STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Linden		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents received adequate supervision and assistance devices to prevent accidents for 1 (Resident #20) of 6 residents reviewed for accidents and supervision. The facility failed to ensure adequate supervision and implementation of safety interventions for a resident assessed to be at risk for elopement. This resulted in Resident #20 exiting the building on 03/19/2026 without staff knowledge or supervision, placing the resident at risk for harm. The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 03/19/2026 and ended on 03/20/2026. The facility had corrected the noncompliance before the survey began. This failure could result in residents leaving the facility without supervision, placing them at risk for injury, harm, or death.Findings included: Record review of a face sheet dated 04/14/2026 indicated Resident #20 was a [AGE] year-old male that admitted to the facility on [DATE] with diagnoses of CVA (medical emergency caused by blocked or ruptured blood vessels restricting blood flow to the brain), hemiplegia (the severe or complete paralysis of one side of the body, usually caused by brain damage [such as stroke, tumor, or trauma] on the opposite side), and bipolar disorder (a chronic mental health condition characterized by extreme mood swings, including emotional highs [mania or hypomania] and lows [depression]). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #20 had a BIMS of 07 which indicated moderate cognitive impairment. The MDS also revealed Resident #20 was mobile per walker and required partial (helper does less than half) assistance with toileting. Resident #20 required stand by assistance for transfer and bed mobility. Resident #20 was coded as having wandering behaviors 1-3 days. Record review of a care plan dated 03/19/2026 revealed Resident #20 was at high risk for elopement and had a wander guard on his left wrist as of 03/19/2026. There was no care plan for elopement prior to 03/19/2026. Record review of an elopement risk assessment dated [DATE] revealed Resident #20 was a moderate risk for elopement with a numerical score of 5. Record review of an elopement risk assessment dated [DATE] revealed Resident #20 was a high risk for elopement with a numerical score of 6. The assessment revealed Resident #20 voiced desire to leave the facility.Record review of a progress note written by LVN A on 03/19/2026 at 11:47 a.m., revealed Resident #20 was noted to be outside of the facility by the side of the road and was found by LVN B when she was returning to work from break. Resident #20 was assisted back inside the facility and assessed for injury with none found. A Wanderguard was placed on the resident, and his care plan was updated. Family, MD, Administrative nurses were notified.During an observation and interview on 04/14/2026 at 10:00 a.m., the Administrator revealed the area of the facility grounds where Resident #20 was located by LVN B on 03/19/2026 was flat grassy terrain approximately 10 feet from the entrance of the facility and 4 feet from the residential street running adjacent to the building. The speed limit sign read 20 miles per hour. Resident #20 was approximately 40 yards from the road running parallel to the facility and the posted speed limit was 35 miles per hour. She stated Resident #20 had not made it to the road when he was noted outside and returned to the facility.During an interview on 04/14/2026 at 1:00 p.m., LVN A stated she was the nurse that was on duty the day Resident #20 eloped. She stated she last saw (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2026

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #20 at around 11:15 a.m.- 11:20 a.m. She stated he was at the nurse's station attempting to call family member and was unsuccessful. She stated he headed back down towards his room with his walker, and she went on to assist the next resident. She stated at 11:30 a.m., she received a phone call from LVN B stating Resident #20 was out by the road next to the facility. She stated not wanting to leave the other residents unattended, she alerted the Activity Director, and the Activity Director went out to assist LVN B to bring Resident #20 back inside the facility. She stated when he came in, she immediately assessed him, and he had no injuries, and she applied a Wanderguard. She stated she thought he must have exited the front door because the front door only locked when someone wearing a Wanderguard got within a few feet of it. She stated it alarmed if someone with a Wanderguard attempted to exit or actually exited and no alarm ever sounded. LVN A stated once Resident #20 was assessed and safe, she notified the DON, Administrator, MD, and Resident #20's family member. She stated when she questioned Resident #20, he stated he wanted to go home. LVN A stated she was the nurse that completed Resident #20's quarterly elopement risk assessment the day before on 03/18/2026 and she was aware he went from a moderate risk for elopement to a high risk for elopement. She stated he had recently started saying I got to go. She stated he never exited any door or even went up to the doors prior to his elopement. LVN A stated she was not aware that she needed to immediately put intervention in place for Resident #20. She stated on 03/20/2026 the Administrator provided education to her about the process of implementing an intervention for any assessment that changes a resident to a high risk resident and contacting an administrative nurse for guidance if you are unsure what intervention to put in place. LVN A stated Resident #20 has had no further attempts at elopement. He sat near the nurse's station for the remainder of the day. She stated she was instructed to test the Wanderguard at the door and she did. During an interview on 04/14/2026 at 2:10 p.m., LVN B stated on 03/19/2026 she was returning from her lunch break around 11:30 a.m. and noted a resident walking through the yard of the facility toward the residential road that runs alongside the building. She stated when she got closer, she saw that it was Resident #20 and pulled over on the side of the residential road to assist him back to the facility. She stated she called LVN A and told her about Resident #20 being in the yard headed to the road. She stated within 2 minutes the Activity Director came out and assisted her to get Resident #20 back into the building. She stated Resident #20 was in no distress and the weather was between 65-70 degrees with no rain. She stated Resident #20 was difficult to understand but she made out he was headed home. During an interview on 04/14/2026 at 2:30 p.m., the Activity Director stated she was in the hallway on 03/19/2026 around 11:30 a.m. when LVN A asked her to go outside and assist LVN B with Resident #20. She stated she found LVN B walking with Resident #20 back towards the building when she went out the front door. She stated they were about 10 feet from the side of the residential road that ran beside the facility. The Activity Director stated she met them in the yard and assisted Resident #20 back to the facility while LVN B moved her car. She stated Resident #20 was not in any distress when returned to the facility. During an interview on 04/14/2026 at 2:40 p.m., the Director of