

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: 675398	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2026
NAME OF PROVIDER OR SUPPLIER Focused Care of Center		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Timpson Center, TX 75935	
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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to be adequately equipped to allow residents to call for staff through a communication system which relayed the call directly to a staff member or to a centralized staff work area from toilet and bathing facilities for 3 of 20 residents (Resident #45, Resident #17, and Resident #41) reviewed for call lights. The facility failed to ensure Resident #17's emergency call light string in the bathroom would reach the floor as it was approximately four feet above the floor on 8/10/2026. The facility failed to ensure Resident #41's emergency call light string in the bathroom would reach the floor as it was approximately two feet above the floor on 8/10/2026. The facility failed to ensure Resident #45's emergency call light string in the bathroom would reach the floor. The call light cord for Resident #45 was two 1/2 feet above the floor on 8/10/2026. These failures could place residents at risk of injury, pain, hospitalization, and a diminished quality of life. Findings included: 1. Record review of an admission Record for Resident #45 dated 8/11/2026 indicated he admitted to the facility on [DATE] and he was [AGE] years old with muscle weakness, lack of coordination, and dementia (confusion). Record review of a Quarterly MDS Assessment for Resident #45 dated 5/29/2026 indicated he had intact cognition with a BIMS score of 12. He required set up assistance with personal hygiene, intermittently required assistance with toilet hygiene and required use of a cane with walking. Record review of a care plan for Resident #45 dated 11/21/2024 indicated he was at risk for falls related to impaired mobility. Interventions included to be sure call light was within reach and encourage resident to use it for assistance as needed. During an observation on 8/10/2026 at 10:00 am, Resident #45 was in his room. The call light string was two 1/2 feet above the floor. During an observation on 8/10/2026 at 11:00 am, Resident #45 was walking down the hallway. He said she was able to go to the bathroom on his own. During an observation and interview on 8/10/2026 at 11:30 am, CNA A said Resident #45 was assigned to her that day. She observed the call light that was two 1/2 feet above the floor and said (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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #45 would not be able to reach it if he had a fall in the bathroom and would not be able to call for help. She said all staff were responsible for checking the call light strings to ensure they were long enough to reach the floor. 2. Record review of an admission Record for Resident #17 dated 8/11/2026 indicated she was admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia (a decline in thinking that can interfere with daily life), hypertension, (high blood pressure) and depression (sadness or loss of interest in doing things). Record review of a Quarterly MDS Assessment for Resident #17 dated 6/3/2026 indicated she had moderate impairment in thinking with a BIMS score of 7. She required partial/moderate assistance with toileting hygiene and required supervision or touching assistance with walking. Record review of a care plan for Resident #17 dated 3/4/2026 and revised on 3/7/2026 indicated he had poor safety awareness and may need as needed moderate assist with transfer due to weakness. Interventions included ensuring call light was in reach and answer promptly. During an observation and interview on 8/10/2026 at 9:39 AM, Resident #17 was lying on her bed. She said she had been at the facility for about five to six months. The call light string in the bathroom was short, approximately four feet above the floor. She said she used the bathroom on her own. 3. Record review of an admission Record for Resident #41 dated 8/11/2026 indicated she was admitted to the facility on [DATE] and was [AGE] years old with diagnoses of COPD (a group of lung disease that affect breathing), type 2 diabetes, hypertension, (high blood pressure) and major depressive disorder (persistent sadness or loss of interest in doing things). Record review of a Quarterly MDS Assessment for Resident #41 dated 5/22/2026 indicated she had moderate impairment in thinking with a BIMS score of 12. She required partial/moderate assistance with toileting hygiene and required supervision or touching assistance with walking. Record review of a care plan for Resident #41 revised 3/1/2026 indicated she had a history of falls. Interventions included ensuring call light was in reach. During an interview on 8/10/2026 at 9:31 am, Resident #41 was lying in