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	06/18/2026

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

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to transmit accurate, encoded, complete MDS assessments to the CMS system within 14 days of admission for 1 of 17 residents records reviewed for MDS transmission (Residents # 68).The facility failed to ensure that CR 68's admission MDS dated [DATE] was completed within 14 days of admission.This failure put residents at risk of not having their assessments completed timely which could result in denial of services or denial of payment for services. Findings included:Record review of CR #68's face sheet dated 02/06/26 revealed CR #68 was admitted to the facility on [DATE]. Her diagnoses included fracture of right femur, malignant neoplasm unspecified female breast (Breast cancer) diabetes mellitus (body inability to process glucose), dementia, essential hypertension (high blood pressure), major depressive disorder, and muscle weakness.Record review of CR #26's admission MDS dated with ARD date of 02/12/26 revealed the admission MDS was signed as completed on 02/26/26 which was 20 days after admission. Interview with the MDS Coordinator on 6/18/26 at 10:00 AM., She said she was new to the position during the time of the MDS and she was in the process of doing new admission and trying to meet up with the workload. She said Late MDS assessment may result in late care plans and delay services as well as the facility's billing process. In an interview with the DON on 06/18/26 at 3:00pm, she said she was new to the facility she was a month. Record review of the facility's provided policy on resident assessment, dated 01/20/21 revised 04/25/21 did not address completing the MDS in a timely manner.During an interview with the facility Administrator on 06/18/26 at 3:40pm, he said that was what the facility had. revealed Policy: Section: Resident Assessment Policy: Comprehensive Care Planthe policy did not addressed Resident's assessment and completion.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 (Resident #22) of 6 residents reviewed for accuracy of assessments.The facility failed to accurately complete the MDS assessment to indicate Resident #22 did not receive insulin. This failure could place the residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Record review of Resident #22's face sheet dated 6/18/2026 revealed she was admitted into the facility originally on 11/16/2018 and readmitted on [DATE] with diagnoses that included Parkinsonism (an umbrella term that refers to conditions with similar, movement-related effects). unspecified diastolic congestive heart failure (when the heart muscle is too stiff to relax and fill properly with blood between beats), unspecified atrial fibrillation (an irregular and chaotic heartbeat.), and obesity (an unhealthy, excessive amount of body fat that increases the risk of other health problems). Record review of Resident #22's MDS assessment completed on 4/10/2026 revealed in section N- Medication, Resident #22 was coded to have received one insulin injection during the last 7 days or since admission/entry or reentry if less than 7 days. Record review of Residents #22 order summary dated 6/18/2026 and medication administration record date 6/18/2026 for the month of June 2026, did not reveal any current or discontinued insulin orders. During an interview on 6/17/2026 at 3:58 pm, the MDS coordinator stated that Ozempic is considered insulin and was the reason Resident #22 was coded as receiving insulin within the last 7 days on her most recent MDS assessment. The MDS coordinator stated that Ozempic lowered blood sugar, was GLP-1 receptor agonist, and was an injection. The MDS coordinator stated she would double check on Ozempic's drug classification.During an interview on 6/17/2018 at 4:00 pm, the MDS coordinator stated that Ozempic is not considered insulin and she would do a modification MDS immediately.During an interview on 6/18/2026 at 2:45 pm, the MDS coordinator stated that she was employed at the facility since December 2025. The MDS coordinator stated that her training included 1-2 weeks with the Regional Director of Clinical Reimbursement (RDCI) onsite at the facility. The MDS coordinator stated that she used a drug manual as a resource for completing part N- Medication on MDS assessments. The MDS coordinator stated that the RDCI is also a resource she could utilize. The MDS coordinator stated she incorrectly coded Ozempic as insulin. The MDS Coordinator stated that Resident #22's incorrect coding was an isolated discrepancy. The MDS coordinator stated that the corporate reimbursement does audits of her MDS assessments. The MDS coordinator stated that the risk to residents of not coding MDS assessments correctly could lead to inaccurate development of the care plan.During an interview on 6/18/2026 at 12:00 p.m., the ADON stated she was responsible for opening a MDS assessment for new residents but was not involved in coding medications in section N. During an interview on 6/18/2026 at approximately 2:34 pm, the DON stated that she does not complete any part of the MDS assessment and only served to provide clinical input as needed.During an interview on 6/18/2026 at 2:42, the RDCI stated he had worked for the facility for one year. The RDCI stated that Ozempic is not insulin. The RDCI stated that MDS coordinator should look up a medication if not sure what classification it fell under. The RDCI stated that there is a resource in PCC the MDS coordinator could utilize. The RDCI stated there had not been any specific training performed on Ozempic's classification for the MDS coordinator. The RDCI states that he visits the facility at least once every 2 weeks. The RDCI stated that the risk of coding medication incorrectly depended on why a resident received it. During an interview on 6/18/2026 at 3:00 p.m., the Administrator stated he was not involved with completing MDS assessments. The Administrator stated his involvement was limited to ensuring MDS assessments were completed and submitted in a timely manner.Record review of facility policy titled Resident Assessment: Comprehensive Care Plan effective 1/20/2021 and revised on 4/25/2021 reads in part. The Interdisciplinary Team will continue to develop the plan in conjunction with the RAI (MDS3.0) and (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CAAS.Record review of the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual effective October 1, 2025, reads in part on page 481. Code medications in Item N0415 according to the medication's therapeutic category and/or pharmacological classification, not how it used. Record review of the FDA's Drug Approval and Database, Ozempic's medication guide dated 10/14/2025 revealed Ozempic is a glucagon-like peptide receptor agonist.