STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676204	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Road Baytown, TX 77521

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately consult with the resident's physician and resident's representative when there was a deterioration in the resident's physical and mental status for 1 of 1 CR (CR #1). The facility failed to notify the resident's physician and the resident's representative of CR #1's restless nighttime behavior with repeated attempts to get out of bed and crawl onto the floor, and the need for a mattress on the floor for CR#1 to sleep on. This failure could place residents at risk of not receiving adequate and timely intervention and a decline in condition. Record review of CR#1's admission record dated [DATE] revealed a [AGE] year old female, admitted [DATE] and discharged [DATE] to the hospital, with diagnoses that included peripheral vascular disease (a slow and progressive disorder of the blood vessels), heart failure (a condition in which the heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen), aphasia (primarily a language disorder that affects an individual's ability to communicate effectively and lead to difficulties in speaking, understanding, reading, and writing), type 2 diabetes mellitus (a chronic disease that is characterized by high levels of sugar in the blood.), hemiplegia (a condition where one side of the body experiences paralysis or weakness due to damage to the brain or spinal cord), cerebral infarction (most common type of stroke. It occurs when a blood vessel in the brain becomes blocked, cutting off oxygen supply to brain tissue), and end stage renal disease (a condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). Record review of CR#1'S MDS, dated [DATE], revealed a BIMS score of 00, indicating severe cognitive impairment.Record review of CR#1's Baseline Careplan Section C, behavioral concerns was blank.Record review of CR#1's electronic medical record in the miscellaneous document section, revealed a document titled MPOA-Designation of Healthcare Agent, dated and notarized on [DATE]. The MPOA listed FM E as the first agent, and FM F as the second agent. Record review of CR#1's admission summary, written by RN A, with effective date of [DATE], revealed CR#1 was awake, alert, oriented x 1, uncooperative and combative. Record review of an addendum to CR#1's admission summary written by RN A, dated [DATE] at 1:03 p.m., revealed a mattress was left on the floor at bedside in CR#1's room because CR# 1 would not stay in bed, was observed sleeping on the mattress on the floor, and other interactions indicated CR#1 was content lying on the mattress that was on the floor. Record review of CR#1's blood sugar log, dated [DATE] at 7:48 a.m. and recorded by LVN B, revealed CR#'1's blood sugar was 124 mg/dL, and at 11:06 a.m. was 141 mg/dL.Record review of CR#1's progress note, dated [DATE] at 8:34 a.m. written by LVN B, revealed the resident remained resting, was compliant with wound care, and denied discomfort. Record review of CR#1's BP and pulse log dated [DATE] recorded by LVN B at 11:11 a.m. revealed CR#1's blood pressure was 121/52 with a pulse of 60 bpm.Record review of CR#1's progress note, dated [DATE] at 11:22 a.m. written by LVN B, revealed resident was resting on the mattress at bedside and was responsive to voice.Record review of CR#1 progress note, dated [DATE] at 12:36 p.m. written by LVN B, revealed CR#1 had a change in condition, was slow to respond, had audible moaning, required CPR, and was transferred to 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676204	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Road Baytown, TX 77521

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency room. CR#1 had a heard rate of 48, and a weak and thready radial pulse. CR#1 blood pressure could not be obtained because the Dinamap (blood pressure machine) was not reading it. During an interview on [DATE] at 6:22 pm, FM F stated she arrived at the facility on [DATE] and observed CR#1 laying on the mattress on the floor. FM F stated she observed CR#1 drooling from the mouth and was present when CR#1 was discharged to the hospital.During an interview on [DATE] at 4:18 p.m., FM E stated he was CR#1'S MPOA. FM E stated he visited CR#1 on [DATE] and left that night. FM E stated CR#1 was sitting up in her wheelchair, smiling, and appeared to be fine. FM E stated FM F called him on [DATE] a little after 12:00 p.m. and stated CR#1 was on the floor. FM E stated that no one from the facility notified him CR#1 was being placed on a mat on the floor. FM E stated that the only problem CR#1 had was that she liked to sit on the edge of the bed. FM E stated that CR#1 would not try to get out of bed by herself. During an interview on [DATE] at 10:21 a.m., LVN B stated she worked at the facility for 1 year and 5 months. LVN B stated that on [DATE], she informed FM E during his visit that CR#1 had trouble sleeping the night before. LVN B stated that was the extent to what she notified FM E. LVN B stated when she arrived at the facility on [DATE] for her day shift, she received report from the night shift nurse assigned to CR#1, RN A, who informed her that that CR#1 was up all night