

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/23/2026
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)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to ensure reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for the bedrooms of 1 of (Resident #1) 5 resident rooms reviewed for resident call systems. The facility failed to ensure the call lights in the rooms were within reach for Resident #1, making it inaccessible if the resident needed assistance. This failure could place residents at risk of being unable to have a means of directly contacting caregivers. Findings included: Record review of Resident #1's face sheet, dated 07/23/26, reflected an [AGE] year-old female that was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: urinary tract infection, anuria (a medical emergency defined as the absence of urine production or passing less than 100 milliliters of urine per day) and oliguria (low urine output), hypoglycemia (low blood sugar), metabolic encephalopathy (a brain function disorder caused by systemic illness, organ failure, or chemical imbalances), chronic obstructive pulmonary disease (a long-term lung condition causing blocked airflow and breathing problems), gout due to renal impairment (when kidneys don't function optimally, they fail to filter uric acid effectively, leading to dangerous build-up in the blood), acute metabolic acidosis (a serious medical condition where too much acid builds up in the body or too much base (bicarbonate) is lost, causing a sudden drop in blood pH below 7.35), dysphagia (trouble swallowing), myocardial infarction (when blood flow to the heart muscle is blocked, causing tissue damage or death), lack of coordination (a loss of full control of bodily movements that commonly affects walking, balance, and fine motor skills), dysarthria (a motor speech disorder characterized by slurred, slow, or difficult-to-understand speech) and anarthria (a severe medical condition involving the complete loss of the ability to articulate or produce spoken words), extended spectrum beta lactamase resistance (enzymes produced by bacteria that break down and destroy common antibiotics), acute pyelonephritis (a sudden, serious bacterial infection of the kidney), hypomagnesemia (an electrolyte disorder featuring low blood magnesium levels), disorder of kidney and ureter (kidney stones, ureteral obstructions, and infections), altered mental status (a sudden or progressive change in a person's thinking, awareness, attention, or level of consciousness), need for assistance with personal care, hypotension (low blood pressure), atrial fibrillation (a common heart problem where the upper chambers of the heart beat fast and out of rhythm), hyperkalemia (high blood potassium levels), muscle weakness, unsteadiness on feet, cognitive communication deficit (a breakdown in communication caused by impaired mental processes like attention, memory, and executive function rather than a pure loss of speech or language mechanics), hypertension (when the force of blood pushing against your artery walls is consistently too high), abnormalities of gait and mobility (a change in how a person walks or moves, such as limping, shuffling, or losing balance), bell's palsy (a sudden, temporary condition that causes weakness or paralysis on one side of the face, drooping of (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the mouth, and trouble closing the eye), acute pancreatitis without necrosis or infection (inflammation and swelling of the pancreas), arthritis (a general term for conditions that cause joint pain, swelling, and stiffness), spinal stenosis (the narrowing of the spaces within the spine), acute kidney failure (a sudden, rapid loss of kidney function that happens over hours or days), shortness of breath, type 2 diabetes (a chronic condition where blood sugar levels are too high because the body does not make enough insulin or cannot use it properly). Record review of Resident #1's Quarterly MDS assessment, dated 05/21/26, reflected a BIMS score of 05, which indicated severe cognition impairment. The MDS assessment under Section GG-Functional Abilities, reflected Resident #1 was dependent with toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, supervision with oral hygiene and substantial assistance with showering/bathing self. Record review of Resident #1's care plan, revised 10/07/25, reflected Resident #1 required two staff members present for ADL care at all times. It further reflected that Resident #1 was at risk for increased falls and fractures as evidenced by history of falls and unsteady gait. The interventions included: ensuring call light was in reach and answered promptly. Resident #1's care plan also reflected that Resident #1 complained of increased pain, discomfort and was at risk for injury from decreased ADLs with arthritis. Intervention included: the resident being able to call for assistance. During an interview and observation on 07/23/26 at 10:35 AM, Resident #1 was observed lying upright in her bed. Resident #1's call light was observed tangled around her bed rail with the call button facing the floor. Resident #1 attempted several times to reach her call light with her left hand but was unable as it was tangled and not within reach. Resident #1 expressed that she was unable to grab her call