STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675751	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Odessa	2443 W 16th St Odessa, TX 79763

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 1 of 1 set of window blinds in room [ROOM NUMBER] and 1 of 1 resident smoking areas. 1. The facility failed to ensure the blinds were not broken.2. The facility failed to ensure adequate cleaning in the designated smoking area. These failures placed the staff, residents, and visitors at risk of living, working and visiting in an unsafe, unsanitary, and uncomfortable environment. Findings include: Observation on 01/06/2026 at 10:04 AM revealed the blinds were broken in room [ROOM NUMBER]. Both Bed A and Bed B were occupied and not interviewable. Observation on 01/07/2026 at 10:05 AM revealed the ground around the outside patio and the ground of the smoking area was littered with smoked cigarette butts. During an interview on 01/08/2026 at 11:05 AM with the Administrator, she stated there was not a policy for cleaning the smoking area. She said her expectation was for maintenance staff to clean all grounds daily, including the smoking area. During an interview on 01/08/2026 at 11:20 AM with the Regional Maintenance Supervisor, he said the staff utilized a chart for documenting when the smoking area was cleaned. He said the requirement was three times per week. He said that his expectation was for the smoking area to be free of litter and cigarette butts to prevent fire hazards. He said an ashtray and metal bucket were provided for cigarette butts. During an interview on 01/08/2026 at 3:23 PM with the DON, she said she was aware of the broken blinds in room [ROOM NUMBER]. The DON said the resident did it and the blinds had been replaced once already. She said they could be a safety issues and a privacy issue. During an interview on 01/08/2026 at 3:50 PM with the Administrator, she said the cigarette butts littering the ground were an issue of cleanliness and a safety hazard. She said maintenance staff was responsible for keeping the smoking area clean and free from litter, including cigarette butts. Record review of the facility's Smoking Policy, dated 10/12/2022, revealed It is the policy of this community to accommodate residents who desire to smoke, including electronic cigarettes by taking reasonable precautions, providing a safe environment for them, and protecting the non-smoking residents. Record Review of the facility's Smoking Area Weekly Cleaning Log for December, 2025 and January, 2026, revealed Smoking Area will be cleaned 3 times a week. Each Monday, Wednesday and Friday in December was marked as complete with a staff member's initials. Monday, January 5th and Wednesday, January 7th was marked as complete.

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 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. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety.1. The facility failed to discard cabbage in a box dated 12/8/2025, containing brown and rotted leaves, in the reach-in cooler.2. The facility failed to ensure an opened bag of grits in the dry storage room was properly sealed and dated.These failures could place residents at risk for food borne illness.The findings included:1. Observation on 1/6/2026 at 9:00 AM in the reach-in cooler revealed 2 boxes of raw cabbage with a label indicating it was received on 12/8/2025. The box was opened, and cabbage was visible; approximately 25% of the cabbage leaves had turned black or were rotten.2. Observation on 01/6/2026 at 9:15 AM in the dry storage room revealed a bag of grits on a rack. The bag had been opened and was rolled over. The bag was not sealed or placed in a sealed bag or container. There was also no open date on the grits.During an interview on 01/6/2026 at 9:10 AM, the Food Service Supervisor stated the truck had just come in and they didn't have time to clean the refrigerator yet. All dietary staff were responsible for properly labeling and dating food items stored in the cooler and discarding items past their use-by dates or if it was of poor quality.During an interview 01/6/2026 at 9:20 AM the Food Service Supervisor stated the bag of grits should have been placed in a sealed bag, and failing to ensure food was properly sealed could result in deterioration in food quality and potential contamination from pests.During an interview 1/6/2026 at 2:00PM the Administrator stated the bad cabbage should have been removed and the grits properly stored. The Administrator stated failing to do so could result in deterioration in food quality, food borne illnesses, and contamination from pests. Record review of facilities policy titled Food Storage dated 4/1/2022 revealed:Food is delivered at the appropriate temperature and inspected prior to storage for signs of contamination.b. Packages remained properly sealede. Food product in good quality 6. Food removed from its original packaging will be labeled with the following a. Received date b. Open date c. Contents in the Package 9. Opened package or leftover food is to be tightly wrapped or covered in airtight, clean containers. It should be labeled, dated with opened or use by date. Do not keep leftovers in the refrigerator for more than 7 days.Record review of FDA Food Code 2022 in part revealed:3-302 Preventing Food and Ingredient Contamination3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation.(A) FOOD shall be protected from cross contamination by:(4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the FOOD in PACKAGES, covered containers, or wrappings(7) Storing damaged, spoiled, or recalled FOOD being held in the FOOD ESTABLISHMENT as specified under S 6-404.11

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment for 1 resident (Resident #2) of 3 residents reviewed for informed consents.The facility failed to obtain a signed informed consent based on information of the benefits, risks, and options available for Resident #2 prior to administering an increased dose of Seroquel, a psychotropic medication (a psychoactive drug taken to exert an effect on the chemical make-up of the brain and nervous system).This failure could place residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party or being aware of the benefits and risks of the medications prescribed.Findings Included:Record review of Resident #2's admission Record, dated 01/08/2026, revealed he was a [AGE] year-old male originally admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), diabetes mellitus (a group of diseases that affect how the body uses blood sugar), and Alzheimer's (the most common form of dementia).Record review of Resident #2's Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score was not available due to the resident not being able to complete the interview. Record review of Resident's #2's Care Plan, dated 10/22/2025, revealed: Focus - The resident is on antipsychotic medication Seroquel r/t: behavior disturbance. Goal - Resident will show decreased number of episodes of hallucinations throughout the next review date. Interventions - Administer medications as ordered. Monitor/document for side effects and effectiveness. Educate resident/family regarding medication risks and benefits. Monitor/record occurrence of targeted behavior and document per protocol. Obtain consent from resident or RP prior to medication use. Pharmacy and physician to review resident's medication profile for continuing usage monthly.Record review of Resident #2's physician orders for Seroquel, printed 01/08/2026, revealed Seroquel Oral Tablet 25mg (Quetiapine Fumarate), give 1 tablet by mouth two times a day for behaviors, was ordered 09/15/2023. The physician orders revealed the dose was changed on 04/19/2024 to Seroquel Oral Tablet 50mg (Quetiapine Fumarate), give 1 tablet by mouth two times a day for behaviors.Record review on Resident #2's consents reflected a consent for Seroquel Oral Tablet 25 MG twice daily for behaviors was signed by his responsible party on 09/18/2023. There was not a consent for the increased dosage.In an interview on 01/08/2026 at 11:00 AM the DON said she would look for an updated consent. The DON said she was not aware of the necessity for a new consent when doses were increased. In an interview on 01/08/2026 at 1:05 PM the DON said she did not have an updated consent for the increased Seroquel dosage for Resident #2. She said the DON and the ADON were responsible for medication consents. The DON said the consequence of not having a new consent signed by the resident's responsible party could cause the responsible party to not be aware of the risks and side effects of an increased dose. On 01/08/2026 at 6:30 PM the DON was unable to supply a policy on consents prior to exit. She stated she did not think there was a policy addressing consents for psychotropic medications specifically.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 4 resident (Resident #13) reviewed for privacy, in that: CNA A and CNA B did not completely close Resident #13's window blinds while providing incontinent care and a change of clothes for the resident. This deficient practice could place residents at-risk of loss of dignity due to lack of privacy.The findings include: Record review of Resident #13's admission record dated 01/08/2026 revealed she was admitted to the facility on [DATE] with diagnosis of dementia, muscle wasting and atrophy. She was [AGE] years of age. Record review of Resident #13's MDS assessment dated [DATE] revealed: Cognitive Skills for Daily Decision Making = Severely impaired - never/rarely made decisions. Bladder and bowel = Urinary Continence - Frequently incontinent. Bowel continence = Always incontinent. Record review of the current care plan for Resident #13, last reviewed/revised: 01/07/2026, revealed in part: Resident is incontinent at times of: Bowel and bladder. Resident will remain