STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Pasadena	3434 Watters Rd Pasadena, TX 77504

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents received medications that were free of significant medication errors for 2 of 5 residents (Resident #1 and #2) reviewed for medications. -The facility failed to ensure that Resident #1's blood pressure medication Metoprolol was held when the blood pressure was low.-The facility failed to ensure Resident #2 blood pressure medication Midodrine was held when the blood pressure was out of the parameter it should be held. These failures could place residents with high or low blood pressure at risk of fainting or stroke due to not getting their blood pressure medication as ordered by their physician. Record review of Resident #1's admission face sheet dated 3/17/2026 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (a condition were the blood flow to part of the brain is blocked), peripheral vascular disease(a condition which narrowed arteries reduce blood flow to the arms and legs), hypertension (high blood pressure), heart failure (a condition where the heart muscle doesn't pump blood as well as it should), chronic kidney disease (progressive loss of kidney function to remove waste from the blood), atrial fibrillation (irregular heart rhythm), chronic embolism/thrombosis (blood clot in a deep vein) and chronic obstructive pulmonary disease((lungs and airway disease that restrict breathing). Record review of Resident #1 quarterly MDS dated [DATE] Section C:500 revealed a BIMS score of 15 indicating the resident was cognitively aware. Record review of Resident #1's physician's order dated 9/8/2025 revealed Metoprolol Tartrate oral tablet 25 mg. Give 1 tablet by mouth to times a day for hypertension. Hold if SBP<110 or DBP<60 or heart rate <60. Record review of Resident #1's MAR for March 2026 revealed Metoprolol 25mg was not documented as held on 3/9/2026 when Resident #1 blood pressure was 106/70. There was no number coded on 3/9/2026 indicating whether the resident had refused or the, or Resident #1 was not in the facility. Resident #2 Record review of Resident #2's admission face sheet revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included depression (a mood disorder that that causes persistence loss of interest), anemia (a condition where there is not enough healthy red blood cells), hyperlipidemia (high levels of fat in the blood), cerebral infarction (a condition were the blood flow to part of the brain is blocked), hypotension (low blood pressure), acute respiratory failure (a condition where there is insufficient oxygen in the body), and type 2 diabetes (high blood sugar). Record review of Resident #2's quarterly MDS dated [DATE] Section C:500 revealed a BIMS score of 09 indicating the resident was moderately cognitively impaired for decision making. Record review of Resident #2's physician's order dated 2/27/2026 revealed Midodrine HCL oral tablet 10 mg. Give 1 tablet by mouth three times a day. Hold if SBP is greater than 120 or heart rate is greater than 60. Record review of Resident #2's MAR for March 2026 revealed Midodrine 10 mg was not documented as held on 3/2/2026 when the blood pressure was 137/73 and heart rate was 75 and on 3/3/2026 when the blood pressure was 133/63 and heart rate was 78 at 9:00 pm and on 3/5/2026 at 3:00pm when the blood pressure was 124/76 and the heart rate was 85.In an interview on 3/18/2026 at 4:05 pm with LVN B she said if residents refused their medications, it should be reported to the nurse, and the nurse should notify the physician. She said there should be no blanks on the MARs. She said blanks on the MARs was an indication the (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications were not given. She said if residents refused their medications, it should be documented on their MARs. She said if the blood pressure was high and midodrine was given it would get higher and that could cause a stroke. She said if it's too low and Midodrine was not given it could cause the residents to faint and fall. She said if Metoprolol was given when the blood pressure was low it would cause the blood pressure to get lower and could cause the resident to get dizzy and fall. In an interview with Med Aide C on 3/18/2026 at 6:09 pm she said all medications should be signed when they were given. She said if the resident refused the medication, it should also be documented as refused, or resident not in the building. If it's blood pressure medication and it's out of parameter, the doctor ordered the medication should also be documented as not with the parameter. She said blanks on the MARs would be a medication error. She said there should be no blanks on the MARs. She said in the case of Midodrine if it's too high and the medication was given it could cause the resident to have headache or get a stroke, if the blood pressure was low and the medication was not given it could cause the resident to faint and fall. She said it Metoprolol was not held when the blood pressure was low it could cause the blood pressure to drop lower and could cause the resident to get dizzy and fall. In an interview on 3/18/2026 at 6:52 pm with LVN C she said if medications were given or not given, they should be documented. She said if it was not documented it was not done. She said there should be no blanks on the MARs. She said blanks on the MARs could be an indication that the medications were not given. She said if the blood pressure was low and Midodrine was not given the resident could pass out and it's too high and Midodrine was given the blood pressure would get higher, and it could result in a stroke. She said if Metoprolol was not held when the blood pressure was low, the blood pressure would get lower and could cause the resident to get dizzy and faint. In an interview on 3/18/2026 at 7:00 pm with LVN D he said if medications were given or not given, they should be documented. He said if it was not documented it was not done. He said there should be no blanks on the MARs. Blanks on the MARs was an indication that the medication was not given. He said if the blood pressure was low and Midodrine was not given the resident could pass out and if it was too high and Midodrine was given the blood pressure would get higher, and it could result in a stroke. He said in if Metoprolol was too low and the medication was not given it would cause the blood pressure to get lower and the resident passed out. In an interview on 3/18/2026 at 7:05 pm with the DON she said there should be no blanks on the MAR. She said the Nurses should follow the physician's order. She said if blood pressure medications were not given as ordered, the blood pressure could get too high or too low. She said when medications were given it should be documented. She said if it's not documented it was not done. She said she was going to in-service the staff on documentation and following physician's orders.Record review of the facility's policies and procedure title Charting and Documentation dated July 2017 read in part. Policy Statement All services provided to the resident progress towards care plan goal or any changes in the resident's medical, physical, functional or psychosocial condition and shall be documented in the residents' medical records. 7. Documentation of procedures and treatment specific details includinge. Whether the residents refused the procedure/treatment.g. The signature and title of the individual documenting.

