STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675079	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Allenbrook	4109 Allenbrook Dr Baytown, TX 77521

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare and distribute food in accordance with professional standards for food safety in that -The facility failed to ensure that dented cans were not stored with undented cans.The facility failed to ensure that one of 2 refrigerators in the dining room was free from expired food products. These failures placed residents at risk of foodborne illness.Findings included:Kitchen observation with Dietary Manager on 03/10/26 at 8:30AM revealed there was one 28 oz can, of tomato soup that was dented stored together with un-dented can goods. The Dietary Manager removed the dented can from the shelf and said it was supposed to be in the office for return.Observation of Refrigerator #1 in the dining room revealed-2-5 lbs. of containers of cottage cheese -expired 02/16/266-one-quart half and half milk with expired date of 03/04/262-Gallons of milk with expired date of 03/01/262-Gallons of milk with expired date of 03/08/26 andone gallon of milk with expired date of 03/09/26.The dietary Manager took all expired products out of the freezer.During an interview with Dietary Manager on 03/10/26 at 11:00AM, she said she usually checks all refrigerators and freezers for expired food products every Monday, but she was off Monday 03/09/26. She said all kitchen staff are supposed to check for expired food items in the freezer and refrigerators. She said expired food items and food products should not be served to anyone because serving expired food products may cause food born illness and sickness.During an interview with facility registered dietitian on 03/11/26 at 11:30AM, she said she worked 8 hours weekly at the facility and as needed. She said her focus was on the residents. She said from time to time, she would walk round the kitchen for general sanitation, provide education to staff and in-serviced staff in the areas that need improvement pending on her findings. She said no person should be served expired food products because expired food products can result in food born illness. She said she had done in-services on food rotation first in and first out and would do another in-service on food rotation.During an interview with facility Administrator on 03/11/26 at 4:00PM, she said expired food items and products should not be stored in the refrigerator or freezer for consumption. She said the Registered Dietitian would in-service all dietary staff on food rotation and ensure that all expired food items and products are removed from the refrigerators.Record review of facility's policy dated 04/2022 revised 02/2026 titled Food production.Policy: Left-over foods should be handled in a manner to prevent the spread of food borne illness. 6. Any foods that have a manufacturer's expiration or use-by date should be left in the original container and should be discarded according to this date.Definitions:Expiration date: when food is considered no longer safe to consume to avoid illnessUse by/Best by/Sell by date: guidelines provided by manufacturers indicating when a product will be at its best flavor and quality. It does not mean the product is unsafe to consume after this date. After the best by date, food is still safe to eat but its taste, texture and overall quality may decline. (Example: bread might be stale)Freeze by: dates refer to the recommended date to freeze a product to maintain quality. It does not indicate food safety.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the assessment accurately reflected the status for one (Resident #10) of 18 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #10's annual MDS assessment accurately reflected her lack of natural teeth in her oral cavity.This failure could place residents at risk for receiving inadequate care and services due to inaccurate assessments.The findings included: Record review of Resident #10's face sheet dated 03/11/26 indicated she was admitted to the facility on [DATE] and was re-admitted on [DATE]. Her diagnoses included Chronic obstructive pulmonary disease (lung disease), dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, essential hypertension (high blood pressure), generalized anxiety disorder, chronic pain syndrome, major depressive disorder, lack of coordination, schizoaffective disorder and bipolar .Record review of Resident #10's annual MDS assessment dated [DATE] revealed her BIMS score was 4 out of 15 indicating severe cognitive impairment. Record review of the MDS section on oral dental, she was assessed as having obvious or likely cavity or broken natural teeth.Record review of Resident #10's care plan initiated 01/17/22 with a revision date of 01/17/26 indicated Resident #10 had oral/dental health problems, decayed missing teeth r/t Poor oral hygiene.Intervention: Resident #10 will be encouraged to comply with mouth care at least daily through review date. Date Initiated: 01/17/2022 Revision on: 01/08/2026.Observation on 03/11/26 at 12:20pm, revealed Resident #10 had mechanical-altered diet. She feeds herself and ate 100% of the meal served. Observation indicated she had no teeth in her oral cavity.In an interview on 03/11/26 at 2:00pm Resident #10 said she was tired and just wanted to rest. During an