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	06/25/2025

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 - Immediate jeopardy to resident health or safety 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** Based on interview and record review the facility failed to ensure residents were free from abuse for 1 of 8 residents (Resident's #1) reviewed for resident abuse. The facility failed to ensure Resident #1 was free from physical abuse on 11/21/24, when Resident #2 hit Resident #1 numerous times with the foot pedal of a wheelchair. The physical assault on Resident #1 resulted in worsening of a brain bleed with a midline shift (increased pressure in the brain). The noncompliance was identified as PNC. The immediate jeopardy (IJ) began on 11/21/24 and ended on 11/21/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of serious injury, physical harm, serious impairment, or death. The findings included: 1. Record review of the face sheet, dated 06/23/25, reflected Resident #1 was a [AGE] year-old male who initially admitted to the facility on [DATE] and discharged from the facility on 01/17/25. The diagnoses included: Alzheimer's disease (a brain disorder that slowly destroys a person's memory and thinking skills), seizures, difficulty in walking, and arthritis (inflammation of the joints). Record review the quarterly MDS assessment, dated 10/25/24, reflected Resident #1 had unclear speech and was sometimes understood by others. Resident #1 was sometimes able to understand others. The MDS reflected a staff assessment was completed because Resident #1 was rarely/never understood. The staff indicated Resident #1 had poor short-term and long-term memory problems. The staff indicated Resident #1 had severely impaired decision making skills. The MDS reflected Resident #1 had physical behavioral symptoms directed toward others and wandering 4 to 6 days during the 7-day look-back period. Record review of the comprehensive care plan, initiated 05/23/22, reflected Resident #1 was on the secured unit for wandering and exit seeking behaviors. Record review of the order summary report, dated 06/23/25, reflected Resident #1 had an order for the secured unit due to exit seeking behaviors, which started on 10/11/23. (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
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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Physical Aggression Received incident report, dated 11/21/24, reflected Resident #1 wandered into another resident's room and was struck by a wheelchair leg rest. The injuries included the following: a laceration to the back of the right hand, a laceration to the back of the head, and a laceration to the right forearm. The incident report reflected Resident #1 was confused with impaired memory. The incident report reflected he was a wanderer. The incident report reflected a staff statement from LVN A, which reflected Resident #1 was laying on the floor between Resident #2's bed and Resident #2's wheelchair. Resident #1 was bleeding from multiple areas to the scalp, right hand, and right forearm. Resident #2 was holding a wheelchair leg rest in his hand stating he [Resident #1] came into my room, and I hit his f**king a**. The incident report reflected the DON and Administrator were notified on 11/21/24. Record review of the neurological assessment form, dated 11/21/24 at 8:45 PM, reflected Resident #1 was at the emergency room. The assessment was blank. The neurological assessments did not restart until 11/22/24 at 7:53 PM, when he returned to the facility. Record review of Resident #1's nursing progress notes reflected the following: 1. On 11/21/24 at 10:20 AM, LVN A documented 8:40 AM - Witnessed fall noted with 1 cm x 0.5 cm laceration to the right eyebrow. No further injuries noted. Hospice nurse was notified and received consent to send to the emergency room for evaluation and treatment . 2. On 11/21/24 at 7:57 PM, LVN A documented Returned to the facility at 6 PM from emergency room status post fall with a diagnosis of subdural hematoma (brain bleed). 3 sutures to the right eyebrow and remove in 7 days. 3. On 11/21/24 at 10:07 PM, LVN A documented sent back to the emergency room per ambulance at 8:20 PM for multiple skin tears, lacerations, and contusions to scalp, right hand/arm following altercations involving another resident. DON and Administrator notified. 4. On 11/21/24 at 10:38 PM, LVN A documented Resident #1 noted by this nurse to be laying on the floor between Resident #2's bed and Resident #2 sitting in his wheelchair. Resident #1 was bleeding from multiple areas to scalp, right hand and forearm. Resident #2 holding a wheelchair leg rest in his hand stated he came in my room, and I hit his f**king a**. 911 called and Resident #1 was transported to the emergency room. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the emergency department records, dated 11/21/24, reflected Resident #1 arrived at the emergency room by ambulance on 11/21/24 at 8:41 PM. The provider notes history reflected Resident #1 was assaulted by another resident at a nursing facility. Resident #1 was struck in the head multiple times with a metal wheelchair leg .this is Resident #1's second visit for the day. Resident #1 had gone back to the nursing facility and was found by the staff with another resident striking him with a leg that had been removed from a wheelchair. Resident #1 sustained some skin tears to his hands . The physical exam reflected Head: sutured wound to right eyebrow from the fall earlier. Two 4-5 mm signs to right scalp which appear new. No active bleeding . Musculoskeletal: Resident #1 has some skin tears that are superficial to his right hand and a hematoma to his right lower triceps area no long bone deformity good movement at shoulder elbow and wrist bilaterally . A CT scan was completed of the head without contrast. The results reflected Increase in size and prominence of known left subdural hematoma as detailed above with small left right midline shift. The scans were compared to the ones completed earlier in the day on 11/21/24. The emergency department records reflected Resident #1 was transferred to another hospital for higher level of care on 11/22/24 at 1:02 AM by air flight. The diagnosis was subdural hematoma (brain bleeding). 