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 its medication error rate was not greater than 5 percent or greater. The facility had a medication error rate of 16.67% based on 5 errors and 30 opportunities which involved 3 of 4 residents (Resident #71, Resident #62, and Resident #11) reviewed for medication administration.1.RN A failed to administer 3 medications separately through Resident #71's gastrostomy tube (G-tube). 2.RN A failed to flush in between administering medications through Resident #11's G-tube. 3.RN B failed to administer the correct order of Senna oral tablet 8.6 mg to Resident #62.RN B administered Senna Plus 50 mg to Resident #62. These failures could place residents at risk of increased hospitalization, adverse side effects, and a decline in health. Record review of Resident #71's face sheet dated 6/17/2026 revealed a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Cerebral Infarction (the most common type of stroke which occurs when a blood vessel in the brain becomes blocked, cutting off oxygen supply to brain tissue), Gastrostomy Status (the presence of a Gastrostomy tube), and Aphasia (primarily a language disorder that affects an individual's ability to communicate effectively and lead to difficulties in speaking, understanding, reading, and writing). Record review of Resident #62 face sheet dated 6/17/2026 revealed a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Acquired Hemolytic Anemia (a condition where your body doesn't have enough healthy red blood cells), 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), Anxiety Disorder (a type of mental health condition where a person experiences excessive, persistent fear, worry, or nervousness that is harder to control than normal anxiety and can interfere with daily life), Discoid Lupus Erythematosus (a long-lasting skin condition that causes round, coin-shaped patches of skin to become red, scaly, and sometimes raised), and Type 2 Diabetes Mellitus (a chronic disease that is characterized by high levels of sugar in the blood).Record review of Resident #11's face sheet dated 6/17/2026 revealed a [AGE] year old female admitted to the facility initially on 12/30/2023 and readmitted on [DATE] with diagnoses that included unspecified sequelae of cerebral infarction(long-term effects that remain after a person has had a stroke caused by a blockage in a brain artery), Dysarthria following cerebral infarction (speech problem that happens when part of the brain that controls speech gets damaged by a stroke), aphasia (primarily a language disorder that affects an individual's ability to communicate effectively and lead to difficulties in speaking, understanding, reading, and writing), and gastrostomy status (the presence of a Gastrostomy tube). Record review of Resident #71's order summary dated 6/17/2026 revealed the following active orders :1.Do not cocktail medications. Order date 6/6/2023 with a start date of 6/6/2023.2.Give 5-10 cc of water between each medication. Order date 6/6/2023 with a start date of 6/6/2023.3. Amlodipine 5 mg. Give one tablet via G-tube one time a day. Hold if SBP <100; DBP <60. 4. Propranolol hydrochloride 40 mg. Give one tablet three times a day for HTN. Hold for SBP<100 or DBP <60 or HR <55.5. Multivitamin tablet. Give one tablet via G-tube one time a day for supplement. Record review of Resident #62's order summary dated 6/17/2018 revealed the following active order:1.Senna Oral Tablet 8.6 mg. Give one tablet by mouth two times a day for constipation with a start date of 9/7/2022. Record review of Resident #11's order summary dated 6/17/2018 revealed the following active orders:1.Sucralfate oral suspension 1gm/10 ml- Give 10 ml via G-tube every 6 hours for stomach ulcers with a start date of 2/19/2026. 2.Lactulose oral solution 10gm/15ml (Lactulose) Give 60 ml via G-tube four times a day for elevated ammonia level with a start date of 2/20/2026. During an observation on 6/17/2026 at 8:40 a.m., RN A was observed as she prepared to administer medications to Resident #71. RN A placed one Multivitamin 1 tablet, one Amlodipine 5 mg tablet (lowers blood pressure), one Propranolol hydrochloride 40 mg tablet (lowers blood pressure and heart (continued on next page)

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	676204	A. Building B. Wing	06/18/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rate) inside a plastic medication crushing pouch and crushed the 3 tablets together. RN A poured the crushed medications into one medication cup and entered Resident #71's room. RN A entered Resident #71's room and informed him she was going to administer his medications. RN A placed the medication cup with crushed meds on Resident #71's bedside table and poured water into the medication cup. RN A aspirated the contents of the medication cup into a 60 ml syringe, stopped the current tube feeding that was in progress, and administered the 3 medications together through Resident #71's G-tube. During an observation on 6/17/2026 at 9:02 a.m., RN B was observed as she prepared to administer medications to Resident #62. RN B removed from one tablet of Senna Plus 50 mg and placed it into a medication cup. RN B was then observed handing the medication cup to Resident #62 who swallowed the tablet.During an observation on 6/17/2026 at 1:00 pm, RN A was observed as she prepared to administer medication to Resident # 11. RN A entered Resident #11's room with three medication cups. One cup had 10 ml of Sucralfate oral suspension 1gm/10 ml, and the other 2 cups had 30 ml each of Lactulose oral solution 10gm/15 ml. RN A put on PPE, informed Resident #11 she was going to administer medication, raised the bed, inspected the G-tube site, stopped the feeding that was in progress, and flushed the G-tube with 30 ml of water. RN A administered 60 ml of Lactulose 60 ml followed by 10 ml of Sucralfate. RN flushed 30 ml of water after administration of Sucralfate and resumed the tube feeding. During an interview on 6/17/2026 at approximately 8:55 a.m., RN A stated she had been employed at the facility since February 2026. RN A stated she the facility had educated her on G-tube medication administration. RN A stated her opinion of do not cocktail medication meant not to mix medication solutions. RN A stated she was aware that she should have flushed in between administrations of medications and administered each medication separately for Resident #71. RN A stated she felt there would have been too many flushes of water for Resident #71. RN A stated she had never taken her concerns to the DON or Resident #71's physician. RN A stated that nursing judgement should be used. RN A stated the risk to residents of administering multiple crushed medications simultaneously through a G-tube was drug incompatibility.During an interview on 6/17/2026 at 11:55 a.m., RN B was asked to show surveyor the bottle of Senna that Resident #62 received earlier that morning. RN B opened her medication cart and retrieved a bottle of Senna Plus 50 mg tablets. Surveyor asked RN B if that was the correct order for Resident #62. RN B looked at Resident #62's medication order and stated it was not. RN B stated that Resident #62 should have received one Senna 8.6 mg tablet. RN B agreed that the difference between the two Senna medications was that Senna Plus 50 mg included docusate sodium. RN B stated she had made a mistake. RN B stated that she had been trained on medication administration. RN B stated that the risk of administering incorrect medication to a resident includes adverse drug effects. During an interview on 6/17/2026 at 1:15 pm, RN A stated she should have flushed in between the medications she had administered to resident #11. RN A stated the facility had trained her in medication administration through a G-tube. RN A stated that the risk of not flushing in between medications was drug incompatibility, and adverse effects. During an interview on 6/18/2026 at 12:00 p.m., the ADON stated she has been employed by the facility since March 2026. The ADON stated that cocktailing medication is not allowed at the facility per policy. The ADON stated that cocktailing medication meant mixing medication together and administering to a resident. The ADON stated that nurses should be flushing the G-tube in between medication administrations. The ADON stated that nurses and medication aides had been trained in medication administration and should always use medication rights when administering medication. The ADON stated that nurses had been trained in medication administration through a G-tube. The ADON stated that risk to residents of not following facility policy when administering medication through a G-tube included a clogged G-tube and hospitalization. During an interview on 6/18/2026 at 2:34 pm, the DON stated nurses should be flushing in between administering medication through a feeding tube and should never mix medication. The DON stated nurses and med aides should always be referring to the foundational medication rights when administering medication and facility policy The DON stated that nurses and medication (continued on next page)

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	676204	A. Building B. Wing	06/18/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aides had been trained in medication administration and should always use medication rights when administering medication The DON stated nurses had been trained in medication administration through a G-tube The DON stated the risk to residents of not following facility policy for medication administration could lead to resident harm and adverse effects. During an interview on 6/18/2026 at 3:00 p.m., the Administrator stated that all nurses and med aides should be using the medication rights for administration. The Administrator stated he was not aware of the clinical steps of administering medication through a gastrostomy tube. The Administrator stated the risk to residents of not receiving the correct medication was adverse health effects. Record review of facility policy titled General Guidelines for Administering Medication via Enteral Tube with an effective date of 9/2018 and revised 8/2020 reads in part.4. Enteral tubes are flushed with at least 15 ml of purified or sterile water before administering medications between each medication, and after all medications have administered. 5. Crushed medications are not mixed. 6. Each medication is administered separately to avoid interaction and clumping. The enteral tubing is flushed with at least 15 ml of water between each medication to avoid physical interaction of the medications. Record review of facility policy titled General Guidelines for Medication Administration with an effective date of 9/2018 and revised in 8/2020 reads in part.4. At a minimum, the 5 rights-right resident, right drug, right dose, right route, and right time should be applied to all medication administration and reviewed at three steps in the process of preparation: when the medication is selected, when the dose is removed from the container, and after the dose is prepared and the medication is put away.

