STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675293	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on interview and record review the facility failed to ensure residents with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 3 residents (Resident #1) reviewed for pressure injury. The facility failed to ensure RN E performed wound care to Resident #1's right heel DTI (deep tissue injury-pressure induced damage to underlying tissues to intact skin) per the physician's orders. The facility failed to ensure RN E applied kerlix (rolled gauze) and ace wrap (elastic wrap) appropriately to Resident #1's right foot/leg. These failures could place residents at risk for deterioration of wounds. Findings included: Record review of Resident #1's face sheet dated 10/29/24 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #3 had diagnoses which included diabetes (high blood sugar), pressure induced deep tissue damage of right heel, pressure ulcer to other site (skin/tissue damage caused from pressure), gangrene (dead tissue caused from infection or lack of blood flow), right great toe amputation, and peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 was understood and usually understood others. The MDS indicated Resident #1 had a BIMS score of 12 which indicated he had moderate cognitive impairment. The MDS indicated Resident #1 had one unstageable pressure ulcer due to wound bed coverage of slough/eschar (dead tissue), one unstageable deep tissue injury, and diabetic foot ulcers (open wounds on feet of people with diabetes). The MDS indicated he received dressing changes to feet. Record review of Resident #1's undated care plan indicated he had at deep tissue injury to right heel with an intervention to administer treatments as ordered and monitor for effectiveness. (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
	675293	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's order summary report printed 10/29/24 revealed an order to cleanse right heel with normal saline/wound cleanser and pat dry, apply betadine and leave open to air every day shift for pressure ulcer with a start date of 10/12/24. There was an order to cleanse left foot with normal saline/wound cleanser and pat dry, apply Medihoney, cover with dry dressing, and wrap with rolled gauze every night shift for wound care with a start date of 10/12/24. The was an order to wrap bilateral (both) legs with kerlix and ace wrap for cellulitis/edema every day shift with a start date of 10/20/24. During an observation on 10/29/24 at 10:35 AM, RN E performed wound care to Resident #'s right foot heel wound. RN E washed hands, put on a gown and gloves, then removed the old elastic wrap, rolled gauze, then removed gloves, sanitized her hands, and put on new gloves. RN E then cleansed the wound to right heel with normal saline, patted dry, applied Medihoney (medical grade honey used to treat wounds), covered the right heel with a dry adhesive dressing. RN E then removed her gloves and gown and placed in the trash. RN E then proceeded to wrapped Resident #1's right foot with rolled gauze from behind his toes to just above his ankle and then wrapped the same area with an elastic wrap without wearing gloves or a gown. During an interview on 10/29/24 at 4:30 PM, RN E said she had worked at the facility for two weeks and had only worked five shifts. RN E said she did not know the residents well yet. RN E said she performed wound care to Resident #1's right foot that morning. RN E said she cleansed Resident #1's right heel with normal saline, patted it dry, and applied Medihoney, and covered it with a dry dressing per his orders. Surveyor asked RN E to confirm orders and she pulled up Resident #1's orders in the computer and said the right foot was supposed to have been painted with betadine. RN E said she thought she had been putting the Medihoney on it because it had an open area. RN E said the order for the kerlix (rolled gauze), and ace (elastic) wrap was supposed to be to both legs and would be like she had applied it to his feet above the ankle. RN E said if she did not perform wound care per the physician's orders, it could place the resident at risk of sepsis, infection, and could impede the healing of his wounds. RN E said she would let the physician and the DON know of her mistake and redo Resident #1's wound care to his right heel wound. During an interview on 10/30/24 at 2:34 PM, NP F said the paint with betadine was for Resident #1's right heel to dry out the scab and ensure no infection. NP F said the Medihoney was for the plantar (bottom of foot) wound on the left foot with the slough (dead tissue). NP F said he removed the slough to the left foot plantar wound last visit to improve the granulation and to improve the wound. NP F said the Medihoney was not a good choice for the scab on the right heel because