2. Record review of the face sheet, dated 06/23/25, reflected Resident #2 was an [AGE] year-old male who initially admitted to the facility on [DATE] and discharged from the facility on 01/19/25. The diagnoses included: Alzheimer's disease (a brain disorder that slowly destroys a person's memory and thinking skills) and prostate cancer with metastasis to the bone. Record review of the quarterly MDS assessment, dated 12/14/24, reflected Resident #2 had clear speech and was sometimes understood by others. Resident #2 was sometimes able to understand others. The MDS reflected Resident #2 had a BIMS score of 3, which indicated severe cognitive impairment. The MDS reflected Resident #2 had inattention that was continuously present and did not fluctuate. The MDS reflected Resident #2 had verbal and other behavioral symptoms, rejection of care, and wandering 1 to 3 days during the 7-day look-back period. Record review of the comprehensive care plan, initiated on 01/24/24, reflected Resident #2 was on an antipsychotic medication for a history of aggression and aggressive behaviors which placed him at an increased risk for mood swings. The interventions included: administer medications per orders and monitor and record occurence of targeted behaviors and document per protocol. Record review of the Physical Aggression Initiated incident report, dated 11/21/24, reflected Resident #2 was sitting in his wheelchair holding the footrest in his right hand above his head with Resident #1 lying on the floor between Resident #2 and the bed. Resident #2 stated he was in my room, and I hit his f**king a**. The incident report Resident #1 and Resident #2 were immediately separated, and Resident #2 had no injuries. The incident report reflected Resident #2 was confused with impaired memory and was agitated. The DON, Administrator, and physician were notified on 11/21/24. Record review of Resident #2's nursing progress notes reflected the following: 1. On 11/21/24 at 10:09 PM, LVN A documented Sent to emergency room per the nurse practitioner orders for extreme agitation and threat to facility following altercation with another resident. Administrator and DON notified. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 11/21/24 at 10:20 PM, LVN A documented This nurse heard a noise, and Resident #2 was noted sitting in his wheelchair holding the footrest in his right hand and above his head with Resident #1 lying on the floor between Resident #2 and the bed. Resident #2 stated he was in my room. Separated the residents while another nurse called 911. Notified Administrator, DON, and nurse practitioner. Resident #2 was ultimately sent to the ER due to extreme agitation and threat to facility. 3. On 11/22/24 at 5:28 PM, LVN BB documented Resident #2 returned from the emergency room due to behaviors/aggression; Resident #2 was transferred with a wheelchair to [a different room]; Resident #2 was awake, alert, skin and warm and dry, color good, respirations even/unlabored with no distress noted; resident was quiet, friendly, and talking with staff; Resident #2 transferred to bed and resting quietly . Record review of the after visit summary, dated 11/21/24, reflected Resident #2 was seen in the emergency room for aggressive behaviors and medical clearance for psychiatric admission. Record review of the provider investigation report, dated 11/28/24, reflected the resident to resident physical altercation occurred on 11/21/24 and was reported to the state agency on 11/21/24. The report reflected LVN A saw Resident #1 in Resident #2's room on the floor. LVN A saw Resident #2 strike Resident #1 with a wheelchair foot pedal. The injuries included skin tears to arms and head and Resident #1 was sent to the emergency room for evaluation of an existing subdural hematoma (brain bleed). The provider response included the separation of Resident #1 and Resident #2 by units. Resident #2 was placed in a private room with increased monitoring until moved to behavioral unit for an in-patient stay. The investigation summary reflected Resident #2 initiated contact with Resident #1 when he wandered into his room. Resident #1 felt it was his fault and apologized. Resident #2 apologized as well but understood his reaction was excessive. Record review of a Room Audit form, undated, reflected rooms 1 - 12, 20, and 23 were inspected for assistive devices to include: oxygen, splints, walking boots, heel elevators, catheters, intravenous or enteral pumps, restraints, side rails, suction machines, other equipment, and fall mats. Record review of the in-patient behavioral hospital records, dated 12/10/24, reflected Resident #2 was admitted to the hospital on [DATE] at 3:52 PM with a principal diagnosis of dementia (memory loss) with behaviors. The records reflected Resident #2 was discharged back to the facility on [DATE]. Record review of the in-service education An Activity-Based Approach to Memory Care, dated 10/27/24, reflected an outside company conducted dementia care training to include dementia definitions, different activities, and managing the environment. Record review of the invoice, dated 11/24/24, reflected an outside company requested payment for in-service education that was provided. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/23/25 at 9:31 AM, Resident #1's family member stated he was at the facility for a little over 2 years. The family member stated he was no longer residing in the facility. The family member stated in November of 2024, Resident #1 had a really bad fall and was sent to the emergency room with lacerations that had to be sutured (stitched). The family member stated Resident #1 also had a hematoma and bruising above his eye and a CT scan showed a subdural hematoma (brain bleed). The family member stated Resident #1 returned from the emergency room and was assaulted and beaten by another resident. The family member stated he was hit multiple times with a metal wheelchair leg and had bleeding on his brain which had gotten worse and bigger. The family member stated Resident #1 was air flighted to another hospital. During an interview on 06/23/25 at 3:21 PM, LVN A stated on 11/21/24 she was sitting at the nurses' station around 8 PM. She stated she heard a muffled noise, multiple times as she was charting and got up to investigate. LVN A stated she was unable to identify the noise and sat back down to start charting again. LVN A stated she heard the muffled noise again but was much louder and sounded like moaning. LVN A stated she walked out of the nurses' station toward the short hallway and saw Resident #2 sitting in his wheelchair in front of his bed as the door was open. LVN A stated Resident #2 had something in his hands, which was lifted above his head, so she hurried toward his room. She said as she walked into the room, Resident #2 had swung the object down, and then she noticed Resident #1 was laying on floor with his right arm up trying to deflect the hits. LVN A stated Resident #2 was saying something that she was unable to recall. She said Resident #2 was getting ready to hit Resident #1 again when she noticed he had a wheelchair foot pedal. LVN A stated Resident #2 had hit Resident #1 in the head and arms. LVN A stated there was blood everywhere. She stated she attempted to remove the wheelchair foot pedal from Resident #2, but he would not let go of it and remained extremely agitated. LVN A stated she was the only staff member in the secured unit and knew she was not able to leave Resident #1 and Resident #2 alone, so she pulled Resident #2 with the wheelchair foot pedal out of the room and down the hallway to the doors for the female secured unit. LVN A stated she opened the door and hollered for help. LVN A said when the other nurse arrived, she left the other nurse with Resident #2, instructed her to call 911 and went to check on Resident #1. LVN A stated she completed first aid on Resident #1 until emergency services arrived. LVN A stated Resident #2 was placed on one-to-one monitoring until he was sent to the emergency room per orders from the nurse practitioner. LVN A stated Resident #2 was territorial about his space and did not like other residents' in his room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/23/25 at 4:34 PM, the DON stated she remembered receiving a phone call notification back in November 2024, in which Resident #2 had struck Resident #1 with a wheelchair foot pedal. The DON stated Resident #1 and Resident #2 were immediately sent to the emergency room after the incident. The DON stated Resident #1 was transferred to another hospital for a higher level of care for a subdural hematoma (brain bleed). The DON stated Resident #2 returned to the facility from the emergency room and then was sent to an in-patient behavioral hospital for approximately one month. The DON stated neurological assessments were in progress from a fall that Resident #1 had obtained earlier in the day. The DON stated the incident occurred in Resident #2's room, which was directly across from the nurses' station. The DON stated Resident #2 remembered Resident #1 entered his room but did not remember hitting him. The DON stated Resident #2 valued his space and was particular about his space. The DON stated Resident #2 was moved to a room close to the nurses' station, on the hallway with less traffic to try to prevent other residents from wandering into his room. The DON stated Resident #2 was moved off the secured unit and had no further issues. The DON stated Resident #2 had a private room and there was no residents who wandered into his room in the general population.The DON stated she was unable to locate the in-service education provided in November of 2024. The DON stated education on abuse and neglect was completed after the incident and the dementia training was re-done in December 2024. The DON stated she conducted a room audit to search for things that could have been used as weapons. During an interview on 06/24/25 at 10:38 AM, the DON stated the dementia care trainer reported that she did the initial training in October 2024, then provided additional education in November 2024 after the resident-to-resident altercation between Resident #1 and Resident #2, and again in December 2024. The DON stated the trainer did not complete the entire training, only the parts that were pertinent such as the dementia disease process and de-escalation techniques. During interviews completed on 06/25/25 between 9:53 AM and 1:29 PM, CNA B, CNA D, CNA S, CNA T, CNA U, CNA V, CNA W, CNA X, CNA Y, CNA Z, LVN E, LVN F, LVN G, LVN H, LVN K, RN L, RN M, LVN Q, Housekeeper N, Housekeeper O, Laundry Aide P, COTA R, ST AA, the MDS Coordinator, the Housekeeping Supervisor, the AD, the Medical Records Coordinator, the DOR, the Social Worker, and the ADON were able to verbalize the different types of abuse, the abuse coordinator, and when to report abuse. The facility staff were able to verbalize resident-to-resident altercations could have been considered physical abuse. The staff reported residents' should have been immediately separated, placed on monitoring, and reported to the abuse coordinator. Record review of the Abuse policy, last revised 01/01/23, reflected The purpose of this policy is to ensure that reach resident has the right to be free from any type of abuse .abuse is a willful infliction of injury .with resulting physical or emotional harm or pain to a resident .residents will not be subjected to abuse by anyone, including .other residents . The noncompliance was identified as PNC. The noncompliance began on 11/21/24 and ended on 11/21/24.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the resident environment remained free of accident hazards as possible, and each resident received adequate supervision to prevent incident and accidents for 2 of 8 residents (Resident #1 and Resident #3) reviewed for accident hazards and supervision. 1. The facility failed to ensure adequate supervision was provided to prevent a resident-to-resident physical altercation on 11/21/24. Resident #2 repeatedly hit Resident #1 with a metal wheelchair pedal, which resulted in worsening of a brain bleed with a midline shift (increased pressure in the brain). 2. The facility failed to ensure adequate supervision was provided to prevent Resident #3 from falling, which resulted in a nasal fracture on 06/02/25. An immediate jeopardy (IJ) was identified on 06/24/25 at 12:55 PM. The IJ template was provided to the facility on [DATE] at 1:30 PM. While the IJ was removed on 06/25/25 at 1:32 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been provided education on supervision of residents on the secured units, effective communication practices, reporting on/off duty, and fall management and response policies. These failures could potentially place residents at risk of further serious injury/harm, serious impairment, or death from inadequate supervision on the male secured unit. The findings included: 1. Record review of the face sheet, dated 06/23/25, reflected Resident #1 was a [AGE] year-old male who initially admitted to the facility on [DATE] and discharged from the facility on 01/17/25. The diagnoses included: Alzheimer's disease (a brain disorder that slowly destroys a person's memory and thinking skills), seizures, difficulty in walking, and arthritis (inflammation of the joints). Record review the quarterly MDS assessment, dated 10/25/24, reflected Resident #1 had unclear speech and was sometimes understood by others. Resident #1 was sometimes able to understand others. The MDS reflected a staff assessment was completed because Resident #1 was rarely/never understood. The staff indicated Resident #1 had poor short-term and long-term memory problems. The staff indicated Resident #1 had severely impaired decision making skills. The MDS reflected Resident #1 had physical behavioral symptoms directed toward others and wandering 4 to 6 days during the 7-day look-back period. Record review of the comprehensive care plan, initiated 05/23/22, reflected Resident #1 was on the secured unit for wandering and exit seeking behaviors. Record review of the order summary report, dated 06/23/25, reflected Resident #1 had an order for the secured unit due to exit seeking behaviors, which started on 10/11/23. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Physical Aggression Received incident report, dated 11/21/24, reflected Resident #1 wandered into another resident's room and was struck by a wheelchair leg rest. The injuries included the following: a laceration to the back of the right hand, a laceration to the back of the head, and a laceration to the right forearm. The incident report reflected Resident #1 was confused with impaired memory. The incident report reflected he was a wanderer. The incident report reflected a staff statement from LVN A, which reflected Resident #1 was laying on the floor between Resident #2's bed and Resident #2's wheelchair. Resident #1 was bleeding from multiple areas to the scalp, right hand, and right forearm. Resident #2 was holding a wheelchair leg rest in his hand stating he [Resident #1] came into my room, and I hit his f**king a**. The incident report reflected the DON and Administrator were notified on 11/21/24. Record review of the neurological assessment form, dated 11/21/24 at 8:45 PM, reflected Resident #1 was at the emergency room. The neurological assessments did not restart until 11/22/24 at 7:53 PM, when he returned to the facility. Record review of Resident #1's nursing progress notes reflected the following: 1. On 11/21/24 at 10:20 AM, LVN A documented 8:40 AM - Witnessed fall noted with 1 cm x 0.5 cm laceration to the right eyebrow. No further injuries noted. Hospice nurse was notified and received consent to send to the emergency room for evaluation and treatment . 2. On 11/21/24 at 7:57 PM, LVN A documented Returned to the facility at 6 PM from emergency room status post fall with a diagnosis of subdural hematoma (brain bleed). 3 sutures to the right eyebrow and remove in 7 days. 3. On 11/21/24 at 10:07 PM, LVN A documented sent back to the emergency room per ambulance at 8:20 PM for multiple skin tears, lacerations, and contusions to scalp, right hand/arm following altercations involving another resident. DON and Administrator notified. 4. On 11/21/24 at 10:38 PM, LVN A documented Resident #1 noted by this nurse to be laying on the floor between Resident #2's bed and Resident #2 sitting in his wheelchair. Resident #1 was bleeding from multiple areas to scalp, right hand and forearm. Resident #2 holding a wheelchair leg rest in his hand stated he came in my room, and I hit his f**king a**. 911 called and Resident #1 was transported to the emergency room. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the emergency department records, dated 11/21/24, reflected Resident #1 arrived at the emergency room by ambulance on 11/21/24 at 8:41 PM. The provider notes history reflected Resident #1 was assaulted by another resident at a nursing facility. Resident #1 was struck in the head multiple times with a metal wheelchair leg .this is Resident #1's second visit for the day. Resident #1 had gone back to the nursing facility and was found by the staff with another resident striking him with a leg that had been removed from a wheelchair. Resident #1 sustained some skin tears to his hands . The physical exam reflected Head: sutured wound to right eyebrow from the fall earlier. Two 4-5 mm signs to right scalp which appear new. No active bleeding . Musculoskeletal: Resident #1 has some skin tears that are superficial to his right hand and a hematoma to his right lower triceps area no long bone deformity good movement at shoulder elbow and wrist bilaterally . A CT scan was completed of the head without contrast. The results reflected Increase in size and prominence of known left subdural hematoma as detailed above with small left right midline shift. The scans were compared to the ones completed earlier in the day on 11/21/24. The emergency department records reflected Resident #1 was transferred to another hospital for higher level of care on 11/22/24 at 1:02 AM by air flight. The diagnosis was subdural hematoma (brain bleeding). 2. Record review of the face sheet, dated 06/23/25, reflected Resident #2 was an [AGE] year-old male who initially admitted to the facility on [DATE] and discharged from the facility on 01/19/25. The diagnoses included: Alzheimer's disease (a brain disorder that slowly destroys a person's memory and thinking skills) and prostate cancer with metastasis to the bone. Record review of the quarterly MDS assessment, dated 12/14/24, reflected Resident #2 had clear speech and was sometimes understood by others. Resident #2 was sometimes able to understand others. The MDS reflected Resident #2 had a BIMS score of 3, which indicated severe cognitive impairment. The MDS reflected Resident #2 had inattention that was continuously present and did not fluctuate. The MDS reflected Resident #2 had verbal and other behavioral symptoms, rejection of care, and wandering 1 to 3 days during the 7-day look-back period. Record review of the comprehensive care plan, initiated on 01/24/24, reflected Resident #2 was on an antipsychotic medication for a history of aggression and aggressive behaviors which places him at an increased risk for mood swings. Record review of the Physical Aggression Initiated incident report, dated 11/21/24, reflected Resident #2 was sitting in his wheelchair holding the footrest in his right hand above his head with Resident #1 lying on the floor between Resident #2 and the bed. Resident #2 stated he was in my room, and I hit his f**king a**. The incident report Resident #1 and Resident #2 were immediately separated, and Resident #2 had no injuries. The incident report reflected Resident #2 was confused with impaired memory and was agitated. The DON, Administrator, and physician were notified on 11/21/24. Record review of Resident #2's nursing progress notes reflected the following: 1. On 11/21/24 at 10:09 PM, LVN A documented Sent to emergency room per the nurse practitioner orders for extreme agitation and threat to facility following altercation with another resident. Administrator and DON notified. (continued on next page)

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	455900	A. Building B. Wing	06/25/2025

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.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 11/21/24 at 10:20 PM, LVN A documented This nurse heard a noise, and Resident #2 was noted sitting in his wheelchair holding the footrest in his right hand and above his head with Resident #1 lying on the floor between Resident #2 and the bed. Resident #2 stated he was in my room. Separated the residents while another nurse called 911. Notified Administrator, DON, and nurse practitioner. Resident #2 was ultimately sent to the ER due to extreme agitation and threat to facility. 3. On 11/22/24 at 5:28 PM, LVN BB documented Resident #2 returned from the emergency room due to behaviors/aggression; Resident #2 was transferred with a wheelchair to [a different room]; Resident #2 was awake, alert, skin and warm and dry, color good, respirations even/unlabored with no distress noted; resident was quiet, friendly, and talking with staff; Resident #2 transferred to bed and resting quietly . Record review of the after visit summary, dated 11/21/24, reflected Resident #2 was seen in the emergency room for aggressive behaviors and medical clearance for psychiatric admission. Record review of the provider investigation report, dated 11/28/24, reflected the resident to resident physical altercation occurred on 11/21/24 and was reported to the state agency on 11/21/24. The report reflected LVN A saw Resident #1 in Resident #2's room on the floor. LVN A saw Resident #2 strike Resident #1 with a wheelchair foot pedal. The injuries included skin tears to arms and head and Resident #1 was sent to the emergency room for evaluation of an existing subdural hematoma (brain bleed). The provider response included the separation of Resident #1 and Resident #2 by units. Resident #2 was placed in a private room with increased monitoring until moved to behavioral unit for an in-patient stay. The investigation summary reflected Resident #2 initiated contact with Resident #1 when he wandered into his room. Resident #1 felt it was his fault and apologized. Resident #2 apologized as well but understood his reaction was excessive. Record review of a Room Audit form, undated, reflected rooms 1 - 12, 20, and 23 were inspected for assistive devices to include: oxygen, splints, walking boots, heel elevators, catheters, intravenous or enteral pumps, restraints, side rails, suction machines, other equipment, and fall mats. Record review of the in-patient behavioral hospital records, dated 12/10/24, reflected Resident #2 was admitted to the hospital on [DATE] at 3:52 PM with a principal diagnosis of dementia (memory loss) with behaviors. The records reflected Resident #2 was discharged back to the facility on [DATE]. Record review of the in-service education An Activity-Based Approach to Memory Care, dated 10/27/24, reflected an outside company conducted dementia care training to include dementia definitions, different activities, and managing the environment. Record review of the invoice, dated 11/24/24, reflected an outside company requested payment for in-service education that was provided. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/23/25 at 9:31 AM, Resident #1's family member stated Resident #1 was at the facility for a little over 2 years. The family member stated he was no longer residing in the facility. The family member stated in November of 2024, Resident #1 had a really bad fall and was sent to the emergency room with lacerations that had to be sutured (stitched). The family member stated Resident #1 also had a hematoma and bruising above his eye and a CT scan showed a subdural hematoma (brain bleed). The family member stated Resident #1 returned from the emergency room and was assaulted and beaten by another resident. The family member stated he was hit multiple times with a metal wheelchair leg and had bleeding on his brain which had gotten worse and bigger. The family member stated Resident #1 was air flighted to another hospital. The family member stated the staff at the facility did not watch Resident #1. The family member stated multiples times when she visited the facility, the facility staff had to spend up to 5 minutes searching for Resident #1 because they did not know where he was. The family member stated Resident #1 was usually found in another resident's room. The family member stated the facility staff would be sitting behind the nurses' station, talking or no where to be found. The family member stated on several occasions there was only one staff member on the secured unit. During an observation on 06/23/25 on the male secured unit was as follows: 10:00 AM - Surveyor entered the secured unit. LVN C was sitting up at the nurses' station. CNA W followed the surveyor onto the secured unit from the DON's office. Resident #3 was sitting against the wall, leaned back in his wheelchair with his eyes closed. Resident #9 was standing up on the short hallway, walking toward the dining room. He pulled out a chair and sat down. LVN C walked out of the secured unit toward the DON office, approximately 2 minutes. 