Plant Operations (DPO) stated he was notified of Resident #20's elopement and was instructed to check all exit doors to confirm proper function. He stated he did so immediately. The DPO stated he checked all exit doors on a routine basis as part of his facility inspection. He stated all exit doors functioned properly. During an interview on 04/14/2026 at 2:48 p.m., the MDS Coordinator stated she was instructed to complete elopement assessments on all residents in the facility and compare them with the previous assessment to ensure all residents had the proper elopement risk with interventions. She stated she audited all 40 residents and checked their care plans for interventions, and no resident's status changed. During an interview on 04/14/2026 at 2:58 p.m., the DON stated she was called about the incident on 03/19/2026 as soon as it happened and directed LVN A to apply the Wanderguard after she assessed Resident #20 and to complete another elopement assessment and update his care plan. She stated she was working night shift and was not in the facility on 03/19/2026 during the time of the incident. The DON stated she or her designee began monitoring all new admits and high-risk (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	individuals for accuracy of assessments and interventions each day for 2 months. She stated she or designee also audited all elopement risk assessment and care plans to ensure that all staff had resident information stayed up to date in the EHR. During an interview on 04/14/2026 at 3:10 p.m., the Administrator stated she was called about the incident on 03/19/2026 with Resident #20 around 11:40 a.m., she was out of the facility at the time. She stated she instructed LVN A to ensure the functioning of the Wanderguard and place Resident #20 on increased supervision. She stated she called the DPO and asked him to check the grounds and test all Wanderguards and exit doors for proper functioning. Upon her return to the facility, she obtained statements from all employees on duty to determine how Resident #20 exited the facility. No statement indicated any alarm was sounded prior to Resident #20 being located outside of the facility. She stated it was her belief Resident #20 exited the facility through the front door as it was the only door that would not have alarmed since Resident #20 was not wearing a Wanderguard at the time. She stated she began the inservice training on the facility's Elopement Policy and Procedure to include where to find additional information on all residents deemed to be high risk for elopement. All nurses received training on identifying residents that were high risk for elopement and promptly putting interventions in place when high risk residents were identified and updating the care plan, so the rest of the facility becomes aware of the change. The Administrator stated she directed the MDS nurse to complete an elopement assessment audit for all residents to validate that all assessments were current and accurate. She stated the audit did not find any new high risk elopement residents. She stated she directed the social worker to validate that each resident deemed a high risk for elopement had the information updated in their chart to alert all staff of the resident's high-risk status. She stated she conducted a root cause analysis to pinpoint the area of breakdown and counseled LVN A. She stated an Ad Hoc QA meeting was held to discuss elopement and develop a plan to prevent elopements such as this occur again. She stated they planned to discuss the performance improvement plan monthly for the next 2 months to ensure it worked. Review of facility policy titled ?Elopement' dated 11/01/2019 revealed, if a resident triggers for high elopement risk, staff is to immediately notify the charge team and interdisciplinary team to review the care plan and implement necessary interventions. The facility had corrected the noncompliance on 03/20/2026 by the following:- Returning Resident #20 to the facility with no injury- Reassessing Resident #20's elopement status and providing a Wanderguard to ensure his safety.- Updating Resident #20's care plan to ensure all staff were aware of his elopement status- Education with LVN A on accurate elopement assessment and prompt interventions for high-risk residents on 03/19/2026.- 100% nursing staff on all shifts received education on wandering/elopement and resident safety and included new process of checking all assessments scored as high risk for accuracy and intervention each day in morning meeting.- All Wanderguard systems and door alarms were checked for proper functioning.- DON and/or designee were monitoring new admissions and high-risk residents to ensure interventions were in place daily for 2 months.- DON and/or designee were auditing elopement risk assessments weekly for 2 months to ensure care plans reflect the needs and concerns in the assessments.- The ad hoc Quality Assurance and Performance Improvement committee that was completed with the medical director and interdisciplinary team will be discussed at QAA meetings for a minimum of 3 months or until a pattern of compliance is maintained. Record review of an Ad Hoc Quality Assurance (QA) Meeting Sign-in Sheet dated 03/20/2026 indicated the facility had an QA meeting addressing the incident. The QA Meeting Sign-in Sheet indicated the DON, ADON, Medical Director, LVN A, Director of Plan Operations, Activity Director, MDS Coordinator, Medical Records staff member, Director of Therapy, Director of Plant Operations and the Administrator attended. Record review and interview of the sampled residents from 04/13/2026 to 04/14/2026 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #7, Resident #8, Resident #15, Resident #17, Resident #19, Resident #21, Resident #36, Resident #37 and Resident #48) revealed they had not eloped. They stated they had not attempted to elope. All staff interviewed (LVN A, LVN B, CNA C, CNA D, RN E, [NAME] F, CNA J, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA K, LVN L, CNA M, Housekeeper N, Housekeeper O, the Social Worker, the Activity Director, the Dietary Manager, and ADON) on 04/14/2026 and 04/15/2026 verbalized they had been in-serviced on risk management related to elopement, the facilities policy on elopement, how to respond when an elopement occurred and how to prevent elopement. Each staff member was able to verbalize the definition of elopement, how to recognize each resident's elopement risk and interventions, and how to respond to an elopement situation. The nurses were able to verbalize the importance of accurate elopement assessments and providing immediate intervention for new high-risk residents. Record review of an ?Inservice Training Report' dated 03/19/2026 indicated all staff were in-serviced on the facility Elopement policy and the process of ensuring high risk residents have interventions in place. The training was conducted by the Administrator. Record review of an ?Inservice Training Report' dated 03/20/2026 indicated LVN A was inserviced on accurate risk assessments and providing immediate intervention for newly identified high risk residents. Record review of ?Door Locks and Alarm Checks' dated 03/19/2026 to 04/15/2026 indicated all doors, locks and alarms had been tested daily since 03/19/2026. Record review of ?New admission and High-Risk Monitoring List' dated 03/20/2026 indicated review occurred daily since 03/20/2026. Record review of ?Elopement Risk Assessment Audit' dated 03/20/2026 indicated elopement risk assessments were reviewed weekly since 03/20/2026. During an observation and interview on 04/14/2026 at 1:10 p.m., Resident #20 was observed wearing a Wanderguard to his left wrist. Resident # 20 was walked up to the door and said It won't let me out. It is going to lock. The door locked and alarm sounded when surveyor attempted to open door with Resident #20 within 3 feet of the door. The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 03/19/2026 and ended on 03/20/2026. The facility had corrected the noncompliance before the survey began.