| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675751 | A. Building<br>B. Wing | 05/27/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Focused Care at Odessa | 2443 W 16th St<br>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) |
|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assured the accurate acquiring and administering of all medications to meet the needs of 1 of 5 (Resident #1) residents reviewed for pharmacy services in that: MA A failed to ensure Resident #1 took her medications at the time of administration and left them on the bed side table. This failure could place residents at risk for medication overdose, medication under-dose, drug diversion, and not receiving therapeutic doses of prescribed medications. The findings included:Review of Resident #1's admission Record, dated 5/21/26 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included End Stage Renal Disease (kidney no longer works the way it needs to). Resident #1 was on dialysis. Review of Resident #1's Quarterly MDS Assessment, dated 5/20/26 revealed:She had a BIMS score of 15 of 15 (indicating her cognition was intact) and showed no signs of delirium.She needed supervision or cueing for most ADLs. Review of Resident #1's Care Plan, initiated 8/6/24, revealed:Focus: History of End Stage Renal Disease.Goal: Resident will have no signs or symptoms of kidney failure throughout the review date.Interventions: Administer medications as ordered. Review of Resident #1's Order Summary, dated 5/21/26 revealed:No orders for self-medicationShe received dialysis services.She received Sevelamer Carbonate tablets 800 mg by mouth (a phosphate binder used to control high levels of phosphate levels for people on dialysis) at meal times for End Stage Renal Disease. An observation and interview with Resident #1 on 5/26/26 at 3:34 revealed two large pills in a medication cup on Resident #1's bedside table. There were no staff present. Resident #1 stated she was asleep when medication was delivered, but it was just the phosphate binders. The DON was brought to Resident #1's room and shown the pills. The DON stated the medications needed to given with staff supervision and given with meals. In an interview on 5/27/26 at 10:08 a.m. with the ADON and DON, the ADON stated she just in-serviced staff about not leaving medication unattended on 4/15/26. The ADON stated it was just a routine in-service and not one initiated because of an issue. The DON, who was present, stated she talked to the MA who said Resident #1 did not want to take the medication at the time of medication pass. The DON said the MA should have brought the medication to the cart. The DON said she did not know why the medications were left at bedside. The DON said the risk to the resident was the resident could take the medication at the wrong time, or take a double dose of the medication, if the resident even took the medication at all. The DON stated other residents could take the medication when Resident #1 left her room for smoke breaks which could cause choking or adverse reactions. The DON stated MA A had been a CNA for a long time, but had only been a MA for a few months. The DON stated MA A was not a MA the last time she did MA competency checks. In an interview on 5/27/26 at 10:41 a.m., MA A stated she had been a MA for 2 - 3 months. MA A said Resident #1 told her (MA A) that she (Resident #1) was eating. MA A said Resident #1 usually took her pills while eating and said Resident #1 told MA A she would take them but did not. MA A stated she told Resident #1 to take the pills, but Resident #1 was a her way or no way resident. MA A stated the risk to the residents was someone could go into the room and take<br>(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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | them and the other resident could get sick from taking the wrong medication. MA A stated this was the first time Resident #1 did not take her medications to MA A's knowledge. MA A said Resident #1 usually took her medications while MA A gave the roommate her medications. MA A said not leaving the medications unattended was covered in her class and she should've known better. Review of the facility's MA Competency checklist, undated, revealed one of the items on the checklist was: Remain with the resident until all medications have been taken. Review of the facility's in-service dated 4/15/26, by the DON revealed the subject of the training was, Please ensure residents take all medications in the cup. Do not leave medications at bedside. MA A did not participate in the in-service |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep all essential equipment working safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical and patient care equipment in safe operating condition for 1 of 1 laundry room reviewed for physical environment. The facility failed to maintain the clothes washers in working condition. This failure placed residents who relied on the facility for laundry services improperly cleaned clothes and diminished quality of life. Findings included:Review of Resident #1's admission Record, dated 5/21/26 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included End Stage Renal Disease (kidney no longer works the way it needs to). Resident #1 was on dialysis. Review of Resident #1's Quarterly MDS Assessment, dated 5/20/26 revealed:She had a BIMS score of 15 of 15 (indicating her cognition was intact) and showed no signs of delirium.She needed supervision or cueing for most ADLs. In an observation and interview on 5/21/26 at 9:20 a.m. the Laundry Supervisor stated the facility did have problems with the industrial washer breaking down; the hot water was not getting hot. The Laundry Supervisor stated the facility had to use special soap for resident clothing and she did not get the order in on time. The Laundry Supervisor stated it would delivered on 6/1/26. The Laundry Supervisor stated the soap used on the bed linens and towels would eat the resident's clothing. The Laundry Supervisor said she did not get the credit card from the Housekeeping Supervisor to get regular soap for resident's clothing out of petty cash or ask a sister facility for the right soap. The Laundry Supervisor said she did not know she did not ask to trade with a near by facility under the same corporation umbrella. The Laundry Supervisor stated sometimes the aides would not clean the bowel movement off the sheets or wrap the linens around a soiled brief. The Laundry Supervisor said the Laundry Department did not have a hopper (specialized sink for washing off BM from linens) equipped in the room. The Laundry Supervisor said the third washer may or may not work on getting the resident's clothes clean and the laundry staff were doing half loads in the washer. Observation at that time of the smallest washer (consumer sized) showed the washer was over filled with sheets - there were too many sheets for the agitator to move the sheets. The Laundry Supervisor stated the industrial washer was essential equipment for the facility to have linens. In an interview on 5/21/26 at 9:47 a.m., the Housekeeping Supervisor said there were three different laundry detergents she could order off the computer and the other laundry soap was for the small washer. The Housekeeping supervisor said she did not know to order the soap from the chemical company. In an interview on 5/21/26 at 12:07 p.m., Resident #1 stated the facility had two washers and the clothes came back stinking. Resident #1 said she talked to the head of laundry about it and was told the facility did not want to pay for a new washer. Resident #1 said the facility washed the poop linens in the same washer as the resident's clothes and that was why they stunk. In an interview on 5/22/26 at 1:13 p.m., CNA B stated she was not aware of any laundry complaints. She stated the laundry was able to keep up with the demand for linens. CNA B said the washing machine broke the week of 5/11/26 thru 5/15/26 but the facility got it fixed. CNA B stated the facility had enough back up linens to get through. In an interview on 5/22/26 at 1:34 p.m., CNA C stated showers were given the best CNAs could. CNA C said there were sometimes issues with getting enough linens, and sometimes the residents went without showers. CNA C said the last time the facility was short on linens was the week before when the washer broke again. CNA C stated the linens did not smell but she did not know if they were clean because she did not smell bleach on the towels. Review of washing machine repair receipts dated 2/27/26, 3/11/26, 3/23/26 revealed the facility had routine maintenance completed on the washing machine Interview on 5/21/26 at 10:50 a.m. the Administrator said there was no policy for essential equipment. |