bed. She said she had been at the facility for two 1/2 years and was able to go the bathroom on her own. She said she never noticed the call light string in the bathroom being too short. The call light string was approximately two feet above the floor. During an interview on 8/10/2026 at 4:00 PM, the Administrator said all staff were responsible for checking the call lights daily to ensure they were in reach. She said residents could be at risk of being on the floor for a long time if they needed help and could not reach the string. During an interview on 8/11/2026 at 11:00 am, the DON said all staff were responsible for checking to make sure call lights were in reach. She said the call light should hang long enough so if a resident fell, they would be able to reach it. She said there could be a delayed response for the staff to find if a (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident was not able to reach the string to call for help. Record review of a facility policy titled Quality of Life-Accommodation of Needs revised August 2009 indicated, .Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being. 3. In order to accommodate individual needs and preferences, adaption may be made; e. installing longer cords so that they are easily accessible .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 observation, interview, and record review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible for 1 of 10 residents (Resident #5) reviewed for safe transfers. The facility failed to ensure CNA C used a mechanical lift to transfer Resident #5 on 8/11/2026. This failure could place residents at risk of falls or injuries. Findings included: Record review of an admission Record for Resident #5 dated 8/11/2026 indicated he was admitted to the facility on [DATE] and he was [AGE] years old with diagnoses of cerebral palsy (a group of permanent movement disorders that appear in early childhood), BPH (enlarged prostate), and hypertension (high blood pressure). Record review of a Quarterly MDS Assessment for Resident #5 dated 7/31/2026 indicated he had severe impairment in thinking with a BIMS score of 4. He required substantial/maximal assistance with toileting hygiene, and he used a wheelchair for mobility. Record review of a care plan for Resident #5 dated 1/29/2026 indicated he had a history of falls with interventions that were initiated on 5/28/2026 for a mechanical lift for all transfers to wheelchairs. Record review of a POC Task for Resident #5 undated indicated he required a mechanical lift for transfers every shift. Record review of a list of residents who required a sling/mechanical lift for transfers undated indicated Resident #5 was on the list. During an observation on 8/11/2026 at 1:20 pm, CNA C was in the room of Resident #5 to provide incontinent care. Resident #5 was sitting on a lift sling in a specialized wheelchair. CNA C placed gloves on her hands and positioned the wheelchair by the bed and pulled the linens back. CNA C grabbed Resident #5 around his upper back and interlocked her fingers and lifted him out of his chair and transferred him to the bed. After care was provided CNA C positioned Resident #5 to sit on the side of the bed and transferred him back to his wheelchair wrapping her arms around his upper back. During an interview on 8/11/2026 at 1:38 pm, CNA C said she had been employed for a month. She said she was a new nurse aide. She said she had a skills check off during orientation on using mechanical lifts. She said she did not use a lift for Resident #5 because she felt comfortable with transferring him without assistance and never used the mechanical lift on him but other staff did. Record review of a mechanical lift transfer competency evaluation for CNA C dated 7/7/2026 indicated she demonstrated using a lift for transfers. During an interview on 8/12/2026 at 9:36 a.m., the DON said Resident #5 required a mechanical lift for all transfers. She said the nurse aides could see in their POC what kind of transfers residents required. She said staff were trained in how to use a mechanical lift during their yearly evaluations with competency skills check offs and on hire. She said if staff did not use the appropriate technique for transfers a resident could be at risk for injury. She said all staff had access to the POC for each resident so they would be able to see who required a mechanical lift for transfers. The Administrator was unavailable for an interview on 8/12/2026. Record review of a facility policy titled Safe Lifting and Movement of Residents revised July 2017 indicated, .In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. 2. Manual lifting of residents shall be eliminated when feasible. 5/ Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary .		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 1 of 1 kitchen reviewed for food safety requirements and kitchen sanitation. The facility failed to ensure the ice machine was properly cleaned on 8/10/2026 at 9:30 AM. The facility failed to ensure the water filter for the ice machine was clean on 8/10/2026 at 9:30 AM. These failures could place residents who eat from the kitchen at risk of foodborne illnesses. Findings include: During an observation on 08/10/2026 at 9:30 AM, the ice machine located in the dining area had black and brown substance on the white plastic water curtain guard located in the ice machine above the ice. The water filter located behind the machine was dark brown in color. During an interview with the dietary manager on 8/10/2026 at 9:35 AM, she stated the facility maintenance supervisor was responsible for changing the water filters and cleaning the ice machine. She stated she was not sure of the cleaning timeframe or when the ice machine was last cleaned. She stated she did not know how often the water filter was changed. During an interview with the administrator on 8/10/2026 at 10:00 AM, she stated the facility maintenance supervisor was responsible for maintaining the water filter for the ice machine and cleaning the ice machine. She stated she believed it had been checked and cleaned in the last week. She said she would have to ask the maintenance director for the cleaning schedule and when the filters were last changed. During an interview with the maintenance supervisor on 8/12/2026 at 10:00 AM, he stated he had been at the facility for over a year. He stated he was responsible for cleaning and maintaining the ice machine. He stated he changed the water filter to the ice machine monthly and as needed. He said he visually inspects the filter weekly. He stated there had been water issues with the city requiring him to change the filter more frequently. He stated he last inspected the filter last week (week of 08/02/2026). He said he had deep cleaned the ice machine in July 2026. He said he cleans the machine quarterly and as needed. He said that he may have missed that small section of the guard located in the ice machine that had the dark substance on it. He said he maintains a log book for all his maintenance tasks. He said not having a clean water filter and regular cleaning of the ice machine puts residents at risk for consuming contaminated ice and cause the ice machine to not work properly. Administrator not available for follow up interview on 8/12/2026. Record review of a facility policy titled Ice Machines and Ice Storage Chests revised September 2005 indicated, 3. Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacture's instructions. Record review of Manitowoc service manual dated May 2005 indicated in section 4-3 Clean and sanitize the ice machine every six months for efficient operation. If the ice machine requires more frequent cleaning and sanitizing, consult a qualified service company to test the water quality and recommend appropriate water treatment.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 6 residents (Resident #16 and Resident #5) reviewed for infection control. The facility failed to ensure CNA B washed or sanitized her hands or changed gloves while performing incontinent care for Resident #16 on 8/10/2026. The facility failed to ensure CNA C washed or sanitized her hands, change gloves, did not place dirty linens on the floor, and clean the resident properly when incontinent care was provided to Resident #5 on 8/11/2026. These failures could place residents at risk of exposure to communicable diseases and infections. Findings included: 1. Record review of an electronic face sheet for Resident #16 indicated she was a [AGE] year-old female that admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease (progressive brain disorder that slowly destroys memory, thinking skills), morbid obesity (having a Body Mass Index of 40 or higher), and muscle weakness. Record review of Resident #16's Quarterly MDS dated [DATE] indicated Resident #16's BIMS score was not completed because Resident #16 was rarely or never understood. Resident #16 was dependent for toileting hygiene. Record review of Resident #16's care plan dated 11/14/2024 indicated: I have ADL self-care performance deficits related to disease processes. I need substantial assist to moderate assist for ADLs due to weakness, incontinence, and cognitive deficits. I feed myself at times and need a wheelchair for locomotion with interventions that included: The resident requires substantial assistance by 1 staff with personal hygiene and oral care. and The resident requires substantial assistance by 1 staff for toileting. During an observation on 08/10/2026 at 9:45 AM, Resident #16's incontinent care was provided by CNA B and CNA A. CNA B provided the majority of the care with CNA A helped to turn Resident #16. After cleaning Resident #16 from front to back CNA B rolled Resident #16 onto her right side and CNA B changed gloves but did not wash or sanitize hands