

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675751	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2026
NAME OF PROVIDER OR SUPPLIER  Focused Care at Odessa		STREET ADDRESS, CITY, STATE, ZIP CODE  2443 W 16th St Odessa, TX 79763	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure allegations of abuse were reported immediately, but not later than 2 hours after the allegation was made to the State Agency for 1 of 4 residents (Resident #20) reviewed for abuse in that: The facility did not report to the State Survey Agency that Resident #20 reported an allegation of abuse to the administration within 2 hours of the incident. This deficient practice could place residents at risk for not having all allegations of abuse and neglect reported to the State Survey Agency in a timely manner. Findings Include: Record review of Resident #20's admission record dated 01/07/2026 revealed he was admitted to the facility on [DATE] with diagnosis of Parkinson's disease, schizophrenia, muscle wasting and atrophy. He was [AGE] years of age. Record review of Resident #20's MDS assessment dated [DATE] revealed in part: BIMS = 5 indicating severe impairment. Mobility devices wheelchair. Functional abilities - Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) = Dependent - Helper does all of the effort. Resident does none of the effort to complete the activity Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Record review of the current care plan for Resident #20, last reviewed/revised: 11/05/2025, revealed in part: The resident has limited physical mobility related to weakness. The resident will maintain current level of mobility through review date. The resident uses wheelchair for locomotion on and off unit, requires limited to extensive staff assistance to propel. The resident is dependent on staff for assistance with transferring X 2 person assist using Hoyer lift. The resident requires extensive staff assistance with bed mobility. Record review of an undated note written by CNA F indicated in part [CNA F] saw [LVN C] grab Resident #20 and pulled him by his shirt and pulled him up in an abusive manner I was walk to lay him down and I asked him for help and that when pulled him in abuse manner I look at [Resident #20] and he stated I think he broke my leg all I could do was say I'm sorry and I cried because I thought it was very wrong signed [CNA F]. Record review of LVN C's facility's Disciplinary Action Record dated 01/02/2026 revealed in part: Recommended action - suspend. Facts regarding incident: Violation of policy - Resident [#20] states pulled him up with shirt. Corrective action to be taken suspension for 3 day. Team member signature and date = done over phone. Record review of LVN C's facility's employee termination form dated 01/06/2026 revealed in part: Reason for separation failure to adhere to company policies. Description of incident: Resident [#20] states employee [LVN C] pulled him up by his shirt. During an interview and observation on 01/07/2026 at 3:40 PM revealed Resident #20 was in his bed awake and alert. Resident #20 said that LVN C had been rude to him. The resident said he felt intimidated by him just by the way the LVN looked at him. Resident #20 said whenever LVN C was working at the facility and was his nurse, he felt scared and threatened by the LVN. Resident #20 said he did not recall if he had reported LVN C to someone. Resident #20 said he did not recall being physically mistreated by LVN C just that he felt the LVN did not like him. During a</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>telephone interview on 01/08/2026 at 3:04 PM the state surveyor called LVN C and a message was left to call back but the LVN never returned the calls. During an interview on 01/08/2026 at 3:42 PM the DON said regarding Resident #20 that there was a note found under the SW's door that indicated that LVN C had aggressively pulled the resident up on his Broda-chair (a type of reclined wheelchair). The DON said that occurred on or about 12/30/2025 and LVN C was suspended via phone call as LVN C was off from work when the allegation occurred. The DON said after the suspension LVN C was terminated due to the incident with Resident #20. The DON said that the Administrator had called LVN C on 01/07/2026 to terminate him over the phone. The DON said she was not sure if the Administrator had reported the allegation to the state. During an interview on 01/08/2026 at 4:45 PM the Administrator said LVN C had been suspended due to the allegation made by CNA F and the allegations of LVN C being inappropriate. The Administrator said she had done a safe survey to investigate the allegation brought against LVN C. The Administrator said CNA F had no phone to be reached at and the CNA had not returned to work after the note was left in the SW designee's office on 01/02/2026. The Administrator said she and the SW designee had interviewed Resident #20 on 01/02/2026. The Administrator said she had interviewed Resident #20 with the SW designee present and the resident had said he was sliding down his chair and that LVN C had pulled him up by his shirt. The Administrator said they did safe surveys and some of the residents did say they were scared of LVN C as he was intimidating. The Administrator said she had not reported the allegation to the state because the resident said LVN C had only pulled him up by his shirt. The Administrator said the letter was found under the SW designee's door on Friday 01/02/2026. During an interview on 01/08/2026 at 5:05 PM the SW designee said she remembered finding the note on the floor when she entered her office on Friday morning 01/02/2026 and that she had handed it to the Administrator. She said she did not know why CNA F had placed the note under her door instead of the Administrator's office. Record review of the facility's Abuse policy dated 02/01/2017 revealed in part: The purpose of this policy is to ensure that each resident has the right to be free from any type of abuse, neglect, intimidation, involuntary seclusion/confinement and or misappropriation of property. All events that involve an allegation of abuse or involve a suspicious serious bodily injury of unknown origin must be reported immediately or not later than 2 hours of alleged violation.</p>		