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	07/02/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 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 provide a safe, clean, and comfortable homelike environment for 2 of 20 resident's (Resident #7 and Resident #37) reviewed for a homelike environment.1. The facility failed to ensure Resident #7's wall was free from peeling paint at the head of her bed with approximately 4 different areas measuring approximately 1-2 inches wide and 2-3 inches long.2. The facility failed to ensure Resident #7's wall was free from peeling paint by her pillow that measured approximately 6-8 inches at the widest point and a foot long at the longest point.3. The facility failed to ensure Resident #7's air condition/heat unit was free from peeling paint and/or caulk around the unit leaving approximately half inch gaps around the top of the unit.4. The facility failed to ensure Resident #37's wall was free from peeling paint at the midway area of his bed that measured approximately 10 inches at the widest point and a foot long at the longest point.These failures could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life.Findings included:1. Record review of Resident #7's face sheet dated 6/30/25 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #7 had diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), diabetes (high blood sugar), and hypertension (high blood pressure).Record review of Resident #7's quarterly MDS assessment dated [DATE], indicated she had a BIMS score of 13, which indicated she was cognitively intact. Resident #7 used a walker for mobility. Resident #7 was independent to needed supervision for most ADLs.During an observation and interview on 6/30/25 at 11:36 AM, Resident #7 was sitting in her chair in her room. Resident #7 said she wanted her room painted because the paint was peeling off the wall, and she did not like it, and it looked bad. There was peeling paint at the head of her bed with approximately 4 different areas measuring approximately 1-2 inches wide and 2-3 inches long and peeling paint by her pillow that measured approximately 6-8 inches at the widest point and a foot long at the longest point. There was peeling paint and/or caulk around the air condition/heating unit leaving approximately half inch gaps around the top of the unit.2. Record review of Resident #37's face sheet dated 6/30/25 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #37 had diagnoses which included chronic obstructive pulmonary disease (COPD- a group of lung diseases that block airflow and make it difficult to breathe), senile degeneration of the brain (decline in cognitive function associated with aging), lack of coordination, and nicotine dependence.Record review of Resident #37's annual MDS assessment dated [DATE], indicated he had a BIMS score of 9, which indicated he had moderate cognitive impairment. The MDS indicated Resident #37 had continuous inattention. The MDS indicated Resident #37 was independent or needed set-up/clean-up assistance for most ADLs.During an observation and interview on 6/30/25 at 12:01 PM, Resident #37 had peeling paint on the wall beside his bed, about midway down his bed, that measured approximately 10 inches at the widest point and a foot long at the longest point. Resident #37 said it did not bother him, and he had lived in worse.During an observation on 7/02/25 at 9:35 AM, Resident #37 was lying in bed asleep. Resident #37's room continued to have peeling paint beside his bed that measured approximately 10 inches at the widest point and a foot long at the longest point. During an interview on 7/02/25 at 9:51 AM, RCP A said Resident #7 had not said anything to her about not liking the peeling paint on her wall. RCP A said she would report any issues with repairs to the nurse or the maintenance man. RCP A said the nurse put needed repairs in the maintenance logbook. RCP A said the maintenance man was responsible for ensuring the rooms were in good repair. RCP A said peeling paint in the residents' rooms was not homelike. RCP A said she would not want her walls like that. RCP A said peeling paint in her room would not make her feel good and would bother her. RCP A said peeling paint on the resident's wall would bother the resident also.During an interview on 7/02/25 at 9:58 AM, RCP F said he had worked at the facility for about 2 years. RCP F said he would report any resident reports of needed repairs to the maintenance man and put it in the maintenance logbook. RCP F said the maintenance man was responsible for repairing and maintaining the residents' rooms. RCP F said peeling paint in a resident's room was not homelike and he would not want peeling paint in his house. RCP F said it would not make him feel good to have peeling paint and would make the resident not feel good and not happy. RCP F said it was important to provide a homelike environment to make sure the resident was happy, and the facility was their home.During an interview on 7/02/25 at 10:16 AM, RN B said peeling paint in a resident's room would not be homelike. RN B

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 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 that respiratory care was provided consistent with professional standards of practice for 2 of 9 residents reviewed for respiratory care. (Resident #7 and Resident #26)1. The facility failed to ensure Resident #7's oxygen concentrator (takes air from the surroundings, extracts oxygen and filters it into purified oxygen for resident to breathe) air intake area (mouth of the oxygen concentrator bringing in the air that will be processed) was not covered in gray fuzzy dust-like and hair-like particles.2. The facility failed to ensure Resident #7 had an order and care plan for oxygen therapy.3. The facility failed to ensure Resident #26's oxygen concentrator air intake area was not covered in gray fuzzy dust-like and hair-like particles.These failures could place residents at risk of respiratory complications or respiratory infection. Findings included:1. Record review of Resident #7's face sheet dated 6/30/25 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #7 had diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), diabetes (high blood sugar), and hypertension (high blood pressure).Record review of Resident #7's quarterly MDS assessment dated [DATE], indicated she had a BIMS score of 13, which indicated she was cognitively intact. The MDS did not indicate