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	04/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44128 Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, or mistreatment are reported immediately or not later than 2 hours for 1 of 6 residents reviewed for abuse and neglect. (Resident #1) The facility staff (RCP A, LVN B, and the Social Worker) failed to report an allegation of abuse immediately to the Abuse Coordinator after Resident #1 alleged that RCP D threw a blanket on her face and told her to shut the hell up. This failure could place residents at risk for abuse and neglect. Findings included: Record review of a face sheet dated 04/09/25 revealed Resident #1 was a [AGE] year-old female and was admitted on [DATE] with diagnoses including schizoaffective disorder bipolar type (combines symptoms of both schizophrenia (like hallucinations and delusions) and bipolar disorder (like mania and depression), diabetes, and high blood pressure. Record review of a quarterly MDS dated [DATE] revealed Resident #1 was understood and understood others. The MDS revealed a BIMS score of 9, indicating moderate cognitive impairment. The MDS indicated Resident #1 required substantial to maximal assistance with most ADLs. Record review of a care plan last revised on 04/10/25 revealed Resident #1 was verbally aggressive related to schizoaffective disorder and mental/emotional illness, ineffective coping skill and poor impulse control with past history of verbal disruption, screaming, cursing, making accusations, telling family untruths about staff and other residents. This focus area of the care plan was last revised on 04/17/23. (continued on next page)