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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 failed to 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 communicate disease and infections for 2 of 4 residents reviewed for infection control. RN A failed to utilize PPE prior to administering medication to Resident #71 through a gastrostomy tube.RN B failed to use clean technique while preparing medication for Resident # 62 by placing a medication capsule into her left hand before placing the capsule into a medication cup.RN B failed to perform hand hygiene after administering medication and exiting Resident #62's room. This failure could place residents at risk by exposing them to care that could lead to the spread of infection and communicable diseases.Record review of Resident #71's face sheet dated 6/17/2026 revealed a [AGE] year old male originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Cerebral Infarction (the most common type of stroke which occurs when a blood vessel in the brain becomes blocked, cutting off oxygen supply to brain tissue), Gastrostomy Status (the presence of a Gastrostomy tube), and Aphasia (primarily a language disorder that affects an individual's ability to communicate effectively and lead to difficulties in speaking, understanding, reading, and writing). Record review of Resident #71 order summary dated 6/17/20126 revealed Resident #71 had an active order for Enhanced Barrier Precautions with a start date of 5/6/2026 due to the presence of a G-tube. Record review of Resident #62 face sheet dated 6/17/2026 revealed a [AGE] year old female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Acquired Hemolytic Anemia (a condition where your body doesn't have enough healthy red blood cells), 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), Anxiety Disorder (a type of mental health condition where a person experiences excessive, persistent fear, worry, or nervousness that is harder to control than normal anxiety and can interfere with daily life), Discoid Lupus Erythematosus (a long-lasting skin condition that causes round, coin-shaped patches of skin to become red, scaly, and sometimes raised), and Type 2 Diabetes Mellitus (a chronic disease that is characterized by high levels of sugar in the blood). During an observation on 6/17/2026 at 8:40 a.m., RN A was observed as she prepared to administer medications to Resident #71. RN A entered Resident #71's room and informed him she was going to administer his medications. Observation revealed a bright orange Enhanced Barrier Precautions laminated poster on the wall directly behind Resident #71's bed. Observation of RN A revealed she stopped the continuous feeding that was in process, lifted Resident #71's gown, grabbed the G-tube extension from Resident #71's abdomen, and attached a syringe for a medication administration flush. Surveyor asked RN A if facility policy required PPE for medication administration through G-tube. RN A stated no, not typically if it is just a G-tube. Survyeor discreetly pointed to EBP poster on wall. RN A stated oh, I better stop what I'm doing right now. RN A proceeded to don PPE retrieved from a 3-drawer plastic cabinet located inside Resident #71's room. During an interview on 6/17/2026 at approximately 8:55 a.m., RN A stated she had been employed at the facility since February 2026. RN A stated she did not receive a full orientation and was placed on the floor the first day of her employment. RN A stated the facility did not educate her on EBP and EBP was a relatively new practice. RN A stated EBP was started one to two months ago. RN A stated if the facility trained her on EBP, she did not remember it. RN A stated she felt nervous and may have missed steps. RN A stated the risk to residents of not following EBP included cross contamination and infection. During an observation on 6/17/2026 at 9:02 a.m., RN B was observed as she prepared medication for administration to Resident #62. RN B was observed as she removed a medication bottle from her medication cart, poured one capsule into the palm of her left hand, closed the medication bottle, and placed the capsule that was in her left hand into a medication cup. RN B walked into Resident #62's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room with the medication cup she had prepared, and a cup of water. RN B informed Resident #62 it was time to take morning medication. RN B moved the bedside table away from Resident #62's bed and moved closer to Resident #62. RN B handed the medication cup and the cup of water to Resident #62. Afterwards, RN B returned the bedside table to its original position and left Resident #62's room. RN B immediately walked back to her medication cart and began to chart on the laptop without performing hand hygiene. During an interview on 6/17/2026 at approximately 9:10 a.m., RN B stated she had been employed by the facility since February 2026. RN B stated she had been trained in infection control and medication administration. RN B stated had received training on infection control. RN B stated PPE should be used when performing any direct care activity with residents who have wounds, catheters, trach's, or G-tubes. RN B stated that the training she had received included the importance of hand hygiene. RN B stated she should have performed hand hygiene immediately after leaving Resident #62's room. RN B also stated that medication should have never been