yelling and constantly tried to get out of bed. LVN B stated when she first saw CR#1 during her initial rounds on [DATE] between 7:30 a.m. and 8:00 a.m., CR#1 was on the mattress on the ground and appeared to be resting quietly and did not appear in any distress. LVN B stated at approximately 11:00 a.m. on [DATE], CR#1 was still resting on the mattress on the floor with her eyes closed and her chest rising and falling. LVN B stated CR#1 had no audible moaning. LVN B stated she asked CR#1 if she needed anything for pain, and CR#1 said no. LVN B stated CNA C did not notify her if CR #1 had refused breakfast. LVN B stated she did not ask RN A if she had notified CR#1's physician or her representative about CR#1's overnight behavior and the need for a mattress on the floor. LVN B stated she did not think that CR#1 was able to make her own decisions. LVN B stated she did not know if CR#1 had a MPOA. LVN B stated that CR#1's physician and representative should have been made aware that CR#1's was up all night and slept on the floor. LVN B stated the risk of not notifying appropriate parties for a change in condition or deterioration in the status of a resident included possible missed interventions. During an interview on [DATE] at 11:33 a.m., CNA C stated she had worked at the facility for a couple of months as a CNA. CNA C stated she cared for CR#1 for the first time on [DATE] during her shift of 6:00 a.m. to 2 p.m. CNA C stated that she first saw CR #1 during her initial rounds in the 6:00 o'clock hour and CR#1 was okay and breathing. CNA C stated she later delivered CR#1's breakfast tray. CNA C stated that she got on the floor to check on CR #1 who appeared to still be asleep. CNA stated that CR#1 looked okay. She was normal, not someone who was having a problem. She was breathing and she looked calm looking. CNA C stated she placed the breakfast tray on the nightstand inside CR#1's room and notified LVN B the tray was left on the nightstand for CR#1. CNA C stated that LVN B instructed her to leave the tray in the room and let CR #1 sleep. CNA C stated that she checked on CR#1 at least 3-5 times before lunch. CNA C stated she bent down to check on CR#1 and watched CR#1's chest rise and fall, since CR#1 was still asleep on the floor.During an interview on [DATE] at 11:56 a.m., the ADON stated she had worked at the facility for about one month. The ADON stated the only issue she heard about CR#1 was that she was trying to get out of the bed into her wheelchair during the day. The ADON stated that she became aware on [DATE] that night staff had difficulty with CR#1. The ADON stated the physician, and the family should have been notified about CR#1's nighttime behavior, aggressiveness, and about CR#1 sleeping on the floor on a mattress. The ADON stated the expectation for nurses was to notify the family, administration, or the physician regarding aggressiveness and inability to sleep. The ADON stated that the physician could have helped by ordering medication or another intervention. The ADON stated that the risk of not notifying appropriate parties of resident changes or deterioration could lead to hospitalization or death. During an interview on [DATE] at 12:31 p.m., RN D stated that she had worked at the facility since [DATE]. RN D stated that the was not directly caring for CR#1. RN D (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676204	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Road Baytown, TX 77521

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated on [DATE], FM E who was the MPOA of CR#1 asked RN D why did not the facility notify him that CR#1 slept on a floor the night before. RN D stated FM E stated if he were notified of CR#1's behavior that led to her sleeping on the floor, he would have returned to the facility to check on CR#1. RN D stated that she would notify a resident's representative when there for any change in condition, not just for emergencies. RN D stated that she would have expected the family to have been notified if a resident was sleeping on the floor or had behavior that kept them from sleeping. RN D stated the risk of not notifying appropriate parties in a change in condition or a deterioration in status included no new orders.During a telephone interview attempt on [DATE] at 1:15 p.m., a phone call was placed to RN A but RN A did not answer. The Surveyor left a voicemail that explained purpose of call with a request to return the call. RN A did not call the Surveyor back as of exit date from facility. During an interview on [DATE] at 1:23 p.m., the DON stated that she had worked at the facility for about 9 months. The DON stated she was not familiar with CR#1 who had been discharged to the hospital. The DON stated she had not worked in the facility during the days that CR#1 was an active resident. The DON stated that a reasonable nurse would have notified CR#1's family and physician for help with CR#1's behavior. The DON stated that her expectation for nurses was to notify the family of CR#1 if the behavior of CR#1 was bad enough to put a mattress on the floor. The DON stated that the risk to residents of not communicating deterioration of resident's behavior or a change in condition was missed communication and lack of care. During a telephone interview on [DATE] at 2:39 p.m., CNA G stated was the CNA that cared for CR#1 on the night of [DATE]. CNA G stated that CR#1 was a difficult resident, refused care, and would not stay on the bed. CNA G stated that CR#1would crawl down from the bed onto the floor where she would be restless, and was constantly tried to move around. CNA G CNA G stated the idea of the mattress on the floor was for CR#1 not to land hard on the floor. CNA G stated that CR#1's nurse was fully aware of CR#1's behavior and the mattress on the floor.During an interview on [DATE] at 4:25 p.m., the Administrator stated from his understanding CR#1 kept trying to get out of the bed by herself. The Administrator stated that the CR#1 displayed real time changes. The Administrator stated that prior to the night of [DATE] and morning of [DATE], CR#1 had not slept on the floor on a mattress. The Administrator stated that on [DATE] LVN B informed the family that CR#1 had trouble sleeping. The Administrator stated that LVN B did not inform the physician or the MPOA of CR#1's inability to sleep the night of [DATE] nor of her yelling throughout the night, nor that CR#1 slept on the floor. Record review of facility policy titled, Resident Rights, dated 2001 and revised in December of 2016, revealed, .these rights include the resident's rights to.be treated with respect, kindness, and dignity.be notified of his or her medication condition and of any changes in his or her condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676204	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Road Baytown, TX 77521

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of the resident for 1 (CR#1) of 1 resident reviewed for baseline care plans. The facility failed to provide the CR#1's representative with a summary copy of the baseline care plan. The facility failed to incorporate CR#1's sleeping preferences in the baseline care plan. This failure could result in residents not receiving inadequate care or having their needs met. Record review of CR#1's admission record dated 4/21/2026 revealed a [AGE] year old female, admitted [DATE] and discharged [DATE] to the hospital , with diagnoses that included peripheral vascular disease (a slow and progressive disorder of the blood vessels), heart failure (a condition in which the heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen), aphasia (primarily a language disorder that affects an individual's ability to communicate effectively and lead to difficulties in speaking, understanding, reading, and writing), type 2 diabetes mellitus (a chronic disease that is characterized by high levels of sugar in the blood.), hemiplegia (a condition where one side of the body experiences paralysis or weakness due to damage to the brain or spinal cord), cerebral infarction (most common type of stroke. It occurs when a blood vessel in the brain becomes blocked, cutting off oxygen supply to brain tissue), and end stage renal disease (a condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). Record review of CR#1'S MDS, dated [DATE], revealed a BIMS score of 00, indicating severe cognitive impairment.Record review of CR#1's electronic medical record in the miscellaneous document section revealed a document titled MPOA- Designation of Healthcare Agent dated and notarized on 4/3/2025. The MPOA listed FM E as the first agent, and FM F as the second agent.Record review of CR#1's baseline care plan section 1 part I, signed by the ADON and dated 4/17/2026, revealed no comments under section 1 part I of additional comments or preferences. During an interview on 4/21/2026 at 4:18 p.m., FM E stated he was CR#1'S MPOA. FM E stated that CR#1 did not like to lay down flat but preferred to sit up right to sleep. FM E stated that CR#1 could verbalize yes or no to questions. FM E stated he did not receive a summary copy of CR#1's baseline care plan. During an interview on 4/22/2026 at 1:23 p.m., the DON stated that baseline care plans should be completed with a resident's representative if they have one or if the resident was cognitively impaired. The DON stated that the risks to residents of not including resident's preferences and not giving a copy to the resident's representative of the baseline care plan could lead to missed communication, and a lack of care. During an interview on 4/22/2026 at 4:25 p.m., the Administrator stated a summary copy of the baseline care plan would be given to the resident or a resident's representative if requested. The Administrator then stated that the facility should have included CR#1's representative in the baseline care plan creation, and that a summary should have been given to CR#'1's representative per facility policy.Record review of facility policy titled Baseline Care Plan effective 11/01/2019 reads in part.The facility must provide the resident and their representative with a summary of the baseline care plan to include the minimum: Resident initial goals, a summary of medications and dietary instructions, any services and treatments administered by the facility and personnel acting on behalf of the facility such as therapy or psych services, information to properly care for the resident upon admission, address specific health and safety concerns.