STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676050	A. Building B. Wing	02/13/2026

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 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 # 2 #10, #11, 21, and #52) of 18 residents reviewed for accuracy of assessments. The facility failed to ensure Resident # 2's MDS assessment accurately reflected discontinuation of G-tube and falls. The facility failed to ensure Resident #10's quarterly MDS assessments accurately reflected her impairment to her upper extremity on one side. Resident #11's annual comprehensive MDS assessment did not reflect his lack of natural teeth in his oral cavity. Resident #21's comprehensive significant change MDS assessment did not reflect his use of upper denture. Resident #52's significant change comprehensive MDS assessment did not reflect his lack of natural teeth in his oral cavity. These failures could place residents at risk of receiving inadequate care and services due to inaccurate assessments. The findings included: Resident #10 Record review of Resident #10's admission record dated 02/12/2026 revealed the resident was a [AGE] year old female who admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the diagnoses including hemiplegia (paralysis) and hemiparesis (weakness) of the left side, seizures (sudden uncontrolled surge of abnormal electrical activity in the brain that causes temporary changes in behavior, movement, sensation or consciousness), left shoulder pain, and fracture of shaft of left fibula (a break in the midsection of the calf bone). Record review of Resident #10's Quarterly MDS dated [DATE] that was modified on 02/13/2026 revealed she had a BIMS score of 6 out of 15 indicating severe cognitive impairment and she was coded in section GG for Functional Abilities as having an impairment of her upper extremities on one side. Record review of Resident #10's Quarterly MDS dated [DATE] modified 02/13//2026 revealed she had a BIMS score of 7 out of 15 indicating severe cognitive impairment and she was coded in section GG for Functional Abilities as having an impairment of her upper extremities on one side. Observation and interview on 02/10/2026 at 09:57 am of Resident #10 lying in bed appropriately dressed and groomed, in her room with her left arm at the elbow bent upward toward her chest and her left ankle positioned inward. The resident was awake, alert, and oriented to person, and place and said she sometimes participated in therapy or exercises and did not seem to understand what a splint was. Resident #10 said she broke her left leg before, and her ankle had been positioned that way since. Resident #10 said and showed surveyor that she could move her arm but could not bend her left arm straight. Resident #10 said she had no pain at that time in her body and had no care concerns. Resident #11Review of Resident #11's face sheet, printed on 02\11\26, reflected an [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included Essential hypertension (primary diagnoses), overactive bladder, type 2 diabetes mellitus (high blood sugar, insulin resistance, and relative lack of insulin), benign prostatic hyperplasia (also known as enlarged prostate), congestive heart diseases, shortness of breath, difficulty in walking, major depressive disorder, and vascular dementia. Record review of Resident # 11's comprehensive annual MDS dated [DATE] revealed his BIMS score was 12 out of 15 which indicated moderate impairment on cognition. Record review of section on oral dental L indicated he was assessed as having obvious or likely cavities or (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	broken natural teeth in his oral cavity. Record review of Resident #11's care plan with a revision date of 11/24/25 revealed Resident #11 was care planned as at risk for altered oral/dental health problems r/t obvious or likely cavity or broken natural teeth. Observation and interview on 02/10/26 at 12:40 PM, revealed Resident # 11 was in bed during an interview, he said was doing fine. His lunch was on his bedside table untouched. He said he had his dentures and they were in his nightstand. He said he does not wear them because they don't fit right.Observation revealed his meal was a mechanically altered diet. He said he did not like what was served and was not hungry. He requested pudding which was provided. Resident #21Review of Resident #21's face sheet, dated 02\11\26, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included Dementia, schizoaffective disorder, psychotic disturbance, mood disturbance, essential hypertension, type 2 diabetes mellitus, congestive heart diseases, shortness of breath, difficulty in walking, muscle weakness, major depressive disorder, convulsion, and anemia Record review of Resident # 21's comprehensive Significant Change MDS dated [DATE] revealed his BIMS score was 8 out of 15 which indicated moderate impairment in cognition. Record review of Resident #21's care plan with a revision date of 12/31/25 revealed Resident #21 was care planned for falls as Resident #21 had an actual fall on 08/31/25 - Witnessed fall no injuries, 11/07/25 - Unwitnessed fall, no injuries, 12/16/25 - Unwitnessed fall, no injuries,12/25/25 - Witnessed Fall, no injuries. Date Initiated: 01/10/2025. Revision on: 12/29/2025. Goal: Resident #21 will be free from preventable falls through review date. Date initiated: 01/13/2025. Revision on: 12/31/2025. Target Date: 04/04/2026 Record review of Resident # 21's quarterly MDS assessment dated [DATE] revealed his BIMS score was 03 out of 15 which indicated severely impaired cognition.Record review of section on Fall History (section L) indicated section on fall history was left blank. Record review of Resident # 21's quarterly MDS assessment dated [DATE] revealed his BIMS score was 10 out of 15 which indicated moderate impaired cognition.Record review of section on Fall History (section L) indicated section on fall history was left blank. Resident #52 Review of Resident #52's face sheet, printed on 02/12/26, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included dementia, psychotic disturbance, mood disturbance, anxiety, depression, schizoaffective disorder, bipolar disorder, benign prostatic hyperplasia, chronic pain, hypothyroidism, malignant neoplasm (also known as enlarged prostate) muscle weakness, lack of coordination, unsteadiness on feet, difficulty in walking, type 2 diabetes mellitus ((high blood sugar, insulin resistance, and relative lack of insulin), and seizures. Record review of Resident # 52's comprehensive Significant Change MDS assessment dated [DATE] revealed his BIMS score was 15 out of 15 which indicated intact cognition.Record review of section on Fall History (section L) indicated section on fall history was left blank. Record review of Resident # 52's annual comprehensive MDS assessment dated [DATE] revealed his BIMS score was 15 out of 15 which indicated intact cognition.Record review of section on Fall History (section L) indicated section on fall history was left blank. Record review of Resident #52's care plan with revision date of 01/21/26 revealed Resident #52 was care planned for resident had an actual fall on 08/25/25 - witnessed fall, no injury, 09/13/25 - witnessed fall, no injury.09/15/25 - witnessed fall, no injury, 10/11/25 - witnessed fall, no injury, 01/19/25 - unwitnessed fall, minor injury, 01/15/26 - unwitnessed fall, no injury. Date Initiated:06/23/25 Revision on: 01/15/26Goal: Resident #52 will resume usual activities without further incident through the review date. Date initiated: 06/23/25 Revision on:01/21/26. Target Date: 04/13/26. Observation and interview on 01/10/26 at 11:10AM revealed Resident # 52 was in bed alert and oriented. Observation indicated he was on G-Tube feeding. He said he gets his feeding every 2-3 hours, and he was doing well. He said he used to have frequent falls resulted from being dizzy. He said he bumped his head on one occasion and had to be transported to the hospital and had a few stitches at the back of his head. He said he was getting better. In an interview with MDS nurse on 02/11/26 at 2:00PM, she looked at Resident #21 and #52's MDS and said it was an overlook on her side. She would do a modification on Resident #21 and 52's (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS. Interview with DOR on 02/12/2026 at 12:33 pm regarding Resident #10 who said Resident #10 was discharged from therapy services after receiving therapy services related to her left sided upper and lower body hemiplegia and hemiparesis from 09/17/2025 through 09/26/2025. The DOR said she conducted monthly contracture management screens and quarterly reviews of ADL significant change reports and Resident #10 was part of those reviews because she had limited ROM in her upper and lower extremities on her left side after a stroke. Record review on 02/12/2026 at 1:32pm of Resident #10's therapy discharge notes dated 09/26/2025 revealed she received therapy for left sided hemiplegia and limitations to her left upper and lower extremities. Interview on 02/12/2026 at 2:44PM, with MDS Nurse who when shown Resident #10's 09/03/2025 Q MDS section GG which reflected B. Lower extremity (hip, knee, ankle, foot) -no impairment, stated, that was my error, the resident has left sided impairments, and I just coded that wrong. When shown Resident #10's, Q MDS dated [DATE] section GG was also coded as B. Lower extremity (hip, knee, ankle, foot) -No impairments, the MDS Nurse said it was her error, and she must have mis-clicked the MDS option. The MDS Nurse said that Resident #10 had both one-sided upper and lower extremity impairments and that she would modify and update both MDS assessments. The MDS Nurse was not sure if the facility had a specific policy and procedure on MDS accuracy and said accuracy of the MDS assessments were important because that was how residents' needs were met. The MDS Nurse said she had been trained upon hire and in 2023 and was trained at a sister facility location during that time, by a regional person, who conducted a 2-week training for her specific to the MDS Nurse role. The MDS Nurse said she received updated training for her role as MDS based on updates to MDS processes. During a telephone interview with Regional MDS on 02/13/2026 at 1:21 pm he said he had been in his role for almost 1 year and was regional oversight for multiple buildings and completed MDS training with on-site MDS staff. Regional MDS said the training covered anything MDS related including MDS accuracy and care plans. Regional MDS said most meetings