Resident #7 was receiving oxygen therapy.Record review of Resident #7's undated Care Plan Report indicated she had potential for ineffective airway clearance, anxiety, and disturbed sleeping pattern related to chronic obstructive pulmonary disease. The care plan report did not indicate Resident #7 was receiving oxygen therapy.Record review of Resident #7's Order Summary Report dated 6/30/25 did not reflect an order for oxygen therapy.Record review of Resident #7's Medication Administration and Treatment Administration Records dated 6/01/25-6/30/25 did not indicate administration of oxygen therapy.During an observation and interview on 6/30/25 at 11:36 AM, Resident #7 was sitting in her chair in her room, and she reached over and put the oxygen tubing in her nose and over her ears. Resident #7 said she used her oxygen as needed for shortness of breath. Resident #7's oxygen was set on 2 LPM and the tubing was dated 6/30/25. Resident #7's oxygen concentrator's air intake area was covered in gray fuzzy dust and hair-like particles. Resident #7 said she did not know how often the facility cleaned the oxygen concentrator.During an observation on 7/01/25 at 1:45 PM, Resident #7's oxygen concentrator continued to have gray fuzzy dust and hair-like particles covering the air intake area.2. Record review of Resident #26's face sheet dated 6/30/25 indicated he was [AGE] years old and admitted to the facility on initially on 6/19/19 and re-admitted on [DATE]. Resident #26 had diagnoses which included chronic obstructive pulmonary disease, and hypertensive (high blood pressure) heart disease with heart failure. Record review of Resident #26's quarterly MDS assessment dated [DATE], indicated he had a BIMS score of 12, which indicated he had moderate cognitive impairment. The MDS indicated Resident #26 was receiving oxygen therapy.Record review of Resident #26's undated Care Plan Report indicated he had ineffective breathing pattern related to COPD and emphysema. Interventions included administer medications as ordered and may utilize oxygen as needed per physician orders. Resident #26 also had potential for problems related to COPD: problem with ineffective airway clearance related to excessive and tenacious secretions, problem with anxiety related to breathlessness and fear of suffocation, problem with disturbed sleep pattern related to cough or inability to assume recumbent position (lay flat) and used routine oxygen related to shortness of breath with exertion, upon rest and when lying flat. Interventions included administer oxygen per physician orders and change tubing/cannula per facility protocol. Resident also had continuous oxygen therapy related to COPD. Record review of Resident #26's Order Summary Report dated 6/30/25 reflected an order to clean/change oxygen concentrator filters every night shift on Sundays and an order for oxygen at 2-3 LPM by nasal cannula PRN shortness of breath with a start date of 4/14/22. Record review of Resident #26's Licensed Nurse Medication Administration Record dated 6/01/25-6/30/25 indicated there was an order to clean/change oxygen concentrator filters every night shift on Sundays and indicated RN D had completed the task on 6/29/25. Record review of Resident #26's Medication Administration Record dated 6/01/25-6/30/25 indicated he could have oxygen 2-3 LPM PRN shortness of breath and to document if oxygen was in use. The Medication Administration Record indicated he used oxygen daily 6/01/25-6/30/25.During an observation on 6/30/25 at 10:33 AM, Resident #26 self-propelled himself into room. Resident #26 was wearing oxygen by a nasal cannula in his nose attached to an oxygen tank hung on the back of his wheelchair. Resident #26 had an oxygen concentrator in his room with oxygen running at 3

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 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 nurse aides were able to demonstrate competency in skills and necessary techniques to care for resident's needs, as identified through resident assessments and described in the plan of care for 1 of 2 RCPs (RCP E) reviewed for nurse aide competencies. The facility failed to ensure RCP E was competent in performing a safe mechanical lift (machine used to lift and transfer a resident from one surface to another, such as from chair to bed/bed to chair) transfer on Resident #2 when RCP E did not place the legs of the mechanical lift in the wide position when lowering or transferring the resident and did not lock the lift wheels while lifting or lowering the resident. This failure could place residents at an increased and unnecessary risk of injury.Findings included:Record review of Resident #2's face sheet dated 7/02/25 indicated she was [AGE] years old and admitted to the facility on [DATE] and re-admitted [DATE]. Resident #2 had diagnoses which included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), diabetes (high blood sugar), hypertension (high blood pressure), weakness, blindness in one eye and low vision in the other.Record review of Resident #2's quarterly MDS assessment dated [DATE], indicated she had a BIMS score of 13, which indicated she was cognitively intact. The MDS indicated Resident #2 was dependent to needed substantial assistance in most ADLs.Record review of Resident #2's undated Care Plan Report indicated she was at risk for falls related to poor vision, inability to bear weight, weakness, and decreased sense of safety. Resident #2 had an ADL self-care performance deficit related to weakness, inability to bear weight and loss of vision from a cerebrovascular accident (stroke) with interventions including the resident required total assistance of two staff to move between surfaces using a Hoyer mechanical lift.During an observation on 7/01/25 at 8:38 AM, RCP E performed a mechanical lift transfer from a wheelchair to bed on Resident #2. RCP E placed the mechanical lift legs in the wide position around Resident #2's wheelchair. RCP E and RCP A attached the lift pad that was already under Resident #2. RCP E then did not lock the mechanical lift wheels and lifted Resident #2 up out of the wheelchair. The mechanical lift rolled toward the resident while RCP E was raising Resident #2 up. RCP E pulled Resident #2 backwards while RCP A moved the wheelchair from under the resident. RCP E the moved the mechanical lift legs to closed/narrow position, pulled Resident #2 backwards, turned toward the bed and then pushed Resident #2 over the bed. RCP E then