3:00 PM, LVN B said the nurses never wore PPE to provide care and wore gloves. LVN B said she had never worn PPE while providing care to Resident #1 and said she only wears gloves. LVN B said Resident #1 was non-compliant. LVN B said she had been in-serviced on EBP and said it was only for residents who had MRSA (a type of bacteria that causes skin infections and is resistant to many antibiotics). LVN B said the staff also used PPE during Covid (a contagious disease cause by coronavirus SARS-CoV-2). LVN B said the charge nurse and DCO were responsible for ensuring precautions were used. LVN B said if proper PPE were not worn with a resident on EBP precautions, it could cause infection and spread germs. During an interview on 5/19/2026 at 3:11 PM, CNA C said she wore PPE when the staff told her to. CNA C said the nurses do not tell the CNAs when to wear PPE. CNA C said sometimes the residents had a sign on the door and the staff put out PPE. CNA C said she did not know any residents who required PPE while providing care. CNA C said Resident #1 was not on EBP precautions and she was not required to wear PPE while providing her care. CNA C said she only wore gloves while providing her care. CNA C said mask and respirator were PPE. CNA C said she did not know what EBP meant. CNA C said the charge nurse and DON were responsible for ensuring EBP and PPE were available to use. CNA C said staff could get sick and cause cross-contamination. CNA C said she was in-serviced before she was hired on EBP. During an interview on 5/20/2026 at 9:12 AM, CNA D said she was not sure about PPE. CNA D said EBP was when the staff put on gloves, gowns, and goggles. CNA D said the residents would have a sign on the door. CNA D said EBP were for residents who had Covid and other reasons, but she could not recall. CNA B said she took EBP training last week. CNA D said the nurse was responsible for ensuring PPE and EBP were followed. CNA D said a resident could get sick through cross-contamination. CNA D said there were not any residents on EBP precautions. During an interview on 5/20/2026 at 9:26 AM, LVN E said EBP was for residents who had wounds, catheters, tracheostomy, and feeding tubes. LVN E said there were a couple of residents on the male secure unit and one resident on the women's unit. LVN E said the male resident was currently in the hospital. LVN E said the staff placed signs on the door but sometimes the sign got torn up. LVN E said the storage containers with PPE should be outside the resident's room. LVN E said the ADON was the infection preventionist. LVN E said a resident could get an infection if staff were not wearing proper PPE. During an observation on 5/20/2026 at 9:26 AM, LVN E went to the medication closet and there (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were face shields and the blue gowns in supply closet on the male secure unit. During an interview on 5/20/2026 at 12:20 PM, the ADON said a resident with tracheostomy, wounds, feedings, IVs (Intravenous- a medical procedure that involves delivering fluids, medications, or nutrients directly into a vein). The ADON said an EBP sign was on the wall in the resident's room. She said the DCO was the one who made the decision to place the sign in the room. The ADON said the facility just ordered extra mask. The ADON said the staff were supposed to know what to wear by the type of residents they are providing care for. The ADON said the sign was to remind them. The ADON said the nurse administration was observing staff when she was working on the floor but said she was not watching to see if they were using PPE. During an interview on 5/20/2026 at 12:32 PM, the DCO said he expected the staff to wear PPE while providing care to residents with wounds, foley catheters, tracheostomy, feeding tube, ostomies, and dialysis ports. The DCO said he expected staff to wear PPE while direct care or if they were touching the resident. DCO said the staff were aware due to the sign at the top of the resident's headboard. The DCO said the facility was implementing EBP on the EMR. The DCO said he had done in-services on EBP. The DCO said he was responsible for ensuring PPE was worn. The DCO said a resident could get an infection and could have secondary complications. During an interview on 5/20/2026 at 1:11 PM, the ADM said she expected the nurses to use EBP and PPE while providing care as well as handwashing. The ADM said the administration and nurses were responsible and monitoring through checkoffs. The ADM said a staff member could get sick or cross-contamination could make a resident ill. The ADM said she expected the staff to know which residents were on EBP precautions and expected staff to know what types of residents who required EBP. Record review of an enhanced barrier precautions policy, dated 4/1/2024, and titled, Enhanced Barrier Precautions indicated, .Enhanced Barrier Precautions (EBP) are a CDC guidance to reduce the transmission of multi-drug resistant organisms (MDRO) in health care settings.EBP require team members to wear a gown and gloves while performing high-contact care activities with resident who are infected or colonized with a targets MDRO or have open wound or indwelling medical device. Procedure: 1. Determine residents MDRO status on admission to community.2. Determine if a resident has any wounds.Determine if any of the following indwelling medical devices are in use: urinary catheter, g-tube, tracheostomy, central lines.EBP will be implemented if any of the above wounds or invasive medical devices are present. 