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 2 of 17 residents (Resident #3 and Resident #21) reviewed for pharmacy services.1.The facility failed to administer (7) doses of Multivitamin with minerals, (9) doses of Pepcid (famotidine-medication to reduce stomach acid), and (10) doses of Stress B Complex (dietary supplement designed to support energy and immune system function during times of stress) for Resident #3.2. The facility failed to administer (12) doses of Multivitamin with minerals, (14) does of famotidine, and (10) doses of GlycoLax (medication for constipation) for Resident #21 from 3/01/2026 to 4/13/2026.These failures could place residents at risk for not receiving the intended therapeutic benefit of prescribed medications. 1. Record review of a face sheet dated 4/15/2026 indicated Resident #3 was [AGE] year-old male originally admitted on [DATE] and readmitted on [DATE] with diagnoses including hypoglycemia (a condition in which your blood sugar (glucose) level is lower than the standard range), CVA (stroke), and convulsions (involuntary, rapid, and rhythmic shaking of the body caused by erratic electrical activity in the brain). Record review of a significant change MDS assessment dated [DATE] indicated Resident #3 required dependent assistance with ADLs such as transfer, toileting, and dressing. The MDS indicated Resident #3 had a BIMS score of 99, which indicated severely impaired cognition. Record review of MD orders dated March 2026 revealed the following orders for Resident #3: Multivitamin with minerals give one per PEG (percutaneous endoscopic gastrostomy- feeding tube) daily- start date 3/04/2026 and no stop date. Pepcid 40mg give one per PEG daily-start date 3/04/2026 and no stop date. Stress B-Complex 500mg give one per PEG daily-start date 3/04/2026 and no stop date. Record review of the MAR dated March 2026 revealed the following missed doses of medication for Resident #3: Multivitamin with minerals was missed on 3/24/26, 3/27/2026, 3/28/2026, and 3/29/2026. Pepcid 40mg tablet was missed on 3/26/2026, 3/27/2026, 3/28/2026, and 3/29/2026. Stress B-Complex was missed on 3/04/2026 through 3/13/2026. Record review of the MAR dated April 2026 revealed the following missed doses of medication for Resident #3: Multivitamin with minerals was missed on 4/01/2026 through 4/03/2026. Pepcid 40mg tablet was missed on 4/01/2026 through 4/03/2026. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Stress B-Complex was missed on 4/01/2026 through 4/03/2026. During an interview on 4/14/2026 at 11:40 a.m., RN E stated she had not given Multivitamin with minerals, Pepcid, and Stress B- Complex to Resident #3 on the dates marked as not administered on the MAR in both March and April because the medications were not available in the facility. She stated she checked the medication rooms and the other medication carts and when she could not find them, put them on the list of items that needed to be reordered. She stated she did not think to call the MD and inform him the facility was out of the medication. RN E stated she was unsure who reordered over the counter medications. She stated she had been instructed to make a list that was kept in the medication room with all over-the counter medications that needed to be reordered. 2. Record review of Resident #21's face sheet dated 4/13/2026 revealed he was [AGE] years old and admitted to the facility initially on 2/17/2014 and readmitted on [DATE]. Resident #21 had diagnoses including cerebral palsy (permanent movement and posture disorders caused by abnormal brain development or damage, typically occurring before birth), gastroparesis (delayed emptying of stomach contents), gastrostomy (also call PEG tube-device inserted through the abdominal wall directly into the stomach to deliver nutrition, fluids, and medications when oral intake was insufficient), quadriplegia (unable to move body, typically caused from damage of the spinal cord in the neck). Record review of Resident #21's quarterly MDS assessment dated [DATE] revealed he had no speech and was rarely/never understood and sometimes understood others. Resident #21 was unable to complete the BIMS because he was rarely/never understood. Resident #21 was dependent on staff assistance for all ADLs. Record review of MD orders dated April 2026 revealed the following orders for Resident #21: Multivitamin-minerals give one tablet per PEG tube one time a day for supplement- start date 2/28/2024 and no stop date. Famotidine 20mg give one tablet two times daily for acid indigestion-start date 5/28/2026 and no stop date. GlycoLax powder (polyethylene Glycol 3350) give 17 grams by PEG two times a day for constipation with 4-8 ounces of water-start date 5/19/2025 and no stop date. Record review of the MAR dated March 2026 revealed the following missed doses of medication for Resident #21: Multivitamin-minerals were missed on 3/13/26, 3/14/2026, 3/15/2026, 3/18/2026, 3/19/2026, 3/23/2026, 3/24/2026, 3/27/2026, 3/28/2026, 3/29/2026, and 3/31/2026. Famotidine 20 mg tablet was missed on 3/09/2026, 3/11/2026, 3/12/2026, 3/13/2026, 3/14/2026, 3/23/2026, 3/24/2026, 3/27/2026, 3/28/2026, 3/29/2026 and 3/31/2026. GlycoLax powder was missed on 3/31/2026. Record review of the MAR dated April 2026 revealed the following missed doses of medication for Resident #21: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Multivitamin-minerals tablets were missed on 4/02/2026. Famotidine 20 mg tablets were missed on 4/01/2026, 4/02/2026 and 4/03/2026. GlycoLax powder was missed on 4/01/2026, 4/02/2026, 4/03/2026, 4/06/2026, 4/07/2026, 4/09/2026, 4/10/2026, 4/12/2026 and 4/13/2026. Record review of Resident #21's Administration notes indicated: 3/09/2026 LVN A documented Famotidine tablet 20 mg - OUT OF STOCK 3/11/2026 RN E documented Famotidine tablet 20 mg - on order 3/12/2026 RN E documented Famotidine tablet 20 mg - on order 3/13/2026 LVN A documented Famotidine tablet 20 mg - OUT OF STOCK 3/13/2026 LVN A documented Multiple Vitamins-Mineral - OUT OF STOCK 3/14/2026 LVN A documented Famotidine tablet 20 mg - OUT OF STOCK 3/14/2026 LVN A documented Multiple Vitamins-Mineral - OUT OF STOCK 3/15/2026 LVN A documented Multiple Vitamins-Mineral - OUT OF STOCK 3/18/2026 LVN A documented Multiple Vitamins-Mineral - OUT OF STOCK 3/19/2026 LVN A documented Multiple Vitamins-Mineral - OUT OF STOCK 3/23/2026 LVN A documented Multiple Vitamins-Mineral - OUT OF STOCK 3/23/2026 LVN A documented Famotidine tablet 20 mg - OUT OF STOCK 3/24/2026 LVN A documented Multiple Vitamins-Mineral - OUT OF STOCK 3/24/2026 LVN A documented Famotidine tablet 20 mg - OUT OF STOCK 3/27/2026 LVN A documented Famotidine tablet 20 mg - OUT OF STOCK 3/27/2026 LVN A documented Multiple Vitamins-Mineral - OUT OF STOCK 3/28/2026 LVN A documented Multiple Vitamins-Mineral - OUT OF STOCK 3/28/2026 LVN A documented Famotidine tablet 20 mg - OUT OF STOCK 3/29/2026 LVN A documented Famotidine tablet 20 mg - OUT OF STOCK 3/29/2026 LVN A documented Multiple Vitamins-Mineral - OUT OF STOCK (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/31/2026 RN E documented Multiple Vitamins-Mineral - on order 3/31/2026 RN E documented Famotidine tablet 20 mg - on order 3/31/2026 RN E documented GlycoLax Powder - on order 4/01/2026 LVN A documented Famotidine tablet 20 mg - OUT OF STOCK 4/01/2026 LVN A documented GlycoLax Powder - OUT OF STOCK 4/02/2026 LVN A documented GlycoLax Powder - OUT OF STOCK 4/02/2026 LVN A documented Multiple Vitamins-Mineral - OUT OF STOCK 4/02/2026 LVN A documented Famotidine tablet 20 mg - OUT OF STOCK 4/03/2026 LVN A documented Famotidine tablet 20 mg - OUT OF STOCK 4/03/2026 RN E documented GlycoLax Powder - on order 4/06/2026 LVN A documented GlycoLax Powder - OUT OF STOCK 4/07/2026 LVN A documented GlycoLax Powder - OUT OF STOCK 4/09/2026 ADCO documented GlycoLax Powder - ordered 4/10/2026 LVN A documented GlycoLax Powder - OUT OF STOCK 4/12/2026 LVN A documented GlycoLax Powder - OUT OF STOCK 4/13/2026 RN E documented GlycoLax Powder - on order During an observation on 4/14/2026 at 3:20 PM, RN E showed she had MVI with minerals, famotidine, and GlycoLax in her medication cart for Resident #21. During an observation and interview on 4/14/26 at 3:35 PM, Resident #21 was lying in bed. Resident #21 was non-verbal. Resident #21 blinked twice, indicating he was not having any stomach pain at that time. Resident #21 blinked once indicating staff took good care of him. During an interview on 4/15/2026 at 9:34 AM, LVN A said she had worked at the facility for six months as nurse after graduating nursing school. LVN A said they had a clip board in the supply closet to write down any OTC medications or supplies that were needed. LVN A said the central supply person who was doing the ordering, no longer worked at the facility. LVN A said she thought Activity Director and the DCO were doing the ordering now. LVN A said she documented in Resident #21's chart the medications were not given because the Pepcid and the MVI with minerals were not available in the building at time of administration. LVN A said she was not sure why they were not available, but she did not have them. LVN A said she had written on the clip board in the supply room several times and told the Central Supply person. LVN A said she knew they had hired a new person and were trying to get things straightened out. LVN said she did not notify the MD that the (continued on next page)

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications were not available because she did not know she needed to. LVN A said she was still learning the processes. LVN A said the nurse was responsible for ensuring the resident received their medications as ordered by the MD, but if the medications were not available, she could not give them. LVN A said the Pepcid (famotidine) and GlycoLax not being available for Resident #21 could be real bad because he was a quadriplegic. During an interview on 4/15/2026 at 10:20 AM, MD P said he would expect his orders to be followed. Md P said it was general nursing for nursing staff to let him know if the resident was not getting medications as he prescribed. MD P said he didn't think missing doses of the MVI with minerals, GlycoLax, or famotidine affected Resident #21. During an interview on 4/15/2026 at 1:10 PM, the DCO stated she was temporarily responsible for ordering and reordering supplies and medications. She stated in the past it had been the responsibility of the medical records designee to order supplies and over the counter medications. She stated the medical records staff member was terminated and the assignment of ordering supplies and medications was reassigned to the activity's director temporarily until a new medical records staff member could be hired and trained. The DCO stated there had been a gap in time when supplies were not ordered timely, because of the lack of communication between the floor staff and herself on how low the over-the-counter medication supplies were. She stated there were a few items that the facility ran out of. She stated had she known the facility was completely out she would have run to the local stores and obtained the medications for the residents. The DCO stated she expected all orders to be followed and the staff to inform her if the facility is out of particular medication and if they are unable to obtain it the MD should be called for further direction. The DCO stated did not feel there was a significant adverse effect on the residents for missing over the counter medications. During an interview on 4/15/2026 at 1:13 PM, RN E said she had worked at the facility since January 2026 full-time. RN E said she believed the last order for the MVI with minerals was made by the previous ordering person and the MVI with minerals was ordered wrong, but she did not know why the famotidine was not available. RN E said not receiving the famotidine could have caused Resident #21 to have increased abdominal pain. RN E said if medications or supplies were not available in the facility the MD should be notified to see if alternative interventions or medications were needed. During an interview on 04/15/2026 at 2:30 PM, the Administrator said she expected the nurses to communicate with DCO and herself any problems they have getting anything they need for the residents from clothing to medications and equipment. The Administrator said the facility would have sent the van driver to the store for the medications had they known the facility was out. During an interview 4/15/2026 at 3:28 PM, the ADCO said the person who was supposed to be ordering those OTC medications and supplies was not doing their job and they fired her about two weeks ago. The ADCO said in all reality, they could have bought those OTC medications at the store down the street. During an interview on 4/15/2026 at 3:59 PM, the DCO said Resident #21 not receiving the Pepcid (famotidine) could have led to Resident #21 having increased discomfort. The DCO said if a medication was not available the nurse should have notified the MD for a replacement or let her know if it was something she could just run and get from the store. Record review of the facility's policy titled Administering Medications, dated revised on April 2019 stated . medications were administered in a safe and timely manner, and as prescribed . medications (continued on next page)

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Focused Care at Linden	1201 W Houston St Linden, TX 75563

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were administered in accordance with the prescribers orders, including any required time frame . the individual administering medication checks the label THREE times to verify the right resident, right medication, right dosage, right time, and right method/route of administration before giving the medication . Mediations must be administered within one (1) hour of their prescribed time, unless otherwise specified .

