STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675293	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to send a copy of the transfer or discharge notice to a representative of the Office of the State Long-Term Care Ombudsman for 2 of 2 residents (Resident #1 and Resident #2) reviewed for discharge notices. The facility did not ensure Ombudsman A was provided with a copy of the 30-day discharge notices for Resident #1 and Resident #2. This failure places residents at risk of not having access to an advocate who could have informed them of their options and rights and being inappropriately discharged from the facility. The findings included: 1. Record review of the face sheet, dated 06/24/26, reflected Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of unspecified dementia without behaviors (loss of cognitive functioning that interferes with daily life). Record review of the quarterly MDS assessment, dated 06/05/26, reflected Resident #1 had clear speech, was understood by others, and was able to understand others. Resident #1 had a BIMS score of 12, which reflected moderately impaired cognition. The MDS reflected no active discharge planning was occurring for the resident to return to the community. Record review of Resident #1's comprehensive care plan, dated 07/22/25, reflected that she required 24-hour supervision and treatment, and the discharge plan was to remain in the facility for long-term care. Record review of Resident #1's Notice of Intent to Discharge letter, dated 06/11/26, reflected a formal notification of discharge from the facility was being provided to Resident #1's family member because Medicaid pending supporting documents were not received. Ombudsman A's contact information was provided in the letter, and the bottom of the letter reflected a copy of the letter should have been sent to Ombudsman A through first class mail. 2. Record review of the face sheet, dated 06/24/26, reflected Resident #2 was an [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of unspecified dementia with other behavioral disturbance (loss of cognitive functioning that interferes with daily life). Record review of the quarterly MDS assessment, dated 05/06/26, reflected Resident #2 had clear speech, was understood by others, and was able to understand others. Resident #2 had a BIMS score of 10, which reflected moderately impaired cognition. The MDS reflected no active discharge planning was occurring for the resident to return to the community. Record review of Resident #2's comprehensive care plan, dated 02/05/26, reflected no care plan was in place to address discharge goals. Record review of Resident #2's Notice of Intent to Discharge letter, dated 06/11/26, reflected a formal notification of discharge from the facility was being provided to Resident #2's family member because Medicaid pending supporting documents were not received. Ombudsman A's contact information was provided in the letter, and the bottom of the letter reflected a copy of the letter should have been sent to Ombudsman A through first class mail. During an interview on 06/24/26 at 1:25 p.m., Ombudsman A stated she was unaware that Resident #1 and Resident #2 had been issued a 30-day discharge notice from the facility. She stated the facility were supposed to provide her with a copy of the notices so she could have contacted the family and appealed the decision if it was wanted. Ombudsman A stated she liked to know when discharge letters were issued so she could have informed the resident or the resident's family of their rights. During an interview on 06/24/26 at 2:04 p.m., the BOM stated she was responsible for writing (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the 30-day discharge notices and mailing them, after the Administrator reviewed and signed them. She stated 30-day discharge notices were not common and she did not issue them regularly. The BOM stated she typed Resident #1 and Resident #2's letters on 06/11/26 but did not mail them to Resident #1 and Resident #2's family member until 06/15/26. She said she did not mail a copy of the letters to Ombudsman A. She stated Ombudsman A's contact information was provided on the letter and the family could have contacted Ombudsman A if they chose to. The BOM stated she was unaware that a copy of the letter needed to be provided to Ombudsman A. During an interview on 06/24/26 at 2:54 p.m., the Administrator stated she only issued a 30-day discharge notice from the facility as a last resort. She stated Resident #1 and Resident #2's family members had been asked on multiple occasions over multiple months to provide financial documents required to be sent with the Medicaid application process. The Administrator stated the requested documents were never received. She stated the 30-day discharge letters were sent on 06/15/26 and Ombudsman A was not provided with a copy of the letter. She stated Ombudsman A's contact information was provided to the family in the letters. She stated Ombudsman A was notified today on 06/24/26 after the surveyor intervention. She said it was important to ensure Ombudsman A was provided with a copy of the 30-day discharge notices so she could have communicated with the family and made an appeal as needed. Record review of the Transfer or Discharge Notice policy, dated December 2016, reflected . A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman.