STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675849	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Burnet Bay	3921 N Main Baytown, TX 77521

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, records review and interview, the facility failed to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 5 (Resident #4, # 10, #12, #51 and Resident #64) of 18 residents reviewed for accuracy of assessment.Resident #4, #10, #12's and #51's MDS did not reflect their lack of natural, broken\lose teeth in their oral cavity.Resident #64 was not assessed for her fall on 12/04/25.These failures could place residents at risk of receiving inadequate care and services due to inaccurate assessments. Findings included:Record review of Resident #4's face sheet, dated 05/06/26, reflected [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Essential hypertension (primary diagnoses), dementia (a group of symptoms affecting memory, thinking and social abilities), psychotic disturbance, overactive bladder, degenerative disease of envious system (a condition that damages, and destroys part of the nervous system over time) Record review of Resident #4's Significant change MDS dated [DATE] revealed her BIMs score was 7 out of 15 indicated sever cognitive impairment. Record review of section L on oral cavity revealed, Resident #4 was assessed as having all natural teeth in her oral cavity.Record review of Resident #4's care plan with a target date of 02/29/26 revealed resident #4 was care plan for Mechanical Soft texture, Regular consistency diet. initiated 07/27/2023- target date 02/19/26Dental care: I have oral/dental health problems r/t Poor nutrition, Poor oral hygiene. Target date 02/29/26:Interventions: Coordinate arrangements for dental care, transportation as needed/as ordered. Diet as Ordered. Consult with dietitian and change if chewing/swallowing problems are noted. Monitor/document/report PRN any signs and symptoms of oral/dental problems needing attention:Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions. Provide mouth care as per ADL personal hygiene.Observation on 05/05/26 at 10:00AM, revealed Resident # 4 was in bed sleeping attempt was made to communicate but did not respond verbally. Observation on 05/06/26 at 12:30PM, revealed she was in the dining room. Her meal was puree diet. Observation indicated she had no teeth on her upper oral cavity. An attempt was made to have an interview, but she did not answer. She attempted to speak but could not answer fully. During an interview with CNA E said Resident #4 did not have any teeth in her upper oral cavity. Review of Resident #10's face sheet, dated 05/06/26, reflected [AGE] year-old female who was admitted to the facility on [DATE] re-admitted on [DATE]. Her diagnoses included chronic congestive heart failure, chromic kidney failure, schizophrenia, dementia (a group of symptoms affecting memory, thinking and social abilities) mood disturbance and presence of cardiac pacemakers (device that sends electrical impulses to the heart muscle to keep a suitable heart rate and rhythm), altered mental status, and essential hypertension (high blood pressure), and cognitive communication deficit (lack of communication)Record review of Resident #10's admission MDS dated [DATE] revealed her BIMs score was 0 out of 15 indicated sever cognitive impairment. Record review of section L oral cavity indicated she had all her natural teeth in her oral cavity. She was coded as none of the above.Record review of Resident review of Resident #10's care plan with a target date of 06/18/26 indicated she (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was care-plan for impaired Dentition: Date Initiated: 05/05/2026Interventions: Assess cracked/loose teeth, bleeding gum, foul breath, white patches, or mouth, pain and report to MDDate Initiated: 05/05/2026 Maintain oral hygiene Date Initiated: 05/05/2026Diet: I am on a NAS, Pureed texture, Regular consistency Date Initiated: 01/25/20 Observation on 05/05/26 at 10:00am revealed Resident #10 was in bed alert. Attempt was made to have an interview but did not answer. She was none-communicative. Observation revealed she had few teeth on her lower oral cavity dark red in color.Observation on 05/06/26 at 12:30PM revealed her lunch was on her table. During an interview with CNA E on 05/06/26 at 1:40PM, she said Resident does not speak and was a total care resident. CNA E said resident #10 does not have any teeth on her upper oral cavity but had few in front (4). She said Resident #10 does not communicate and her