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	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Midland	2000 N Main 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to treat residents with respect, dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 2 of 7 residents (Resident # 63 and #136), and 5 residents in the confidential group interview. CNA F told Resident #63 to urinate in her brief instead of going to the bathroom per Resident # 63's request. Staff were on their cell phones while providing direct care to residents (including Resident #136). This failure resulted in a diminished quality of life for the identified residents and could affect additional residents by causing a loss of self-esteem and increased isolation. The findings included: Record review of Resident #63"s admission Record, dated 6/18/25, revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia, pain, and need for personal care. Record review of Resident #63's Quarterly MDS, dated [DATE], revealed: She had a mental status of 2 of 15 (indicating severe cognitive impairment) She needed moderate assistance from staff for toilet hygiene. She was needed maximum assist from staff for transfers from the toilet. Record review of Resident #63's care plan, updated 5/21/25, revealed: The resident has bowel and bladder incontinence and is at risk for skin breakdown related to incontinence of urine related to confusion. The identified goal was the resident will remain free from skin breakdown due to incontinence and brief use through the review date. Identified interventions included: clean peri-area with each incontinence episode and encourage fluids during the day to promote prompted voiding responses. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/17/25 02:51 PM revealed Resident #63 crying out in her room because she needed to go to the bathroom and wanted to sit down. CNA F told Resident #63 to calm down. CNA F told Resident #63 to urinate in her brief because Resident #63's brief was dry. During an interview on 6/18/25 at 3:30 p.m. five, alert lucid residents stated staff were always on their phones while providing care including wound care and passing medications. The resident who had wound care stated the staff member who did the wound care would not change gloves after being on their phone either. The residents stated half the time staff were on their phones watching television shows or typing to their friends. The residents said it made them uncomfortable, and like the staff were not here to care for us. The female residents stated they heard staff tell residents to urinate in their briefs. The residents reported last time was a night or two prior to the meeting. Record review of Resident #136's admission Record, dated 6/19/25, revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnosies including stroke and amnesia. Resident #136's admission MDS was in process of being completed. Observation on 6/17/25 at 12:34 p.m. LVN G was in the dining room, sitting next to Resident #136 scrolling on social media on her phone. During an interview on 06/19/25 09:22 AM the DON stated her expectations for cell phones were they be used for professional reasons only such as appointments, labs, or amusing residents. The DON said the staff were here for resident centered care. The DON said the staff had more important things to do than to be scrolling on social medial. The DON said if it was her she would be upset because staff needed to be paying attention to her while providing care, that staff need to ask if the resident 'could roll over' if they 'are comfortable . The DON stated the staff needed to talk to the residents. The DON said there was no reason to be on the phone while passing pills. The DON said the only reason it would be ok to be on the phone while doing wound care was if they were doing a telehealth appointment with the telehealth person but not changing gloves was . ewww and she expected gloves to be changed. The DON said it was never acceptable for staff to tell a resident to go to the bathroom in the brief unless it was unsafe for some reason and then they should transfer the resident onto a bedpan. The DON stated even if it was just the one time the resident caught themselves due to their cognitive status they should be taken. The DON said the unspoken message to the resident was my needs are more important than yours and the residents should always feel like the priority. The DON said the residents would not feel like the priority if they were told to go to the bathroom in their brief. The DON said she did monitor for cell phones but when she did the staff were documenting on the electronic documentation program or the cell phone magically disappeared. The DON said she had to work the floor for the night shift at least once a week and she did rounds a lot. The DON stated staff signed a cell phone policy on hire. The DON said she in-services on cell phones but there was not a set frequency, and she did not remember when the last one was. During an interview on 6/19/25 at 12:05 p.m. the Administrator stated staff were allowed to use their cell phones if it was business related. The Administrator said the staff were not allowed to use social media unless they were looking up something for the residents on social media. The Regional Corporate Director who was present stated staff telling residents to urinate in their brief was not consistent with corporate policy and the expectation was the resident be taken to the bathroom if they wanted to go to the bathroom. The Regional Corporate Director stated if it was him, he would not be pleased and he would not like it if the staff treated him like that. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/19/25 at 5:56 p.m. the DON stated she did discuss cell phone use during the town hall meetings and dignity issues but she did not scribble it down so she knew she could not get credit for it. Record review of the facility's policy and procedure on Quality of Life, Dignity, revised August 2009, revealed: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Policy Interpretation and Implementation. Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: promptly responding to resident's request for toileting assistance. Staff shall treat cognitively impaired residents with dignity and sensitivity. Record review of the facility's employee handbook on Personal Cell Phones, Blue Tooth Devices, and Pagers Usage, revised 1/2023, revealed: Corporation team members may not use their cell phones, smart watches, blue tooth devices, MP3 players, and other electronic devices for personal calls and text messaging. These devices may only be used for Corporation approved applications. Facility team members should never use their phones while working on the floor or in a resident's room and must be set to silent.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible and each resident received adequate supervision to prevent accidents for 1 of 5 (Resident #48) residents reviewed for smoking safety. The facility failed to ensure Resident #48's lighter, and cigarettes were not stored on their person. These failures could affect residents who smoke by putting them at risk of bodily harm or physical impairment. The findings included: Review of Resident #48's admission Record, dated 6/19/25, revealed he was a [AGE] year old male admitted to the facility on [DATE] with diagnoses including tobacco use. Review of Resident #48's Quarterly MDS, dated [DATE], revealed: He scored a 15 of 15 on his mental status exam (indicating he was cognitively intact). He needed set up or was independent with his ADLs. Review of Resident #48's Care Plan, last revised on 1/22/23 revealed: Resident #48 was an independent smoker, and he could go to the nurse's station to request his smoking material and go to the smoking area and smoke independently. He understood he could not share cigarettes or lighters with other residents at any time. Upon finishing he must return ALL smoking material to the nurse's station. The Goal was Resident will remain free from smoking related injuries through the next evaluation. Identified interventions included Resident will keep all lighters with facility staff for safety. Review of Resident #48's Order Summary, dated 6/19/25, revealed he was not on oxygen. Review of Resident #48's Safe Smoking Assessment, dated 4/12/25, revealed: Resident #48 was safe to smoke unsupervised at the time of the evaluation signed by the DON. Observation on 6/17/25 at 11:38 a.m. revealed a lighter unattended on Resident #48's bedside table in his room. The DON was shown the lighter, she took it and stated Resident #48 went out on pass by himself a lot. The DON stated she Resident #48 was an independent smoker. The DON said her question every day was what were her aides, nurses and housekeepers looking at when they entered the room. Review of the facility's policy and procedure on Smoking, effective 3/1/17, revealed: It is the policy to accommodate residents who desire to smoke by taking reasonable precautions, providing a safe environment for them, and protecting the non-smoking residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure: Incendiary devices will be stored by facility staff. Resident will not be allowed to possess any lighters, cigarettes, or other smoking materials. All vaping material will also be secured. Electronic cigarettes will follow the same rules as tobacco. IDT will develop an individualized plan for safe storage, use of smoking materials assistance and required supervision for residents who smoke. This is documented on the Resident Smoking Assessment, the resident's Plan of Care, and discussed with the resident and Responsible Party at resident care conference meetings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that drug records were in order and that an account of all controlled drugs were maintained, for 8 of 10 Residents (#5, #11, #34, #45, #56, #62, #63 and #186) and 1 of 2 medication carts