it could cause the scab to fall off and introduce infection. NP F said Medihoney was for a healthy wound with good tissue, or it could be used for chemical debridement (removal) of slough/dead tissue. NP F said he would expect his wound care orders to be followed because his orders were what he felt was best to treat the wounds. NP F said Resident #1 had venous problems and needed to control the edema in his legs or the wounds would not heal. NP F said the rolled gauze and elastic wrap was for light compression of the legs to control edema and improve blood flow. NP F said there should be no pressure on the DTI on the right heel. NP F said the rolled gauze and elastic wrap should be from the base of toes up to below the knees, and the area of the DTI on the right heel should be left opened. NP F said the Resident #1 had a venous problem and he could have increased swelling if the facility was only wrapping to the top of his ankles, but he did not feel there would be a negative issue to the DTI. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675293	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 3:22 PM, the ADON said she was also the Infection Preventionist. The ADON said betadine was used on DTIs to draw the fluid out of the wound scab to help it shrink the wound without the wound opening. The ADON said Medihoney would be used to heal an open wound. The ADON said by RN E using Medihoney on the DTI, it could cause the scab to come off the DTI, causing it to open and cause further damage. During an interview on 10/30/24 at 3:41 PM, the DON said Medihoney on a DTI could cause the wound to open and deteriorate. The DON said RN E was very upset that she made the mistake of performing the wrong wound care to Resident #1's right foot. The DON said rolled gauze and elastic wrap to bilateral legs should be wrapped from behind the resident's toes to mid-calf area and the DTI to Resident #1's right heel should not be covered to not put more pressure on it. The DON said by RN E wrapping over the DTI on the right heel, it could cause increased pressure to the area and actually cause it to open and impede the healing process. The DON said she was responsible for ensuring staff were educated and performing resident care appropriately. During an interview on 10/30/24 at 4:22 PM, the ADM said she would expect staff to follow the facility's policies. The ADM said she would expect staff to follow the physician's orders. The ADM said physician's orders should be followed to prevent negative resident outcomes. The ADM said if staff were not following the physician's orders for wound care, it could negatively affect the wound healing. The ADM said the nurse managers, the DON and the ADON, were responsible for ensuring staff were performing resident care appropriately and per the facility's policies, but as the ADM, she was ultimately responsible. Record review of the facility's policy titled Skin Management: Prevention and Treatment of Wounds dated 10/06/2022 indicated . the purpose of this procedure was for prevention and treatment of skin breakdown such as pressure injuries, diabetic ulcers, arterial ulcers, and skin wounds .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675293	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation, interviews and record review, the facility failed to ensure a resident with urinary incontinence, based on the resident's comprehensive assessment, received appropriate treatment and services to prevent urinary tract infections (UTI) for 1 of 5 residents (Residents #2) reviewed for urinary catheters. 1. The facility failed to ensure Resident #2 had an indwelling urinary catheter (tube inserted into the bladder to drain urine) securement/anchor device (used to secure an indwelling urinary catheter). 2. The facility failed to ensure CNA A performed hand hygiene and changed gloves appropriately while providing incontinent care/indwelling urinary catheter care to Resident #2. These failures could place residents at risk for indwelling urinary catheter dislodgement, urethral (empties urine from the bladder and out of the body) damage, pain, and urinary tract infections. Findings included: 1. Record review of Resident #2's face sheet dated 10/30/24 indicated she was [AGE] years old and was admitted to the facility on [DATE]. Resident #2 had diagnoses which included mild dementia (progressive or persistent loss of intellectual functioning with impairment or memory and thinking and often with personality changes), history of femur fracture (broken long bone of upper leg), weakness, and lack of coordination. Record review of Resident #2's admission MDS assessment dated [DATE] indicated Resident #2 was understood and understood others. The MDS indicated Resident #2 had a BIMS score of 13 which indicated she was cognitively intact. Resident #2 required maximal assistance from staff for toileting hygiene. The MDS indicated Resident #2 had an indwelling catheter (urinary catheter) and was occasionally incontinent of bowel. The MDS indicated Resident #2 had obstructive uropathy (urine could not drain through the urinary tract due to blockage). Record review of Resident #2's care plan, initiated on 8/20/24, indicated she had an indwelling catheter and was at risk for increased UTIs due to Obstructive Uropathy and she was on enhanced barrier precautions (EBP) related to having an indwelling catheter with interventions to maintain EBP when performing any type of device care such as but not limited to urinary/catheter care. Record review of Resident #2's Order Summary Report dated 10/30/24 revealed an order to check foley catheter placement, ensure foley was secured to reduce friction and pulling every shift with an order date of 8/23/24. Record review of Resident #2's TAR dated 10/01/24-10/31/24 indicated LVN B documented on 10/30/24 on the day shift indicating she had checked Resident #2's foley catheter placement and ensured foley was secured by a catheter secure to reduce friction and pulling. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675293	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/30/24 at 1:46 PM, CNA A and CNA B entered Resident #2's room to perform incontinent care and urinary catheter care on Resident #2. CNA A and CNA B went to the resident's bathroom and washed their hands, and then put on gowns and gloves. CNA A then put a gait belt around Resident #2's waist while she was sitting in an electric recliner/lift chair, then CNA A reached across the resident and got the lift chair remote and raised the lift chair to an almost standing position and placed the Resident #2's walker in front of her. CNA A and CNA B assisted Resident #2 to a standing position. CNA A then moved Resident #2's wheelchair out of the way, while CNA B assisted Resident #2 to her bed. CNA A then went into the Resident #2's closet cabinet and got a clean brief and brought it back to Resident #2's bedside table, then CNA A grabbed the resident's bed remote and raised the bed. CNA B pulled the Resident #2's pants down to her ankles, while CNA A placed supplies on the bedside table. Then CNA A unfastened Resident #2's brief and pushed down between Resident #2's legs. CNA A then proceeded, without changing her gloves or performing hand hygiene, to obtain a moistened wipe from the bedside table with her right hand and placed her left hand on the resident's labia (outer parts of the female private parts) to hold open and then cleansed the foley catheter tube with the wipe going down the tubing in the direction away from the resident's body, repeating twice, then she cleaned the areas on each side of the catheter with a clean wipe. Then CNA A assisted Resident #2 turn onto her left side by placing her left same gloved hand on the resident's side over her shirt and her same gloved right hand and on her bare hip, then CNA A proceeded to clean a small bowel movement from the resident's bottom. CNA A then removed the old brief from under Resident #2 and discarded it and then removed her gloves. CNA A went to the bathroom and washed her hands, put on clean gloves, while CNA B placed a clean brief under Resident #2. CNA A and CNA B then assisted Resident #2 to turn back onto her back and CNA A placed a new catheter securement device on the Resident #2's right upper leg and secured the brief in the front. CNA A and CNA B then pulled Resident #2's pants up. CNA A said Resident #2 did not have a catheter securement device on when they changed Resident #2, and she should have had one. CNA A said she did not know how long Resident #2 had not had a catheter securement device. During an interview on 10/30/24 at 2:23 PM, Resident #2 said she thought the staff were real good at the facility. Resident #2 said she did not know how long she had not had a catheter securement device. During an interview on 10/30/24 at 2:05 PM, CNA B said she had worked at the facility since 10/17/24 and normally worked the night shift. CNA B said CNA A should have changed gloves after touching Resident #2's things and prior to providing urinary catheter care. CNA B said if staff touched something dirty and then touched the urinary catheter, it could spread germs and cause the resident an infection. CNA B said residents with urinary catheters were supposed to have a securement device. CNA B said the device kept the catheter from pulling/tugging on the resident. During an interview on 10/30/24 at 2:14 PM, CNA A said she had worked at the facility PRN for about three months. CNA A said the urinary catheters should have a catheter securement device to secure the catheter, so it does not pull, or tug and it also keeps the catheter in place. CNA A said she should have changed her gloves before starting urinary catheter care after touching multiple items in Resident #2's room to protect Resident #2 from any germs that may have gotten on her gloves and then spread to the urinary catheter. CNA A said not changing her gloves prior to performing urinary catheter care placed Resident #2 at a higher risk of infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675293	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 3:22 PM, the ADON said she was also the facility's Infection Preventionist. The ADON said CNA A should have changed her gloves after touching multiple items in Resident #2's room and before performing urinary catheter care. The ADON said anything that could have been on the resident's items had contaminated CNA A's gloves and was transferred to Resident #2's urinary catheter and placed Resident #2 at risk of infection. The ADON said a urinary catheter should have a securement device in place, so the urinary catheter does not pull or tug on the resident. The ADON said if there was not a catheter securement device in place, the catheter could get pulled out, tear the resident's urethra, and could cause an infection/UTI. During an observation and interview on 10/30/24 at 3:32 PM, LVN B said she had worked at the facility for a couple of weeks. LVN B said she was Resident #2's nurse for the day. LVN B said she was not sure if she had charted in Resident #2's TAR that she had checked to ensure Resident #2's urinary catheter was in place and had a catheter securement device in place. LVN B looked in the computer. LVN B said she had checked that it was completed on the TAR, but LVN B said she did see Resident #2's urinary catheter was draining clear urine, but LVN B said she did not actually visualize Resident #2 had a catheter securement device attached to her catheter. LVN B said the catheter securement device was to keep the urinary catheter in place and to keep it from pulling and to cut down on UTIs. LVN B said if she was checking it off as done on the TAR, she should be making sure the catheter securement device was actually there. LVN B said it was habit to go down the list in the TAR and to check things off. During an interview on 10/30/24 at 3:41 PM, the DON said CNA A should have washed her hands and put on clean gloves prior to performing Resident #2's urinary catheter care. The DON said CNA A touched everything in the resident's room and contaminated her gloves and then transferred whatever could have been on her gloves to Resident #2's foley catheter. The DON said it was an infection control issue and placed Resident #2 at risk of infection. The DON said urinary catheters should have a securement device to keep it from pulling/dislodging. The DON said LVN B should not be documenting the securement device was in place without visually confirming it. The DON said she was responsible for ensuring staff were providing resident care appropriately and per the facility's policies. During an interview on 10/30/24 at 4:22 PM, the ADM said she would expect staff to follow the facility's policies. The ADM said she would expect staff to follow the physician's orders. The ADM said physician's orders should be followed to prevent negative resident outcomes. The ADM said if Resident #2 had an order for a urinary catheter securement device, she would expect staff to ensure the resident had it in place. The ADM said she was not a nurse but would think the urinary catheter securement device was to prevent the urinary catheter from dislodging and for the comfort of the resident. The ADM said CNA A should have changed her gloves after handling multiple things in Resident #2's room that could have been contaminated and before performing urinary catheter care. The ADM said by CNA A not changing her gloves before providing urinary catheter care placed the resident at risk of infection or causing illness. The ADM said the nurse managers, the DON and the ADON, were responsible for ensuring staff were performing resident care appropriately and per the facility's policies, but as the ADM, she was ultimately responsible. Record review of the facility's policy titled Perineal Care dated 10/01/2021 indicated . it was the policy of the facility to provide cleanliness and comfort to the resident, to prevent infections and skin irritation . place the equipment on the bedside stand . arrange the supplies so they could be easily reached . wash and dry hands thoroughly . fold bedspread or blanket toward the foot of the bed . raise the gown or lower the pajamas . put on gloves . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675293	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Catheters-Insertion and Care: Indwelling, Straight, Supra-pubic, and External dated 04/2021 revealed . it was the policy of the community that the resident with a urinary catheter would be provided services in a safe and appropriate manner to minimize the risks of urinary tract complications . attach catheter strap to leg to assist in securing tubing . Record review of the undated CDC Indwelling Urinary Catheter Insertion and Maintenance revealed CAUTI (catheter-associated urinary tract infections) were costly and increased morbidity . maintenance catheter care essentials . when an indwelling urinary catheter was indicated, the following interventions should be in place to help prevent infection . use indwelling catheters only when medically necessary . properly secure indwelling catheters to prevent movement and urethral traction . maintain good hygiene at the catheter-urethral interface . maintain unobstructed urine flow . maintain drainage bag below level of bladder at all times . use a catheter securement device to anchor the catheter . perform peri and catheter care per facility policy . assess the patient for any pain or discomfort . inspect for redness, irritation and drainage . once a urinary catheter was inserted, maintaining it according to evidence-based guidelines was crucial to prevent CAUTI .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675293	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 5 residents (Resident #1 and Resident #3) reviewed for infection control. 1. The facility failed to ensure RN E followed the Enhanced Barrier Precautions (EBP) (interventions to prevent spread of infection in high-risk residents) policy of wearing a gown and gloves until she completed Resident #1's pressure ulcer wound care to his right heel. 2. The facility failed to ensure CNA D followed the EBP policy of wearing a gown while performing urinary catheter (tube inserted into the bladder to drain urine) care for Resident #3 who had a urinary catheter. 3. The facility failed to ensure CNA D changed her gloves after providing urinary catheter care to Resident #3 prior to touching Resident #3's clean catheter securement device, brief, bedding, pillows, and catheter drainage bag. These failures could place residents at risk for cross-contamination, increased risk of infection and the spread of infection. Findings included: 1. Record review of Resident #1's face sheet dated 10/29/24 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #3 had diagnoses which included diabetes (high blood sugar), pressure induced deep tissue damage of right heel, pressure ulcer to other site (skin/tissue damage caused from pressure), gangrene (dead tissue caused from infection or lack of blood flow), right great toe amputation, and peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 was understood and usually understood others. The MDS indicated Resident #1 had a BIMS score of 12 which indicated he had moderate cognitive impairment. The MDS indicated Resident #1 had one unstageable pressure ulcer due to wound bed coverage of slough/eschar (dead tissue), one unstageable deep tissue injury, diabetic foot ulcers (open wounds on feet of people with diabetes), and MASD (moisture associated skin damage). The MDS indicated he received dressing changes to feet. Record review of Resident #1's undated care plan indicated he was on EBP for chronic wound or skin opening requiring a dressing change with the following interventions: place EBP sign inside resident's room within close proximity to resident to inform staff of resident specific needs; staff would maintain EBP while performing any type of device care such as urinary catheter care and wound care. The care plan indicated Resident #1 had at deep tissue injury to right heel. The care plan indicated Resident #1 was at risk for frequent infections related to diabetes. The care plan indicated Resident #1 had cellulitis (bacterial skin infection) to both feet/legs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675293	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/29/24 at 10:35 AM, RN E performed wound care to Resident #'s right foot heel wound. RN E washed hands, put on a gown and gloves, then removed the old elastic wrap, rolled gauze, then removed gloves, sanitized her hands, and put on new gloves. RN E then cleansed the wound to right heel with normal saline, patted dry, applied Medihoney (medical grade honey used to treat wounds), covered the right heel with an adhesive dressing. RN E then removed her gloves and gown and placed in the trash. RN E then proceeded to wrapped Resident #1's right foot with rolled gauze from behind his toes to just above his ankle and then wrapped the same area with an elastic wrap without wearing gloves or a gown. During an interview on 10/29/24 at 4:30 PM, RN E said she had worked at the facility for two weeks and had only worked five shifts. RN E said she removed her gown and gloves after applying the adhesive dressing over Resident #1's right heel wound because the wound was covered, and she did not think she needed them anymore. RN E said she had just been educated about the EBP and the facility was not good about telling them things. RN E said she should have worn the gown and put gloves back on to apply the rolled gauze and elastic wrap to prevent the potential spread of infection. 2. Record review of Resident #3's face sheet dated 10/29/24 indicated he was [AGE] years old and admitted to the facility initially on 3/10/23 and readmitted on [DATE]. Resident #3 had diagnoses which included neuromuscular dysfunction of bladder (nerves and muscles controlling the bladder do not work), diabetes (high blood sugar) with gangrene, cellulitis of leg lower extremity (bacterial infection), and right below the knee amputation. Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated Resident #3 was understood and understood others. The MDS indicated Resident #3 had a BIMS score of 15 which indicated he was cognitively intact. Resident #3 was dependent on staff for toileting hygiene. The MDS indicated Resident #3 had an indwelling catheter (urinary catheter) and was always continent of bowel. Record review of Resident #3's undated care plan indicated he was on EBP for chronic wound or skin opening requiring a dressing change and had an indwelling catheter with the following interventions: place EBP sign inside resident's room within close proximity to resident to inform staff of resident specific needs; staff would maintain EBP during high contact resident care activities such as providing hygiene, changing briefs, or toileting; staff would maintain EBP while performing any type of device care such as urinary catheter care and wound care. The care plan indicated Resident #3 had an indwelling catheter and was at risk for increased UTIs and chronic infection. The care plan indicated Resident #3 was at risk for frequent infections related to diabetes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675293	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/29/24 at 2:40 PM, CNA D performed urinary catheter care on Resident #3. CNA D washed her hands in the resident's bathroom, put on gloves, filled a wash basin with soapy water and placed on Resident #3's bedside table as she moved his things. CNA D removed Resident #3's brief and placed in the trash and then removed her gloves, performed hand hygiene with ABHR and put on clean gloves. CNA D did not put on a gown prior to leaning over Resident #3's bed allowing the front of her clothing to touch the resident's sheets and pillow used to prop his left leg on. CNA D then proceeded to perform urinary catheter care by using a multi-folded washcloth to clean the urinary catheter insertion site at the head of the penis (male organ used for urination), penis shaft, and the urinary catheter tubing using a clean area of the washcloth and wiping away from the resident down tubing appropriately. CNA D did not change her gloves then proceeded to remove Resident #3's catheter securement device from his left leg and then she washed the area of the leg. CNA D did not change gloves and proceeded to replace the catheter securement device with a new one to his left leg. CNA D then proceeded without changing gloves to remove the pillows from under Resident #3's legs and placed on opposite side of the bed by reaching across the bed allowing her clothing to touch resident's bedding. CNA D then proceeded to help resident put on a new brief and picked up his urinary catheter bag from the bed rail and put it through the leg of the new brief and helped pull the brief up toward his waist. CNA D then took the wash basin to the bathroom and dumped the water in sink and removed gloves and washed her hands. There was an Enhanced Barrier Precautions sign on Resident 3's bathroom wall and a cart with PPE also in the bathroom. During an interview on 10/29/24 at 3:00 PM, CNA D said she had worked at the facility for almost two years as a CNA. CNA D said she had received education on infection control upon hiring and she had been in-serviced on EBP in the past. CNA D said she just completely forgot to change her gloves after cleansing Resident #3's private areas and urinary catheter. CNA D said by not changing her gloves appropriately, she cross-contaminated from his penal area to the rest of his stuff, bedding, and bedside table. CNA D said by not changing her gloves it placed the resident at risk of infection. CNA D said the EBP was for anytime a resident had an internal device or wound and staff should wear gown and gloves to protect the resident from staff. CNA D said Resident #3 had urinary catheter and she should have worn a gown and gloves during his care, but she was nervous and forgot. CNA D said wearing the gown and gloves prevented staff from transferring germs or bacteria from staff to the residents. CNA D said the EBP was to prevent the spread of infection. During an interview on 10/30/24 at 3:00 PM, Resident #3 said he felt his care, and everything was going great, and he had no concerns. Resident #3 said he did not remember anyone wearing a gown when performing any care for him, but he did not require much care due he was able to most of it himself. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675293	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 3:22 PM, the ADON said she was also the Infection Preventionist. The ADON said CNA D should have removed her gloves after performing urinary catheter care to Resident #3. The ADON said CNA D contaminated the resident's room when she touched multiple items in his room wearing the same gloves, she used to clean his urinary catheter. The ADON said CNA D should have also been using the EBP of gown and gloves while performing close contact care. The ADON said the purpose of the EBP was to protect the resident from transferring germs/bacteria from staff to residents and residents to staff, and for both of their safety and health. The ADON said CNA D contaminated Resident #3's entire room by touching multiple items in his room with the same gloves used to perform urinary catheter care and by allowing her clothing to come in contact with his bedding, she could have potentially transferred anything to him from another resident or from him to another resident. The ADON said EBP should be used through the completion of performing wound care to prevent the potential of spreading infection. During an interview on 10/30/24 at 3:41 PM, the DON said CNA D should have changed her gloves when going from clean to dirty after performing catheter care on Resident #3 to prevent from transferring anything that was on his urinary catheter. The DON said whatever was on his urinary catheter was on everything else she touched with the same gloves. The DON said CNA D should have changed gloves to prevent the spread of infection. The DON said CNA D should have been wearing a gown and gloves when providing close contact care for EBP to prevent spread of infection in high-risk residents with urinary catheters or wounds. The DON said RN E should have continued to wear a gown and gloves while completing the wound care on Resident #1 to prevent the potential for spreading infection. The DON said the EBP protects both the resident and staff from spreading infection. The DON said she was responsible for ensuring staff were educated and performing resident care appropriately. During an interview on 10/30/24 at 4:22 PM, the ADM said she would expect staff to follow the facility's Infection Control policies. The ADM said CNA D should have changed her gloves when they became contaminated prior to handling multiple items in Resident #3's room. The ADM said CNA D should have been wearing a gown and gloves while providing urinary catheter care to Resident #3 as part of the EBP to prevent the spread of infections. The ADM said by CNA D not wearing a gown and gloves during urinary catheter care or changing her contaminated gloves after providing urinary catheter care on Resident #3 ran the risk of spreading germs and creating an infection. The ADM said the nurse managers, the DON and the ADON, were responsible for ensuring staff were performing resident care appropriately and per the facility's policies, but as the ADM, she was ultimately responsible. Record review of the facility's policy titled Infection Control Plan with a revised date of 10/25/22 indicated . the communities' infection control policies and practices were intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections . all personnel would be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675293	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Linden	1201 W Houston St Linden, TX 75563

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Enhanced Barrier Precautions dated 4/01/24 indicated . Enhanced Barrier Precautions (EBP) were a CDC guidance to reduce the transmission of Multidrug-resistant organism (MDRO) in the health care settings, including nursing homes . EBP require team members to wear a gown and gloves while performing high-contact care activities with residents who were infected or colonized with a targeted MDRO, or have an open wound or indwelling medical device . determine if a resident had any wounds . determine if any of the following indwelling medical devices were in use . urinary catheter . EBP would be implemented if any of the above . wounds . invasive medical devices were present . place signage on resident's closet door, maintain PPE (personal protective equipment) in resident's room and assure all team members were aware of resident status and need for EBP during high contact care . high contact resident care activities . bathing/showering . providing hygiene . changing briefs or assisting with toileting . device care . urinary catheter . wound care .