STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455900	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Mount Pleasant	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 - Some	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** 47708 Based on interviews and record review the facility failed to ensure residents were free from abuse for 5 of 66 residents (Resident #1, #2, #3, #4, and #5) reviewed for resident abuse. The facility did not ensure Resident (Resident #1, #2, #3, #4, and #5) were free from abuse. This failure could place residents at risk of physical harm, mental anguish, or emotional distress. The findings included: 1. Record Review of Resident #1's face sheet dated 2/11/25 at 2:15 p.m., indicated Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of senile degeneration of brain (progressive deterioration of brain tissue and function that occurs beyond what's considered normal aging), Muscle weakness (a lack of muscle strength, meaning the muscles may not contract or move as easily as they used to), Delusional disorders (a psychotic disorder that can make it hard for a person to distinguish between what's real and what's imagined to be true), essential hypertension (high blood pressure). Record Review of Resident #1's MDS assessment dated [DATE] indicated, Resident #1 usually understood others and usually made himself understood. The MDS assessment indicated Resident #1 had a BIMS score of 9, which indicated Resident #1 was moderately impaired. The MDS assessment indicated Resident #1 had behaviors of hitting, kicking, pushing, scratching, grabbing, abusing others sexually that occurred 1 to 3 days. The MDS assessment indicated verbal behavior directed towards others occurred 1 to 3 days (threatening others, screaming at others, cursing at others). The MDS assessment indicated Resident #1's need for assistance with bathing, dressing, using the toilet, or eating was not coded on the MDS assessment. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #1's care plan, dated on 12/26/24, indicated Resident #1 had potential to be physically aggressive when other residents touch him or try to enter his room r/t Dementia and Poor impulse control and takes offense to being redirected. He also is very possessive about his personal belongings and does not like belongings moved or room cleaned. The Care plan interventions included the resident needs his personal space in his room. The resident does not react well to being touched; When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later; The resident's triggers for physical aggression are being touched by other residents or other residents entering his room. The resident's behaviors is de-escalated by removing him to a quiet area. Record Review of Resident #2's face sheet dated 2/11/25 at 2:19 p.m., indicated Resident #2 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of Alzheimer's (progressive disease that destroys memory and other important mental functions), Post-traumatic stress disorder (a mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it), Violent behavior (the intentional use of physical force or power, threatened or actual, against self (suicidal), or another (homicidal) and essential hypertension (high blood pressure). Record Review of Resident #2's MDS assessment dated [DATE] indicated, Resident #2 sometimes understood others and sometimes made himself understood. The MDS assessment indicated Resident #2 had a BIMS score of 2, which indicated Resident #2 was severely impaired. The MDS assessment indicated Resident #2 had no behaviors of hitting, kicking, pushing, scratching, grabbing, abusing others sexually. The MDS assessment indicated verbal behavior directed towards others occurred 1 to 3 days (threatening others, screaming at others, cursing at others). The MDS assessment indicated Resident #2's need for assistance with bathing, dressing, using the toilet, or eating was not coded on the MDS assessment. Record Review of Resident #2's care plan, revised on 1/23/25, indicated Resident #2 had potential to be physically aggressive confusion and delusions. Resists ADL care at times. Dx of PTSD which can contribute to anxiety and aggressive behaviors. The Care plan interventions included, administer medications as ordered; Monitor/document for side effects and effectiveness; analyze times of day, places, circumstances, triggers, and what deescalates behavior and document and assess and address for contributing sensory deficits. Record Review of facility incident report titled Physical aggression initiated, dated on 1/5/25 at 2:04 p.m., revealed, Resident sitting at dining room table eating breakfast when another resident begins touching his napkin resident started cursing loudly and slapping resident in the face. This nurse intervened and got in between residents. Resident #1 then stood up grabbed a cup off his tray striking other resident in the head. This Nurse separated the residents to de-escalate the situation. Resident #1 in room. No Injuries noted. During an interview on 2/10/25 at 10:34 a.m., Resident #1 stated he did not remember this incident. Resident #1 stated, I don't see any damage on my hands. Resident #1 stated, I try not to let things bother me too long. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/10/25 12:44 p.m., LVN A stated she had been employed at the facility for one year and worked part time at the facility. LVN A stated she worked all shifts. LVN A stated at the time of this incident t she was serving breakfast and both residents (Resident #2) and (Resident #1) were sitting next to each other. LVN A stated Resident #2 fidgeted a lot, and Resident #2 was messing with Resident #1's napkins on his tray. LVN A stated Resident #1 yelled at Resident #2 to stop messing with his napkins. LVN A stated she did not feel like Resident #2 understood what was going on. LVN A stated Resident #2 starting cursing at Resident #1. LVN A stated while she was in between the two-resident trying to console Resident #2 , Resident #1 had stood up Resident #1 had swung a cup over her body and hit Resident #2 in the head. LVN A stated there were no injuries from either resident. LVN A stated she reported this incident to the DON, the provider, both families of the residents and the Administrator. LVN A stated she believe this incident happened on a Sunday (1/5/25) in the dining room. LVN A stated abuse and neglect in-services was completed following this incident. LVN A stated Resident #1 was placed on 15 minute checks until he was picked up by EMS to a behavior hospital. LVN A stated the police was notified. During an interview on 2/10/25 at 1:36 p.m. The Administrator stated she tried to keep the residents (Resident #1 and Resident #2) at a distance. The Administrator stated Resident #1 hit Resident #2 in the head with his plastic cups because he was Resident #1's napkins on his tray. The Administrator stated Resident #2 was very anxious and very fidgety. The Administrator stated Resident #2 was passed away unrelated to this incident. The Administrator stated there were no injuries to either resident. The Administrator stated police was not notified of this incident. 2. Record Review of Resident #3's face sheet dated 2/11/25 at 2:21 p.m., indicated Resident #3 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of senile degeneration of brain (progressive deterioration of brain tissue and function that occurs beyond what's considered normal aging), Bipolar (a disorder associated with episodes of mood swings ranging from depression lows to manic highs), Muscle weakness (a lack of muscle strength, meaning the muscles may not contract or move as easily as they used to), essential hypertension (high blood pressure). Record Review of Resident #3's MDS assessment dated [DATE] indicated, Resident #3 understood others and made himself understood. The MDS assessment indicated Resident #3 had a BIMS score of 11, which indicated Resident #3 was moderately impaired. The MDS assessment indicated Resident #3 had behaviors of hitting, kicking, pushing, scratching, grabbing, abusing others sexually that occurred 1 to 3 days. The MDS assessment indicated Resident #3 had no verbal behavior directed towards others which included (threatening others, screaming at others, cursing at others). The MDS assessment indicated Resident #3's need for assistance with bathing, dressing, using the toilet, or eating was not coded on the MDS assessment. Record Review of Resident #3's care plan, revised on 10/18/24, indicated Resident #3 was on antipsychotic medication Schizophrenia and Bipolar disorder placing him at increased risk for adverse behaviors, delusions, self-isolation, and adverse medication side effects. The Care plan interventions included, administer medications as ordered; Educate resident/family regarding medication risks and benefits; Monitor/record occurrence of targeted behavior and document per protocol; Pharmacy and physician to review resident's medication profile for continuing usage monthly and obtain consent from resident or RP prior to medication use. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #4's face sheet dated 2/11/25 at 2:23 p.m., indicated Resident #4 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses Alzheimer's (progressive disease that destroys memory and other important mental functions), osteoarthritis (degeneration of joint cartilage and the underlying bone), Anxiety disorder (any of a broad range of disorders characterized by a continuous state of anxiety or fear, lasting at least a month, generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities) and Muscle weakness (a lack of muscle strength, meaning the muscles may not contract or move as easily as they used to). Record Review of Resident #4's MDS assessment dated [DATE] indicated, Resident #4 sometimes understood others and sometimes made himself understood. The MDS assessment indicated Resident #4 BIMS was not coded. The MDS assessment indicated Resident #4 had behaviors of hitting, kicking, pushing, scratching, grabbing, abusing others sexually that occurred 1 to 3 days. The MDS assessment indicated verbal behavior directed towards others occurred 1 to 3 days (threatening others, screaming at others, cursing at others). The MDS assessment indicated Resident #1's need for assistance with bathing, dressing, using the toilet, or eating was not coded on the MDS assessment. Record Review of Resident #4's care plan, revised on 3/17/24, indicated Resident #4 had potential to be verbally and physically aggressive agitation, poor impulse control and protective of personal space/room. The Care plan interventions included, administer medications as ordered. Monitor/document for side effects and effectiveness Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document; Monitor behaviors and document observed behavior and attempted interventions; Assess resident's coping skills and support system; Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. and Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Record Review of progress note dated 10/24/24 at 12:25 p.m., indicated, This nurse walked out of the med room on the men's secured unit and witnessed Resident#4 hit another Resident #3 with his fist in the left cheek. Resident #4 and another resident were in Resident #3's room and Resident #4 was pulling on Resident #3's clothes and thought he was in his own room. No aggression was noted towards Resident #4 by Resident #3. Resident #4 and the other resident were redirected out of Resident 3's room without further incident. Small. reddened area noted to Resident #3's left cheek, no swelling at this time. Neuros started, pain and head to toe assessment completed on resident. PCP/DON notified. During an interview on 2/10/25 at 2:14 p.m., Resident #3 stated he did not remember this incident. Resident #3 stated he felt safe. Resident #3 stated he was doing okay. During an interview on 2/10/25 at 2:16 p.m., Resident #4 stated, I was just laying down. Resident #4 repeated again, I was laying down to the surveyor multiple times. Resident #4 did not answer any questions from the Surveyor. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/10/25 at 2:50 p.m., LVN B stated she had been the charge nurse since October of 2024. LVN B stated she worked PRN at the facility. LVN B stated when she walked out of the med room on the secured unit something caught her attention on the hall. LVN B stated Resident #3 was at the doorway of his room. LVN B stated she saw a fist hit come through the doorway striking Resident #3 in the cheek. LVN B stated Resident #4 and Resident #6 was standing in the doorway of Resident #3 room. LVN B stated Resident #4 was putting on Resident #3's clothes in Resident #3 room. LVN B stated Resident #4 thought that Resident #3's room was his room because at one time that was his room. LVN B stated she asked what happened to both residents. LVN B stated Resident #3 said the two residents (add identifiers) was in his room, and he told them to get out. LVN B stated Resident #4 hit Resident #3. LVN B stated she separated the two residents. LVN B stated both residents were compliant. LVN B stated she notified the doctor, DON, and the Administrator. LVN B stated neither resident had any injuries. LVN B stated you can tell Resident #3 was hit because he had a little bit of red on his left cheek. LVN B stated the police was not notified. During an interview on 2/12/25 at 10:06 a.m., The Administrator stated Resident#4 went into Resident# 3's room rummaging through Resident #3's clothes. Resident#4 did not understand it was not his room. Resident#3 tried to get Resident #4 to leave, the nurse was moving towards them to intervene and saw Resident#4 strike Resident#3 on the cheek. The Administrator stated LVN B was a witness to this incident. The Administrator stated LVN B reported this incident to her. The Administrator stated the police was called and notified of incident. The Administrator stated the police declined onsite visit after description of incident. The Administrator stated the reason why this incident happened was due to cognitively impaired resident mistook the closet for his own. The Administrator stated, GDR meetings were discussed in weekly SOC and then monthly QAPI and all residents on anti-psychotic medications are reviewed in the GDR, most recently 2/4/25. The Administrator stated there was no injuries from either resident. The Administrator stated the interventions that were put in place after this resident-to-resident altercation, The closets that should not be available to all have been secured. The Administrator stated both residents were placed on 24-hour report for monitoring post incident. The Administrator stated in-services completed following this incident was related to closet system. 3. Record Review of Resident #5's face sheet dated 2/11/25 at 2:24 p.m., indicated Resident #5 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of Alzheimer's (progressive disease that destroys memory and other important mental functions), cognitive communication deficit (the inability to think of the correct word), Anxiety disorder (any of a broad range of disorders characterized by a continuous state of anxiety or fear, lasting at least a month, generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities) and essential hypertension (high blood pressure). Record Review of Resident #5's MDS assessment dated [DATE] indicated, Resident #5 understood others and made herself understood. The MDS assessment indicated Resident #5 had a BIMS score of 3, which indicated Resident #5 was severely impaired. The MDS assessment indicated Resident #5 had no behaviors of hitting, kicking, pushing, scratching, grabbing, abusing others sexually. The MDS assessment indicated Resident #5 had not verbal behavior directed towards others occurred which included (threatening others, screaming at others, cursing at others). The MDS assessment indicated Resident #5's need for assistance with bathing, dressing, using the