were virtual unless there was an identified issue then an on-site 1:1 in-service or training would be conducted. Regional MDS said they kept no copies of any in-services with staff, and the training was mostly conversations. Regional MDS said they were unaware of and had not identified through any audits any significant issues with accuracy of MDS assessments or care plans. The Regional MDS said the expectation would be that the MDS assessments and care plans would be accurate to ensure continuity of resident care. The Regional MDS said that although he had conducted audits, he had not conducted any specific audits on accuracy of assessments or care plans. The Regional MDS said that he had done training with the facility MDS Nurse, but the training had been virtual, and group related. Record review on 02/12/2026 at 4:12 pm of Resident #10's Quarterly MDS dated [DATE] and Quarterly MDS dated [DATE] revealed they had both been modified by the MDS Nurse and reflected in section GG Functional Limitation in Range of Motion.1. Impairment on one side. and was coded for impairment on one side for both upper and lower extremities. Resident # 2Record review of the face sheet for Resident # 2 revealed admission date 5/8/25, with diagnoses including cerebral infarction (lack of blood flow to the brain), dysphagia (trouble swallowing after stroke), tracheostomy (surgical opening in the neck to provide an alternate airway), Diabetes (high blood sugar from inadequate insulin secretion), seizures (sudden disruption of brain activity), hypertension (high blood pressure), and anxiety disorder (excessive worry or fear). Record review of the Quarterly MDS dated [DATE] revealed Resident # 2 was usually understood and usually understands, BIMS score of 12, indicating moderately impaired cognition, maximum staff assistance required for toileting, bathing and personal hygiene, and frequently incontinent of bowel and bladder, and presence of feeding tube while a resident. Observation and interview with Resident # 2 on 2/10/26 revealed she was in bed, resting, watching TV, and had a tracheostomy with clean dressing and tubing present. There was a suction machine and ambu bag on the dresser in the corner of the room. There was no feeding tube present. When asked how she was, she motioned to her trach and whispered she couldn't talk. She nodded her head as if to say ok. Interview with LVN C at 10:00am revealed Resident # 2 eats ate her own meals, and they monitor her (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	eating. She said Resident # 2 used to have a feeding tube, but it was discontinued in December, and they were trying to wean her off the trach. She said she eats ate her meals on her own. Observation on 2/11/26 at 12:15pm revealed Resident # 2 was sitting on the side of her bed with her lunch tray on the bedside table. She was eating her meal with no assistance. Record review of Resident # 2's physician orders dated February 2026 revealed regular diet with regular liquids. Further record review of the care plan dated 6/5/25 revealed monitor and document intake and offer substitute if less than 50% was eaten. Record review of progress note dated 12/16/25 revealed Resident # 2's feeding tube was discontinued by physician order on 12/16/25. The feeding tube removal was not reflected in the 12/25/25 MDS. Record review of Resident # 2's quarterly MDS dated [DATE] revealed no falls since admission or prior assessment. Resident # 2 had a fall on 8/23/25, since the prior assessment on 8/15/25. The fall on 8/23/25 was not captured in the 9/24/25 MDS assessment. In an interview with MDS nurse on 2/13/25 at 10:18am, she said she wasn't sure if Resident #2's feeding tube fell out or if it was discontinued, but it should have been taken off the MDS. She also said Resident # 2's fall on 8/23/25 should have been coded on the 9/24/25 MDS. She said the risk of not having an accurate MDS assessment would be not having an accurate picture of the resident. In an interview with the DON on 2/13/25 at 10:20am, she said the MDS reflects the resident's condition, and the feeding tube removal and fall for Resident # 2 should be coded on the appropriate MDS. She said the risk of having an inaccurate assessment would affect the plan of care for the residents. Record review of facility's policy titled MDS Completion Accuracy and Timeliness, dated effective 11/2023 and revised 11/15/2023, revealed in part: 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 - Some	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 II residents with mental illness were provided with an accurate PASRR Level I for II (Resident #21 and Resident #52) of 5 Residents reviewed for PASRR screening. -Resident #21 did not have an accurate and updated PASRR Level II assessment reflecting a diagnosis of mental illness. -Resident #52 did not have an accurate and updated PASRR Level II assessment reflecting a diagnosis of mental illness. These failures 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 #21's face sheet, dated 02/11/26, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses include schizoaffective disorder, psychotic disturbance, mood disturbance, major depressive disorder, essential hypertension, type 2 diabetes mellitus, congestive heart diseases, shortness of