STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675985	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Midland	2000 N Main St Midland, TX 79705

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 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 all alleged violations involving of abuse were reported immediately, but not later than 2 hours after the allegation was made, to other officials (including to the State Agency) for two (Resident #1and Resident #2) of 4 residents reviewed for reporting an allegation of abuse, in that: The facility failed to report, within 2 hours, an allegation of physical altercation between Resident #1 and Resident #2 that occurred on 05/24/2026. This failure could result in unreported incidents of abuse and lead to physical and psychological injuries to residents. Findings included:Record review of Resident #1's face sheet dated 6.10.26 reflected an [AGE] year-old male with an initial admission date of 3.31.26, with diagnoses which included Dementia, Muscle weakness and Muscle wasting. Record review of Resident #1's quarterly MDS assessment section C, cognitive patterns, dated 4.6.26 reflected a BIMS score of 6 (severe impairment). Record review of Resident #2's face sheet dated 6.10.26 reflected a [AGE] year-old male with an initial admission date of 5.29.24, with diagnoses which included Epilepsy, muscle wasting and Dementia. Record review of Resident #2's quarterly MDS assessment section C, cognitive patterns, dated 4.11.26 reflected a BIMS score of 4 (severe impairment). Record review of a progress note for Resident #1 documented by RN B dated 5/24/2026 11:14 pm Nurses Note: This writer was notified by the aide that the resident was involved in physical altercation with Resident #2. Upon arrival this nurse observed resident lying on the floor with Resident #2 pushing and kicking each other. Resident #2 had wooden stick which he used to hit the resident with on the face resulting in cut to left eyebrow and skin tear to nose. Residents were noted to be upset and agitated after the incident. Both residents were separated from staff. Injuries were assessed and treated per the protocol. Physician, DON, local authority and RP notified. Resident sent to the hospital via EMS for further evaluation. During an interview on 6.9.26 at 12:45 pm Resident #2 stated that the other resident (Resident #1), he did not know his name, was beating on the glass door at the entrance of the unit. He stated he went out and told him to stop, and the other resident (Resident #1) attacked him. He stated he did not remember any stick or anything like that. He stated that the other resident (Resident #1) punched him in the face multiple times. He stated he went to the hospital for a day or so and then came back. He stated that resident (Resident #1) was no longer on his hallway. He stated he had no concerns now that Resident #1 was no longer on the same unit as him. He stated he felt safe in the facility. During an interview on 6.9.26 at 12:50 pm The Administrator stated she was informed of an incident involving Resident #1 and Resident #2 but thought it was only a verbal exchange and did not know that anything physical occurred. She stated she did not learn that anything physical had occurred until shown the progress note made by the RN B, during this interview, that notated a resident-to-resident altercation occurred with injury and Resident #2 was sent out. She stated that her expectation for herself would have been to do an investigation of the incident. She stated she should have asked for the details on the incident upon learning about it instead of assuming it was just a verbal exchange. She stated she was the abuse coordinator and that she should have done an investigation and reported it to state within 2 hours. She stated that by not investigating and reporting (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the incident to the state, could put the other residents at risk of injury or safety. During an interview on 6.10.26 at 10:35 am CNA A stated that she was working the evening of the incident. She stated the way the unit was set up, they could see everything. She stated that Resident #1 had a history of sitting at the door and would bang on it. She stated he was doing that on the night of the incident (5.24.26) when Resident #2 came out holding a wooden back scratcher (not a stick) and stated, If you don't stop hitting that door, I will hit you with this. She stated Resident #1 was in a wheelchair and left the doors and went all the way down the hall and asked for a cup of ice water. She started Resident #1 then went back to the end of the unit, approached Resident #2 and dumped the cup of ice water on Resident #2's head. She stated that was when the fight broke out. She stated she ran down and had to pulled Resident #1 off of Resident #2. She stated Resident #2 did get hit a couple of times in the face (with a fist not the back scratcher) and sustained a small cut above his left eye. She stated the two residents were separated and the RN B was informed. She stated that when Resident #1 left the door he was leaving and nothing else was going to happen. She stated she did keep an eye on him as he left the door and went to get water. She stated the incident was quick and the residents were separated quickly. During an interview on 6.10.26 at 10:45 pm RN B stated she did write the progress note about the incident on 5.24.26. She stated she was working that night and heard yelling