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NAME OF PROVIDER OR SUPPLIER Focused Care at Pasadena		STREET ADDRESS, CITY, STATE, ZIP CODE 3434 Watters Rd Pasadena, TX 77504	

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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 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 maintain medical records on each resident that are complete and accurately documented for 1 (Resident #2) of 5 residents reviewed for medical records. The facility failed to maintain a complete and accurate MAR for Resident #2. This failure could place residents at risk of an incomplete medical record and possibly not being given medication and treatment as ordered by their physician. Record review of Resident #2's admission face sheet dated 3/18/2026 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included anemia (a condition where the blood does not have adequate healthy blood cells), depression (mood disorder that causes a persistent feelings of sadness and loss), hyperlipidemia (high levels of fat in the blood), cerebral infarction (a condition were the blood flow to part of the brain is blocked), hypotension (low blood pressure), acute respiratory failure (a condition where there is insufficient oxygen in the body) and type 2 diabetes (high blood sugar). Record review of Resident #2's quarterly MDS dated [DATE] Section C:500 revealed a BIMS score of 09 indicating the resident was moderately cognitively impaired for decision making. Record review of Resident #2's physician's order dated 2/27/2026 revealed Midodrine HCL oral tablet 10 mg. Give 1 tablet by mouth three times a day. Hold if SBP is greater than 120 or heart rate is greater than 60. Record review of Resident #2's MAR dated March 2026 revealed Midodrine HCL oral tablet 10 mg. Give 1 tablet by mouth three times a day. Hold if SBP is greater than 120 or heart rate is greater than 60. The blood pressure, and pulse were not documented as given on 3/12/2026 at 9:00pm. That section of the MAR was blank. In an interview on 3/18/2026 at 4:05 pm with LVN B she said if a resident refused their medication, it should be reported to the nurse, and the nurse should notify the physician. She said there should be no blanks on the MARS. She said blanks on the MAR indicate that the medication was not given. She said if the resident refused his/her medications it should be documented on the MAR. In an interview with Med Aide C on 3/18/2026 at 6:09 pm she said all medications should be signed when they were given. She said if the resident refused the medication, it should also be documented as refused, or resident not in the building. She said blanks on the MAR could be a medication error. She said there should be no blanks on the MAR. In an interview on 3/18/2026 at 6:62 pm with LVN C she said if medications were given or not given, they should be documented. She said if it was not documented it was not done. She said there should be no blanks on the MAR, blanks on the MAR were an indication that the medications were not given. In an interview on 3/18/2026 at 7:00 pm with LVN D he said if medications were given or not given, they should be documented. He said if it was not documented it was not done. He said there should be no blanks on the MAR, because it could be an indication that the medication was not given. In an interview on 3/18/2026 at 7:05 pm with the DON she said there should be no blanks on the MAR. She said the Nurses should follow the physician's order. She said when medications were given it should be documented if it's not documented it was not done. She said she was going to in-service the staff on documentation and following physician's orders. Record review of the facility's policies and procedure title Charting and Documentation , dated July 2017 red in part. Policy Statement All services provided to the resident progress towards care plan goal or any changes in the resident's medical, physical, functional or psychosocial condition and shall be documented in the residents' medical records. al records. al records. al records. al records. al records. al records. 3. Documentation in the medical record will be objective (cannot be opinionated or speculative) complete and accurate.7. Documentation of procedures and treatment specific details includinge. Whether the resident refused the procedure/treatment.g. The signature and title of the individual documenting.