teeth had been dark red color. Review of Resident #12's face sheet, dated 05/06/26, reflected [AGE] year-old female who admitted to the facility on [DATE] and re-admitted on [DATE]. Her diagnoses included Alzheimer's disease, Lack of coordination, repeated falls, hypothyroidism, unspecified, malignant neoplasm (Brest cancer) of left female breast, diabetes mellitus (low blood sugar) neuropathy, anemia (low blood count), osteoarthritis, depressive disorders, hypertension heart disease, dementia, behavioral disturbance, lack of coordination, muscle weakness, cognitive communication deficit (lack of communication). unspecified dementia, and behavioral disturbance, Record review of Resident #12's annual MDS dated [DATE] revealed her BIMS score was 5 out of 15 indicated sever cognitive impairment. Record review of section L on dental, Resident #12 was assessed as having all natural teeth in her oral cavity.Record review of Resident #12's care plan revealed she was care-plan for -Impaired Dentition Date Initiated: 05/06/2026 goal: I will not have complications related to impaired dentition such as infection or pain through next review date Initiated: 05/06/2026Intervention: Assess for cracked/loose teeth, bleeding gum, foul breath, white patches, or mouth pain and report to Medical Director. Date Initiated: 05/06/2026 Maintain oral hygiene Date Initiated: 05/06/2026.Record review of Resident #12's clinical record revealed dental group note dated 04/07/26 that revealed X = Missing tooth FX = Fracture RR = Retained root NR = non-restorable. Inflamed. /Swollen, Bleeding Gums: ModerateObservation on 05/06/26 at 12:15PM, revealed Resident #12 was in the dining room. She had regular mechanical altered diet. She fed herself and tolerated her lunch at 90%. During an interview she said she was doing fine and did not speak much. Attempt was made to have an interview about her dentures, but she did not answer. Review of Resident #51's face sheet, dated 05/06/26, reflected [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included Dementia, Anxiety, lack of coordination, Muscles weakness, abnormal gait, and hypertension, Record review of Resident #51's annual MDS assessment dated [DATE] revealed her BIMs score was 11out of 15 indicated moderate cognitive impairment. Record review of section L on dental, she was Resident #15 was assessed as having all natural teeth in her oral cavity. Record review of Resident review of Resident #51's care plan with a target date of 5/06/26 revealed resident #51 was care plan as Impaired Dentition Date Initiated: 05/06/2026Intervention: Assess for cracked/loose teeth, bleeding gum, foul breath, white patches, or mouth pain and report to MDDate Initiated: 05/06/2026. Target date 06/17/26 Maintain oral hygiene Date Initiated: 05/06/2026 Record review of Resident #51's clinical notes indicated resident #51 saw a dentist on 04/07/26: Notes indicated Resident #51 has no teeth in her upper oral cavity. Assessment revealed Pt is healing well following extractions and shows no signs of swelling, erythema or infection.; Denture Step 1 completed. PVS impressions taken for CD/.; Pt presents for annual exam w/ no complaints. No changes to dental charting noted.; Pt tolerated visit well. Observation on 05/05/26 at 9:45AM, Resident #51 was observed in bed. During an interview, she said she had no teeth in her upper oral cavity. She said she only ate soft food and had been waiting to see a dentist but had not. She said she fell, and all her upper teeth fell out of her mouth. During an interview with the facility social worker on 05/06/25 at t2:00PM, she said resident #51 did not fall but she had her upper dentures pulled. She said Resident #51 does not have teeth in her upper oral cavity. Review of Resident #64's face sheet, dated 05/07/26, reflected [AGE] year-old (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	female who admitted to the facility on [DATE]. Her diagnoses included Blindness, muscle weakness, difficulty in walking, unspecified lack of coordination, repeated falls, seizures or convulsions, anxiety, abnormalities of gait and mobility. Record review of Resident #64's Quarterly MDS dated [DATE] revealed Section on fall history (J-1700 and 1800) was coded as 0 indicating there was no fall since admission, and last assessmentRecord review of facility's provided incidents and accidents dated 05/05/25 revealed Resident #64 had an unwitnessed fall on 12/04/25 at 12:25PM.Record review of nurse's notes dated Nursing documentation: 12/4/2025 12:37 revealed: Called to residents' room by