lowered Resident #2 onto the bed, as RCP A guided the resident, and RCP E did not open the mechanical lift legs to the wide position and did not lock the mechanical lift wheels when lowering Resident #2 onto her bed.During an interview on 7/01/25 at 1:52 PM, RCP E said she had worked at the facility for a week and had been training on different halls. RCP E said she had not been checked off on mechanical Hoyer lift transfers yet but had been a CNA for 35 years and had been doing Hoyer lifts all that time. RCP E said the mechanical lift should have the legs in the wide position so it would go around the wheelchair. RCP E said the mechanical lift legs should be closed (narrow position) during transferring the resident because the mechanical lift was easier to push. RCP E said the wheels on the lift should be locked as a safety thing at all times. RCP E said she did not put the mechanical lift wheel locks on because it allowed her to move the mechanical lift to keep the bars out of the resident's face. RCP E said the mechanical lift was more stable with the legs in the wide position. RCP E said the mechanical lift was safer when the mechanical lift legs were closed (narrow position) during a transfer, but the mechanical lift legs should be opened to the wide position when lowering the resident to the bed. RCP E said she did not remember if she put the mechanical lift legs in the wide position or locked the wheels when lowering the position onto the bed.During an interview on 7/01/25 at 2:02 PM, RCP A said she had worked at the facility for approximately three years. RCP A said the mechanical lift legs should be in wide position for stability and so it would fit around the wheelchair. RCP A said the mechanical lift wheels should be locked when lifting or lowering the resident, so the mechanical lift does not move. RCP A said the mechanical lift legs should be in the narrow position during transferring the resident and when lowering the resident onto the bed. RCP A said the lift was more stable with the legs opened wide. RCP A said the legs of the mechanical lift should be opened wide, because it was safer for the resident during transfers and the mechanical lift could tip over and injure the resident. RCP A said she had been checked off on doing safe mechanical lift transfers. RCP A said she was guiding the resident while RCP E performed the mechanical lift on Resident #2 on 7/01/25 and did not notice if RCP E locked the wheels or if the legs were in the wide position during transferring the resident.During an interview on 7/02/25

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for 5 of 17 residents (Resident #3, Resident #24, Resident #39, Resident #48, and Resident #119) and 4 anonymous residents reviewed for palatable food. 1. The facility failed to ensure residents received food that tasted good. 2. The facility failed to ensure residents did not receive cold food. 3. The facility failed to ensure residents received preferred portion sizes. These failures could place residents at risk of weight loss, altered nutritional status and diminished quality of life. Findings included: 1. Record review of a face sheet dated 07/01/25 revealed Resident #3 was a [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses including congestive heart failure, muscle weakness, and anxiety. Record review of a quarterly MDS assessment dated [DATE] revealed Resident #3 was usually understood and usually understood others. The MDS revealed Resident #3 had a BIMS score of 15, which indicated intact cognition. During an interview on 06/30/25 at 2:08 p.m., Resident #3 said, the food ain't good. She said the vegetables had too much salt and were watery. She said when she ate in her room the food was always cold. 2. Record review of a face sheet dated 07/01/25 revealed Resident #24 was a [AGE] year-old female and was admitted to the facility on [DATE] with diagnoses including congestive heart failure, depressive episodes, and anxiety. Record review of an annual MDS assessment dated [DATE] revealed Resident #24 was usually understood and usually understood others. The MDS revealed Resident #24 had a BIMS score of 14 which indicated the resident had intact cognition. During an interview on 06/30/25 at 10:28 a.m., Resident #24 said the food had no taste. She said they were served the same things over and over. She said the food was cold. During an interview on 07/01/25 at 2:35 p.m., Resident #24 said her lunch was not good. She said nothing tasted good. She said the broccoli salad was terrible. 3. Record review of a face sheet dated 07/01/25 revealed Resident #39 was a [AGE] year-old male and was admitted to the facility on [DATE] with diagnoses including congestive heart failure, recurrent depressive disorders, and anxiety. Record review of a quarterly MDS assessment dated [DATE] revealed Resident #39 was usually understood and usually understood others. The MDS revealed Resident #39 had a BIMS score of 15 which indicated the resident had intact cognition. During an interview on 06/30/25 at 10:15 a.m., Resident #39 said the food was terrible. He said it was cold and bland. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of a face sheet dated 07/01/25 revealed Resident #48 was a [AGE] year-old male and was admitted to the facility on [DATE] with diagnoses including muscle weakness, depressive episodes, and anxiety disorder. Record review of a quarterly MDS assessment dated [DATE] revealed Resident #48 was understood and understood others. The MDS revealed Resident #48 had a BIMS score of 12 which indicated the resident had moderate impaired cognition. During an interview on 06/30/25 at 10:16 a.m., Resident #48 said, the food sucks. He said they needed a better variety of vegetables. He said the food was served like they were little kids. He said the portions were small. He said the food did not taste good and was sometimes cold. During an interview and observation on 07/01/25 at 8:43 a.m., Resident #39 said the food was terrible. He said he would like to be served some corn or black-eyed peas. He said all they ever had were mixed vegetables and zucchini. He said one night he was served one boiled egg and 4 pieces of toast. He said every Sunday night they were served tomato soup and a grilled cheese sandwich. He said, Even a dog eats more than that. On his cellphone was a picture dated June 23 at 5:41 p.m. of a plate with a tortilla containing four small pieces of meat, cheese, and a few vegetables. He said there was not enough meat. He said, All it tasted like was salsa. A second picture dated June 24 at 5:26 p.m. was of a plate with two pieces of bread and a small scoop of a cucumber tomato onion salad. He said the bread was a sandwich with only one small slice of meat. The meat was not visible in the picture. He said when he was served a sandwich the bread was hard like it had been left out. During an interview on 07/01/25 at 12:50 p.m., Resident #39 said the broccoli salad he was served at lunch was awful. 