clean, dry, and odor free with no occurrence of skin breakdown throughout the review date. Monitor for incontinence Q2H/PRN, change promptly and apply protective skinbarrier. During an observation on 01/06/2026 at 9:36 AM revealed CNA A and CNA B performed incontinent care and changed Resident #13's clothing. Both CNAs put some gloves on and proceeded to perform the resident care. CNA A then proceeded to undo Resident #13's brief and took some wet wipes to wipe the resident's vaginal area and rectal area. Resident #13's private areas were exposed during the care. CNA A and CNA B then put some pants on Resident #13. CNA A then transferred the resident to her wheelchair, removed her shirt which exposed her breasts and helped the resident put another shirt on. During the resident care the window mini blinds was noted to be open and faced the parking lot area where people would pass by. During an interview on 01/07/2026 at 11:30 AM CNA A and CNA B said they should have closed the window blinds before they performed the personal care for Resident #13. The CNAs said by not closing the blinds the resident could be exposed to the outside while she was nude during the personal care. The CNAs said they had not noticed the blinds were not fully closed. During an interview on 01/08/2026 at 3:30 PM the DON said her expectations was for staff to knock on the door, close the door, pull the privacy curtain, and close the blinds during personal care to provide privacy for the resident. The DON said the failure probably occurred due to staff getting nervous. The DON said the ADON would perform proficiency checks upon hire and yearly or more frequent if needed. During an interview on 01/08/2026 at 4:24 PM the Administrator said the expectation was for the staff to close the door, pull privacy curtain, and close the window blinds during personal care. The Administrator said they should have closed them to provide privacy for Resident #13. The Administrator said the CNAs failed to close the blinds probably because they were nervous. Review of the facility's policy titled Quality of life - Dignity dated August 2001 revealed in part: Each resident shall be cared for in a manner that promote and enhances quality of life, dignity, respect and individuality. Residents will be treated with dignity and respect at all times. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to have nursing staff with appropriate competencies to provide nursing and related services to assure resident safety and attain/maintain the highest practicable well-being of each resident for 1 of 1 nursing staff reviewed for nursing services. The facility did not provide evidence that LVN E was competent and received training on resident care plans and implementing care according to care plans.This failure could place the residents at risk for not receiving required care, complications, injury, hospitalization, and decline in conditionFindings included:During an interview on 1/7/2026 at 3:20PM LVN E stated she did not know how to read care plans. LVN E stated she had not received training in reading or implementing care plans. LVN E stated she had worked at the facility for 7 years. LVN E stated she knew the care plans were located in Point Click Care. LVN E stated the risk of not knowing how to read care plans could result in improper care and not meeting resident needs.During an interview on 1/7/2026 at 3:10 p.m., the MDS Coordinator said the staff have been in-serviced on care plans and there were monthly meetings. He stated he developed care plans according to the assessments completed. During an interview on 1/7/2026 at 4:00PM with the DON, she stated staff were trained in reading and implementing care plans. She stated the MDS Coordinator and herself developed and updated the care plans as needed. She stated the risk of a nurse not knowing how to read a care plan could be resident needs not being met.During an interview on 1/17/2026 at 4:30 p.m., the Administrator said staff were expected to know how to read and implement care plans. She stated she thought LVN E had worked here at least 5 years or more. The risk if staff were not competent in reading and implementing care plans could be a decline in condition.Record review of an in-service titled transfer techniques with no date was provided by the DON and revealed that was the care plan training nurses received. This in-service did not include LVN E.Record review of facility policy titled Comprehensive Care Plan dated 4/25/2021 revealed:Every resident will have an individualized interdisciplinary plan of care in place. The care plan is revised every quarter, significant change of condition, annual or as the resident condition changes on an individualized basis. The care plan process is an ongoing review process. The resident's Care Plan will include participation from residents, representatives, external partners, hospice, therapy, clinicians and not all-inclusive.