

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676094	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Orange		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 Fm 105 Orange, TX 77630	
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 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 provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 3 of 3 medication carts and 3 of 25 residents reviewed for pharmacy services (Residents #42, #61 and #64) (Medication cart for Rooms 109 - Rooms 120, Medication cart for Rooms 217 - Rooms 220 and Medication cart for Rooms 205 - Rooms 216). The facility failed to ensure expired medications were removed from 3 of 3 medication carts. These failures could place residents at an increased risk of receiving medications that were not at their intended potency and potential adverse reactions or side effects. Findings included: Record review of Resident #42's face sheet, dated 06/23/2026, indicated a [AGE] year-old female, admitted [DATE]. Resident #42 had diagnoses which included hypertension (high blood pressure) and hypothyroidism (thyroid does not produce enough hormones to meet the body's needs). Record review of Resident #42's quarterly MDS assessment, dated 04/21/2026, indicated Resident #42 had a BIMS score of 3, which indicated severely impaired cognition with diagnoses of hypertension and hypothyroidism. Record review of Resident #42's physician orders, dated 06/03/2026, indicated she was prescribed amlodipine besylate 2.5 mg every day for hypertension with a start date of 12/22/2022 and levothyroxine 50 mcg daily for low thyroid with a start date of 05/20/2023. Record review of Resident #42's care plan, with a target date of 07/12/2026, indicated Resident #42 had a diagnosis of hypothyroidism and was at risk of complications with interventions of administer medication as prescribed. Resident #42's care plan included a diagnosis of hypertension with a risk of complications and interventions that included administer medication as prescribed. Record review of Resident #61's face sheet, dated 06/03/2026, indicated a [AGE] year-old male, admitted [DATE]. Resident #61 had diagnoses which included Parkinsonism (group of neurologic disorders causing movement problems including tremors, slow movement, balance problems and rigid muscles). Record review of Resident #61's quarterly MDS assessment, dated 03/04/2026, indicated Resident #61 had a BIMS score of 13, which indicated intact cognition with a diagnosis of Parkinsonism. Record review of Resident #61's physician orders, dated 06/03/2026, indicated he was prescribed carbidopa/ levodopa 25 mg/ 100 mg every 8 hours for Parkinson's with a start date of 12/28/2020. Record review of Resident #61's care plan, with a target date of 08/11/2026, indicated Resident #61 was on an antiparkinsonian therapy with interventions administer medication as prescribed. Record review of Resident #64's face sheet, dated 06/03/2026, indicated a [AGE] year-old female, admitted [DATE]. Resident #64 had a diagnosis which included hypertension (high blood pressure). Record review of Resident #64's quarterly MDS assessment, dated 05/13/2026, indicated Resident #64 had a BIMS score of 7, which indicated severely impaired cognition with a diagnosis of hypertension. Record review of Resident #64's care plan, with a target date of 07/13/2026, indicated Resident #64 had a diagnosis of hypertension and interventions that included receive medication as ordered. Record review of Resident #64's physician orders, dated 06/03/2026, indicated she did not have current orders for clonidine 0.1 mg every 8 hours as needed. During an observation and interview on (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/03/2026 at 9:52 a.m., medication cart for Rooms 109 - Rooms 120 with LVN C revealed in the third drawer including medication overflow:*1 medication card with 30 of 30 pills Carbidopa/ Levodopa 25mg/ 100 mg every 8 hours for Parkinson's disease with a use by date of 02/07/2025 labeled for Resident #61. *2 medication cards with 30 of 30 pills Carbidopa/ Levodopa 25mg/ 100 mg every 8 hours for Parkinson's disease with a use by date of 04/18/2025 labeled for Resident #61. *2 medication cards with 30 of 30 pills Carbidopa/ Levodopa 25mg/ 100 mg every 8 hours for Parkinson's disease with a use by date of 09/26/2025 labeled for Resident #61. *1 medication card with 30 of 30 pills Carbidopa/ Levodopa 25mg/ 100 mg every 8 hours for Parkinson's disease with a use by date of 11/25/2025 labeled for Resident #61. *1 medication card with 25 of 30 pills Carbidopa/ Levodopa 25mg/ 100 mg every 8 hours for Parkinson's disease with a use by date of 01/03/2026 labeled for Resident #61. LVN C said the nurses that gave medication off this medication cart were responsible for ensuring all expired medications were removed from the medication cart. She said she was giving medication off this medication cart today (06/03/2026) and was educated on removal of expired medication. She said the other nurses giving medication off this medication cart were the backup to double check and ensure all expired medication was removed off the medication cart. LVN C said these expired medications were overlooked. She said the resident risk of expired medication left on a medication cart was they may not be as effective. She said she had not given any of the expired medication and the medication cart contained a card of the medication that was not expired. During an observation and interview on 06/03/2026 at 10:05 a.m., medication cart for Rooms 217 - Rooms 220 with RN D revealed in the third drawer including medication overflow:*1 medication card with 30 of 30 pills levothyroxine 50 mcg daily for low thyroid with a use by date of 03/17/2026 labeled for Resident #42. *1 medication card with 30 of 30 pills levothyroxine 50 mcg daily for low thyroid with a use by date of 05/12/2026 labeled for Resident #42. *1 medication card with 30 of 30 pills amlodipine besylate 2.5 mg daily for high blood pressure with a use by date of 12/31/2025 labeled for Resident #42. RN D said the nurses that gave medication off this medication cart were responsible for ensuring all expired medications were removed from the medication cart. She said she was giving medication off this medication cart today (06/03/2026) and was educated on removal of expired medication. She said the other nurses giving medication off this medication cart were the backup to double check and ensure all expired medication was removed off the medication cart. RN D said these expired medications were overlooked. She said the resident risk of expired medication left on a medication cart was they may not be as effective. She said she had not given any of the expired medication. During an observation and interview on 06/03/2026 at 11:05 a.m., medication cart for Rooms 205 - Rooms 216 with LVN E revealed in the third drawer including medication overflow:*1 medication card with 17 of 30 pills clonidine HCL 0.1 mg every 8 hours as needed for blood pressure with a use by date of 02/28/2025 labeled for Resident #64. LVN D said the nurses that gave medication off this medication cart were responsible for ensuring all expired medications were removed from the medication cart. She said she was giving medication off this medication cart today (06/03/2026) and was educated on removal of expired medication. She said the other nurses giving medication off this medication cart were the backup to double check and ensure all expired medication was removed off the medication cart. LVN D said these expired medications were overlooked. She said the resident risk of expired medication left on a medication cart was they may not be as effective. LVN D said she had not given any of the expired medication. During an interview on 06/03/2026 at 11:48 a.m., the DON said the charge nurses giving medication off the medication carts were responsible for removing all expired medication off the medication carts. She said the ADONs were responsible for weekly checks of the medication carts to remove expired medication. The DON said all nurses were educated to remove expired medication off the medication carts. She said the expired medications were overlooked. The DON said the potential resident risk of having an expired medication on a medication cart is that the medication potentially may not be as effective. She said her expectation was the nurses would check the dates on all medication and if expired (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	remove them immediately from the medication cart. During an interview on 06/03/2026 at 11:56 a.m., ADON A said the nurses giving medication off the medication carts were responsible for removing all expired medications off the medication carts. She said she was not sure who was responsible for being the backup to ensure all expired medications were removed from the medication carts, but she would find out. ADON A said the expired medications were possibly overlooked. She said all the nurses were educated to remove expired medication from the medication carts. ADON A said the resident risk of expired medication not removed from a medication cart was the medication could be less effective. During an interview on 06/03/2026 at 12:04 p.m., the Administrator said the nurses giving medication off the medication cart were responsible for removing all expired medications off the medication carts. She said the ADON assigned to station A and ADON assigned to station B and DON were the backup to ensure all expired medications were removed off the medication carts. The Administrator said the expired medications were overlooked, the staff did not check the overflow medication for expired medications. She said the nurses were all educated to remove expired medication from the medication carts. She said the resident risk of expired medication on a medication cart was the medication could be less effective. The Administrator said her expectation was all medication carts be checked weekly to say up to date as best as possible including the overflow medication and all expired medication be removed and destroyed timely. During an interview on 06/03/2026 at 12:10 p.m., ADON A said she was now responsible for both nurses' stations until ADON B returned. She said she would check the medication carts weekly on Wednesdays starting today for expired medication and remove the expired medication from the medication cart. During an interview on 