for her to come over to the unit. She stated when she came in the residents were separated but were both laying on the ground still kicking at each other. She stated Resident #2 had a small cut above his left eye. She stated she saw the stick on the ground (back scratcher) but did not see it used in the fight. She stated she assumed it was due to the injury on Resident #2. She stated she bandaged Resident #2 and out of precaution had him sent out to the ER. Record review of facility policy titled: Abuse, dated 2.1.17 indicated: The Facility administrator is the appointed abuse coordinator, and in his/her absence a designee will be appointed. Procedure-the administrator and/or designees are responsible for maintaining ALL facility policies that prohibit abuse, neglect, and misappropriation of funds personal belongings, involuntary seclusion, or corporal punishment. Which include-Investing all allegations, reporting incident investigations and facility response to results of investigation within mandated time frames. 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have evidence that all allegations of abuse were thoroughly investigated for 2 of 4 residents (Resident #1 and #2) reviewed for abuse and neglect. The facility did not investigate an incident in which Resident #1 was in an alteration with Resident #2 on 05/24/2026. This failure could place residents at risk for continued abuse/neglect and could lead to a diminished quality of life and psychosocial harm. The findings included:Record review of Resident #1's face sheet dated 6.10.26 reflected an [AGE] year-old male with an initial admission date of 3.31.26, with diagnoses which included Dementia, Muscle weakness and Muscle wasting. Record review of Resident #1's quarterly MDS assessment section C, cognitive patterns, dated 4.6.26 reflected a BIMS score of 6 (severe impairment). Record review of Resident #2's face sheet dated 6.10.26 reflected a [AGE] year-old male with an initial admission date of 5.29.24, with diagnoses which included Epilepsy, muscle wasting and Dementia. Record review of Resident #2's quarterly MDS assessment section C, cognitive patterns, dated 4.11.26 reflected a BIMS score of 4 (severe impairment). Record review of a progress note for Resident #1 documented by RN B dated 5/24/2026 11:14 pm Nurses Note: This writer was notified by the aide that the resident was involved in physical altercation with Resident #2. Upon arrival this nurse observed resident lying on the floor with Resident #2 pushing and kicking each other. Resident #2 had wooden stick which he used to hit the resident with on the face resulting in cut to left eyebrow and skin tear to nose. Residents were noted to be upset and agitated after the incident. Both residents were separated from staff. Injuries were assessed and treated per the protocol. Physician, DON, local authority and RP notified. Resident sent to the hospital via EMS for further evaluation. During an interview on 6.9.26 at 12:45 pm Resident #2 stated that the other resident (Resident #1), he did not know his name, was beating on the glass door at the entrance of the unit. He stated he went out and told him to stop, and the other resident (Resident #1) attacked him. He stated he did not remember any stick or anything like that. He stated that the other resident (Resident #1) punched him in the face multiple times. He stated he went to the hospital for a day or so and then came back. He stated that resident (Resident #1) was no longer on his hallway. He stated he had no concerns now that Resident #1 was no longer on the same unit as him. He stated he felt safe in the facility. During an interview on 6.9.26 at 12:50 pm The Administrator stated she was informed of an incident involving Resident #1 and Resident #2 but thought it was only a verbal exchange and did not know that anything physical occurred. She stated she did not learn that anything physical had occurred until shown the progress note made by the RN B, during this interview, that notated a resident-to-resident altercation occurred with injury and Resident #2 was sent out. She stated that her expectation for herself would have been to do an investigation of the incident. She stated she should have asked for the details on the incident upon learning about it instead of assuming it was just a verbal exchange. She stated she was the abuse coordinator and that she should have done an investigation and reported it to state within 2 hours. She stated that by not investigating and reporting the incident to the state could put the other residents at risk of injury or safety. During an interview on 6.10.26 at 10:35 am CNA A stated that she was working the evening of the incident. She stated the way the unit was set up, they could see everything. She stated that Resident #1 had a history of sitting at the door and would bang on it. She stated he was doing that on the night of the incident (5.24.26) when Resident #2 came out holding a wooden back scratcher (not a stick) and stated, If you don't stop hitting that door, I will hit you with this. She stated Resident #1 was in a wheelchair and left the doors and went all the way down the hall and asked for a cup of ice water. She started Resident #1 then went back to the end of the unit, approached Resident #2 and dumped the cup of ice water on Resident #2's head. She stated that was when the fight broke out. She stated she ran down and had to pulled Resident #1 off of Resident #2. She stated Resident #2 did get