10:08 AM - Resident #9 stood up from the chair and started walking toward the exit doors, following the MDS Coordinator, who had exited her office. His gait was shuffled. When the exit door shut, Resident #9 turned, and started down the hallway. 10:10 AM - Resident #9 was at the door entrance to the female secured unit. He attempted to open the door and was hitting the door. CNA W redirected Resident #9 to the dining room and encouraged him to sit in the chair. 10:13 AM - Another male resident, sitting at the dining room table, yelled Shut up!, and stood up quickly from the dining room table with an unsteady gait. LVN C was walking out of a room with the hospice nurse, CNA B was coming out of the supply room, and the MDS Coordinator was walking back onto the secured unit. 10:14 AM - LVN C notified surveyor she was responsible for both sides of the secured unit, the male and female sides. LVN C stated she had check on the females and would be back. 10:16 AM - LVN C returned to the male secured unit. 10:17 AM - 2 male residents were wandering around the secured unit, stopping at different rooms, no assistive devices. CNA B exited the secured unit, LVN C was behind the nurses' desk, talking with the hospice nurse. 10:19 AM - CNA B returned to secured unit with coffee. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/23/25 at 3:21 PM, LVN A stated on 11/21/24 she was sitting at the nurses' station around 8 PM. She stated she heard a muffled noise, multiple times as she was charting and got up to investigate. LVN A stated she was unable to identify the noise and sat back down to start charting again. LVN A stated she heard the muffled noise again but was much louder and sounded like moaning. LVN A stated she walked out of the nurses' station toward the short hallway and saw Resident #2 sitting in his wheelchair in front of his bed as the door was open. LVN A stated Resident #2 had something in his hands, which was lifted above his head, so she hurried toward his room. She said as she walked into the room, Resident #2 had swung the object down, and then she noticed Resident #1 was laying on floor with his right arm up trying to deflect the hits. LVN A stated Resident #2 was saying something that she was unable to recall. She said Resident #2 was getting ready to hit Resident #1 again when she noticed he had a wheelchair foot pedal. LVN A stated Resident #2 had hit Resident #1 in the head and arms. LVN A stated there was blood everywhere. She stated she attempted to remove the wheelchair foot pedal from Resident #2, but he would not let go of it and remained extremely agitated. LVN A stated she was the only staff member in the secured unit and knew she was not able to leave Resident #1 and Resident #2 alone, so she pulled Resident #2 with the wheelchair foot pedal out of the room and down the hallway to the doors for the female secured unit. LVN A stated she opened the door and hollered for help. LVN A said when the other nurse arrived, she left the other nurse with Resident #2, instructed her to call 911 and went to check on Resident #1. LVN A stated she completed first aid on Resident #1 until emergency services arrived. LVN A stated Resident #2 was placed on one-to-one monitoring until he was sent to the emergency room per orders from the nurse practitioner. LVN A stated CNA B had left the secured unit on her break. LVN A she was unaware CNA B had left for break and did not recall CNA B reporting that she was leaving. LVN A stated Resident #2 was territorial about his space and did not like other residents' in his room. LVN A stated it had been reported that Resident #2 had spent a majority of his life in prison and his room was like his cell. LVN A stated he would become upset if anyone went into his room and Resident #2 had stated he did not want anyone in his room. LVN A stated Resident #1 was constantly wandering around the secured unit and went in and out of other resident's rooms. During an interview on 06/23/25 at 3:52 PM, the ADON stated he was responsible for completing the staffing schedule for the secured unit. The ADON stated during the week, he tried to schedule a CNA for the female secured unit, a CNA for the male secured unit, and nurse to go between the two secured units. The ADON stated during the week, management staff offices were located on the male secured unit. The ADON stated the management staff provided monitoring and supervision to the residents as well. The ADON stated on the weekends, he scheduled a nurse and a CNA for the female secured unit, and a nurse and a CNA for the male secured unit. The ADON stated the facility recently hired a weekend supervisor who also helped supervise the secured units. The ADON stated the census for the male secured unit had increased within the last few weeks. The ADON stated the facility was working on adding a CNA. The ADON stated he had 2 CNAs orientating this week. The ADON stated he started an action plan for the secured unit staff. The action plan was requested. Record review of the action plan, dated 06/10/25, reflected the following: 1. Issue/concern: secured unit staffing. 2. Measurable goal: with a rise in census facility to determine staffing needs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Intervention: Montessori certification (program offered in a secured unit for dementia care residents) for current transport tech to transport to unit; daily review of admission/discharge with IDT to meet needs of residents; RN weekend supervisor hired. 