STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675089	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure resident call lights were answered in a reasonable time for three (Resident 1, Resident 2, and Resident 4) of three residents reviewed for resident call system. The facility failed to ensure Resident 1, Resident 2, and Resident 4's call lights were answered in a reasonable time to meet their needs with three of three residents being diagnosed with lack of coordination, muscle weakness, blindness, and wheelchair dependency for mobility. This failure could place all residents at risk of the inability to contact the nursing staff and obtain assistance when needed and maintain a dignified existence.Findings include: On 1.13.26 at 9:35 a.m. during initial facility rounds, call light panel at the nurses station was observed to have two call lights on. Observed three staff sitting at the nurse's station typing on computers with no attempt to assist residents observed. In an interview and observation on 1.13.26 at 11:57 a.m. with Resident 1 revealed he felt safe living at this nursing home. He was observed to use a wheelchair for mobility. He was observed to have his call light draped over his left shoulder and clipped to the pocket on his shirt. He stated this made his call light easier to reach while sitting up in his wheelchair. He stated call light response time varied; usually 15 to 30 minutes but sometimes up to 1 hour. He said, Let's test it. [sic]; and pressed his call light button at 11:58 a.m. Record review of face sheet dated 12.20.25 for Resident 1 revealed a male resident with the following diagnoses: muscle weakness, unsteadiness on feet, lack of coordination, hyperlipidemia; unspecified (high cholesterol level) and erosive osteoarthritis) an inflammatory type of arthritis. MDS dated 12.20.25 revealed an alert and oriented male resident able to be interviewed. MDS Section GG-functional abilities revealed Resident 1 requires minimal assistance with activities of daily living. He used a wheelchair for mobility. Care Plan dated 12.20.25 revealed Resident 1 required minimal assistance for activities of daily living like transferring, bathing and dressing. He ate meals independently. In a telephone interview on 1.13.26 at 11:06 a.m., with Floor Tech L, he stated he had worked in the laundry department, and in housekeeping. He stated while cleaning resident rooms, many residents would turn on their call light and wait for staff to answer. He stated many times it took 30 minutes to an hour or longer for the call light to be answered. He stated sometimes the resident would ask him to go get a nurse because their call light had been on for an hour and no one would come answer it. [sic] He stated he would go to the nurses' station and report the residents request but observed the call lights were still not answered timely. Observation on 1.13.26 at 11:59 a.m. revealed RN D, was sitting at the nurse's station charting on a computer. Observed no attempt to answer Residents 1's call light. In an interview and observation on 1.13.26 at 12:00 p.m. with RN D, she stated her expectations for answering resident call lights was Everyone can answer a call light. [sic] She was observed to leave the nurse's station and go to the dining room without answering the active call light for Resident 1. Observation and record review on 1.13.26 at 12:08 p.m. revealed Resident (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1's call light was still activated and had not been answered. Review at 12:08 p.m. of staffing sheet dated 1.13.26 for 6:00 a.m. to 2:00 p.m. shift revealed four certified nurse aides on duty for the shift. All four certified nurse aides were observed in the dining room passing trays for the noon meal. A staff member was not observed to be assigned to answer call lights during meals. In an interview and observation on 1.13.26 at 12:18 p.m. at the nurse's station with the Facility Administrator, she stated, Everyone can answer a call light for a resident and get a nurse if needed. [sic]. The call light for Resident 1 was observed to still be active. Attention was called to the call light panel and the time the call light was activated by Resident 1 to the Facility Administrator. No answer to Resident 1's call light during this interview was observed. Observation on 1.13.26 at 12:20 p.m. revealed Resident 1's call light was answered by CMA G. The call light had been active approximately 23 minutes before being answered. Interview on 1.13.26 at 1:00 p.m. with RN DCO J said her expectations for all staff, including LVN's and RN's, responding to active call lights were that everyone can answer call lights and non-nursing staff can notify nursing if needed. When questioned if she ever observed RNs or LVN's not answering active call lights; RN DCO J stated, I've never had a RN or LVN not answer a call light. [sic] Interview and observation on 1.13.26 at 1:04 p.m. with Resident 2 stated it took anywhere from 15 minutes to one and one-half hours for call lights to be answered by staff. [sic] Resident 2 activated his call light at this time to test response time. Record review of Resident 2's MDS dated 12.27.25 revealed a BIMS score of 15 indicated the resident was alert and able to be interviewed. Under MDS section GG - functional abilities, he required minimal assistance with activities of daily living. He ambulated with a walker and used a wheelchair for mobility. Record review for Resident 2 care plan dated 12.27.25 revealed he was monitored for falls due to unsteadiness, lack of coordination, and history of having a stroke. He identified as a trauma survivor and was monitored for changes in mood and behavior with consultants and psychiatry counseling as needed. Interview on 1.13.26 at 1:20 p.m. with Resident 4 stated it took too long to get the call light answered. She stated, My family member, (Resident 2), must sometimes help me lift my legs up to get into bed. She stated she required extra assistance with many activities of daily living because she was blind. [sic] Record review for Resident 4's face sheet dated 12.27.25 revealed a [AGE] year-old female with the following diagnoses: repeated falls, myocardial infarction (heart attack), anxiety disorder, blindness left eye, low vision right eye, muscle weakness, lack of coordination, malignant neoplasm of kidney (cancer), hypertension (high blood pressure) and polyneuropathy (nerves to hands, fingers, feet and toes are damaged). Record review for Resident 4's MDS dated [DATE] revealed a BIMS score of 15 revealed resident was alert and able to be interviewed. Under MDS section GG - functional abilities, resident needed moderate assistance from another person to complete activities of daily living due to blindness and impaired visual function. She ambulated with a walker. Record review for Resident 4's care plan dated 12/27/25 revealed wound care for cyst removal to right underarm. Cleanse area with normal saline, pat dry, apply antibiotic ointment, dressing and paper tape daily and as needed. She was at high risk for falls due to blindness and impaired visual function and staff were to anticipate her needs. Observation on 1.13.26 at 1:45 p.m. revealed the call light for Resident 2 and Resident 4 had not been responded to at the end of the 45-minute interview. In an interview on 1.13.26 at 1:30 p.m. CMA G stated, Everyone could answer a call light and there was no reason for an LVN or RN to not answer call lights for residents. [sic]. She stated her expectation was a call light should be answered within ten minutes. Interview on 1.13.26 at 2:26 p.m. with CNA H stated, Everyone can answer a call light and notify a nurse if needed. She stated there was always a staff member assigned to the nurse's station to answer call lights when meals are served [sic]. She did not (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	answer when asked who was assigned for that task on 1.13.26 at noon. On 1.13.26 at 2.27 p.m. after 10 minutes of observation attention was drawn to the call light panel with two room lights 202B and 105A activated; RN D, LVN F, and CNA H made no attempt to answer call lights. Observation on 1.13.26 at 2:45 p.m. at the nurse's station revealed the call light panel continued to have two active lights on for 202B and 105A. RN D, LVN F, and CNA H were observed sitting at the nurse's station typing on computers. No attempts to answer active call lights was observed. In an interview on 1.13.26 at 4:22 p.m. with LVN ADCO K and RN DCO J revealed the facility currently has no policy or procedure for any staff member for answering active call lights and assisting residents with needs, activities of daily living and maintaining a dignified life.