interview, she said she does not have any teeth in her oral cavity. She said she used to have dentures but lost them. She said she does not know where they were.Interview with MDS coordinator on 03/12/26 at 3:30PM, she said Resident #10 does not have any teeth in her oral cavity. She looked at the MDS and said the MDS assessment was an oversight. She said an inaccurate assessment may prevent residents from getting needed services. She said she would modify Resident #10's MDS assessment and update the care plan to reflect Resident #10's lack of natural teeth.During an interview with Facility DON on 03/12/26 at 3:10PM, she said all assessments should reflect Resident's condition. She said inaccurate assessment would delay residents from getting needed care and services.Facility's policy on accuracy of resident's assessment was requested on 03/13/26 at 10:20AM. MDS coordinator and Facility DON said the facility followed the RAI manual

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the medication error rates were not 5 percent or greater. During medication administration, a medication error rate of 7 percent was identified (2 errors out of 28 opportunities). These errors involved 2 of 9 residents (resident #20 and resident #52) and 1 of 2 MA (MA J) administering medications. 1. The facility failed to ensure that MA J did not attempt to administer divalproex sodium 500mg oral tablet to Resident #20 during the morning medication pass, when the physician's order indicated the medication was to be administered at bedtime. 2. The facility failed to ensure that MA J did not administer zinc sulfate oral tablet to Resident #52 when the physician's order specified zinc sulfate oral capsule resulting in administration of medication in a form inconsistent with the prescribed order. These failures placed residents at risk for medication errors and potential adverse outcomes.Findings include: Resident #20: Record review of Resident #20's face sheet, dated 3/12/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE], and readmitted on [DATE]. Her diagnoses included seizures (shaking), diabetes (high blood sugar level), hypertension (high blood pressure), hyperlipidemia (high lipid in the blood), mood disorder, and muscle weakness. Record review of Resident #20's quarterly MDS assessment, dated 12/17/2025, revealed a BIMS score of 6 out of 15, which indicated severe cognitive impairment. She required assistance from staff with activities of daily living care. Record review of Resident #20's care plan initiated on 4/11/25 revealed she was at risk of adverse consequences related to receiving anticonvulsants for treatment of mood disorder. Interventions were to give medications per order. Record review of Resident #20's Physician's orders dated 11/18/25 revealed an order for: Divalproex sodium oral tablet delayed release 500mg. Give 1 tablet by mouth at bedtime. During medication administration pass observation on 3/11/26 at 9:05 a.m., the surveyor observed MA J preparing medications for Resident #20. The MA J removed divalproex sodium (medication used to control seizure and helps to stabilize mood) 500mg from the blister pack and placed it into a medication cup with other medications intended for administration to Resident #20. Prior to administering the medication, the surveyor intervened and reviewed the medication blister pack. Upon review, it was determined that the medication removed from the blister pack was the medication ordered to be given at bedtime for Resident #20, indicating a medication administration error. Resident #52: Record review of Resident #52's face sheet, dated 3/12/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Malignant neoplasm (a harmful growth of abnormal cells in the body that can grow quickly and spread to other parts of the body), mood disturbance, anxiety (feeling very worried, uneasy, or afraid), hypertension (high blood pressure), muscle weakness, and lack of coordination. Record review of Resident #52's quarterly MDS assessment, dated 2/19/2026, revealed a BIMS score of 4 out of 15, which indicated severe cognitive impairment. She required assistance from staff with activities of daily living care. Record review of Resident #52's care plan initiated on 8/27/24 revealed she has potential for pressure injury. Interventions were to give medications per order. Record review of Resident #52's Physician's orders dated 2/19/26 revealed an order for: Zinc oral capsule 220 (50mg) zinc sulfate. Give 1 capsule by mouth every day. During medication administration observation on 3/11/26 at 9:30 a.m., the surveyor observed MA J preparing medications for Resident #52. The MA J administered Zinc sulfate (supplement that helps the body heal wounds, fight infections, and keep the immune system strong) 50mg tablets by mouth to Resident #52. During an interview with MA J on 3/11/2026 at 9:50 a.m., she stated that she verified the medication orders prior; however, she acknowledged that she assumed the medication was correct because multiple residents were receiving zinc sulfate. She confirmed that medication orders must be verified against the physician's order before administration. MA J further acknowledged that medication should not be administered if they are not consistent with the physician's order. She identified the potential risk to the resident as the possibility of adverse (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outcomes if medications are administered without a valid physician's order. Specifically, she stated that administering medications without proper authorization could result in the resident becoming ill or not receiving the prescribed medication as ordered for that day, which could negatively impact the resident's health and well-being. MA J also acknowledged that she popped the divalproex sodium medication from the package by accident. She acknowledged that if the medication had been administered, the resident could have received a higher dose than prescribed, which could potentially affect the resident's health. She stated that she was nervous at the time, which contributed to the mistake. During an interview with DON on 3/11/2026 at 10:04 a.m., DON stated that medication administration must follow established protocols, including verification of physician orders prior to administration. She indicated that both MA and nursing staff are expected to adhere to the Five Rights of medication administration (right resident, right medication, right dose, right route, and the right time). The DON reported that she was unable to determine why the MA did not verify the physician's order prior to removing the medication from the medication blister pack. She further stated that she was unable to explain why a zinc sulfate tablet was administered instead of zinc sulfate capsule as prescribed by the physician. She indicated that corrective action would include providing in- service education to MA and nursing staff to reinforce proper medication administration procedures and adherence to physician orders, with the goal of preventing future medication errors. She also confirmed that failure to verify medication orders prior to administration may place residents at risk for adverse effects. She stated that such errors could negatively impact the resident's condition, potentially resulting in a decline in health status and/or a delay in the resident's healing process. During an interview with LVN C on 3/12/2026 at 12:11 p.m., she stated that medication administration process includes verifying the physician's order, confirming the medication belongs to the correct resident, and ensuring the correct medication is administered according to the order. She confirmed that she would not administer a medication that differs from the physician's order. As an example, she stated that if the physician ordered a zinc capsule but only a tablet was available, she would not administer the tablet and would seek clarification first.She stated that different medication forms, such as capsules and tablets, may have different release mechanisms or effects, and administering the incorrect form could result in an adverse reaction or unintended effect for the resident. She reiterated that she verifies orders and seeks clarification before administering medications to ensure resident safety. During an interview with MA K on 3/12/2026 at 12:18 p.m., he stated that he follows the five rights of medication administration, including verifying the right resident, right medication, right dose, right route, and right time. He stated that he also verifies the physician's order before administering medications and ensures that the medication form (capsule, tablet, liquid, or powder) matches the order. He confirmed that he would not administer a medication that does not match the physician's order. When asked about potential risks to the resident if a tablet was administered when a capsule had been ordered, he stated that the medication could interact incorrectly with other medications or cause an adverse or allergic reaction, and therefore it is important to follow the physician's order exactly to ensure resident's safety. During an interview with MA L on 3/12/2026 at 1:03 p.m., she stated that prior to administering medications, she ensures adherence to the Five Rights of medication administration and verifies the medication against the physician's order. She reported that if a physician orders a zinc sulfate capsule and only zinc sulfate tablets are available in the facility, she would withhold the medication and immediately notify the nurse, rather than administer a medication that does not match the prescribed form. She confirmed that she would not administer medications in an incorrect formulation or dosage form that is inconsistent with the physician's order. She acknowledged that administering medications not in accordance with the physician's order may result in adverse reactions, potential drug interactions, and could negatively impact or deteriorate the resident's health status. Record review of facility's policy dated 09/2018 revised 08/2020 titled General Guidelines for Medication Administration. Policy: Medications are administered as prescribed in accordance with good nursing principles and practices. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At a minimum, the 5 rights- right resident, right drug, right dose, right route, and the right time- should be applied to all medication administration. Always employ the MAR during medication administration. Prior to the administration of any medication, the medication and dosage schedule on the resident MAR are compared with the medication label. Medications are administered in accordance with written orders of the prescriber.