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review, the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 2 of 6 residents (Resident #27 and Resident #8) and 1 of 2 medication carts (100/300 hall medication cart) reviewed for drugs and biologicals.1. The facility failed to ensure RN E locked the 100/300 hall medication cart when she went into Resident #27's room on 4/14/2026.2. The facility failed to ensure RN E did not leave Resident #8's medication cards of furosemide (used to increase urine production to decrease fluid levels), carvedilol (used to treat high blood pressure), hydralazine (used to treat high blood pressure), glipizide (used to treat high blood sugar), gabapentin (used to treat nerve pain), Jardiance (used to treat high blood sugar), and clonidine (used to treat high blood pressure) on top of the medication cart unsupervised on 4/14/2026. 3. The facility failed to ensure RN E locked the 100/300 hall medication cart when she went into the medication room on 4/14/2026.These failures could place residents at risk of medication misuse and drug diversion.Findings included:During an observation on 4/14/2026 at 8:51 AM, RN E went into Resident #27's room which was two doors down from where the medication cart was parked against the wall with the drawers facing toward the hallway and left the medication cart unlocked and unsupervised.During an observation beginning at 4/14/26 at 8:53 AM, RN E prepared medications for administration for Resident # 8. RN E placed the medications in a medication cup and then handed the medication card to the surveyor to write down the medications, then the surveyor handed the medication cards back to RN E upside down on top of her medication cart. This process continued for each medication until RN E started to gather supplies to administer Resident #8's Lantus (insulin-used to treat high blood sugar) and RN E then said there was not enough Lantus in the pen, and she needed to go get another pen. RN E placed the medication cup with Resident #8's medications in the medication cart and locked the cart. RN E left the medication cart at 9:07 AM and returned at 9:19 AM and left the following seven medication cards with medications on top of the medication cart: furosemide, carvedilol, hydralazine, glipizide, gabapentin, Jardiance, and clonidine. During an observation on 4/14/2026 beginning at 3:55 PM, RN E was sitting in the 100 hall nurse's station, and the medication cart was sitting in front of the nurse's station with the drawers facing the hallway and it was not locked. Then, the medication room was reviewed with RN E that was located just off the nurse's station in a closed room. RN E left the medication cart unlocked and unsupervised while in the medication room for approximately five minutes. Upon exiting the medication room, there were three staff members standing in front of the unlocked medication cart. RN E then walked from around the nurse's station to medication cart and saw it was unlocked and locked it.During an interview 4/15/2026 at 1:13 PM, RN E said she had worked at the facility since January 2026 full-time. She said the medication cart should be locked at all times when not in her eyesight. RN E she said she was doing some things different than her normal because the surveyor was there and it messed up her routine. RN E said they have residents with dementia who wandered and it was a safety hazard to leave it unlocked and unsupervised. RN E said she was responsible for ensuring the medication cart and the medications were secured in the locked cart. RN E said she normally did not remove the cards from the medication cart but did for the surveyor to review and it messed up her routine. During an interview on 4/15/2026 at 3:59 PM, the DCO said the medication carts should not be left unlocked and medications should not be left out on top of the medication cart. The DCO said it was a rookie mistake and the nurse's first time with the state. The DCO said it was a safety issue leaving the medications on top of the medication cart and leaving the medication cart unlocked and unsupervised.During an interview on 4/15/2026 at 4:24 PM, the EDO said the medication cart should be locked when the nurse walks away. The EDO said someone could have walked away with the medications that was not supposed to have it.Record (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of the facility's policy titled Administering Medications, dated revised on April 2019 stated . medications were administered in a safe and timely manner, and as prescribed . During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by .Record review of the facility's policy titled Storage of Medications, dated revised on April 2007 stated . The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . the nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use . carts used to transport such items shall not be left unattended if open or otherwise potentially available to others .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety requirements.The facility failed to ensure there was minimal carbon buildup on 3 skillets.The facility failed to ensure the stove was clean from debris and black carbon buildup on the stove top.The facility failed to ensure there was no grease buildup on the fryer.The facility failed to ensure the toaster was clear of debris on 4/14/2026.These failures could place residents at risk of foodborne illness and food contamination. Findings included:During initial tour observations in the kitchen on 4/13/2026 at 9:08 AM and accompanied by Dietary Manager, there was yellow to amber colored film build up behind the [NAME] and along the right side of the [NAME] with a baking sheet screwed into wall to divide the [NAME] from the oven. The baking sheet observed to have black area with debris and yellow substance scattered on the baking sheet. The toaster was observed to have crumb debris inside the toast with debris located in the base and corners of the toaster. There were 4 frying pans located on the shelf next to the stove with black carbon build up on the base of the frying pans and one frying pan with thick black buildup on the inside of the pan.During an observation on 4/14/2026 at 11:46 AM, observed black carbon buildup on pots/pans stored next to the stove. The [NAME] also observed to have yellow to amber colored film buildup behind the [NAME] and along the side of the [NAME] with a baking sheet screwed to the wall. The skillets remain stored on shelf next to the stove with observed black carbon buildup.During an interview on 4/15/2026 at 1:08 PM, [NAME] F said all the kitchen staff pitch in to clean the equipment in the kitchens such as pots, pans, surfaces. The manager cleans the [NAME], stove, and big stuff in the kitchen. She said the maintenance man cleans the gas lines. [NAME] F said the kitchen staff clean the industrial equipment monthly. She said they would remove the pots/pans from services if the pan was scorched, burned, or bowed out. She said the black substance on the pots and pans looked like soot. She said the kitchen staff sign off on the checklist cleaning schedule log when the task was completed. The [NAME] said if the pots and pans were in use it could cause a fire. The [NAME] said the manager and kitchen staff were responsible for ensuring the equipment was clean and there was no black build up. During an interview on 4/15/2026 at 1:15 PM, [NAME] G said she was responsible for ensuring the kitchen was clean. She said the kitchen staff changed the oil in the [NAME]. [NAME] G said she cleaned the kitchen stove every couple of days, but she did wipe up spills daily. She said if the [NAME] was not cleaned, it could cause a fire. She said the pots and pans should not have black carbon buildup and stated it could cause a fire. [NAME] G said the aide helper should clean the toaster after every use. She said the debris could cause a fire. [NAME] G said if the pots and pans could not be cleaned up, then they need to be replaced. The [NAME] said she always sweeps and mops at night when she works. She said she usually tries to clean the stove 1 x weekly, but she does not always get it done. She said she puts the stove parts in the sink and puts degreaser and cleaned them off. She said the buildup could cause a fire. [NAME] G said the [NAME] should be cleaned because the