breath, difficulty in walking, muscle weakness, convulsions, and anemia. Record review of Resident #21's face sheet revealed the following diagnoses, schizoaffective disorder, psychotic disturbance, mood disturbance, major depressive disorder, were all present on admission. Record review of Resident #21's PASRR evaluation dated 11/19/24 revealed section 009 diagnoses of Dementia as primary diagnoses was checked no on all section of mental illness and IDD were checked no. Record review of Resident #21's significant change MDS assessment dated [DATE] revealed his BIMS score was 8 out of 15 indicated he was moderately impaired cognition. Section on Level II PASRR screening was left blank.Record review of section on psychiatric \mood disorder, he was checked for schizophrenia Record review of Resident #21's care plan with a revision date of 12/31/25 revealed he was care planned for the use antidepressant medication r/t Depression. Record review of Resident #21's clinical records revealed no evidence of PASRR Level II evaluation. Resident #52 Review of Resident #52's face sheet, printed on 02/12/26, reflected a [AGE] year-old male who was originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included dementia, psychotic disturbance, mood disturbance, anxiety, depression, schizoaffective disorder, bipolar disorder, benign prostatic hyperplasia, chronic pain, hypothyroidism, malignant neoplasm (also known as enlarged prostate) muscle weakness, lack of coordination, unsteadiness on feet, difficulty in walking, type 2 diabetes mellitus (high blood sugar, insulin resistance, and relative lack of insulin), and seizures., Record review of Resident # 52's comprehensive Significant Change MDS assessment dated [DATE] revealed his BIMS score was 15 out of 15 which indicated intact cognition. Record review of section 1 active diagnoses revealed he was checked for anxiety disorder, depression, bipolar disorder and schizophrenia. Record review of Resident #52's care plan with a revision date of 01/21/26 revealed he was care planned for impaired decision-making abilities, is not always understood or able to understand verbal and non-verbal expression Dementia, Schizoaffective disorder and bipolar disorder. Goal: Resident #52 will be able to communicate basic needs on a daily basis through the review date. Date initiated 01/07/26 revision date04/13/26. Record review of Resident #52's Clinical record revealed no evidence of PASRR I and level II evaluation. Observation and interview on 02/10/26 at 11:10AM revealed Resident # 52 were in bed alert and oriented. Observation indicated he was on G-Tube feeding. He said he gets his feeding every 2-3 hours, and he was doing well. During an interview with MDS coordinator on 02/12/26 at 2:00PM, she said she was responsible for ensuring that residents with MI, IDD and related diagnoses had PASRR Leve I assessments on admission and were referred to local authority for Level II evaluation. She said she would complete a 1012 form for Residents #21 and #52. During an interview with Facility DON on 02\13\26 at 8:45AM, she said all MDS assessment should accurately reflect resident's condition if not the care plan would be missed and may result in delayed services. She said reviewed the MDS assessments for completion and occasionally reviewed a few as time permitted. Telephone interview with Regional MDS on (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/13/2026 at 1:21 PM he said he had been in his role for almost 1 year and was regional oversight for multiple buildings and completed MDS training with on-site MDS staff. Regional MDS said the training covered anything MDS related including MDS accuracy and care plans. Regional MDS said most meetings were virtual unless there was an identified issue then an on-site 1:1 in-service or training would be conducted. Regional MDS said they kept no copies of any in-services with staff, and the training was mostly conversations. Regional MDS said they were unaware of and had not identified through any audits any significant issues with accuracy of MDS assessments or care plans. The Regional MDS said the expectation would be that the MDS assessments and care plans would be accurate to ensure continuity of resident care. The Regional MDS said that although he had conducted audits, he had not conducted any specific audits on accuracy of assessments or care plans. The Regional MDS said that he had done training with the facility MDS Nurse, but the training had been virtual, and group related. Policy on PASRR was requested from MDS Coordinator on 02/13/26 at 11:00AM but was not provided.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that it was free of a medication error rate below 5 percent (%) or greater. The facility had a medication error rate of 19.35% based on 6 out of 31 opportunities which involved 1 of 5 residents (Resident #19) and 1 of 3 staff (MA B) observed for medication administration errors.MA B administered Acetaminophen (a drug that is used to treat moderate pain and is a fever reducer), Amlodipine Besylate (a drug used to treated elevated blood pressure), Keppra (a drug used to treat seizures), Clobazam (a drug used to treat seizures), Pregabalin (a drug used for pain), and Cyclobenzaprine (a drug used for muscle pain) 2 hours and 52 minutes after the scheduled time to Resident #19 on 2/11/2026 at 10:53 am.These failures could place residents at risk of not receiving therapeutic effects of the medications and possible adverse reactions. The findings included: Record review of Resident #19's face sheet dated 2/12/2026 revealed an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included transient cerebral ischemic attack (a temporary blockage of blood flow to the brain that can cause symptoms similar to those of a stroke), epilepsy (a chronic neurological disorder that is characterized by recurrent seizures), essential hypertension (a type of high blood pressure that has no identifiable cause), rheumatoid arthritis (an autoimmune disease where the body's immune system mistakenly attacks its own tissues leading to inflammation in the joints potentially affecting other organs), and vascular dementia (a type of dementia caused by problems with blood flow to the brain). Record review of Resident #19's quarterly MDS, dated [DATE], revealed Resident #19 had a BIMS score of 13 indicating intact cognitive function. Record review of Resident #19's physician orders as of 2/11/2026 revealed the following: Tylenol oral tablet 325 mg (Acetaminophen) Give 650 mg by mouth two times a day for right leg pain. Amlodipine Besylate tablet 10 mg Give 1 tablet by mouth one time a day for elevated blood pressure; Hold if SBP <110 or DBP<60 HR 60. Keppra tablet 750 mg (levetiracetam) Give 2 tablets by mouth two times a day for seizures. Clobazam tablet 10 mg. Give 1 tablet by mouth one time a day for seizure. Lyrica oral capsule (Pregabalin) Give 1 capsule by mouth three times a day for pain. Cyclobenzaprine HCL tablet 5 mg Give 1 tablet by mouth three times a day for muscle pain. Record review of Resident #19's MAR on 2/11/2026 revealed the following: Acetaminophen (Tylenol) oral tablet 325 mg. Give 650 mg by mouth two times a day for right leg pain. Start date 8/18/2024. (Scheduled times listed on MAR were 7:00 am and 4:00 pm). Amlodipine Besylate tablet 10 mg. Give 1 tablet by mouth one-time a day for elevated blood pressure (hypertension). Start date 2/24/2025. Hold if SBP<110 or DBP <60 HR 60. (Scheduled time listed on MAR was 7:00 am). Keppra tablet 750 mg (levetiracetam). Give 2 tablets by mouth two times a day for seizures. Start date 8/18/2024. (Scheduled times listed on MAR were 7:00 am and 4:00 pm). Clobazam tablet 10 mg. Give 1 tablet by mouth once a day for seizure. Start date 8/7/2023. (Scheduled time listed on MAR was 7:00 am) Pregabalin 100 mg (Lyrica). Give 1 capsule by mouth three times a day for pain. Start date 2/23/2025. (Scheduled times listed on MAR were 7:00 am, 1:00 pm, and 7:00 pm). Cyclobenzaprine HCL tablet 5 mg. Give 1 tablet by mouth three times a day for muscle pain. Start date 4/15/2025. (Scheduled times listed on MAR were 7:00 am, 1:00 pm, and 7:00 pm) Observation of MA B on 2/11/2026 at 10:35 am revealed her standing in front of a medication cart in hall 100 near room [ROOM NUMBER]. MA B stated she was passing medications and agreed to be observed by surveyor. MA B then entered Resident #19's room and obtained the blood pressure and heart rate of Resident #19. Afterwards, MA B performed hand hygiene and began to gather Resident #19's medication and placed them in a clear medication cup. MA B administered doses of Acetaminophen, Amlodipine, Keppra, Clobazam, Pregabalin, and Cyclobenzaprine as listed on MAR at 10:53 am. Interview with MA B on 2/11/2026 at 3:05 pm regarding the reason she was 2 hours and 52 minutes late giving Resident #19 her 7:00 am medications, MA B stated it is because she is unable to be in two places at one time. MA B stated she was supposed to give medication to residents in hall (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	300 first, also known as the hospital hall. MA B stated that she has received training within the year on medication administration and the 5 rights. When asked if she had mentioned her inability to administer medication on time according to facility policy, MA B stated she had mentioned it to ADON as recently as that day. MA B stated she had not yet notified the nurse caring for the resident about the delayed administration but stated she normally would. MA B stated the risk of not administering medication at the correct time and within correct intervals could make residents become very sleepy and cause unsafe conditions for the residents. Interview with ADON on 2/11/2026 at 3:21 pm revealed that she was not told by MA B that she was unable to administer medications on time as ordered by physician. The ADON stated that she spot-checked in PCC to ensure residents have received their medications on time every morning. The ADON stated that residents residing in the 300 hall are considered more acute and receive their medication before residents that live in the 100 hall. The ADON stated that nurses and medication aides have one hour before and after scheduled administration time to administer medications. The ADON stated that medication administration times have been adjusted previously to ensure residents would receive their medication on time and to alleviate staff burden and distress. The ADON stated the risk of not receiving medication on time could lead to adverse side effects, delayed therapeutic