4. Target date: 06/30/25 and ongoing. During an interview on 06/23/25 at 4:07 PM, the Regional [NAME] President stated the facility had no policy on staffing or supervision of the secured unit. The Regional [NAME] President stated he reviewed the facility assessment and stated the staff was no specified with a number that it was based on the needs of the facility. During an interview on 06/23/25 at 4:34 PM, the DON stated she remembered receiving a phone call notification back in November 2024, in which Resident #2 had struck Resident #1 with a wheelchair foot pedal. The DON stated Resident #1 and Resident #2 were immediately sent to the emergency room after the incident. The DON stated Resident #1 was transferred to another hospital for a higher level of care for a subdural hematoma (brain bleed). The DON stated Resident #2 returned to the facility from the emergency room and then was sent to an in-patient behavioral hospital for approximately one month. The DON stated neurological assessments were in progress from a fall that Resident #1 had obtained earlier in the day. The DON stated the incident occurred in Resident #2's room, which was directly across from the nurses' station. The DON stated Resident #2 remembered Resident #1 entered his room but did not remember hitting him. The DON stated Resident #2 valued his space and was particular about his space. The DON stated Resident #2 was moved to a room close to the nurses' station, on the hallway with less traffic to try to prevent other residents from wandering into his room. The DON stated Resident #2 was moved off the secured unit and had no further issues. The DON stated she was unable to locate the in-service education provided in November of 2024. The DON stated education on abuse and neglect was completed after the incident and the dementia training was re-done in December 2024. The DON stated she conducted a room audit to search for things that could have been used as weapons. The DON stated the typical census in the male secured unit was about 14 - 15 residents. The DON stated the census was currently 19 for the male secured unit. The DON stated the CNAs work 16 hours on the secured unit. The DON stated during the week one nurse was scheduled for both sides of the secured unit and during the weekend there was one nurse for the male side and one nurse for the female side. The DON stated one CNA was scheduled for each side. The DON stated usually the nurses will cover each other when they went on break, and the nurses covered the CNAs during breaks. The DON stated trends were identified with incidents on the secured unit within the last few weeks with the increase in census. The DON stated the facility was working on scheduling additional staff on the secured unit. During an interview on 06/24/25 at 10:38 AM, the DON stated the dementia care trainer reported that she did the initial training in October 2024, then provided additional education in November 2024 after the resident-to-resident altercation between Resident #1 and Resident #2, and again in December 2024. The DON stated the trainer did not complete the entire training, only the parts that were pertinent such as the dementia disease process and de-escalation techniques. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/24/25 at 10:54 AM, CNA B stated on 11/21/24 she was on break when the resident-to-resident altercation happened. CNA B stated she had told the charge nurse she was going on break but the charge nurse did not understand. CNA B stated a lot of things had happened during the day and she had to take a late break. CNA B stated they usually verbally reported when they were going on break or leaving the secured unit. CNA B stated Resident #2 did not like anyone in his room and Resident #1 was constantly wandering. CNA B stated she did not feel like one CNA and one nurse was enough staff to provide adequate supervision on the secured unit because of all the residents with combative and wandering behaviors. CNA B stated she felt like the incident with Resident #1 and Resident #2 could have been prevented because it would have been noticed with an extra set of eyes. 3. Record review of the face sheet, dated 06/25/25, reflected Resident #3 was a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a brain disorder that slowly destroys a person's memory and thinking skills). Record review of the quarterly MDS assessment, dated 05/22/25, reflected Resident #3 had clear speech and was usually understood by others. The MDS reflected Resident #3 was usually able to understand others. The MDS reflected Resident #3 had a BIMS score of 0, which indicated severe cognitive impairment. Resident #3 had inattention that was continuously present and did not fluctuate. The MDS reflected Resident #3 had physical, verbal, and wandering behaviors that happened 1 to 3 days during the 7-day look back period. The MDS reflected Resident #3 used a wheelchair and was dependent on staff for most ADLs. The MDS reflected Resident #3 had fallen with no injuries since the prior assessment. Record review of the comprehensive care plan, updated 06/02/25, reflected Resident #3 fell forward from wheelchair. The interventions included: specialty chair utilized that tilts slightly backward for torso control and therapy to assess chair for safe positioning device. Record review of Resident #3's un-witnessed fall incident report, dated 06/02/25, reflected DON was summoned to the men secured unit by CNA related to Resident #3 falling from wheelchair. Upon arriving, Resident #3 was noted lying on his right side outside the nurses' station door with two puddles of blood noted directly under the resident. Resident #3's wheelchair noted in upright position at the foot of the resident with lift pad in place. Resident #3 confused according to baseline stated, someone was shooting at him, and he tried getting away. A statement from CNA D revealed she was redirecting a resident on the back side of the nurses' station when informed by another resident that Resident #3 was in the floor. Record review of the fall scale assessment, dated 06/02/25, reflected Resident #3 was at high risk for falls. Record review of the pain tool assessment, dated 06/02.25, reflected Resident #3 was complaining of pain to his nose and right side of ribcage, 5 out of 10 on the pain scale. Record review of the emergency record, dated 06/02/25, reflected Resident #3 arrived at the emergency room by ambulance on 06/02/25 at 5:42 PM. The provider history reflected Resident #3 had an unwitnessed ground level fall after falling out of wheelchair. Resident #3 landed on his face and was taking blood thinners. The CT results of Resident #3's face reflected an acute nasal fracture. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #3 order details report, dated 06/04/25, reflected an order to monitor nasal fracture for signs and symptoms of bleeding, increased pain, or labored every shift for 14 days. Record review of the MAR, dated June 2025, reflected Resident #3's nasal fracture was monitored every shift for 14 days. During an interview on 06/24/25 at 9:25 AM, LVN C stated she was not on the male secured unit at the time of Resident #3's fall incident. LVN C stated the ADON and DON handled the incident. LVN C stated Resident #3 was always leaning forward in his wheelchair. LVN C stated Resident #3 had a history of falling and was unable to catch himself during the falls. During an interview on 06/24/25 at 9:47 AM, the ADON stated he and the DON were notified by CNA D that Resident #3 was on the ground. The ADON stated when they entered the secured unit, Resident #3 was laying on the floor. The ADON stated Resident #3 was confused and did not specify what happened but stated oh my, I'm just hurting. The ADON stated the nurse practitioner was immediately notified and new orders were received to send Resident #3 to the emergency room for new onset of pain and bleeding from his nose. The ADON stated the nurse had stepped out of the male secured unit onto the female secured unit. The ADON stated CNA D had to come to the doors of the secured unit, office area, to alert the ADON and DON that Resident #3 was on the ground. The ADON stated Resident #3 received a new tilt wheelchair for his tendencies to lean forward. The ADON stated a medication adjustment was completed. The ADON stated when incidents occurred an incident report was completed with a fall assessment, pain assessment, and skin assessment as needed for injuries. The ADON stated the IDT came together during morning clinical meetings to determine what happened, what contributed to the incident, what could have been done better, and what education needed to be provided. The ADON stated the last two weeks the facility had identified trends on the secured unit related to incidents and the increased census. The ADON stated they had been discussing staffing. During an interview on 06/24/25 at 9:59 AM, CNA D stated she was on the other side of the nurses' station, the back side, passing snacks when Resident #3 had fallen out of his wheelchair. CNA D stated she was alert by another resident that Resident #3 was on the ground. CNA D stated LVN C was on the female secured unit when the incident happened, so she notified the DON. CNA D stated she normally worked on the secured unit and the nurse was responsible for supervising the residents when she was providing cares or giving showers. CNA D stated she communicated with the nurse if she had to leave so the residents had constant supervision. She stated if the nurse was unavailable, she would get the ADON. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/24/25 at 10:05 AM, the DON stated CNA D came and got her and the ADON from the north to assess Resident #3 who had fallen. The DON stated when she arrived on the secured unit, Resident #3 was face down with his cheek on the floor. He had some blood coming from his nose. The DON stated Resident #3 was assessed and his nose was hurting, so he was sent to the emergency room. The DON stated Resident #3 was unable to verbalize what had happened and stated someone was shooting and he dodged the bullets. The DON stated she and the ADON were in the lobby area looking at staffing when CNA D alerted them about Resident #3's fall. The DON stated LVN C was on the female secured unit at the time of the incident. The DON stated she obtained reports from some more with it residents and they reported that Resident #3 was asleep and had fallen forward out of his wheelchair. The DON stated when incidents occurred the nurses completed an incident report, completed assessments, evaluated the environment and causative factors. The DON stated after the incident, the nursing management reviewed the documentation, obtained witness statements, evaluated ways to prevent falls from happening again and to keep residents safe. The DON stated trends on incidents had been identified on the male secured unit related to increased census. The DON stated the facility were looking at staffing changes on the secured unit. This was determined to be an immediate jeopardy (IJ) on 06/24/25 at 12:55 PM. The DON and Regional [NAME] President were notified. The DON was provided the IJ template on 06/24/25 at 1:30 PM and the plan of removal was requested. The following plan of removal was submitted by the facility and accepted on 06/25/25 at 9:13 AM and included the following: The following is a plan of?removal, which has been immediately?implemented?[facility] to remedy the immediate jeopardy [IJ] as a result of alleged deficient practices, which?was imposed on 06/24/25 at 1:30 PM.? Resident #1 was discharged from the facility on 01/17/25. Resident #2 was discharged from the facility on 01/19/25. Resident #3 was sent to the emergency room for evaluation and treatment related to the nasal fracture. He returned to the facility the same day. The facility monitored Resident #3 for [signs and symptoms] of nasal fracture complications per physician orders. Resident #3's care plan was updated to reflect the change in condition on 06/02/25 to reflect interventions related to the fall. On 06/24/25, Clinical Management and IDT (interdisciplinary team) reviewed clinical staff schedule for staffing concerns. Assignments confirmed with staff to meet the needs of the residents. Meaning, a thorough review of the clinical staff schedule was conducted to identify any staffing concerns. Following this review, the facility will include one additional team member for resident supervision support to the secure unit populations from 6 AM - 10 PM, strictly dedicated to the secure unit populations, indicated on the assignment sheet collectively, to float between the memory care populations. Eff[TRUNCATED]