3. Place signage on resident's closet door, maintain PPE in residents' room and assure all team members are aware of resident status and need for EBP during high contact care. 4. High contact resident care activities: dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care, or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care. Record review of CDC guideline titled, Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities, dated June 2021, indicated .Healthcare Infection Control Practices Advisory Committee is a federal advisory committee charted to provide advice and guidance to the Centers for Disease Control and Prevention.Executive Summary.1. Multidrug-resistant organism transmission is common in skilled nurse facilities.2. Enhanced Barrier Precautions is an approach of targeted gown and glove use during high contact resident activities.3. EBP may be applied (when Contact Precautions do not otherwise apply) to residents with any of the following.Wounds or indwelling medical devices, regardless of MDRO colonization status, Infection, or colonization with an MDRO. 4. Effectiveness implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE with hand hygiene products at the point of care. Implementation Approaches.The application of EBP to routine care of residents with wounds or indwelling medical devices requires that staff participate in initial and ongoing training on the facility's expectations about hand hygiene and gown and glove use.Facilities should develop a method to identify resident with wounds or indwelling medical devices, and post clear signage outside of resident rooms indicating the type of PPE required and defining high risk activities. Gown and gloves should be available outside each resident room, and alcohol-based hand (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, sanitary, comfortable, and homelike environment for 3 of 7 resident rooms and 1 of 2 hallways reviewed for environment. (Room # 2, Room # 4, Room # 5, room [ROOM NUMBER], Hallway #1)The facility failed to ensure Room # 2's air conditioning unit was free from gaps to outside on 5/18/2026 at 10:14 AM.The facility failed to ensure Room # 4 had base boards below the air conditioning unit on 5/18/2026 at 10:17 AM.The facility failed to ensure room [ROOM NUMBER]'s floor was not stained under air conditioning unit on 5/19/2026 at 11:50 AM.The facility failed to ensure room [ROOM NUMBER]'s white casing board was secured to wall and patch work along the border below the air conditioning unit was even and in good repair on 5/19/2026 at 11:00 AM.The facility failed to ensure Hallway #1's window seal on the secure men's unit was not broken, exposing wood fragments on 5/18/2026 at 10:14 AM.These failures could place residents at risk of an unsafe, unsanitary, uncomfortable environment, and embarrassment due to rooms not appearing homelike, and a decrease in quality of life and self-worth. Findings included: During an observation on 5/19/2026 at 11:00 A.M., room [ROOM NUMBER] revealed uneven patch work before the air conditioning unit. The patchwork had discoloration of tan/brown mixed with white drywall patching below the air conditioning unit. There was an observed white casing that held electrical wiring partially attached to the wall hanging down on the floor.During an interview on 5/20/2026 at 9:00 A.M., the Maintenance Director said the air conditioning unit started leaking and he said he went into room [ROOM NUMBER] and put mud plaster over it to fix it. The Maintenance Director said the mud was a coal base covering the wall. The Maintenance Director said there should not be space in the air conditioning unit to the outside. The Maintenance Director said the whiteboard was a racetrack (wire cover) to hide cables and phone lines. The Maintenance Director said it was an eye sore meaning it was not pleasing to the eye. The Maintenance Director said he was working on getting a new window on the men's secured unit in reference to the window seal that was broken and exposed the wood. The Maintenance Director said conversations had been back and forth regarding big money spending on how the facility would fix it. The Maintenance Director said he did not feel it was a homelike environment.During an interview on 5/20/2026 at 9:12 A.M., CNA D said no one complained to her about the environment. She said the nurses, CNAs and families were responsible for the resident's room being homelike. She did not say how the residents could be negatively affected. During an interview on 5/20/2026 at 12:40 P.M., the DCO said room [ROOM NUMBER] was not pleasing to the site. The DCO said the facility was pouring financially into the building and had hired an assistant to address the concerns with the building. The DCO said the last remodel did not last and explained the residents on the men's unit were busy. The DCO said the facility tried to give the residents an environment that the residents deserved. The DCO said the facility was actively being worked on. The DCO said he expected the facility to be homelike for the residents. The DCO said the administration was responsible for ensuring the facility and resident rooms were homelike. The DCO said he continued to ask the residents what the facility could do better to keep the residents happy. During an interview on 5/20/2026 at 1:19 P.M., the ADM said she expected resident rooms to be homelike. The ADM said she felt the aesthetics on the secure unit were unpleasant. The ADM said the facility hired a second maintenance assistant to help renovate. The ADM said she was responsible for ensuring the rooms were homelike. The ADM said it could negatively impact the residents' quality of life and demeanor. The ADM said the facility was resolving environmental issues and was starting on the men's unit. Record review of a facility policy, dated May 2017, titled, Quality of Life-Homelike Environment, indicated residents were provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Policy: Interpretation and Implementation.1. Staff shall provide person-centered care (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that emphasizes the residents comfort.2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting.