STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455944	A. Building B. Wing	10/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Clarksville	2407 West Main Street Clarksville, TX 75426

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 - 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** 45810 Based on observation, interview and record review, the facility failed to protect a resident's right to be free from abuse for 2 of 4 residents (Resident #1 and Resident #2) reviewed for abuse. The facility failed to protect Resident #1 from inappropriate sexual touching by Resident #2. This failure could place residents at risk of for psychosocial harm and a diminished quality of life. Findings included: 1. Record review of Resident #1's face sheet dated 10/04/24 indicated she was an [AGE] year-old female who readmitted to the facility on [DATE] with the diagnoses of dementia (loss of cognitive functioning), cognitive communication deficit (result in difficulty with thinking and how someone uses language), diabetes (a chronic condition that affects the way the body processes blood sugar), major depressive disorder (mental illness that negatively affects how you feel, the way you think and how you act), high blood pressure, and facture of her left arm. Record review of Resident #1's quarterly MDS dated [DATE] indicated she had a BIMS score of 3, which means she had severe cognitive impairment. The MDS also indicated Resident #1 required moderate assistance with transfers, bed mobility, and eating, and maximum assistants with toileting and bathing. The MDS indicated Resident #1 had delusions. Record review of Resident #1's care plan revised on 10/04/24 indicated she had a BIMS score of 3, impaired cognitive function, and impaired decision-making abilities. The care plan also indicated Resident #1 had an ADL self-care performance deficit and required extensive assistance of one staff for toileting and transfers. The care plan did not indicate Resident #1 had a reportable incident with another resident. Record review of Resident #1's nurse's note dated 10/4/2024 at 07:00 AM completed by LVN A indicated Incident Note Text: Resident was previously at nurses' station in wheelchair and received her insulin. When went to obtain her to go to dining room for breakfast, she was not there. Search of hallways per staff for location. Found resident in another room in bed with male resident. Assisted to wheelchair per staff and assessed for injuries. Resident teary and when ask if she was ok, she shook her head no. Assured her we were close by. Monitored closely . (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the visit note from the Facility Counseling MD dated 10/5/2024 at 11:16 AM indicated Resident #1 voiced no recollection of being with the male Resident #2 and exhibited no emotional distress. The plan was to continue to provide psychotherapy focused on reducing symptoms of depression, increasing overall sense of well-being, and self-care. 2. Record review of Resident #2's face sheet dated 10/04/24 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses of schizophrenia (mental disorder characterized by hallucinations, delusions, disorganized thinking and behaviors), high blood pressure, psychotic disorder (mental disorder characterized by a disconnection from reality), dementia (loss of cognitive functioning), and bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Record review of Resident #2's quarterly MDS dated [DATE] indicated he had a BIMS score of 8 which means he had moderate cognitive impairment. The MDS also indicated he required supervision for bathing, and he was independent with eating, transverse, and bed. mobility The MDS did not indicate that he had any behaviors. Record review of Resident #2's care plan revised 10/4/2024 after the sexual incident, indicated he had a potential to have behaviors related to dementia, poor impulse control, and schizophrenia hallucinations. The care plan included interventions of 1 on 1 monitoring for sexual behaviors and psychiatric/psychogeriatric consult as indicated. The care plan did not include any behaviors prior to 10/4/2024. Record review of the Provider Investigation Report dated 10/04/24 at 7:00 AM, indicated a search found Resident #1 laying across the bed in Resident #2's room with her pants and brief down and her shirt pulled up. Resident #2 was next to her fully clothed leaned over Resident #1 with his mouth on Resident #1's breast. He stopped when the LVN A walked in. His affect was no different than his usual. Resident #1 was tearful. She was assisted to dress and come out of the room. The report indicated a head-to-toe assessment was completed with no skin issues, no redness, bruising, or pain noted to the perineal area. A psychological assessment was to be completed by the Facility Counseling MD on 10/5/2024 for Resident #1 and Resident #2. The report also noted that Resident #2 would be placed on 1 on 1 supervision. Record review of the visit note from the Facility Counseling MD dated 10/5/2024 at 12:15 PM indicated Resident #2 shared no recollection of the sexual event but said I must have been inappropriate and offered no other details. Resident #2 presented with a calm demeanor and exhibited no emotional distress. The plan was to continue to provide psychotherapy focused on reducing symptoms of depression, increasing overall sense of well-being, and self-care. Record review of the facility in-service dated 10/5/2024 indicated the staff were educated over dementia care and sexuality. Record review of the facility in-service dated 10/5/2024 indicated the staff were educated over abuse and neglect. Record review of the facility 15-minute activity checks dated 10/4/2024 - 10/5/2024 indicated there had continuously been a staff member 1 on 1 with the Resident #2. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 10/05/24 at 11:30 AM, CNA C was sitting outside of Resident #2's room and said she was on 1 on 1 duty for observation of Resident #2. CNA C said she had been on duty 10/04/24 for the 2:00PM-10:00 PM shift and returned on 10/05/24 at 6:00 AM and she had relieved another CNA who worked from 10/04/24 at 10:00PM until 10/05/24 at 6:00 AM. She said Resident #2 had not had any sexual behaviors and she had never known him to have any. CNA C said she was notified of the incident but had not had an abuse and neglect in-service since the incident. During an observation and interview on 10/05/24 at 11:40 AM, Resident #2 was laying in his bed and said he did not recall a woman in his bed on yesterday 10/04/24, nor did he recall any incident. He said he thought he slept through breakfast 10/04/24. Resident #2 said he did not have any close friends, but he tried to be nice to everyone. During an observation and interview on 10/05/24 at 12:00 PM, Resident #1 was sitting in front of the nurse's station in her wheelchair. She was in a pleasant mood and denied anyone hurting her or touching her inappropriately. During an interview on 10/05/24 at 12:30 PM, the Facility Counseling MD said she had been seeing Resident #2 for 1-2 months. She said he had continued to get adjusted to nursing facility but had never spoken of any type of relationship at the facility. She said he had kept to himself. The Facility Counseling MD said Resident #2 was always alert and oriented to person and place but on 10/05/24 he was not and was very forgetful. He told her he must had been inappropriate but did not indicate what was done. During an interview on 10/05/24 at 1:00 PM, LVN A said on 10/04/24 at about 6:45 AM Resident #1 was sitting at the nurse's station and Resident #2 was sitting in the front lobby. She said 15 minutes later the staff were looking for Resident #1 to go to breakfast and she was not at the nurse's station. LVN A said she went down hall 400 while other staff searched other hallways and she found Resident #1 in the room of Resident #2 laying across the middle of his bed with her pants and brief at her knees and her shirt was up to her chin. She said Resident #2 had his mouth on Resident #1's breast and he was fully clothed. She said Resident #1 had her hands cupped over her perineal area. LVN A said once she knocked Resident #2 sat upright. LVN A said she asked Resident #1 if she was ok, and she shook her head no. She said when she asked Resident #1 if he touched her, she said yes and when she asked if Resident #2 did anything else she said no. LVN A said she assisted Resident #1 to put clothes on and removed her from Resident #2's room and placed Resident #2 on 1 to 1 observation. She said she notified the Administrator, the DON, Resident #1's son, and the doctor of the incident. During an observation and interview on 10/05/2024 at 1:30 PM Resident #2 was sitting in the front lobby with CNA C sitting with him. CNA C said he had no behaviors noted. During an interview on 10/05/24 at 4:11 PM, Resident #2 said he had short term memory problems, but he did now remember Resident #1 coming to his room. He said that was the first time she came in there. He said he assisted Resident #1 onto his bed because he did not have a chair in his room. Resident #2 said he had been friends with her, and he thought it was a mutual thing. He said to his recollection she did not tell him no or stop. He then said he had short term memory problems and did not remember anything else about the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/05/24 at 4:23 PM, the DON said her expectation was for the incident of suspected sexual abuse to be immediately reported to the administrator, as it was, and she then followed up with her. The DON said when there was a resident in harms ways she would step in and ensure the residents were safe. She said CNAs were immediately placed on 1 on 1 with Resident #2 to ensure he did not get to do the sexual behavior again. The DON said that all staff were responsible for ensuring abuse was prevented but the administrator was the abuse coordinator. The failure of not preventing abuse placed residents at risk for trauma, pain, and emotional problems. During an interview on 10/05/24 at 4:30 PM, the Administrator said her expectation was for staff to report things right away and they did. She said all the staff were responsible for ensuring that no resident was subject to abuse and neglect. She said the failure placed a risk for emotional trauma and physical trauma. Record review of the facility's policy titled Abuse effective 02/01/2017 and last revised 01/01/23 indicated: The purpose of this policy is to ensure that each resident has 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 residents, family members, or legal guardians, care taker, friends, or other individuals.