5. Record review of a face sheet dated 07/01/25 revealed Resident #119 was a [AGE] year-old male and was admitted to the facility on [DATE] with diagnoses including heart disease, diabetes, and chronic kidney disease. Record review of a MDS assessment dated [DATE] for revealed Resident #119 was usually understood and usually understood others. The MDS revealed Resident #119 had a BIMS score of 15 which indicated the resident had intact cognition. During an interview on 06/30/25 at 2:11 p.m., Resident #119 said the food tasted like he was eating someone else's spit. He said the food had no taste. He said it was horrible. During an observation and interview on 07/01/25 at 12:45 p.m., revealed a lunch tray was sampled with 4 surveyors and the Dietary Manager. The sample tray consisted of Beef Macaroni Casserole, broccoli salad, a roll, and a summer fruit cup. The Beef Mac Casserole was seasoned well, but the macaroni was overcooked and falling apart. The Dietary Manager agreed the macaroni was overcooked. The broccoli salad consisted of cooked broccoli with a dressing. All four surveyors agreed the salad did not taste good . The dressing did not taste like it belonged on cooked broccoli. The dressing was too tangy. The Dietary Manager said he did not like broccoli, and it did not taste good. The broccoli salad was the only vegetable on the tray. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a confidential resident group interview on 12/03/24 at 2:00 p.m., Anonymous Resident #1, Anonymous Resident #2, Anonymous Resident #3, Anonymous Resident #4, Resident #3, Resident #24, and Resident #119 stated they had asked for fried chicken and had not gotten any. They stated they were not served enough meat with meals. They stated the food did not taste good at all and it was cold. During an interview on 07/02/25 at 8:26 a.m., RCP A said Resident #119 had told her he did not like his food. She said he told her it had no flavor, and he could not eat it. She said she reported it to the family. She said she had not gotten food complaints very often. She said residents had told her the portions were not big enough. She said when she heard food complaints she had reported them to the dietary department. During an interview on 07/02/25 at 8:40 a.m., RN B said she heard a lot of food complaints. She said she had heard things like What is this? and I wouldn't give this to my dog. She said residents had told her the food was plain and tasted like water. She said she had heard from the residents who ate on the hall that their food was cold. She said when she first started working at the facility, she reported it to the dietary department. She said she quit reporting it because nothing got better. She said when there were certain people in the kitchen it was horrible. She said, The meals are not up to par here. During an interview on 07/02/25 at 10:40 a.m., the Dietary Manager said he had heard food complaints from staff and residents. He said they had to follow corporate made menus. He said they tried to go above and beyond for each specific resident. He said he had made rounds in the past. He said during those rounds no one really complained to him. He said he was not aware of any concerns mentioned during Resident Council. He said residents not liking the food could lead to weight loss and the resident not getting proper nutrition. During an interview on 07/02/25 at 2:38 p.m., the DCO said she had heard complaints about portion sizes and taste. She said the dietician was very active in the kitchen. She said there was a big employee turnover with cooks in the kitchen. She said they had started asking residents specifically what meals the residents would like and then they serve it the next month. She said residents not liking their food could cause weight loss and illness. During an interview on 07/02/25 at 3:02 p.m., the EDO said she had heard food complaints. She said they had been adjusting the menu to try to please the residents. She said they served a lot of sandwiches. She said residents not liking their food could cause weight loss and unhappiness. She said Resident #48 had requested boiled eggs. She said he was served boiled eggs and toast for breakfast after the request. Record review of a Resident Grievance/Complaint Investigation Report dated 06/26/25 indicated Resident #48 said on 06/23/25 the tortilla hardly had any filling, and the beans were burnt and runny. The corrective action taken was for staff to continue to monitor meals. Record review of the resident council minutes, dated between January 2024 and June 2025, revealed the following: 1. On 01/22/25, .Food & Nutrition Services Department .still coming out cold .Meal of the Month . Entrée: Fried Chicken .Side .green beans & corn - cream style - no broc (broccoli). (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 02/19/25, .Food & Nutrition Services Department .food is coming out burnt or to hard .still coming out cold .would like to have more fried chicken than baked or rosemary . 3. On 03/20/25, .Food & Nutrition Services Department .food hasn't changed, still cold or burnt. Have not got their fried chicken. Still getting rosemary . 4. On 04/23/25, .Food & Nutrition Services Department .still cold coming down the hall .Meal of the Month . Vegetable: no broc (broccoli) . 5. On 05/21/25, .Food & Nutrition Services Department .still cold coming down the hall .Meal of the Month . Entrée: Fried chicken .Vegetable: Carrots, not broc (broccoli) . 6. On 06/18/25, .Food & Nutrition Service Department .some days it is cold & some days it is warm . Record review of a Preparation of Foods facility policy dated 04/2022 indicated, .Food is to be prepared by methods that conserve nutritive value, flavor, and appearance .All food will be prepared by methods that preserve nutritive value, flavor, and appearance with variety of color, and will be attractively served at the proper temperature and in a form to meet the individual needs of the resident .