grease could cause a fire. [NAME] G said everyone should clean a little each day. During an interview on 4/15/2026 at 1:28 PM, The Director of Food Service said she expected the kitchen staff to clean the kitchen daily. She said the deep [NAME] was cleaned every Friday. She said she expected the kitchen staff to clean as they go throughout their day. The Director of Food Service said if the deep [NAME] was cleaned on Friday, it should not have the grease buildup on it when surveyor entered on Monday. She said sometimes the kitchen staff falls short on tasks. She said the kitchen staff try to clean the oven and stove when there is a mess on it. She said she felt she needed a stronger chemical to clean the stove and the staff used a degreaser. She said the buildup of grease on the [NAME], and the stove carbon buildup could cause a fire. She said before the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	previous Director left; she was going to bring a cleaning tool for the stove. The Director of Food Service said the toaster should be cleaned after each use and she expected it to be cleaned daily. She said the debris could also cause a fire. She said the pots and pans should not have the black carbon buildup on them as it could also cause a fire. The Director of Food service said the facility just ordered new skillets and we should have thrown the other ones away. The Director said she does go behind the kitchen staff, but they do not always get things done. She said she was responsible for the kitchen. During an interview on 4/15/2026 at 2:12 PM, the DCO said she expected the kitchen to be cleaned and including the stove, oven, [NAME] and toaster. She said it could be a fire hazard. The DCO said the Dietary Manager was responsible for ensuring the kitchen/equipment was cleaned. During an interview on 4/15/2026 at 2:25 PM, the EDO said she expected the pots and pans to be removed/cleaned depending on the condition. The EDO said the food service employees were responsible for ensuring equipment was clean. She said it depended on buildup on the equipment that it could be frameable or insects could be attracted to food particles causing an issue with pest. Record review of daily cleaning schedule dated 4/13/2026-4/19/2026 indicated the cooks were responsible for cleaning the oven, stove, grill and were signed off completed on 4/13/2026, 4/14/2026 by [NAME] G.Record review of a facility policy titled Kitchen Sanitation dated 3/2026 indicated .Equipment should be maintained in a clean, sanitary condition and free from spills, to minimize the risk of cross contamination. Procedure .1. Clean and sanitize food preparation areas and equipment after use. 2. Clean grills, griddles, vent hoods, microwave ovens, and similar cooking devices after use and as needed. 3. A certified company to maintain the vent hood exhaust system, every 6 months. 4. Store equipment to prevent contamination. 9. Utilize stainless steel cleaner as needed.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 17 residents (Resident #21) reviewed for resident rights.1. The facility failed to ensure RN E closed the window blinds, opening to the parking lot in front of the building, while performing medication administration and tube feeding through Resident #21's PEG tube (tube inserted through the abdominal wall directly into the stomach to deliver nutrition, fluids, and medications when oral intake was insufficient) on 4/14/2026.2. The facility failed to ensure RN E did not discuss Resident #21's family, by saying his family is very demanding and particular about his care and his family doesn't like it when we use too much water, while setting up supplies, providing medication administration and tube feeding through his PEG tube on 4/14/2026.These failures could place residents at risk of humiliation, diminished quality of life, loss of dignity and self-worth.Findings included:Record review of Resident #21's face sheet dated 4/13/2026 revealed he was [AGE] years old and admitted to the facility initially on 2/17/2014 and readmitted on [DATE]. Resident #21 had diagnoses including cerebral palsy (permanent movement and posture disorders caused by abnormal brain development or damage, typically occurring before birth), gastroparesis (delayed emptying of stomach contents), gastrostomy (also called PEG tube), quadriplegia (unable to move body, typically caused from damage to the spinal cord in the neck).Record review of Resident #21's quarterly MDS assessment dated [DATE] revealed he had no speech and was rarely/never understood and sometimes understood others. Resident #21 was unable to complete the BIMS because he was rarely/never understood. Resident #21 was dependent on staff assistance for all ADLs.Record review of Resident #21's Care Plan indicated he required tube feedings related to Cerebral Palsy. The Care Plan indicated Resident #21 had a communication problem related to aphasia (unable to speak) but he understood and could blink his eyes once for yes and twice for no. Resident #21 was dependent on staff for all his ADLs.During an observation and interview on 4/14/2026 beginning at 3:20 PM, RN E raised Resident #21's shirt exposing his bare abdomen and PEG tube. RN E said, while setting up supplies on Resident #21's bedside table, his family is very demanding and particular about his care. RN E said his family doesn't like it when we use to much water as she poured distilled water into a cup on the bedside table. RN E then administered 2 medications to Resident #21 and his bolus feeding (method of delivering nutrition directly into the stomach through a feeding tube using a syringe). RN E said his family doesn't like it when we use to much water again while leaning over the resident to administer medications then flushed the PEG tube with water between each medication and before/after his bolus feeding. The resident's window blinds were left open during the care, with his feeding tube and abdomen exposed. The window by Resident #21's bed opened to the parking lot in front of the building. RN E said Resident #21 could blink once for yes and twice for no if asked questions.During an interview and observation on 4/14/2026 at 3:35 PM after RN E left the room, Resident #21 blinked once, indicating yes, it bothered him to have the window blinds open when the nurse provided care to his PEG tube. Resident #21 blinked once, indicating he would prefer the window blinds to be closed during his PEG tube care. During an interview on 04/15/2026 at 1:13 PM, RN E said she had worked at the facility since January 2026 full-time. RN E said she normally worked on Unit 1 which was all of hall 100 and most of hall 300. RN E said the window blinds of Resident #21's room should have been closed during care for his privacy. RN E said they always closed the blinds during his incontinent care. RN said she thought Resident #21 knew his family was difficult. RN E said she did not feel she was being insulting because Resident #21 knew his family was demanding. RN E said she had a good relationship with Resident #21's family and did not mean anything negative about it. She said she could see where it could be considered a dignity issue with leaving his window (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blinds open during his PEG tube care, but she did not mean anything bad with what was said about his family.During an interview on 4/15/2026 at 3:59 PM, the DCO said the nurse should have closed the window blinds during Resident #21's PEG care and she should not have discussed any issues related to the residents' family in front of the resident. The DCO said it was a dignity and resident rights issue.During an interview on 4/15/2026 at 4:24 PM, the EDO said residents should be provided privacy during care and staff should not talk about the resident's family in the room. The EDO said it could be a dignity issue.Record review of the facility's policy titled Resident Rights dated revised December 2016, indicated . employees shall treat all residents with kindness, respect, and dignity . federal and state laws guarantee certain basic rights to all residents of this facility . these rights include the resident's right to . a dignified existence . be treated with respect, kindness, and dignity . be supported by the facility in exercising his or her rights . privacy and confidentiality .

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to notify the resident's representative when there were changes in the resident's physical, mental, or psychosocial status for 1 of 3 residents (Resident #50) reviewed for notification of changes.The facility failed to notify Resident #50's RP after resident-to- resident incident resulting in a scratch to right forearm on 3/30/2026.This failure could place residents at risk of not having their preferred responsible party represent them in care decisions.Findings Included: Record review of Resident #50's face sheet dated 4/14/2026 indicated an [AGE] year old male who was readmitted on [DATE] with diagnoses including Atherosclerotic heart disease (a type of heart disease when the coronary arteries become narrowed or blocked due to the buildup of plaque which reduces blood flow to the heart muscle), muscle wasting and atrophy (a loss of muscle mass, strength, and function), ataxic (poor muscle control that causes clumsy movements affecting walking, balance, hand coordination, speech and swallowing, and eye movement), dementia (a syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior and ability to perform everyday activities) and cognitive communication disorder (difficulty communicating due to impaired cognitive processes rather than primary speech or language problem). The face sheet identified RP was the emergency contact and responsible party.Record review of Resident #50's Quarterly MDS, dated [DATE], indicated Resident #50 understood and was understood by others. The quarterly MDS also indicated his BIMS score was 3 which meant he was severely cognitively impaired.Record review of Resident #50's Care plan, initiated 3/30/2026 indicated he was involved in Resident-to-Resident altercation. The interventions included monitoring resident for any after effects of the incident and skin assessment to be performed on resident. Resident #50's care plan also his choices and preferences would be identified through interview process with interventions for Resident and/or resident representative would be involved in care planning process.Record review of Progress note dated 3/30/2026 at 1:54 PM indicated Resident #50 was in the bathroom when another Resident came in and grabbed him by the collar of his shirt. Resident #50 put his hands up and another resident grabbed his wrist and forcefully pushed him out of the bathroom to his bed. The progress note indicated Resident #50 had a scratch to right forearm measuring 4.5 cm x 0.3 cm x 0 cm. The progress note did not indicate the RP was notified.During an interview on 4/14/2026 at 4:11 PM, the RP said she believed Resident #50 was cared for but not perfect. She said she was not aware of an incident that occurred on 3/30/2026 and she said she would want to be aware of the incident and the scratch to his arm.During an interview on 4/15/2026 at 1:52 PM, Resident #50 said he did not recall the incident on 3/30/2026. Resident #50 said he would want his RP notified of any changes or concerns with his condition.During an interview on 4/15/2026 at 1:59 PM, RN E said the facility wanted staff to notify the family of any verbal or physical altercations and to also report to the DCO/EDO/Provider. RN E said the nurse would document notification in the progress note.During an interview on 4/15/2026 at 2:12 PM, the DCO said notification depended on the situation. She said notification of RP would be documented in the progress note. She said it would also be documented on the incident report. The DCO said the RP should be contacted if the incident was verbal, physical or if the resident was wandering. She said Resident #50 had a scratch, not a wound. The DCO said the RP did not need to be contacted because it was a scratch, but the RP had the right to be involved in care. She said everyone was responsible for ensuring RP was contacted.During an interview on 4/15/2026 at 2:25 PM, the ADM said she expected the staff to notify the family of any incidents or accidents. The EDO said Resident #50's RP was difficult to reach. The EDO said the staff would document the notification of the RP on the incident report and progress note. The EDO said if the staff could not reach the RP, they should pass the information on the oncoming staff. She said there was no impact on the resident, but the RP had a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Linden		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W Houston St Linden, TX 75563	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right to know. The incident report did not indicate the RP was contacted. The incident report did not indicate the RP was notified.Requested a facility policy related to notification of RP provided to DCO and there was no policy related. The facility did not have a policy for Notification of Resident Representative.Record review of policy titled Abuse last revised on 1/1/2023 indicated .In addition, the facility will notify resident/resident responsible party and inform them of any misappropriations and to whom they report concerns, incidents, and grievances without fear of retribution; and will receive feedback regarding their expressed concerns. These items were listed in the facility admission agreement and were posted within the facility. This list also contains the telephone number at the corporate office if any concerns continue to go unresolved.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an encoded, accurate, and complete MDS discharge assessment was electronically completed and transmitted to the CMS System within 14 days after completion for 1 of 1 resident (Resident #10) reviewed for discharge MDS assessments. The facility did not ensure Resident #10's discharge MDS assessment was transmitted within 14 days of completion. This failure could place residents at risk of not having records completed and submitted in a timely manner as required. Findings included: Record review of Resident #10's, undated face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #10 had diagnoses which included hypertension (high blood pressure) and arthritis. The face sheet indicated Resident #10 was discharged on 11/01/2025. Record review of Resident #10's admission MDS dated [DATE] revealed he had a BIMS of 14, which indicated no cognitive impairment. Resident #10 required supervision with all ADLs. Record review of Resident #10's EHR on 04/15/2026 indicated no discharge MDS was transmitted prior to survey intervention. During an interview on 04/15/2026 at 12:38 p.m., the MDS Coordinator said she was responsible for completing and submitting MDS assessments. She said Resident #10's discharge assessment was completed but not transmitted within 14 days of his discharge. She said the corporate MDS coordinator monitors the MDS assessments she completed. She said it was important to complete and submit discharge assessments because it ensured that proper documentation was collected prior to discharge. She stated Resident #10's discharge assessment was not transmitted because of a software issue. During an interview on 04/15/2026 at 1:30 p.m., the Administrator said she expected the MDS coordinator to follow the MDS Completion and Submission policy. She said the MDS Coordinator was responsible for submitting discharge assessment timely. She said the corporate MDS Coordinator should be ensuring the facility's MDS Coordinator completed and submitted assessments timely. She said timely assessment submission was important ensure the facility was following CMS guidelines. Record review of a facility's MDS Completion and Submission Timeframes policy revised 07/2021 indicated .our facility will conduct and submit resident assessments in accordance with currency federal and state submission timeframes .the assessment coordinator or designee is responsible for ensuring that resident assessment are submitted to CMS QIES assessment submission and processing system in accordance with current federal and state guidelines .timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual . Record Review of the CMS RAI Version 3.0 Manual, dated October 2025, indicated, in Chapter 2, page 2-39 09. Discharge Assessment-Return Not Anticipated (A0310F), Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). The RAI Manual further revealed the discharge assessment-return not anticipated must be submitted within 14 days after the MDS completion date (Z0500B +14 calendar days) .