responses. Interview with the DON on 2/11/2026 at approximately 3:45 pm revealed that she was not aware that MA B had administered Resident #19's medication 2 hours and 52 minutes late. The DON was interviewed while she was at MA B's medication cart and spoke directly to MA B and requested to view administration details screen on PCC. A copy of these specific administration details were requested from the DON, but the DON stated she was unable to do so. The DON stated the risk of not giving medication as ordered could lead to adverse health effects for residents. Interview with RN B on 2/12/2026 at 1:45 pm, she stated she was the nurse that oversaw the care for Resident #19 yesterday. RN B revealed that MA B did not tell her about the late administration of medication. RN B stated the expectation from medication aides was that they notify her if a resident refused medication, if a medication was held, or was going to be late. RN B stated she normally has no issues with medication aides administering medication late. Record review of facility policy titled Administration Procedures for All Medications with an effective date of 09-2018 and revised in 8-2-2020, states in part .at a minimum, review the 5 rights at each of the following steps of the medication administration.check the MAR/TAR for the order. Review of the TAC Title 26 Chapter 557 Rule 557.105, titled Allowable and Prohibited Practices of a Medication Aide, reads in part. A medication aide permitted under this chapter may not.#14. Neglect to administer appropriate medications, as prescribed, in a responsible manner.

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	676050	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Pasadena	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 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 observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs with the services that are to be furnished to attain or maintain the resident's highest practicable physical well-being for 1 of 18 residents (Resident #3) reviewed for care plans. The facility failed to ensure Resident #3's comprehensive care plan included information about her Spanish speaking status. This failure could place residents at risk of not receiving appropriate care and interventions to meet their needs. Findings included: Resident #3 Record review of Resident #3's admission Record dated 02/10/2026, revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including chronic (persisting or recurring illness) peripheral venous insufficiency (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), dysphagia oropharyngeal phase (a swallowing disorder caused by difficulty transferring food from the mouth to the esophagus (the muscular tube that transports food and liquids from the pharynx (the throat) to the stomach and functions as a critical part of the upper digestive system), dementia (decline in mental abilities including memory, thinking, language and reasoning), gastrostomy status (clinical condition of having an artificial opening (stoma) in the stomach, usually with a feeding tube (G-tube) inserted directly through the abdominal wall), and mood disorder (mental health condition characterized by significant, long-term disruptions in emotional state, such as intense sadness (depression) or extreme highs (mania), Record review of Resident #3's Annual MDS dated [DATE] revealed in section A under Language, that her preferred language was coded as Spanish and was also coded as 1. Yes for the question Do you need or want an interpreter to communicate with a doctor or health care staff? Resident #3 was also coded as having a BIMS score of 7 out of 15 that indicated severe cognitive impairment. MDS also revealed in Section V CAA's and Care Planning Resident #3 was identified and coded for communication as a triggered care area and had a care planning decision dated 12/12/2025. Observation with Resident #3 on 02/10/2026 at 10:47 am who was Spanish speaking only. Observation of Spanish speaking signs posted above Resident #3's bed and observed direct care staff including ADON, DON and RN B using mobile device translator applications as needed to communicate with Resident #3. Record review on 02/13/2026 at 10:54 am of Resident #3's undated care plan revealed no care plan for language/communication and no information on her Spanish speaking status. Interview with MDS Nurse on 02/13/2026 at 10:56 am surveyor asked MDS Nurse if Resident #3 had been care planned for her Spanish speaking status and MDS Nurse replied, she should be. Surveyor requested copy of Resident #3's care plan. Record review on 02/13/2026 at 10:58 am of printed copy of Resident #3's undated care plan revealed the following: Focus date initiated 02/13/2026. Resident #3 has an interpretation need.Resident #3 will communicate via an interpreter.Her preferred language is Spanish.She has translation needs. (Interpreter: Spanish). Interview on 02/13/2026 at 11:14 am with MDS Nurse, Administrator and DON (Staff began coming for surveyor interviews in pairs). The MDS Nurse said that Resident #3 did not have a care plan for Spanish speaking or translator needs until surveyor requested a copy of the care plan on 02/13/2026. The MDS Nurse said that Resident #3 had always been Spanish speaking since