STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455900	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER: Focused Care at Mount Pleasant		STREET ADDRESS, CITY, STATE, ZIP CODE: 1606 Memorial Ave, Mount Pleasant, TX 75455	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44637 Based on interview and record review, the facility failed to ensure the resident had the right to be free from abuse for 1 of 8 (Resident #1) residents reviewed for abuse. The facility failed to protect Resident #1 from verbal and physical abuse from LVN A on 9/26/24 resulting in Resident #1 being pushed by LVN A and falling to the floor. The noncompliance was identified as PNC. The noncompliance began on 9/26/24 and ended on 9/27/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for physical and verbal abuse, psychosocial harm, and decreased quality of life. Findings Include: 1. Record review of the face sheet dated 12/19/24 indicated Resident #1 was a [AGE] year-old male, readmitted to the facility on [DATE] with diagnoses including Alzheimer's, PTSD, difficulty walking, violent behavior, lack of coordination, and cognitive communication deficit (communication difficulty caused by cognitive impairment). Record review of the MDS dated [DATE] indicated Resident # 1 sometimes understood others and was sometimes understood by others. The MDS indicated Resident #1 had a BIMS of 02 and was severely cognitively impaired. The MDS indicated during the 7-day look back period Resident #1 did not have any physical behaviors towards others. The MDS indicated during the 7-day look back period Resident #1 had verbal behaviors directed towards others 1-3 days. The MDS indicated Resident #1 required supervision with transfers and walking. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the care plan last updated 12/5/24 indicated Resident #1 was at risk for falls related to weakness, poor balance, and confusion. The care plan indicated Resident #1 ambulated frequently with poor balance and no sense of safety or purpose. The care plan indicated Resident #1 had an actual fall to the ground on 9/26/24 due to being pushed. The care plan indicated Resident #1 had no injuries noted from his fall on 9/26/24. The care plan indicated Resident #1 had the potential to be physically aggressive related to confusion and delusions with a diagnosis of PTSD which can contribute to anxiety and aggressive behaviors and interventions including provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Record review of an incident report dated 9/26/24 indicated, Upon arrival of this nurse to male secured unit it was reported to this nurse that resident had sustained a witnessed fall observed by CNA reported to administrator. This nurse immediately assessed resident for any post injuries and only noted old yellow bruises on skin check. The incident report indicated Resident #1 did not have any new injuries and no signs or symptoms of pain. Record review of the Morse Fall Scale dated 9/26/24 indicated Resident #1 was at high risk for falling, The Morse Fall Scale indicated Resident #1 had previous falls. The Morse Fall Scale indicated Resident #1 did not use any ambulatory aids. The Morse Fall Scale indicated Resident #1 had a weak gait. Record review of the PIR dated 9/26/24 indicated CNA B reported witnessing LVN A push Resident #1 resulting in Resident #1 falling without injury. The PIR indicated Resident #1 was assessed by the ADON. The PIR indicated the assessment revealed Resident #1 with bruising to his right upper thigh, left lower leg, and reddened area to his right back. The PIR indicated LVN A was suspended on 9/26/24 and terminated on 9/30/24. The PIR indicated wellness checks were performed in the unit, notifications were made, safe surveys were complete, and staff were in-serviced regarding abuse and neglect. During an interview on 12/18/24 at 12:24 p.m. CNA B said she was still employed at the facility. CNA B said she did recall the incident with LVN A pushing Resident #1 resulting in a fall. CNA A said LVN A was heading to the restroom and Resident #1 was standing close to the restroom. CNA B said she heard LVN A tell Resident #1 to move, get out of the way. CNA B said Resident #1 responded saying F*** it, f*** it. CNA B said then she heard LVN A say don't pull out your dick it is non-existent. CNA B said Resident #1 got more upset and then she witnessed LVN A push Resident #1 to the ground. CNA B said when she tried to assist Resident #1 up LVN A told her not to help him up to let him get up on his own. CNA B said she immediately went to the Administrator at the time to report the incident and the Administrator at the time walked LVN A out of the building immediately. During an interview on 12/19/24 at 1:01 p.m. the Administrator said if staff witnessed abuse, she expected them to establish resident safety first and then report the abuse to her or the DON. The Administrator said being the Abuse Coordinator she would expect them to report the abuse to her as soon as possible. The Administrator said if a staff member was accused of abuse, they would be removed from providing care and suspended pending investigation of the allegation. The Administrator said if a resident became aggressive with staff, she expected staff to honor resident safety, re-direct the resident, if possible, step away and reapproach later if needed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Abuse policy last revised 1/1/23 indicated The purpose of this policy is to ensure that each resident had the right to be free from any type of Abuse, Neglect, Intimidation, Involuntary Seclusion/Confinement, and or Misappropriation of property .Residents will not be subjected to abuse by anyone, including, but not limited to community staff, other residents, consultants, volunteers, staff of other agencies serving the residents, family members or legal guardians, care taker, friends, or other individuals . All employees are required to be trained in issues related to abuse prohibition practices . The facility had corrected the noncompliance prior to surveyor entrance by the following: Suspending and Terminating LVN A In-servicing staff regarding abuse and neglect The surveyor confirmed the facility had corrected the non-compliance prior to survey starting by: Record review of the Disciplinary Action Record dated 9/26/24 indicated LVN A was suspended due to failure to refrain from abuse of a resident. Record review of the Disciplinary Action Record dated 9/30/24 indicated LVN was terminated due to failure to refrain from abuse of a resident. Record review of an in-service dated 9/27/24 indicated staff were in-serviced regarding abuse and neglect. Staff interviewed (CNA B, LVN C, CNA D, RN E, LVN F, LVN G, LVN H) on 12/18/24 and 12/19/24 between 9:47 a.m. and 12:29 p.m. were able to name all types of abuse including physical, verbal, sexual, emotional, and misappropriation of property. Staff interviewed said if they witnessed abuse they would intervene and then report it immediately. Staff interviewed said the Administrator was the Abuse Coordinator of the facility. Staff interviewed said if a resident became aggressive towards them, they would stay calm, attempt to redirect the resident, step-away from the resident and reapproach the resident at a later time, attempt to find the resident's trigger, document the behavior, and notify the physician. The noncompliance was identified as PNC. The noncompliance began on 9/26/24 and ended on 9/27/24. The facility had corrected the noncompliance before the survey began.