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	07/02/2025

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 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. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards in 1 of 1 kitchen reviewed for food service safety.1. The facility failed to ensure all food items were labeled and dated in Refrigerator #1.2. The facility ensure that wall in the pantry was in good repair. 3. The facility failed to ensure that the pantry was free of rotting food.4. The facility failed to ensure that a scoop for the sugar bin was properly stored. 5. The facility failed to ensure the ceiling under the air conditioner duct was in good repair.6. The facility failed to ensure that all air conditioner vents were clean and free of condensation. These failures could place residents at risk of foodborne illness and food contamination.Findings include: During an observation on 06/30/25 at 8:41 a.m., revealed one plastic bag containing one light brown round food item with no date or label in Refrigerator #1. During an observation 06/30/25 at 8:44 a.m., revealed a wall in the pantry with an air conditioner in the wall. Below the air conditioner there was a large gray stain with peeling paint on the wall. Below the stain and peeling paint there was approximately 3 to 4 feet of the baseboard that was pulled away from the wall. There was a towel on the floor pushed against the baseboard. In the corner at the end of the baseboard, there was a hole in the wall with pieces of sheetrock protruding from the hole. A bin in the pantry contained potatoes with rotten areas and growing sprouts. During an observation on 06/30/25 at 8:53 a.m., revealed there was a cup in the sugar bin. During an observation on 07/01/25 at 11:56 a.m., in the kitchen area the ceiling under the air conditioning duct had several brown stains and was buckled. There were several brackets in place securing the ceiling in place. Between the air conditioning duct and the vent hood over the stove there were five towels stuck in between the vent hood and duct. There were five vents coming from the air conditioning duct and each had gray dust particles built up. One vent had condensation built up and was occasionally dripping onto the kitchen floor. One vent had a black substance on it. During an interview on 07/02/25 at 10:13 a.m., the Maintenance Supervisor said he was not aware of the damage, the baseboard being pulled out or the hole in wall in the pantry. He said he did not go in the kitchen unless he was told about something in the kitchen. He said the Dietary Manager reported any maintenance issues to him. He said the ceiling under the air conditioner duct was old and needed to be replaced. He said he did not know how long it had been buckled and the stains. He said it had been like that at least year. He said the vents dripped because of the heat from the stove caused condensation. He said he did not know who was responsible for cleaning the vents. He said he had cleaned them before. He said he would not go in and clean them unless the DM asked him to clean them. He said the towels were behind the air condition duct to keep the ceiling pushed up and not droop. He said the towels were not to collect condensation. He said he noticed the towels there when he was in the kitchen on 07/01/25. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 07/02/25 at 10:40 a.m., the Dietary Manager said all dietary staff were responsible for dating and labeling food. He said a food items not being dated could cause old or out of date food to be served. He said even though a food item was not labeled staff would still know what the food item was, but dating and labeling food was important. He said, They go hand in hand. He said usually scoops were not left in bulk food items. He said he did not know why the scoop was left in the sugar. He said a scoop being left in the sugar could cause cross contamination. He said all dietary staff were responsible for removing rotting food. He said any rotting food should be thrown away. He said he would have expected for the potatoes to have been thrown out. He said rotten food could lead to foodborne illness. He said he did not know how long the wall had been damaged in the pantry. He said at some point the air conditioner in that wall had frozen up. He said the towel was placed there to absorb the moisture from the air conditioner. He said moisture from the air conditioner caused the baseboard to pull away and caused the hole in the wall. He said he had forgotten to report it to maintenance. He said the moisture could cause mold and the hole being in the wall could increase the chances of pest in the pantry. He said the ceiling being buckled and stained under the air conditioner duct had been that way for at least a year. He said the Maintenance Supervisor was aware because he had done a walk through. He said he did not know why the towels were between the air duct and the vent-o-hood. He said he thought it was the Maintenance Supervisor's responsibility to clean the air conditioner vents. He said the one vent had a lot of condensation since the weather had gotten hot. He said the condensation or dusty particles from the vents could fall into the food and cause cross contamination. During an interview on 07/02/25 at 3:02 p.m., the EDO said anyone that opened foods was responsible for dating and labeling foods. She said, ultimately the DM was responsible for making sure that was done. She said food not being dated could cause food to be kept past the time of consumption and make the resident ill. She said food not being labeled could cause you not to know what the item was, and it not be safe for consumption. She said scoops should not be stored in food items because it could pass germs to the food item. This could cause a risk for infection and spread of germs. She said any food item with obvious signs of aging or decay should not be consumed because you do not want to keep a spoiled item that could make a resident sick. She said they should not have retained the potatoes. She said the wall in the pantry should have been reported to her and to the Maintenance Supervisor and it should have been repaired upon knowledge. She said the ceiling under the air conditioner duct should have been repaired and towels should be utilized in that space. She said condensation dripping could cause a fall. She said the air conditioning vents should be kept clean by dietary staff. She said there were times and places that would require assistance from the Maintenance Supervisor. She said she would have expected the vents to have been kept clean or at least let her know they were not able to clean them. She said the particle or germs from the dirty air conditioning vents could contaminate the food. Record review of a Food Storage facility policy dated 01/2018 indicated, .All food purchased will be wholesome, manufactured, process, and prepared in compliance with all State, Federal, and local laws and regulations. Food will be handled in a safe and sanitary method to prevent contamination and food-borne illness .Stock will be rotated first-in, first-out. Foods will be used or discarded prior to the expiration date . Food removed from its original packaging will be labeled with the following .Receive Date .Open Date . Contents in the Package .Opened package or leftover food is to be tightly wrapped or covered in airtight, clean containers. It should be labeled, dated with the opened or use by date .Do not store scoops in ready to eat food .