hit a couple of times in the face (with a fist not the back scratcher) and sustained a small cut (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	above his left eye. She stated the two residents were separated and the RN B was informed. She stated that when Resident #1 left the door he was leaving and nothing else was going to happen. She stated she did keep an eye on him as he left the door and went to get water. She stated the incident was quick and the residents were separated quickly. During an interview on 6.10.26 at 10:45 pm RN B stated she did write the progress note about the incident on 5.24.26. She stated she was working that night and heard yelling for her to come over to the unit. She stated when she came in the residents were separated but were both laying on the ground still kicking at each other. She stated Resident #2 had a small cut above his left eye. She stated she saw the stick on the ground (back scratcher) but did not see it used in the fight. She stated she assumed it was due to the injury on Resident #2. She stated she bandaged Resident #2 and out of precaution had him sent out to the ER. Record review of facility policy titled: Compliance, dated 2.1.17 indicated: The Facility administrator and/or designee are sponsible for maintaining ALL facility policies that prohibit abuse, neglect, and misappropriation of funds/personal belongings, involuntary seclusion, or corporal punishment. Including. E. Investigating allegations. F. Reporting incidents, investigations, and facility response to results of investigation within mandated time frames.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 4 (Residents #2) residents reviewed for comprehensive care plans. The facility failed to have a care plan for Resident #2's regarding refusals of medications. The failure could place residents at risk for not receiving appropriate care and supervision. The findings included:Record review of Resident #2's face sheet reflected a [AGE] year-old male with an initial admission date of 5.29.24, with diagnoses which included Epilepsy, muscle wasting and Dementia. Record review of Resident #2's quarterly MDS assessment section C, cognitive patterns, dated 4.11.26 reflected a BIMS score of 4 (severe impairment). Record review of Resident #2's progress notes by RN B dated 6/3/2026 7:07 pm indicated: Behavior Note, Note Text:Attempted x 2 to administer Seroquel PRN dose. Refused both times stating I am never taking any medicine again. MD notified. Record review of Resident #2 care plan dated 6/4/26 indicated: There are no notes indicating missed or refused medications in Resident #2's care plan. Record review of Resident #2's progress note dated 6/4/2026 5:44 pm indicated: Behavior Note, Note Text:Resident was throwing ice and shouting at employees, resident was also hitting walls and yelling because he didn't have cigarettes, nurse was also informed that resident refused his morning medicine, no injuries to report resident taken away from area many times then finally remained calm, will continue to follow care plan. During an interview on 6.10.26 at 9:05 am the DON stated that she knew that Resident #2 refused his medications from time to time. She stated that she did not know the MDS Coordinator did not know about Resident #2 refused his medications. She stated it was important and needed to be done because the care plan was for all residents, snapshots of their care and everything anyone new in the facility needed to know to take care of the residents. She stated her expectation was that all residents' care plans were up to date and had all information in them. During an interview on 6.10.26 at 2:45 pm CNA C stated that Resident #1 did have aggressive behaviors. She stated that it was mainly towards the employees. She stated the biggest part about Resident #1 was getting him to take his medications. She stated that the only way she knows how was by trading him a cigarette for him to take his medications. She stated but that did not always work. She stated he refused his medications often. During an interview on 6.10.26 at 3:15 pm NP D stated that the biggest issue was Resident #1 refused medications. She stated she was the one who started the Depakote but looked like a different physician previously put him on Seroquel. She stated that the biggest issue with the resident was that he was refusing his psych meds. She stated she was not getting a lot of support from the family nor the residents to take the medications she was prescribing. She stated with Resident #1 refusing his medications made it difficult to adjust or change meds based on his behaviors or agitation. She stated that was her main issue, how to adjust or help Resident #1 if he did not take his medication. During an interview on 6.11.26 at 10:15 am the MDS Coordinator stated that he did not know about the refusals of medication or he would have put them in Resident #1's care plan. He stated his focus on Resident #1 was his behaviors and aggression towards others. He stated this should have been done and wished they would have communicated to him. Record review of facility policy titled: Comprehensive Care Plan, dated 1.20.21 indicated: Every resident will have an individualized interdisciplinary plan of care in place. 5. The interdisciplinary team will review the healthcare practitioners notes and orders (e.g., dietary needs, medications, routine treatment, etc.) and implement a Comprehensive Care plan to meet the residents immediate care needs.