06/03/2026 at 3:27 p.m., ADON B said the charge nurses were responsible for removing expired medication off the nurses' medication carts and she was responsible for station A that included Resident #61's hall. ADON B said ADON A was responsible for Nurses Station B that included Resident #42 and #64's halls. She said she made weekly checks on the medication carts for her station on Wednesdays. ADON B said all the nurses were educated to remove expired medication off the medication carts. She said the expired medications were overlooked. ADON B said the potential resident risk of expired medication left on a medication cart was the medication could be less effective or could cause side effects. Record review of a facility policy, revised 08/2024, titled, Storage of Medications, indicated, . 8. Outdated, contaminated, or deteriorated medications . are immediately removed from inventory, disposed of according to procedures for medication disposal, . 1. Expiration dates (beyond-use dates) of dispensed medications shall be determined by the pharmacist at the time of dispensing. 4. Re-packaged drugs carry a beyond-use-date determined by the pharmacy based upon a number of factors in addition to applicable law and regulation.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in 1 of 1 kitchen reviewed for food safety requirements. 1. The facility failed to ensure there were paper towels at the handwashing station. 2. The facility failed to ensure the Dietary Manager's hair was inside the hair restraint. 3. The facility failed to ensure Dishwasher A wore a beard restraint. 4. The facility failed to ensure [NAME] A wore his beard restraint correctly. 5. The facility failed to ensure the Dietary Manager, and [NAME] A washed their hands upon entering the kitchen. 6. The facility failed to ensure [NAME] B washed her hands after lifting her shirt up and pulling her pants up. 7. The facility failed to ensure the floor and shelves of the walk-in coolers were free from green and brown colored debris and dark brown stains. 8. The facility failed to ensure 2 log packs of ground beef meat were thawed with running water. 9. The facility failed to ensure staff did not have open hydration drinks on preparation table. These failures could place residents at risk of foodborne illness, and food contamination. Findings included: During an observation of the kitchen on 06/01/2026 at 8:42 a.m. there were no paper towels in the paper towel dispenser, nor any paper towels near the handwashing station. During an observation on 06/01/2026 at 8:47 a.m., there were 2 log packs of ground meat thawing in the sink without running water. During an observation on 06/01/2026 at 9:00 a.m. there were 2 open drinks that belonged to [NAME] A on the preparation table near serving plates and food. During an observation and interview on 06/01/2026 at 9:00 a.m., the Dietary Manager, and [NAME] A, did not wash their hands upon entering the kitchen from outside. The Dietary Manager's hair restraint covered the top of her head leaving the bottom of her hair outside of the hair restraint while in the meal preparation section. During an interview with the Dietary Manager, she said she should have washed her hands when she entered the kitchen. She said all hair must be in the hair restraint while in the kitchen. She said she was rushing and forgot to wash her hands and put all her hair in the hair restraint. She said the potential risk was hair falling in the food and cross contamination. During an interview with [NAME] A, he said he went outside to smoke then came back inside to finish cooking. He said he did not wash his hands because there were no paper towels to dry his hands. He said he had been trained on handwashing, and the potential risk was cross contamination if hands were not washed. During an observation and interview on 06/01/2026 at 9:10 a.m. Dishwasher A was not wearing a beard restraint while in the kitchen. He said he was educated to have a beard restraint on while in the kitchen. He said he forgot to put it on. Dishwasher A said not wearing a beard restraint could place residents at risk for getting hair in their food. During an observation and interview on 06/01/2026 at 9:30 a.m. [NAME] B was observed lifting her uniform shirt up and pulling her pants up. [NAME] B did not wash her hands after pulling her pants up before touching kitchen seasonings. During an interview [NAME] B said she did not immediately wash her hands after pulling up her pants because she was going to go wash the dishes after she put the seasonings up. She said she had been trained on washing her hands and the potential risk was cross contamination. During an observation on 06/01/2026 at 9:50 a.m. the floor and shelves of the walk-in coolers had green and brown colored debris and dark brown colored stains. During an observation on 06/01/2026 at 12:00 p.m., there were 2 logs of ground meat thawing in the sink without running water. During an observation and interview on 06/01/2026 at 12:30 p.m. there were 2 open drinks that belonged to [NAME] A on the preparation table near serving plates and food. During an interview [NAME] A said 2 of the drinks belonged to him. He said he knew not to consume and store his drinks on the