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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 4 residents reviewed for enhanced barrier precautions (Resident #121) infection control practices.The facility failed to ensure RN C donned (put on) a gown prior administering medications and feeding to Resident #121 via g-tube. Resident #121 was on enhanced barrier precautions.These failures could place residents at risk of exposure to communicable diseases, cross-contamination, and infections.Findings included: Record review of Resident #121's face sheet dated 07/07/25, indicated she was a [AGE] year-old female that admitted [DATE] with diagnoses that included: epilepsy (a disorder in which nerve cell activity in the brain disturbed, causing seizures), gastrostomy status (opening allows for a tube to be inserted, providing a direct route for administering food), muscle weakness and dysphagia (difficulty swallowing foods or liquids). Record review of Resident #121's physician's order indicated: dated 6/24/25 enteral feed order one time a day document start and stop times as they pertain to down time if ordered. If continuous during the shift, document 'not applicable' next to start/stop time. jevity 1.5 at 55mL/hr with 30mL/hr water flush for 20 hours. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #121 usually understood others and was usually understood by others. Resident #121 BIMS score was a 15 which indicated she was cognitively intact. She was dependent with ADL's. Resident #121 was always incontinent with bowel and bladder. Record review of the care plan dated 09/13/24 indicated Resident #121 was on EBP (Enhanced Barrier Precautions) due to feeding tube. Interventions (enhanced barrier precautions) sign will be placed inside resident room within close proximity to resident to inform staff of resident specific needs. EBP supplies (gown and gloves) will be readily available. EBP supplies will be discarded in regular trash receptacle unless soiled with blood or bodily fluids. Residents are not restricted to their rooms or limited from group activities, as they are not considered in isolation for EBP only. Staff will maintain EBP (Enhanced Barrier Precautions) during high contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or toileting. Staff will maintain EBP will performing any type of device care such as but not limited to the following: central line care, tracheostomy care, urinary catheter care, feeding tube care, and wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the care plan dated 02/15/24 indicated Resident #121 required tube feeding related to dysphagia and recent vent/inability to swallow. I have pleasure feeding only with speech therapy supervision but am NPO (nothing by mouth) with nursing staff. I choose to sit in the dining room during meals even though I am NPO (nothing by mouth). On 6/24/25 Resident #121 failed the swallow study during hospital stay and am now NPO (nothing by mouth). Interventions: the resident needs the HOB (head of bed) elevated at least 30 degrees during and thirty minutes after tube feed. Check for tube placement and gastric contents/residual volume per facility protocol and record. Discuss with the resident/family/caregivers any concerns about tube feeding, advantages, disadvantages and potential complications. Listen to lung sounds. Monitor/document/report PRN (as needed) any signs and symptoms of: aspiration- fever, shortness of breath, tube dislodged, infection at tube site, self-extubating, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting and dehydration. Obtain and monitor lab/diagnostic work as ordered. Report results to medical director and follow-up as indicated. Provide local care to g-tube site as ordered and monitor for signs and symptoms of infection. Registered dietician to evaluate quarterly and PRN (as needed). Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. Speech therapy evaluation and treatment as ordered. During observation of med pass to Resident #121 on 7/01/25 at 12:15 P.M. revealed RN C checked for g-tube placement, gave medications and started feeding jevity 1.5 cal 55ml/hr via g-tube without donning a gown. During an interview on 7/01/25 at 12:21 P.M., RN C said this was her first day working with Resident #121. She said she was not sure if Resident #121 was on enhanced barrier precautions. She said she had not been wearing her gown when she gave Resident #121 her medications and feedings. She said she did not see the enhancement barrier precaution sign or the PPE material in the resident's room. She said enhanced barrier precautions prevented the spread of infection. During an interview on 7/01/25 at 12:28 P.M., the ADCO said there was an EBP (enhanced barrier precautions) sign in Resident #121's room under her light and the PPE supplies cart was in the resident's room next to her nightstand. He said he would do a one-on-one in-service with RN C and a general all staff in-service over EBP (enhanced barrier precautions). He said it was important for staff to wear their PPE to reduce the risk of infection to the device Resident #121 had. During an interview on 7/02/25 at 10:49 A.M., LVN H said when a resident was on enhancement barrier precautions staff should wear PPE such as their gown and gloves to prevent the nurse or RCP from coming in contact with the back splash from the resident g-tube. She said EBP (enhancement barrier precautions) was to prevent cross contamination when a resident had a g-tube. During an interview on 7/02/25 at 2:46 P.M., the DCO said she expected the staff to follow EBP (enhancement barrier precautions). She said ADCO did one-on-one in-service with RN C yesterday over EBP (enhancement barrier precautions). She said EBP (enhancement barrier precautions) was not only to protect the staff it was to protect the residents from infections as well. During an interview on 7/02/25 at 3:30 P.M., the EDO said she expected the staff to use the new enhancement barrier precautions guidelines, because Resident #121 did have a peg-tube. She said a negative effect of not using enhancement barrier precautions staff could pass on infections to other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's sign, Enhanced Barrier Precautions sign, undated, indicated: Providers All Staff Must Also: Wear gloves and grown for the following high-contact resident care activities .Device care or use: Central line (a central venous catheter), urinary catheter, feeding tube and tracheostomy (an opening into the trachea from outside the neck) . Record review of the facility's policy, Enhanced Barrier Precautions, dated 04/01/2024, indicated: Enhanced Barrier Precautions (EBP) are a CDC guidance to reduce transmission of multidrug-resistant organisms (MDRO) in health care settings, including nursing homes. EBP require team members to wear a gown and glove while performing high-contact care activities with residents who are infected or colonized with a targeted MDRO, or who have open wound or indwelling medical device . 