her admission and readmission and usually required a translator. The MDS Nurse said Resident #3 should have had a communication/Spanish speaking care plan and it must have been an oversight on her part because she was responsible for annual and quarterly updates to resident care plans. The MDS Nurse said that if Resident #3 did not have a care plan for communication and language preferences or needs, it could affect her plan of care and lead to miscommunication. The DON and Administrator both said inaccurate care plans could lead to Resident #3 being unable to communicate (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her needs. The DON, Administrator and MDS Nurse all said that care planning was an IDT effort, and that the SW completed section B of the MDS Hearing, Speech and Vision. Interview on 02/13/2026 at 11:17 am with SW (with Administrator present), she said she completed sections B, C, D, E and Q of the MDS. When asked how the SW completed the assessments for Resident #3, the SW said she used a language line translator application on her mobile device to communicate with Resident #3 because she was Spanish speaking. The SW said she was not aware that Resident #3 did not have a Spanish speaking or communication need care plan. The SW said that she completed care plans for some of the residents as part of the IDT. The SW said that if Resident #3 did not have a Spanish speaking care plan, it could lead to staff not being able to communicate with Resident #3 about her needs. The Administrator then said, it could have the potential of miscommunication with Resident #3. Telephone interview with Regional MDS on 02/13/2026 at 1:21 pm he said he had been in his role for almost 1 year and was regional oversight for multiple buildings and completed MDS training with on-site MDS staff. Regional MDS said the training covered anything MDS related including MDS accuracy and care plans. Regional MDS said most meetings were virtual unless there was an identified issue then an on-site 1:1 in-service or training would be conducted. Regional MDS said they kept no copies of any in-services with staff, and the training was mostly conversations. Regional MDS said they were unaware of and had not identified through any audits any significant issues with accuracy of MDS assessments or care plans. The Regional MDS said the expectation would be that the MDS assessments and care plans would be accurate to ensure continuity of resident care. The Regional MDS said that although he had conducted audits, he had not conducted any specific audits on accuracy of assessments or care plans. The Regional MDS said that he had done training with the facility MDS Nurse, but the training had been virtual, and group related. Record review of facility's policy Comprehensive Care Plan dated as effective 01/20/2021 and revised 04/25/2021 revealed in part: Every resident will have an individualized interdisciplinary plan of care in place.The Interdisciplinary Team will continue to develop the plan in conjunction with the RAI (MDS 3.0) and CAA's.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 on-going review process.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 out of 2 staff (RN B) and 1 of 4 residents (Resident#4) reviewed for infection control. The facility failed to ensure RN B used PPE (Personal Protective Equipment) appropriately while providing care to Resident #4 who was on EBP (Enhanced Barrier Precautions). These failures could place residents at risk for cross contamination, infection and decline in health. Findings include: Resident #4 Record Review of Resident #4's admission record dated 02/10/2026, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including epilepsy (chronic noncommunicable neurological disorder characterized by recurrent, unprovoked seizures caused by sudden excessive electrical discharges in brain cells), dysphagia oropharyngeal phase (a swallowing disorder caused by difficulty transferring food from the mouth to the esophagus (the muscular tube that transports food and liquids from the pharynx (the throat) to the stomach and functions as a critical part of the upper digestive system), dysphagia pharyngoesophageal phase (a swallowing disorder of difficulty transferring food/liquid from the throat to the esophagus, characterized by symptoms like coughing, choking, nasal regurgitation and a sticking sensation in the throat), and cerebral infarction (a medical emergency condition caused by blocked blood flow to the brain, leading to tissue death). Record review of Resident's #4's Annual MDS dated [DATE] revealed a BIMS score of 7 out of 15 that indicated severe cognitive impairment. Record review of Resident #4's Order Summary Report dated 02/13/2026 revealed the following order for Jevity 1.5 at 58 ML/HR X 10 HRS.every evening shift for appetite/nutrition enteral feeding to start at 08:00 pm and stop at 06:00 am. The order dated 02/03/2026 was Active and had a start date of 02/03/2026 with no end or discontinued date. Record review of Resident #4's Order Summary Report dated 02/13/2026 revealed the following order for Jevity 1.5 bolus (a single dose of a drug or other medicinal preparation given all at once) 237 ML three times a day for supplement. The order dated 02/03/2026 was Active and had a start date of 02/03/2026 with no end or discontinued date. Record review of Resident #4's MAR printed 02/13/2026 revealed, Jevity 1.5 bolus 237 ML three times a day for supplement was documented as administered by RN B on 02/10/2026 at 8 am. Record review of facility staffing sheet dated 02/10/2026 on 02/13/2026 at 3:23pm revealed RN B worked on 02/10/2026 on the 6:00 am to 6:00 pm shift. Record review of PPE and General Orientation Checklist, which included Infection Control/Isolation Procedures in-services dated 01/29/2026, revealed RN B signed acknowledgement of both in-services. Observation on 02/10/2026 at 08:58 am of Resident #4's door of her room that was closed and had an EBP sign taped to the front of the door, which read: Stop.Enhanced Barrier Precautions.Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities.Device care or use: feeding tube. Knocked on the door to maintain Resident #4's privacy and dignity to enter and was told to come in but informed by RN B there was patient care being performed. Observed RN B at bedside with enteral feeding plunger syringe connected to Resident #4's enteral feeding tube with milk-like substance inside the syringe. RN B was holding a carton labeled Jevity 1.5 and was 237 ML. RN B was not wearing a gown. When asked if Resident #4 was on EBP, RN B did not reply. Observation of Resident #4's gastrostomy tube site revealed a clean dry white split gauze dressing to site dated 2/10/26. Resident #4 was awake, alert, and oriented X 2-3. Resident #4 said the gastrostomy tube dressings were changed every overnight shift, and she did not know if staff always wore a gown or gloves when giving her feeding or handling her gastrostomy tube. RN B continued the bolus feeding to gravity until the carton was completed. While at the door RN B was asked again if Resident #4 was on EBP and RN B said she was not aware that Resident #4 was on EBP before surveyor asked about it. When surveyor pointed to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBP sign taped on Resident #4's door, RN B said she should have been aware that Resident #4 was on EBP and that she should have been wearing the appropriate PPE while giving Resident #4 her bolus feeding as ordered. RN B said she should have put on a gown. She said that she was new and had only been working at the facility since last week. She said there were a lot of new nurses and new CNAs. Interview and observation with RN B on 02/10/2026 at 10:12 am, RN B returned to Resident #4's bedside and donned and doffed PPE appropriately to administer Resident #4's pain medication. RN B said she should have been wearing PPE the first time she provided care to Resident #4 because Resident #4 had a gastrostomy tube and said she originally did not see the sign posted on Resident #4's room door. Interview on 02/10/2026 at 11:29 am with the Infection Preventionist who was also the ADON said she was the IP since October of 2025. The IP said that all staff were trained on infection control, which included TBP, EBP and contact isolation. The IP said RN B should have seen the EBP signs posted on Resident #4's room door and the supply of PPE at the bedside. The IP said she conducted the last infection control training earlier in the month of February and was responsible for helping to stock and restock PPE daily and posting signs for any transmission-based precautions. The IP said she did not know why RN B did not adhere to Resident #4's EBP status and said that anyone with a gastrostomy tube or indwelling catheter or tube, should have EBP's in place. The IP said RN B could spread or give Resident #4 an infection by providing care without using proper PPE. Interview on 02/10/2026 at 11:35 am with DON who said that all staff should and were expected to adhere to any EBP or TBP order for a resident and that the IP was responsible for ensuring the appropriate PPE and any precautions were set in place for the residents as ordered. The DON said she was not aware that RN B had been observed not using the appropriate PPE while providing care to Resident #4's gastrostomy tube site and said that RN B should have been wearing appropriate PPE as indicated for any resident on EBP's. She said that RN B's failure to donn appropriate PPE and adhere to Resident #4's EBP status could be the spread of infection. Follow up interview with RN B on 02/11/2026 at 1:27 pm said the risk to Resident #4 for her not using EBP could be the spread of infection, or it could cause Resident #4 to get an infection. RN B said she had been trained on ANE and infection control including EBP and TBP during orientation because there was a video about it. RN B said she had subsequently used EBP and appropriate PPE. Record review of facility policy Infection Control Enhanced Barrier Precautions dated Effective 04/01/2024 revealed in part: Enhanced Barrier Precautions (EBP) are a CDC guidance to reduce the transmission of multi-drug-resistant organisms (MDRO), in health care settings, including nursing homes. EBP require team members to wear a gown and gloves while performing high contact care activities with residents. who have indwelling medical device. 2. Determine if any of the following indwelling medical devices are in use: .g-tube.EBP will be implemented if. any of the invasive medical devices are present.