before donning new gloves. CNA B then cleaned bowel movement from Resident #16, placed a new brief on Resident #16 and repositioned clothing, she did not change gloves, wash or sanitize hands. CNA B then removed the gloves and did not wash or sanitize hands and transferred Resident #16 via mechanical lift to her wheelchair. During an interview on 08/10/2026 at 10:01 AM, CNA B said she had worked at the facility for 6 months and had been a CNA for 1 year. She said during incontinent care she forgot to switch out her gloves at the very end. She said she did not wash or sanitize her hands during the incontinent care because she forgot to bring sanitizer with her. She said she should have sanitized her hands in between each glove change. She said it could cause the residents to get an infection by not sanitizing or washing her hands. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/10/2026 at 10:13 AM, CNA A said she had been a CNA for 2 years. She said CNA B did not wash or sanitize her hands in between glove changes. She said by not sanitizing or washing their hands they could spread germs and infection from resident to resident. Record review of CNA competency evaluation for peri/incontinent care, female (without catheter) dated 2/9/2026 for CNA B indicated she had met expectations. Record review of CNA competency evaluation for peri/incontinent care, female (without catheter) dated 1/29/2026 for CNA A indicated she had met expectations. Record review of CNA competency evaluation for peri/incontinent care, female (without catheter) dated 4/30/2026 for CNA A indicated she had met expectations. 2. Record review of an admission Record for Resident #5 dated 8/11/2026 indicated he was admitted to the facility on [DATE] and he was [AGE] years old with diagnoses of cerebral palsy (a group of permanent movement disorders that appear in early childhood), BPH (enlarged prostate) and hypertension (high blood pressure). Record review of a Quarterly MDS Assessment for Resident #5 dated 7/31/2026 indicated he had severe impairment in thinking with a BIMS score of 3. He required substantial/maximal assistance with toileting hygiene. He was always incontinent of urine/bowel. Record review of a care plan for Resident #5 dated 1/29/2026 indicated he had an ADL self-care performance deficit related to disease process and was incontinent of bladder and bowel. Interventions included he required substantial assistance by one staff with personal hygiene. During an observation on 8/11/2026 at 1:20 pm, CNA C was in the room of Resident #5 to perform incontinent care. CNA C placed gloves on her hands without washing or sanitizing them. Resident #5 was in bed, and CNA C removed his shoes and placed them in his wheelchair and removed his pants and placed them on the floor. She opened his brief and pulled it down between his thighs and sprayed perineal cleanser to his groin area. She removed wipes from a package and wiped his groin area down both inner thighs and placed the wipes in the trash. She removed more wipes and cleaned his penis in a circular motion and Resident #5 was uncircumcised. She rolled the brief under his buttocks and rolled him onto his left side and removed the brief and placed it in the trash. She opened his drawer, removed a clean brief, placed it under the resident buttocks, removed more wipes, wiped his rectal area from front to back and placed the wipes in the trash. She positioned the brief under his buttocks and had the resident roll onto his right side and then onto his back and secured the brief. She opened his closet and removed a pair of pants after touching multiple clothing items in the closet with the dirty gloves. She placed the pants on the resident and put his shoes back on. The resident was positioned to sit on the side of the bed and transferred back to his wheelchair. She handed him a ball, gloves, and cup that were on his dresser. She removed her gloves and placed them in the trash and did not wash or sanitize her hands after glove removal. She opened his personal refrigerator and handed him a drink. She removed the under pad from the bed and placed it on the floor and straightened the bed. She removed the trash, tied it, and took it to the soiled linen closet down the hall and placed it in the trash. She did not wash her hands after placing the bag in the trash and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surfaces that may be contaminated. 2. You must perform hand hygiene after contact with bodily fluids . Record review of a facility policy titled Laundry and Bedding, Soiled revised October 2018 indicated, .Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control. Handling: 1. All used laundry is handled as potentially contaminated until it is properly bagged and labeled for appropriate processing. b. Laundry that is contaminated with blood or body substances is placed in leak-proof bags, or containers .		