2. Determine if any of the following indwelling medical devises are in use: urinary catheter, g-tube, 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, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator . Record review of the facility's policy, Infection Control, revised date 10/25/2022, indicated: This communities' infection control policies and practices are intended to facilitate maintaining as safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections . Record review of the facility's policy, Personal Protective Equipment, dated 08/25/2021, indicated: Personal protective equipment appropriate to specific task requirements is always available .1. All personnel who performed tasks may involve exposure to blood/body fluids are provided appropriate personal protective equipment (PPE) at no charge .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation and interview the facility failed to maintain all mechanical and electrical equipment in safe operating condition for 1 of 1 kitchen reviewed for safe operating condition.The facility failed to ensure Freezer #2 maintained a safe storage temperature and not allow food items to thaw.This failure poses a risk of essential kitchen equipment malfunctions causing foods to be held at an unsafe temperature and cause food borne illness. Findings included: Record review of a Kitchen Freezer Log for June 2025 revealed on 06/27/25 the morning temperature for Freezer #1 was 5 degrees. The temperature was initialed by [NAME] G. The evening temperature for 06/27/25 was 2 degrees Fahrenheit. On 06/28/25, the morning temperature was 0 degrees Fahrenheit, and the evening temperature was 3 degrees Fahrenheit. The morning temperature was initialed by the Dietary Manager. On 06/29/25, the morning temperature was 2 degrees Fahrenheit, and the evening temperature was 0 degrees Fahrenheit. The morning temperature was initialed by the Dietary Manager. On 06/30/25, the morning temperature was 0 degrees Fahrenheit. There were no initials. During an observation and interview on 06/30/25 at 8:44 a.m., revealed the outside digital thermometer on the upper right-hand corner of Freezer #1 read Hi. In the freezer was 1 package of egg rolls thawed and soft to the touch. There was one package of breaded shrimp thawed and soft to the touch. There was 1 box of containing three briskets. One brisket was soft to the touch and another brisket was thawed but cold. [NAME] G said they had been having problems with Freezer #1. She said the Maintenance Supervisor had worked on Freezer #1 on Friday, 06/27/25. During an observation and interview on 06/30/25 at 8:56 a.m., the Dietary Manager said sometimes the door stayed open and it caused ice buildup and food items would thaw. There was a small amount of ice noted at top of Freezer #1. He said the freezer would need to be thawed out. He said the thermometer on the outside of the freezer always read Hi. The Dietary Manager said they used a thermometer inside the freezer. The Dietary Manager had difficulty finding a thermometer in the freezer. A digital thermometer was placed in the freezer by the surveyor. During an observation on 06/30/25 at 8:57 a.m., revealed the digital thermometer in Freezer #1 read 58 degrees Fahrenheit. Within seconds of the door being opened an alarm sounded. The outside digital thermometer on the upper right-hand corner of Freezer #1 read Hi. During an observation on 06/30/25 at 9:01 a.m., revealed the digital thermometer in Freezer #1 read 50 degrees Fahrenheit. Within seconds of the door being opened an alarm sounded. The outside digital thermometer on the upper right-hand corner of Freezer #1 read Hi. During an observation on 06/30/25 at 9:15 a.m., revealed the digital thermometer in Freezer #1 read 50 degrees Fahrenheit. Within seconds of the door being opened an alarm sounded. The outside digital thermometer on the upper right-hand corner of Freezer #1 read Hi. During an observation and interview on 06/30/25 at 2:59 p.m., revealed there was a thermometer attached to a shelf inside Freezer #1. The temperature was 28 degrees Fahrenheit. The Dietary Manager said he had thrown out the food items that had thawed and removed things to increase air circulation and the temperature was returning to normal. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 07/01/25 at 8:05 a.m., revealed the temperature in Freezer #1 to be 28 degrees Fahrenheit. The briskets were soft to touch. The Dietary Manager said he stayed until 8:00 p.m. on 06/30/25 and the temperature had come down to 20 degrees Fahrenheit. Within seconds of the door being opened an alarm sounded. He said he was in the process of finding an alternative freezer at this time. The outside digital thermometer on the upper right-hand corner of Freezer #1 read Hi. During an observation on 07/01/25 at 11:00 a.m., the temperature in Freezer #1 was 24 degrees Fahrenheit. Outside digital thermometer reads Hi. Within seconds of the door being opened an alarm sounded. The outside digital thermometer on the upper right-hand corner of Freezer #1 read Hi. During an interview on 07/02/25 at 10:13 a.m., the Maintenance Supervisor said he had worked on Freezer #1 on Friday, 06/27/25. He said the fans were frozen up in the freezer. He said he pulled them all out and got them to where they could run. He said he thought the fans were burned up on that freezer. He said on Friday, 06/27/25 the fans were running but running slow. He said the temperature was right at freezing on 06/27/25. He said he had no documentation. During an interview on 07/02/25 at 10:40 a.m., the Dietary Manager said the Maintenance Supervisor did work on Freezer #1 on Friday, 06/27/25. He said he was not at work that day, so he was not sure what the Maintenance Supervisor had done. He said he did work over the weekend, and the freezer was working fine. He said he felt the documented temperatures on the Kitchen Freezer Log were not accurate because it would have taken awhile for the food items to have thawed out. He said they used a thermometer inside the freezer to monitor the temperatures because the outside built-in digital thermometer had been reading hi. He said the outside digital thermometer had not been working for a while. He said food items not being kept frozen could cause foodborne illness if the temperatures got to the temperature danger zone. During an interview on 07/02/25 at 3:02 p.m., the EDO said she expected frozen foods to be kept frozen solid. She said the freezer should freeze the food solid and keep the food frozen. She said all of the food in the freezer had been thrown away. She said the Dietary Manager told her there were issues on Friday, 06. 27/25. She said if they used food that was not stored properly at the right temperature it could make a resident ill with foodborne illness. Record review a Food Storage facility policy dated 01/2018 indicated, .Freezer will be maintained at 0 degrees F (Fahrenheit) or below; or at a temperature where frozen foods remain frozen . Record review of a Supplies and Equipment, Environmental Services facility policy dated 2001 indicated, . Equipment must be ready for use at all times of the day and night to serve the residents' needs .