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #8) of 15 residents reviewed for care plans. The facility failed to ensure Resident #8 had a comprehensive care plan for pain. This failure could place residents at risk of not having their individualized needs met and a decline in their quality of care and life. Findings included: Record review of the face sheet, dated 04/14/2026, reflected Resident #8 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of heart failure (a chronic condition where the heart cannot pump enough blood to meet the body's needs), morbid obesity (complex chronic disease in which you have a body mass index (BMI) of 40 or higher), and pain. Record review of the quarterly MDS assessment, dated 01/21/2026, reflected Resident #8 had a BIMS of 12, which indicated moderate memory impairment. Resident #8 had required substantial (helper does more than half the work) assistance with ADLs such as transfer, dressing, and toileting. Resident #8 received opioids for pain. Record review of the consolidated physician order for April 2026, reflected Resident #8 had an order for Tramadol 50mg one tablet every 8 hours as needed for pain dated 12/11/2025. Record review of the MAR for April 2026 reflected. Resident #8 was administered tramadol 8 times from 04/01/2026 to 04/15/2026 for pain. Record review of Resident #8's comprehensive care plan, dated 03/17/2026, reflected no care plan for pain. During an interview on 04/15/2026 at 12:40 p.m., the MDS Coordinator stated the care plans included all things that were coded on the MDS. She stated the care plan should be reviewed by the nursing staff to know the individual care instructions for each resident. The MDS Coordinator stated items such as falls, high risk medication usage, hospice services, and diagnoses should be care planned for resident safety. She stated not care planning an important item with the interventions could result in the staff not knowing what is needed for the management of the individual resident condition. She stated she overlooked Resident #8's pain care plan, but it should have been care planned to ensure a full picture of his needs in his care plan. During an interview on 04/15/2026 at 1:00 p.m., the DON stated it was the responsibility of the MDS nurse to create the comprehensive care plan and all nurses' responsibility to ensure that acute changes be updated on the care plan. She stated all major diagnoses, conditions, medications, and falls should be care planned with interventions to alert the staff of the potential of these situations recurring and to give instructions on what to do in those cases. The DON stated she did not feel care planning had a negative impact on the residents. During an interview on 04/15/2026 at 1:30 p.m., the Administrator stated she expected the MDS nurse and administrative nurses to ensure the care plans were complete and accurate for each individual. She stated care plans were meant to be a blue print to individual resident care and were important to individualized care. Record review of the Care Plans, Comprehensive Person-Centered policy, dated April 2021, reflected A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.the comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the (continued on next page)

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	675293	A. Building B. Wing	04/15/2026

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;.and which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions.the interdisciplinary team reviews and updates the care plan. at least quarterly.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review the facility failed to post the daily nurse staffing information with the current date, resident census, and numbers of staff actual hours worked at the beginning of each shift in a place readily accessible to residents and visitors for 2 of 3 days, in that: The facility failed to update and post the daily nurse staffing information on 04/14/2026 and 04/15/2026. This failure could affect residents, their families, and facility visitors by placing them at risk of not having access to information regarding staffing data and facility census. The findings included: An observation on 04/14/2026 at 9:30 a.m. revealed the daily nurse staffing pattern posted was from 04/13/2026. An observation on 04/15/2026 at 10:45 a.m. revealed the daily nurse staffing pattern posted was from 04/13/2026. An observation on 04/15/2026 at 2:00 p.m. revealed the daily nurse staffing pattern posted was from 0413/2026. During an interview on 04/15/2026 at 2:45 p.m., the DON stated the night nurse was responsible for changing the staffing posting each day and she would take over checking to ensure it was done. She stated not changing it each day was an oversight on the part of the night nurses. She stated failure to post the staffing numbers could give the public inaccurate information on the staffing of the building that was caring for their loved ones. During an interview on 04/15/2026 at 3:00 p.m., the Administrator stated, it was the responsibility of the night nurse to ensure the staffing numbers were posted daily. She stated it was to be checked by the DON during the week and the weekend supervisor on weekends. The Administrator stated not posting the information would give the public inaccurate information. Record review of a policy titled Posting Direct Care Daily Staffing Numbers, revealed within two (2) hours of the beginning of each shift, the shift supervisor shall compute the number of direct care staff and complete the Nursing Staff Directly Responsible for Resident Care form. The shift supervisor shall date the form, record the census and post the staffing information in the location designated by the Administrator.