preparation counter because of the potential of cross contamination. He said he was busy preparing and serving food and forgot. During an interview on 06/01/2026 at 1:15 p.m., the Dietary Manager said she was responsible for ensuring kitchen staff adhered to all required regulations regarding food safety. She said she expected all kitchen staff, including herself, to wash hands upon entering the kitchen and for paper towels to be at (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the handwashing station so staff could dry their hands. She said she did not know who took the ground meat out of the freezer to thaw. She said the meat was thawing since approximately 6:00 a.m. She said the Administrator intervened and told her to discard the ground meat due to it thawing without water running. She said staff had been educated on thawing meat with running water to ensure meats were held at proper temperatures to prevent food borne illnesses. The Dietary Manager said all staff must wash their hands after adjusting any clothing to prevent cross contamination. She said she expected the walk-in cooler to be clean and free of debris and residue to prevent food borne illnesses and cross contamination. The Dietary Manager said staff should only consume and store drinks at the hydration station to prevent contamination. During an interview with the Administrator on 06/03/2026 at 4:00 p.m., she said her expectations were for staff to wash their hands before and after break, between duties, and upon entering the kitchen. She said she expected staff to know their role and execute it. She said the Dietary Manager was responsible for the staff in the kitchen. The Administrator said she was responsible for making rounds and ensuring they were following regulations. She said she goes to the kitchen every day to watch the serve out process and when the food truck comes in. She said the potential risks of sanitation failures were food borne illness, and cross contamination. Record review of the facility's policy titled Hand Washing/Glove Use Last revised date: 03/2026, indicated: POLICY: Handwashing is necessary to prevent the spread of bacteria that may cause foodborne illnesses. Food and Nutrition Services team members should clean their hands in a handwashing sink or approved handwashing facility. Hands should not be washed in a sink used for food preparation, ware washing, or in a service sink used for the disposal of mop water or similar waste. PROCEDURE 1. Hands and exposed portions of their arms should be kept clean. 5. Frequency of Handwashing: a. Clean hands and exposed portions of arms b. Before engaging in food preparation including working with exposed food, c. Before using clean equipment d. Before handling clean utensils f. After entering the kitchen g. At the beginning of the shift. After returning from break k. After hands have touched bare human body parts other than clean hands (such as face, nose, hair). l. After coughing, sneezing, or blowing your nose, using tobacco products, eating or drinking. Record review of the facility's policy titled Kitchen Sanitation Effective date: 03/2026, indicated: POLICY Equipment should be maintained in a clean, sanitary condition and free from spills, to minimize the risk of cross contamination. PROCEDURE 1. Clean and sanitize food preparation areas and equipment after use. 6. Maintain restrooms with toilet paper, soap and paper towels. 10. Sweep and mop floors including under the shelves routinely. Record review of the facility's policy titled Personnel Guidelines Last revised date: 03/2026, indicated: POLICY: Food and Nutrition Services team members will follow hygiene and sanitary practices to prevent contamination. PROCEDURE 3. Hands and Fingernails a. Wash hands prior to beginning work. b. Wash hands after using the restroom, eating or drinking, using tobacco products, coughing, sneezing, blowing nose, before putting on gloves, after removing gloves, and after engaging in other activities that contaminate the hands. 4. Hair Restraints a. Wear hair restraints that are designed to effectively keep hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service or single-use articles b. Hair restraints may include items such as hair bonnets and nets, beard restraints, and clothing that covers body hair. Hair should be fully covered with hair restraints within the department. Hair coverings should completely restrain hair, should not be worn outside the community and remain clean. 7. Eating and drinking are not permitted in food service, food storage, or preparation areas. Record review for thawing meat facility policy was unavailable due to the facility not providing one.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe, clean and comfortable homelike environment for 1 of 3 halls (Hall 100) and 1 of 22 occupied rooms on Hall 100 (room [ROOM NUMBER]) reviewed for a homelike environment. 1.The facility failed to provide a comfortable home-like living room area at the end of Hall 100 with unbroken end table and chairs without stains. 