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. (continued on next page)

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F 0926 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 follow their own established smoking policy for 1 of 9 residents reviewed for smoking. (Resident #37)The facility failed to ensure Resident #37 followed the smoking policy and did not have smoking supplies (cigarettes and lighter) at his bedside. This failure could place residents at risk for injury or harm. Findings included:Record review of Resident #37's face sheet dated 6/30/25 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #37 had diagnoses which included chronic obstructive pulmonary disease (COPD- a group of lung diseases that block airflow and make it difficult to breathe), senile degeneration of the brain (decline in cognitive function associated with aging), lack of coordination, and nicotine dependence.Record review of Resident #37's annual MDS assessment dated [DATE], indicated he had a BIMS score of 9, which indicated he had moderate cognitive impairment. The MDS indicated Resident #37 had continuous inattention. The MDS indicated Resident #37 was independent or needed set-up/clean-up assistance for most ADLs. The MDS did not indicate Resident #37 was using tobacco at the time of the assessment.Record review of Resident #37's undated Care Plan Report indicated he had a behavior problem related to anxiety, low frustration tolerance with poor impulse control, and often refused to follow smoking rules and attempted to hide cigarettes and lighter. Interventions included to intervene as necessary to protect the rights and safety of others. Resident #37 had impaired cognition with poor judgement, sense of safety, decision making skills related to dementia, very poor memory and often thought staff were talking about him, keeping his money, and not following smoke break times. Resident #37 was a smoker of tobacco and had a history of not following smoking rules and was very anxious and aggressive if smoke breaks were late. Interventions included for resident to keep all lighters/matches with facility staff for safety, and resident would participate in supervised smoke breaks. Record review of Resident #37's Safe Smoking assessment dated [DATE] indicated Resident #37 required direct supervision while smoking, all smoking materials would be kept at the nurse's station, the evaluation had been discussed with the resident and explained to his family/responsible party.During an observation and interview on 6/30/25 at 12:01 PM, Resident #37 said he smoked. Resident #37 said he kept his smoking supplies in his room when he had them. Resident #37 said he had a lighter in his room, but said it was out of fluid, then Resident #37 demonstrated with his red zippo-like (refillable) lighter that it flicked and sparked but did not light. Resident #37 said he was out of cigarettes and would not have money to buy more until Thursday (7/03/25) when he got paid.During an observation and interview on 7/01/25 at 2:25 PM, Resident #37 was lying in his bed and still had a red zippo-like lighter on his nightstand and had an empty box of cigarettes. Resident #37 said he was out of cigarettes now, but he kept his cigarettes and lighter in his room when he had them. During an observation on 7/02/25 at 8:00 AM, upon arrival at facility, Resident #37 was observed outside in the smoking area smoking and the Director of Environment Services was supervising the smoke break. During an observation on 7/02/25 at 9:35 AM, Resident #37 was lying in bed asleep. There was a red zippo-like lighter and an almost full pack of cigarettes lying on top of his nightstand in plain view. During an interview on 7/02/25 at 9:41 AM, the Director of Environmental Services said Resident #37 smoked when he wanted to and often would tell her that he did not need a babysitter while she was supervising the smoke breaks. The Director of Environmental Services said they were supposed to stay with the residents during the smoke breaks, but Resident #37 would get mad, so they would watch him through the window of the dining room. The Director of Environmental Services said she guessed the EDO knew it and he kept his cigarettes in his room. The Director of Environmental Services said they were supposed to supervise the residents during smoke breaks to ensure they were safe, and they had to light their cigarettes for them. The Director of Environmental Services said the policy said the residents were not supposed to have cigarettes or lighters in their rooms. The Director of Environmental Services said they should not have smoking supplies in their rooms, because they could smoke in the rooms and start a fire and it was a big no, no. The Director of Environmental Services said she had reported it to EDO previously and they have had a meeting about it and took all the supplies from residents. The Director of Environmental Services said Resident #37 was upset about it but he gave his smoking supplies to her but now had them back in his room. The Director of Environmental Services said Resident #37 had told her that morning (7/02/25), his hospice nurse brought him cigarettes yesterday (7/01/25) and apparently left them with him in his room. The Director of Environmental Services said the Activity Director kept all the extra cigarettes locked up and they had the