inspected for medication reconciliation. Medication Aide (MA) A did not document the administration of a controlled medication on the individual controlled medication records after administering the medication. This failure could place residents at risk of under dose, overdose and drug diversion. The findings were: RESIDENT #5 Record review of Resident #5's admission record, dated 06/18/25, indicated he was admitted to the facility on [DATE] with diagnosis of epilepsy (a brain disease that causes repeated seizures due to abnormal electrical signals). He was [AGE] years of age. Record review of Resident #5's order summary report dated 06/18/2025 indicated in part: Phenytoin Sodium Extended Oral Capsule 100 MG. Give 1 capsule by mouth three times a day for Seizures. (MG = milligrams) Record review of Resident #5's Phenytoin medication record indicated 80 pills and the blister pack had 79 pills. RESIDENT #11 Record review of Resident #11's admission record, dated 06/18/25, indicated she was admitted to the facility on [DATE] with diagnosis of chronic pain syndrome. She was [AGE] years of age. Record review of Resident #11's order summary report dated 06/18/2025 indicated in part: Acetaminophen-Codeine (Narcotic pain medication) Oral Tablet 300-60 MG. Give 1 tablet by mouth two times a day for PAIN. Record review of Resident #11's Acetaminophen-Codeine medication record indicated 2 pills and the blister pack had 1 pill. RESIDENT #34 Record review of Resident #34's admission record, dated 06/18/25, indicated she was admitted to the facility on [DATE] with diagnoses of anxiety disorder. She was [AGE] years of age. Record review of Resident #34's order summary report dated 06/18/2025 indicated in part: Clonazepam Oral Tablet 0.5 MG. Give 1 tablet by mouth two times a day for anxiety. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #34's Clonazepam medication record indicated 59 pills and the blister pack had 58 pills. RESIDENT #45 Record review of Resident #45's admission record, dated 06/18/25, indicated she was admitted to the facility on [DATE] with diagnosis of pain, joint pain and muscle spasms. She was [AGE] years of age. Record review of Resident #45's order summary report dated 06/18/2025 indicated in part: Acetaminophen-Codeine Tablet 300-30 MG Give 1 tablet by mouth three times a day for pain. Pregabalin (medication to treat nerve pain) Capsule 50 MG Give 1 capsule by mouth three times a day. Record review of Resident #45's Pregabalin medication record indicated 77 pills and the blister pack had 76 pills. Record review of Resident #45's Acetaminophen-Codeine medication record indicated 52 pills and the blister pack had 51 pills. RESIDENT #56 Record review of Resident #56's admission record, dated 06/18/25, indicated he was admitted to the facility on [DATE] with diagnosis of anxiety disorder. He was [AGE] years of age. Record review of Resident #56's order summary report dated 06/18/2025 indicated in part: Alprazolam Oral Tablet 0.5 MG. Give 1 tablet by mouth three times a day for anxiety. Record review of Resident #56's Alprazolam medication record indicated 59 pills and the blister pack had 58 pills. RESIDENT #62 Record review of Resident #62's admission record, dated 06/18/25, indicated she was admitted to the facility on [DATE] with diagnoses of chronic pain syndrome and fibromyalgia (a long-term condition that involves widespread body pain). She was [AGE] years of age. Record review of Resident #62's order summary report dated 06/18/2025 indicated in part: Acetaminophen-Codeine Tablet 300-60 MG Give 1 tablet by mouth every 6 hours for pain. Pregabalin Oral Capsule 150 MG. Give 1 capsule by mouth two times a day for fibromyalgia . Record review of Resident #62's Acetaminophen-Codeine medication record indicated 95 pills and the blister pack had 94 pills. Record review of Resident #62's Pregabalin medication record indicated 5 pills and the blister pack had 4 pills. RESIDENT #63 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #63's admission record, dated 06/18/25, indicated she was admitted to the facility on [DATE] with diagnosis of chronic pain syndrome. She was [AGE] years of age. Record review of Resident #63's order summary report dated 06/18/2025 indicated in part: Tramadol Oral Tablet 50 MG. Give 1 tablet by mouth three times a day for pain Record review of Resident #63's Tramadol medication record indicated 51 pills and the blister pack had 50 pills. RESIDENT #186 Record review of Resident #186's admission record, dated 06/18/25, indicated she was admitted to the facility on [DATE] with diagnoses of anxiety disorder and epilepsy. She was [AGE] years of age. Record review of Resident #186's order summary report dated 06/18/2025 indicated in part: Lorazepam oral Tablet 0.5 MG. Give 1 tablet by mouth two times a day for anxiety. Phenytoin Sodium Extended oral capsule 100 MG. Give 1 capsule by mouth three times a day for seizures. Record review of Resident #186's Lorazepam medication record indicated 50 pills