toilet, or eating was not coded on the MDS assessment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #5's care plan, revised on 10/18//24, indicated Resident #5 had Anxiety, dementia, and confusion. The Care plan interventions included, analyze key times, places, circumstances, triggers, and what de-escalates anxiety; Evaluate for side effects of medications; Explore coping skills with resident and explain all procedures; Monitor for non-verbal signs of anxiety: restlessness, trembling, rocking, and pacing; Monitor resident frequently for changes in behavior; and Offer to talk with resident and redirect resident with calm and reassuring conversation. Record Review of grievances reviewed on 2/10/25 at 9:21 a.m. indicated there were no grievances related to abuse and neglect. During an interview on 2/11/25 at 9:28 a.m., Resident #5 stated he did not know about the resident-to-resident altercation between him and another resident becauuse it had been so damn long ago. During an interview on 2/11/25 at 9:30 a.m., Resident #1 stated he did not remember this incident. During an interview on 2/1//25 at 9:38 a., LVN C stated she was on the floor outside of the dementia care unit and when she walked back in the dementia care unit, she overheard the two residents arguing (Resident #5 and Resident #1). LVN C stated Resident #1 wanted Resident #5 to move away from him because he was watching television. LVN C stated Resident #5 was talking too much when Resident #1 was watching television. LVN C stated this incident happened so fast that by the time she walked into the unit Resident #1 had jumped up and went towards and strike Resident #5 in the upper body region. LVN C stated she believed Resident #5 was struck on his cheek. LVN C stated, This incident happened so long ago, I'm trying to remember it. LVN C stated both residents were separated. LVN C stated an aide helped her separate the two residents, but she could not remember which aide helped her on this incident. LVN C stated there was no injuries from either resident. LVN C stated, Resident #5 stated call the police because he assaulted me. LVN C stated she reported this incident to the DON and Administrator. LVN C stated the police came and talked to both residents. LVN C stated by the time police came the two residents had forgot about the whole incident. LVN C stated Resident #1 told police, I haven't struck anybody. LVN C stated Resident #1 was placed on 15 min check 72 hours and staff charted on both residents for 72 hours. LVN C stated Resident #1 was sent to a behavior hospital. LVN C stated the police did not complete a police report they just came and talked to the residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/11/25 at 1:04 p.m., the Administrator stated this incident happened in the living area of the dementia care unit. The Administrator stated Resident #1 denied hitting Resident #5 in face. The Administrator stated she did not know why the incident occurred. The Administrator stated she was the abuse coordinator. The Administrator stated in-services on formalized dementia training and abuse and neglect was completed following this incident. The Administrator stated the DON reported the incident to her. The Administrator stated she discussed resident-to-resident altercation in QAPI meetings. GDR meetings were no less than quarterly but usually completed monthly. The Administrator stated in the GDR meetings that she looked at medication adjustments, behaviors, and behavior inpatient stays. The Administrator stated QAPI meeting were held monthly. The Administrator stated no resident had to go to the hospital following this incident. The Administrator stated the police were notified but the police did not conduct an investigation because the residents did not have any marks on their body. The Administrator stated the family, physician was notified following this incident. The Administrator stated, Inventions that were in place to prevent resident-to-resident altercation was the facility had meetings about what the residents liked and disliked in family meeting, behavior stays for medication adjustments, room changes, special activity schedules, dementia training follow ups, tried the resident briefly off the unit and if that did not work put the resident back in dementia care unit, and changed ambassadors to see if he would respond better to a man. Record Review on abuse policy dated 1/1/23, indicated Policy: 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 [NAME], friends. or other individuals. This includes physical, verbal, sexual, physical /chemical restraint in the event of resident-. to-resident abuse, the facility will immediately protect the resident being abused and all other residents in the facility. If the initial determination is that the perpetrator is a threat to the health and safety of the residents in the facility, as determined by the attending physician/or other physician, the resident will be discharged as soon as possible. During the time that the perpetrator has not been discharged , the facility will monitor this resident one---0n--one to protect all other residents. The Director of Nursing will coordinate this and set up monitoring. If a threat does not exist then an assessment will be completed, and behavior will be care planned to meet resident's needs and protect others.