2.The facility failed to ensure the 2 over bed tables in an occupied resident room (#101) were in good repair and did not have lose trim on 1 over bed table and areas of missing laminate on the other over bed table. The failure could place residents at risk for an uncomfortable, unhomelike environment, and a diminished quality of life. Findings included:During an observation on 06/01/2026 at 9:30 a.m., the living room at the end of Hall 100 had 2 fabric chairs with discolored stained areas on the seat cushion approximately 5 inches on the first chair and the next chair had several 2-inch discolored spots on the seat cushion. In between the 2 chairs was an end table with the front leg leaning to the left at the bottom of the leg.During an observation on 06/01/26 at 9:35 a.m., room [ROOM NUMBER] had an overbed table with lose trim on 1 over bed table and areas of missing laminate on the other over bed table.During an interview on 06/01/2026 at 9:50 a.m., the maintenance supervisor said the chairs needed to be cleaned, and the end table and said the overbed tables needed to be replaced. He said the environment should be free of broken tables to promote safety and overbed tables should have smooth finish to be able to sanitize the surface. He said the end table must have been broken during the past weekend and said it had not been reported to him. He said he attempted to reattach the trim on the overbed table in room [ROOM NUMBER], however he should have replaced both overbed tables. He said he did not notice the other overbed table was worn and missing laminate last week.During an interview on 06/03/2026 at 3:45 p.m., the Administrator said she expected the overbed tables and furniture, to be free of stains and to be in good repair for a safe homelike environment for the residents. She said the furniture should have been reported to maintenance and was not reported. Record Review of the Maintenance Service Policy dated 02/01/2017 indicated Maintenance service shall be provided to all areas of the building, grounds, and equipment.PROCEDURE The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 1.Functions of maintenance personnel include but are not limited to: A. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. B. Maintaining the building in good repair and free from hazards.No policy on homelike environment was provided.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who need respiratory care were provided with such care, consistent with professional standards of practice for 1 of 25 residents (Resident #5) reviewed for respiratory care. The facility did not ensure Resident #5's oxygen concentrator was set at 3 LPM on 06/02/26 at 8:43 a.m. as ordered. This failure could place residents who required respiratory care at risk of not receiving proper care and treatment and decreased quality of life. Findings included:Record review of the admission record indicated Resident #5 was admitted on [DATE] and was [AGE] years old with diagnoses of chronic obstructive pulmonary disease (a disease which makes it hard to breathe in and out) and high blood pressure. Record review of physician orders dated May 2026 indicated Resident #5 had an order for oxygen at 3 LPM per concentration via nasal cannula continuous. Record review of care plan dated 03/06/2026 indicated Resident #5 had oxygen therapy related to COPD (Chronic Obstructive Pulmonary Disease), shortness of breath, Hypoxia (body's tissues do not receive an adequate supply oxygen), respiratory failure (occurs when respiratory system cannot adequately supply oxygen or remove carbon dioxide), pulmonary hypertension (high blood pressure which affects the arteries in the lungs).During an observation on 06/02/2026 at 8:43 a.m., Resident #5 was in her bed and was receiving oxygen and the concentrator was set on 5 LPM. During an interview and observation on 06/02/2026 at 8:53 a.m., LVN F checked the physician's orders and said the oxygen was ordered at 3 LPM per concentrator for Resident #5. LVN F walked down the hall to Resident #5's room and said this concentrator should not be on 5 LPM. Resident #5 said a nurse came in at night and turned the knob; however, she did not know who she was. Resident #5 said she felt ok. LVN F said for residents with COPD; too much oxygen can cause respiratory issues. LVN F checked Resident #5 O2 saturation and it was 99 % and LVN F said she would report the concentrator being on the wrong setting to the physician, family and DON. During an interview on 06/03/2026 at 1:00 p.m., the DON said her expectation was for the nurses to follow the physician's orders. The DON said the nurses are to check the concentrator at least daily however when the nurse enters room with resident on concentrator they were to check concentrators. DON said to much oxygen can slow respiratory rate.During an interview on 06/03/2026 at 3:45 p.m., the Administrator said she expected the nurses to follow the physician's orders or call the physician for new orders. She said the DON was responsible for the nurses to follow physician orders. She said maybe we should monitor closer in case the resident is changing concentrator. Record review of the Oxygen Therapy policy dated 04/2021 indicated It is the policy of this community to ensure all oxygen administration is conducted in a safe manner. Procedure 1. Verify there is an order for Oxygen administration to include: a. Method of Delivery b. Flow rate.		