and the blister pack had 49 pills. Phenytoin medication record indicated 25 pills and the blister pack had 24 pills. During an observation and interview on 06/17/25 at 12:20 PM along with MA A halls A, C and E medication cart was inspected for controlled medications accuracy. Resident's #5, #11, #34, #45, #56, #62, #63 and #186 controlled medication blister packs did not match the count indicated on their respective sheet. MA A said she usually signed out the controlled medication sheets when she performed the count with the oncoming staff but that she probably should have signed it out as soon as she had administered the medication. During an interview on 06/17/25 03:36 PM the DON said it was expected for the staff that was administering the controlled medication to sign it out right after they administered the medication. The DON said this was supposed to be done in case the staff member had to leave in a hurry and the count would not be correct. During an interview on 06/19/25 at 06:45 PM the Administrator was made aware of the controlled medication sheets not matching the count in the medication blister packets. The Administrator said he agreed with what the DON had stated regarding the controlled medications needed to be signed as soon as it was administered. Record review of the facility's policy titled Receiving controlled substances and dated 09-2028 indicated in part: Medications classified by the drug enforcement administration (DEA) as controlled substances and medications classified as controlled substances by state law are subject to a special ordering, receipt and recordkeeping requirements by the facility in accordance with federal and state laws and regulations. Controlled substance inventory sheets are filed appropriately. A hard bound log book or in accordance with facility policy, is utilized to track the controlled substance from delivery to disposition.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were maintained on each resident that were accurately documented for 1 of 8 residents (Resident #8) reviewed for medical records. The facility failed to ensure documentation was completed for Resident #8's emergency room visit on 05/28/2025. This deficient practice could place residents at risk of having inaccurate records due to incomplete documentation. Finding included: Record review of Resident #8's admission Record dated 06/19/2025 revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, atrial fibrillation (irregular heartbeat), chronic obstructive pulmonary disease (lung disease that blocks airflow and causes difficulty breathing), and bipolar disorder. She was her own responsible party. Record review of Resident #8's Quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a mental status exam score of 8 indicating cognitive impairment, she used a wheelchair for mobility, she was independent or required set-up assistance for all ADLs except showering/bathing for which she required partial assistance, she had no documented falls since the previous assessment. In an interview on 06/17/2025 at 5:45 PM the DON stated that Resident #8 was taken to the emergency room on [DATE] from a restaurant on the next street. She stated the resident arrived at the emergency room at 6:18 AM after going to the restaurant. She stated that the front door of the facility had been locked and Resident #8 had not been informed that she could not get back inside the building unless someone let her in. The DON stated that because she was locked out Resident #8 went to the restaurant a block over to get assistance to get back inside the facility. She stated that Resident #8 was upset that the door was locked, and the restaurant staff called 911 rather than the facility. She stated the paramedics opted to take her to the emergency room to be checked out instead of bringing her back to the facility. She stated that Resident #8 was discharged from the emergency room and returned to the facility at approximately 10:30 AM. She stated that Resident #8 was her own responsible party and used to live in the neighborhood so she was familiar with what businesses would be open early in the morning. The DON stated that when the resident returned to the facility, she was happy and laughing. She stated that LVN B did a head-to-toe assessment on Resident #8 but was instructed not to document anything by the Regional Compliance RN. The DON stated that she did not agree with this directive and LVN B should have documented the assessment and an incident report because the resident was out of the facility when she was sent to the emergency room. She stated she did not understand why LVN B was told not to document on Resident #8. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/18/2025 at 9:55 AM LVN B stated she was the nurse for Resident #8's hall 05/28/2025. She stated she was told that Resident #8 was at the emergency room after being picked up by paramedics from a local fast-food restaurant. She stated that when Resident #8 returned to the facility from the emergency room that she (LVN B) did an assessment that she did not document. She stated she did not document anything because she was told by the Regional Compliance RN that because Resident #8 had been out of the facility when she was taken to the emergency room there was no reason to document anything. She stated an assessment on a resident returning to the facility from the emergency room was something she had always documented in the past and the reason she did not was because she was specifically told not to. LVN B stated an incident report should have been completed as well as an assessment since Resident #8 was taken to the emergency room from the restaurant. In an interview on 06/18/2025 at 11:00 AM LVN C stated that she was working in the facility on 05/28/2025 when Resident #8 returned from the emergency room. She stated she was working on a different hall and was not the nurse responsible for Resident #8 that day. She stated that she was told that Resident #8 had been taken to the emergency room by paramedics by the DON. She stated that the emergency room visit should have been documented to include why the resident was sent to the emergency room, when she left the facility to go to the restaurant and the assessment when she returned to the facility. She stated an incident report should have been done since Resident #8 was out of the facility when she was taken to the emergency room. She stated she was not sure why there was nothing documented. In an interview on 06/18/2025 at 11:51 AM the Administrator stated that since he was not a nurse, he did not direct the nursing staff, but he believed that the nurses should have documented something on Resident #8's return to the facility. He stated he would never tell a nurse what to document, and he can't imagine that the Regional Compliance RN would tell the nurses not to document on Resident #8 when she returned to the facility. In an interview on 06/18/2025 at 2:55 PM the Regional Compliance RN stated she knew that LVN B did an assessment when Resident #8 returned to the facility, but it was not documented. She stated I don't think I remember saying that when asked if she told the staff not to document. She stated she expected nursing to document when a resident goes to the emergency room, adding that they were supposed to put a note in the chart when a resident goes to the emergency room and/or when they came back to the facility. The Regional Compliance RN stated, She should have been charted on for sure. She stated she did not know why staff would say she told them not to document. She stated she told all her facility DON's that any resident who went to the hospital needed to be documented on. She stated that she and the DON told the nurses that there should have been documentation and that they could do a late entry if she was assessed. In an interview on 06/19/2025 at 9:10 AM NP D stated Resident #8 was her own responsible party and was able to sign herself out on pass so her being sent to the emergency room from the restaurant was not an issue in her opinion. She stated that she did expect the staff to document an assessment on the resident after she returned from the emergency room, and it was concerning to her that there was no documentation. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/19/25 at 3:02 PM the Medical Director stated he was notified of Resident #8 being sent to the emergency room from the restaurant. He stated that Resident #8 could make her own decisions about leaving the facility even if they are bad, and she was known to leave the building. He stated he did expect the nurses to document that she had gone to the emergency room and to assess her when she returned. In an interview on 06/19/25 at 3:07 PM NP E stated the nursing staff definitely should have documented something about the resident going to the emergency room and she expected at least an assessment would have been documented on her return to the facility. She stated it was concerning to her that there was no documentation on Resident #8's emergency room visit on 05/28/2025. Review of the facility's policy Incident and Accident dated 03/01/2017 revealed, in part: Accidents or incidents involving residents shall be investigated and reported to the Executive Director of Operations. Licensed nurse will complete an incident and accident report when staff is aware that an accident occurred. Review of facility in-service Communication with Doctor dated 06/12/2025 revealed, in part: Documentation should be very descriptive and based on the resident's condition, response to new medication, improvement of symptoms being addressed, response to stopping previous medication, changing the dose, etc. Nurses must do a complete assessment of the residents and document that assessment. On 06/19/2025 at 4:00 pm the DON stated the facility did not have a policy specific to documenting assessments when a resident returns to the facility from the hospital or emergency room.