another resident, upon entry noted resident laying on fall matt next to bed. Resident stated she was trying to get back in bed by herself and lost her balance. Resident states she did not hit her head she landed on her bottom Observation on 05/05/26 at 10:40am revealed Resident # 64 was in her room.Observation and interview on 05/06/26 at 1:30Pm revealed Resident #64 was in her room. She was alert and oriented. Observation revealed she was blind. She said she had been blind since childhood and she has a daughter. She requested her stick that was on her nightstand. She said sometimes she bumps into things without knowing. She said she was doing well. During an interview with MDS coordinator and MDS supervisor on 05/07/26 at 11:40AM, MDS coordinator looked at all identified MDS assessments and acknowledged that the Identified MDS assessments. She said inaccurate assessment may delayed services for residents. The MDS supervisor's inaccurate assessment may also lead to care plans not being accurate. During an interview with the DON on 05/07/26 at 2:20PM, she said she expects all MDS assessment to accurately reflect resident conditions to provide accurate services.Record review of facility's provided policy titled MDS Completion Accuracy and Timeliness dated 11\20\23 revised 11\15\23 revealed POLICY The purpose of this policy is to ensure accuracy and timeliness of MDS completion.PROCEDURE 1. Each facility must follow most updated MDS RAI rules and regulations for completing each MDS accurately and timely.2. Each facility must also utilize most updated Texas TAC rules for MDS accuracy.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level I for residents with mental illness were provided with an accurate PASRR Level I for 1 (Resident #10) and) of 4 Residents reviewed for PASRR screening.-Resident #10 did not have an accurate and updated PASRR Level 1 assessment reflecting a diagnosis of mental illness. This failure could place residents with mental illness at risk of not receiving a PASRR Evaluation for individualized care, or special services to meet their needs Findings included:Review of Resident #10's face sheet, dated 05/06/26, reflected [AGE] year-old female who was admitted to the facility on [DATE] re-admitted on [DATE]. Her diagnoses included chronic congestive heart failure, chromic kidney failure, schizophrenia, mood disturbance, presence of cardiac pacemaker, altered mental status, and Essential hypertension. High blood pressure)Record review of Resident #10's PASRR evaluation dated 11\19\23 revealed section C for diagnoses of Dementia as primary diagnoses was checked no. Section on IDD and MI was all checked no on all section of mental illness and IDD Record review of Resident #10's admission MDS dated [DATE] revealed his BIM score was 0 out of 15 indicated he was severely cognitive impaired on cognition. Section on level 11 PASRR screening was left blank.Record review of section I on psychiatric \mood disorder, she was checked yes for schizophrenia Record review of Resident #10's clinical records revealed no evidence of PASRR level 1 evaluation.During an interview with MDS coordinator and MDS supervisor on 05/07/26 at 11:40AM, MDS coordinator looked at all identified MDS assessments and acknowledged that Resident 10 Should have been refer to PASRR local authority for PASRR evaluation with diagnoses. She said PASRR evaluation was not done because Resident #10 was not on any antidepression medication. MDS supervisor said form 1092 should have been done to decide if Resident #10 needed services or not. He said not assessing residents correctly may prevent residents from receiving needed services.Record review of Facility provided policy dated 11/2023 revised 11/15/23 revealed POLICY The purpose of this policy is to ensure PASRRs are being obtained and completed timely and accurately.PROCEDURE 1. PASRRs are obtained from referring entity by the admissions department.2. PL1s are put in to Simple LTC by the facility CRC within 72hours of resident admitting to facility. The completed PL1 must also be uploaded into the resident's EMR.3. Communicate with LIDDA/LMHA to ensure all active positive PL1s have a completed PE and upload the PE into the resident's EMR.4. Review recommended Specialized Services on the PE once the PE is submitted.5. When discharging a resident to another NF, the facility is responsible for completing a PASRR for the NF.6. Follow Texas PASRR Policy for all mandatory meetings and care coordination including any changes that may require a change in resident's PASRR status