placed in her bare palm but should have been poured from the medication bottle directly into a medication cup. RN B stated she knew better and realized her mistakes. RN B stated she was nervous while being observed by surveyor. RN B stated the risk to residents when staff do not follow correct infection control practices included cross contamination and infection. During an interview on 6/17/2026 at 11:41 a.m., LVN C stated she had been employed by the facility for four years. LVN C stated she had been trained in infection control which included EBP. LVN C stated that EBP means she would don PPE if she provided any direct care to a resident with a wound, G-tube, central line, or trach. LVN C stated the facility had an in-service regarding EBP on 6/12/2026. LVN C stated for medication administration, she would pour the tablet or capsule directly from it's original container into a medication cup. LVN C stated placing a medication directly into the bare palm would be a break in infection control. LVN C stated if staff did not follow proper infection control measures, the risk to residents could lead to preventable infections.During an interview on 6/17/2026 at approximately 1:00 p.m., CNA D stated when a resident was on EBP, she would put on PPE if she provided any direct care such as providing incontinent care. CNA D stated residents would be placed on EBP if they had wounds, a trach, or devices such as a urinary catheter, or a feeding tube. CNA D stated the risk to residents if staff did not follow EBP could lead to infection. During an interview on 6/18/2026 at 12:00 p.m., the ADON stated she has been employed by the facility since March 2026. The ADON stated she had been enforcing EBP as soon as she arrived at the facility. The ADON stated the most recent staff training on EBP was performed on 6/8/2026. The ADON stated the staff had also been trained on handwashing recently. The ADON stated that any resident who has a foley catheter, trach, or any type of indwelling device, PPE should be donned by staff if providing direct high contact care which included g-tube medication administration. The ADON stated that hand hygiene should be performed after leaving a resident's room. The ADON stated the expectation was for staff to handwash and/or sanitize their hands before and after administering medication. The ADON stated that the expectation for staff was to pour medication into a cup. The ADON stated staff should never put medication in their hands. The ADON stated the risk to residents of not following correct infection control practices could lead to infection.During an interview on 6/18/2026 at 2:34 pm, the DON stated she had been employed at the facility for one month. The DON stated that EBP training for staff had been performed almost weekly and was also addressed during morning meetings. The DON stated during morning meetings she would randomly ask staff members which residents were on EBP and what did that meant for the care being provided. The DON stated the ADON does rounds every morning which included PPE supplies were available for staff. The DON stated that hand hygiene was also addressed in morning meeting with a common phrase repeated of Gel in, Gel out which reminded staff to sanitize their hands before and after they left a resident's room. The DON stated the risk to residents of not following correct infection control procedures would be cross contamination, and the spread of infection. During an interview on 6/18/2026 at 2:52 pm, Med Aide E stated that she had been trained by the facility on EBP. Med Aide E stated if a resident was on EBP, it meant she would (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	need to put on PPE if she provided any direct care such as incontinent care. Med Aide E pointed to an EBP poster that listed activities where PPE would be required to be used. Med Aide E stated that medication should always be poured from the original container into a medication cup. Med Aide E stated the risk to residents of not following EBP could lead to infection and staff taking an infection home with them.During an interview on 6/18/2026 at 3:00 p.m., the Administrator stated that all staff had been educated on EBP by the ADON which included the importance of hand hygiene. The Administrator stated staff who do not follow correct infection control practices placed residents at risk for the spread of infection. Record review of facility policy titled Infection Control: Enhanced Barrier Precautions, effective 4/1/2024, reads in part. EBP are a CDC guidance to reduce the transmission of 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 are infection or colonized with a targeted MDRO or have open wound or 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 above wounds or invasive medical devices are present. 4. High contact resident care activities: device care or use of: feeding tube. Record review of facility policy titled Infection control: Hand Hygiene effective 8/4/2021 and revised 10/24/2022, reads in part. You should always perform hand hygiene: before and after providing any type of care. after contact with medical equipment or other environmental surfaces that may be contaminated. Record review of facility policy titled General Guidelines for Medication Administration, effective 9/2018 and revised on 8/2020, reads in part.'Medications are administered as prescribed in accordance with good nursing principles and practices.