

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/31/2026
NAME OF PROVIDER OR SUPPLIER  Focused Care at Sherman		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity for 2 of 6 residents (Residents #1 and #) reviewed for resident rights. 1. The facility failed to ensure Resident #1 was not exposed while in a public area of the facility. 2. The facility failed to ensure Resident #2's urine collection bag had a privacy cover. These failures could cause the residents to become embarrassed and have lowered levels of self-esteem. Findings included: 1. Record review of Resident #1's quarterly MDS assessment, dated 01/21/26, reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia, diabetes, and heart failure. The MDS reflected the resident severe cognitive impairment with a BIMS score of 7, she used a wheelchair for mobility, and she was totally dependent on staff for her ADLs, including lower body dressing. Record review of Resident #1's care plan, dated 11/20/25, reflected she had an ADL self-care deficit, and was incontinent of bowel and bladder. Observation and interview on 01/31/26 at 9:00 AM revealed Resident #1 was by the front door, in the main lobby in a reclining chair, watching television. The resident had a blanket that had been moved to the side of the chair, and she was not clothed from the waist down, leaving her brief exposed. The resident was asked if she wanted to cover up, which she replied she did not want to cover up. When asked about her pants, she stated she did not need them. Observation on 01/31/26 at 12:05 PM revealed Resident #1 was sitting in the dining room eating her noon meal, still in her reclining chair, with her left leg exposed up to her hip with her brief exposed. Other residents were observed in the immediate area around the resident. 2. Record review of Resident #2's quarterly MDS assessment, dated 01/11/26, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included kidney failure, complications of indwelling urinary catheter, and Parkinson's disease. The MDS reflected that the resident had moderate cognitive impairment with a BIMS score of 9, and he was dependent on staff for most of his ADLs. Record review of Resident #2's care plan, dated 12/19/25, reflected he had bladder incontinence and had an indwelling catheter, and he had an ADL self-care deficit. Observation on 01/31/26 at 12:08 PM revealed Resident #2 was eating his noon meal in the main dining room. His urine collection bag was hanging from his wheelchair and did not have a privacy cover. Interview on 01/31/26 at 2:11 PM with the Activity Director revealed respect was important for the overall dignity of the resident, and it was just respectful to protect it. She stated it was important to protect the resident's dignity for their self-esteem. Interview on 01/31/26 at 2:15 PM with LVN A revealed respect and dignity were important for all residents for their self-esteem. She stated the facility was their home, and they deserved to feel comfortable in their environment. Interview on 01/31/26 at 2:18 PM with CNA B revealed protecting the residents' right to privacy included keeping them from being exposed to other residents, and it was important for their dignity and self-esteem. Interview on 01/31/26 at 2:24 PM with CNA C revealed all residents deserved to be respected and</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  675089	Facility ID:  675089  If continuation sheet Page 1 of 3

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>have their privacy and dignity protected because they were still people and should be treated like family. Interview on 01/31/26 at 2:35 PM with RN D revealed the residents had a right to their privacy and protecting their dignity helped the residents feel safe and helped their self-esteem. She stated she had observed Resident #1 exposed in the main lobby and put her blanket back over her. She stated she educated the resident on keeping herself covered. She stated Resident #1 did what she wanted, and if she did not want to do something, there was no convincing her to do it. Interview on 01/31/26 at 2:40 PM with CNA E revealed respect and dignity were important for the residents to let them know they were still valued. Interview on 01/31/26 at 3:10 PM with the ADON revealed each resident deserved to be treated with respect and dignity which included protecting their privacy. She stated the facility was their home, and staff needed to remember that. She stated she was not aware Resident #1 had been out and about without a privacy cover on his urine collection bag. She also did not know Resident #1 had exposed herself by pulling off her blanket. She stated Resident #1 should have been fully dressed. Record review of the facility's Resident Rights policy, dated December 2016, reflected: Employees shall treat all residents with kindness, respect, and dignity. The resident has a right to: a. a dignified existence b. be treated with respect, kindness, and dignity.</p>

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<p>F 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide bedrooms that don't allow residents to see each other when privacy is needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure full visual privacy for residents for 3 of 12 rooms (rooms [ROOM NUMBER]) reviewed for physical environment. The facility failed to ensure rooms [ROOM NUMBER] had privacy curtains installed to provide privacy for the residents. This failure placed residents at risk for no visual privacy during care which could cause decreased feelings of self-worth. Findings included: Observation on 01/31/26 at 9:15 AM revealed room [ROOM NUMBER] did not have a privacy curtain for Bed B, and there was no track installed on the ceiling for a privacy curtain to be hung. Observation on 01/31/26 at 9:20 AM revealed the privacy curtain for Bed B in room [ROOM NUMBER] was positioned over the window due the window not having a curtain. This left the end of Bed B exposed. Observation on 01/31/26 at 9:40 AM revealed room [ROOM NUMBER] did not have a privacy curtain for Bed B although there was track on the ceiling for a privacy curtain to be hung. Interview on 01/31/26 at 2:11 PM with the Activity Director revealed privacy was important for the dignity of the resident and it was just respectful to protect it. She stated it was important to protect residents' dignity for their self-esteem. Interview on 01/31/26 at 2:15 PM with LVN A revealed privacy and dignity were important for all residents for their self-esteem. She stated the facility was their home, and they deserved to feel comfortable in their environment. Interview on 01/31/26 at 2:18 PM with CNA B revealed protecting the residents' privacy included keeping them from being exposed to other residents, and it was important for their dignity and self-esteem. Interview on 01/31/26 at 2:35 PM with RN D revealed the residents had a right to their privacy and protecting their dignity helped the residents feel safe and helped their self-esteem. Interview on 01/31/26 at 2:40 PM with CNA E revealed privacy and dignity were important for the residents to let them know they were still valued. She stated requests for repairs were placed in the maintenance logbook. Interview on 01/31/26 at 2:44 PM with CNA F revealed she had not noticed the lack of curtains on the 100 Hall. She stated maintenance was responsible for hanging the curtains. She stated repair requests were placed in the maintenance logbook. She stated privacy for the residents was important, so they could change or receive care without being observed by other residents. Interview on 01/31/26 at 3:10 PM with the ADON revealed each resident deserved to be treated with respect and dignity which included protecting their privacy. She stated the facility was their home and staff needed to remember that. An interview was attempted on 01/31/26 at 3:20 PM with the Director of Plant Operations via telephone; however, the attempt was unsuccessful. Record review of the facility's Quality of Life- Homelike Environment, dated May 2017, reflected the following: Residents are provided with a safe, clean, comfortable, and homelike environment.</p>		