light with her left hand. Resident #1 stated she could not use her right hand to grab it. During an interview and observation with LVN A and CNA B on 07/23/26 at 10:47 AM, LVN A and CNA B revealed that the call light for Resident #1 was not within reach. CNA B stated she did not know what happened to Resident #1's call light but she had attached it to the bed. LVN A stated the risk to residents were that they were unable to call for help. CNA B stated the risk to the resident when the call light was not within reach was that anything could happen and they would not be able to call for help. Both LVN A and CNA B stated it was there responsible to ensure the call light was within reach of the residents. A policy regarding call lights was requested but a Bedroom policy was received. The policy did not address call lights.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on interview and record reviews, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of all the facility's resident population in accordance with the facility dietary staff. The facility failed to ensure there were sufficient kitchen staff to timely carry out the functions of lunch services on 07/17/26. This failure could place residents who consumed food prepared from the kitchen at-risk of foodborne illness or nutritional deficiencies. Findings included: During an interview on 07/23/26 at 2:17 PM, the Director of Food & Nutrition Services stated on 07/17/26 she was out sick. She stated she received calls from Food Service Manager E and Food Service Assistant F that they were not getting along. The Director of Food & Nutrition Services stated the Food Service Assistant F clocked out and left in the middle of serving lunch. She stated on 07/17/26, Food Service Assistant F walked out of the building and quit. The Director of Food and Nutrition Services stated she had to call her evening staff to come in early that day to serve lunch. She stated on 07/17/26 the residents were served lunch around 2:00 PM. She stated the residents were served ham and cheese sandwiches. She stated the effect of the staff quitting was not having proper staff and caused the lunch to be late. During an interview on 07/23/26 at 2:23 PM, the Food Service Manager C stated on 07/17/26 he and Food Services Assistant D were called into work early by the Director of Food & Nutrition Services. He stated he was not at work during the time that Food Service Assistant F walked out, but he heard about it. He stated when he and Food Service Assistant D went into work early, they prepared lunch because it had not been done by the morning shift. He stated they made the residents peanut butter and jelly sandwiches and ham and cheese sandwiches. Food Service Manager C stated residents received their lunch around 2:00-2:30 PM. He stated lunch was supposed to be served at 12:00PM. He stated the effect of staff walking out was that the residents were served a different meal and it was late being served. During an interview on 07/23/26 at 2:28 PM, Food Service Assistant D stated on 07/17/26 another aide walked out during lunch. He stated he and the Food Service Manager C received a call to go into worker early to assist with lunch. He stated he did not know exactly what had transpired with the staff that walked out. He stated the aide that walked out left the dish area a mess. Food Service Assistant C stated the residents were served ham and cheese and peanut butter sandwiches. He stated that day they were late serving lunch. He stated residents received their lunch around 2:30 PM. An attempted call on 07/23/26 at 2:39 PM was made to interview Food Service Assistant F but received a message from the operator that stated, the person was not able to receive calls and unable to leave a message. An attempted call on 07/23/26 at 2:41 PM was made to interview Food Service Manager E but there (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was no answer. Record review of daily dining schedule on 07/23/26 at 3:44 PM, reflected the following: Breakfast 7:00 AM Lunch 12:00 PM Dinner 5:00 PM Record review of facility's lunch menu for 07/17/26 reflected the following: Lunch on 07/17/26 consisted of: popcorn shrimp, macaroni & cheese, fried okra, roll, chocolate yogurt mousse, iced tea and water. Record review of grievances, dated 07/20/26, reflected residents in general comprised of food service. Record review of Food Service Assistant F's statement to HR on 07/21/26, reflected the following: [Food Service Assistant F] was writing to formally report serious concerns regarding previous work environment. First, [Food Service Assistant F], report instances of personal harassment and bullying. [The] behavior was unacceptable, and [wanted] to discuss the steps that would be taken to address the situation and ensure a safe and respectful environment. A policy regarding dietary staffing was requested on 07/23/26. Record review of the policy, titled Sufficient Staffing, revealed the following: Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. Policy Interpretation and Implementation 1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. 2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. 3. Other support services (e.g., dietary, activities/recreational, social, therapy, environmental, etc.) are also staffed to ensure that resident needs are met.		