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	04/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an undated and untimed written statement of LVN B indicated, On 4/1/25 the 6-2 RCP (RCP A) told me that (Resident #1) had a complaint against (RCP D), the 10-6 rcp from the previous night. I went to speak with (Resident #1), and she stated that the night before (RCP D) threw a blanket at her head and told her to shut the hell up. I asked he if she was okay, and she said yes. She did not have any notable injuries. I asked her why (RCP D) would have done that, and she said she did not know. I informed her that I would tell the administrative team, and someone would come speak to her. I then went to the social worker's office and reported what the resident had told me. The statement indicated it was obtained by the DCO and the ADCO. The statement was signed by the DCO and the ADCO. Record review of an undated and untimed statement by the Social Worker indicated, Resident (Resident #1) state that she wanted to tell me about (RCP D) last night. (RCP D) got mad at her because she told her to pick up the bowls and stuff. (RCP D) threw a blanket at her, and it hit the top of her, and she didn't say she was sorry. The statement was signed by the Social Worker. Record review of a Disciplinary Action Record dated 04/01/25 indicated RCP D was suspended pending investigation of physical abuse allegation made by a resident. The record indicated RCP D was notified of the suspension by phone on 04/01/25 at 2:41 p.m. The record was signed by the ADCO and the DCO. Record review of a police Incident Report dated 04/01/25 at 3:19 p.m. indicated .On April 1, 2025, (police officer) was dispatched to (the facility). Upon arrival, I was met by the Administrator (EDO) .(the EDO) stated that there was an incident where a resident (Resident #1) accused a worker of hitting her in the face with a blanket .(Resident #1) state that a nurse, (RCP D) got mad at her because she asked her to clean her room and take her food tray. (Resident #1) stated that at this point, (RCP D) who was standing in the hallway, threw a blanket and hit her in the face with it .(RCP 1) said in her statement that she was doing rounds and that she would come back to pick up trays after she was finished .(RCP D) said in her statement .she overheard (Resident #1) calling to someone to bring her a blanket and that is when (RCP D) got the blanket and went into the room. (RCP D) said that when she unfolded the blanket, she fanned it up and the edge of it brushed against (Resident #1's) face. (RCP D) said that she was sorry for that immediately and said it was an accident. (Resident #1) was not in any pain or discomfort when (RCP D) left the room according to her statement. Based on my interviews and observations, I believe that this was an unintentional accident and that (RCP D) did fan the blanket, but there was no intention to harm (Resident #1). Record review of an undated Investigation Summary indicated, .Based upon the outcome of the investigation, it was determined that several facility employees failed to follow policy and procedure of notifying the Abuse Coordinator immediately when a suspected/actual resident abuse allegation occurs. The employees received individualized education from the EDO. The social services director was sent home once this was discovered and allowed to return after the investigation was complete. The EDO provided 1:1 education to this employee upon return. Record review of an In-service & Education Record dated 04/02/25 at 9:45 a.m. indicated the EDO educated the Social Worker on .All allegations of abuse, neglect or misappropriation must be reported timely to the Abuse Coordinator EDO is the Abuse Coordinator. The DCO will serve in this capacity in the absence of the EDO .Failure to comply with this requirement will result in disciplinary action to include possible immediate termination . (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	04/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an In-service & Education record dated 04/01/25 indicated the DCO educated LVN B on Any allegations of abuse/neglect/misappropriation must be reported to Abuse Prevention Coordinator . During an observation and interview on 04/09/25 at 10:20 a.m., Resident #1 was resting in bed. There was no bruising or signs of abuse. She said on 3/31/25 she asked RCP D if she would pick up her meal tray. She said when RCP D came in the room she then asked for a blanket. She said RCP D threw the blanket on her and did not spread it out. She said RCP D did not say anything to her. She said she was not injured in any way. She said she reported the incident the next morning to RCP A and RCP A reported it to LVN B. She said RCP D no longer provided care to her and she was ok with it. She said she was not afraid to live in the facility. She said she had no other issues with any staff members. During an interview on 04/09/25 at 10:59 a.m., LVN B said she did not know the specific date of the incident concerning Resident #1. She said RCP A came to her and told her what Resident #1 had reported to her. LVN B said RCP A told her that Resident #1 said RCP D threw a blanket over her head and told her to shut the hell up. She said Resident #1 did not like RCP D. She said she went in to talk to Resident #1. She said Resident #1 told her that RCP D threw a blanket at her head and told her to shut the hell up. She said Resident #1 told her she did not like RCP D, and she was going to try to get another aide in trouble because she did not like her either. She said the EDO (the Abuse Coordinator) was not in the facility at the time, so she did not report the allegation to her. She said she reported the incident immediately to the social worker. She said she was told later that she should have reported the incident to the EDO. During an interview on 04/09/25 at 11:33 a.m., the Social Worker said she interviewed Resident #1 on the morning of 4/1/25 after the incident was reported to her by LVN B. She said LVN B told her Resident #1 was upset with RCP D. The Social Worker said Resident #1 told RCP D threw a blanket on her head. She said the only other thing she told her was that RCP D did not apologize. She said Resident #1 never told her that RCP D said to shut the hell up. The Social Worker said Resident #1 always upset with someone. She said the resident made false accusations against staff. She said she knew the allegation was reported to her before the morning meeting. She said she was disciplined for not reporting the allegation to the EDO. She said she never reported the allegation to the Administrator and did not know how she found out. She just brought me into the office. During an interview on 04/09/2025 at 12:40 p.m., the Social Worker said she said she just did not pay enough attention to what LVN B was telling her. She said she thought LVN B was reporting the behavior of Resident #1 and not that RCP D may have done something abusive. She said she did not realize that it was an abuse allegation until after she was called into the EDO's office. She said she interviewed the resident after leaving the EDO's office and that was when Resident #1 told her that RCP D had thrown the blanket. During an attempted interview on 04/09/2025 at 1:55 p.m., a call was made to interview RCP A. There was no answer. Left a detailed message requesting a return call. A return call was not received. (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	04/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/09/2025 at 2:27 p.m., RCP D said she did not know anything about the allegation made by Resident #1 until she was questioned about it. She said she never threw a blanket. She said she never told the resident to shut up. She Resident #1 was upset with her because she did not pick up the evening meal tray as fast as she wanted her too. She said she did bring Resident #1 a blanket and when she spread the blanket out it did cover her face. She said she immediately removed the blanket and told her she did not mean for that to happen. She said she apologized to the resident. She said she had been reassigned and would not be providing care to Resident #1. During an interview on 04/09/2025 at 2:41 p.m., LVN B said RCP A reported the allegation made by Resident #1 at approximately 10:00 a.m. She said she reported the incident immediately to the Social Worker. She said she did not report it to the EDO because she was not at the facility at the time. She said she was told later that she still should have notified the EDO. She said she really was not thinking about abuse. She said she was thinking more about the resident's behaviors and had been told to report any behaviors to the social worker. She said she then told the DCO at approximately 12:45 p.m. During an interview on 04/09/25 at 2:51 p.m., the DCO said the allegation of abuse made by Resident #1 was reported to the state on 04/01/25 but happened on 03/31/25. She said Resident #1 had asked to speak to her. She said Resident #1 told her RCP D got a blanket and threw it on her from the hallway. She said there were no witnesses to the incident. She said RCP D told her she fanned the blanket out and it went in the resident's face accidently. She said she pulled the blanket down immediately. She said when she first started interviewing RCP D, she did not know what she was talking about. The DCO said she found out about the allegation at approximately 1:00 p.m. on 04/01/25. She said she talked to LVN B. She said LVN B told her she was following instructions from a previous DCO to report any behaviors of Resident #1 to the Social Worker. She said Resident 1's version differed depending on who she told the allegation to. She said she was the one who reported the incident to the EDO. She said she would have expected for the Social Worker to have reported the incident to the EDO immediately after it was reported to her by LVN B. She said allegations of abuse not being reported timely could lead to abuse possibly continuing if it was actually occurring. During an interview on 04/09/25 at 3:28 p.m., the EDO said Resident #1 alleged that evening (03/31/25) RCP D threw a blanket from the hallway that landed on her head and told her to shut the hell up. She said RCP D said she got the resident a blanket. Unfolded the blanket, fluffed it out and touched the resident on the face. RCP D said she removed the blanket and said she was sorry. She said Resident #1 then reported the allegation of abuse to RCP A. The EDO said she was not in the building at the moment. She said RCP A told LVN B about the allegation made by Resident #1. She said LVN B ended up reporting the allegation to the Social Worker. She said once she found out about the allegation, she sent the Social Worker home and did a one on one with her after she returned to worked. She said LVN B and RCP A was given one on one education also. She said it was about three hours from the time the allegation was made to RCP A and LVN B and the time she found out about the allegation. She said the DCO was who reported it to her around 1:00 p.m. She said she would have expected RCP A, LVN B, and the Social Worker to have reported the allegation to her sooner. She said she was out of the facility, but her number was at the desk, and they could have called her. She said she expected all allegations of abuse to be reported to her immediately. She said allegations not being reported timely limited her options to intervene and take action. (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	04/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an Abuse facility policy last revised on 01/01/23 indicated, .The facility staff will adhere to the policies and procedures and will follow the guidelines in the written policy and procedure .All events that involve an allegation of abuse or involve a suspicious serious bodily injury of unknown origin must be reported immediately or not later than 2 hours of alleged violation .

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	04/09/2025

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 0689 Level of Harm - Actual harm 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** 44128 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as possible and provide supervision to prevent avoidable accidents for 1 of 6 residents reviewed for accidents. (Residents #2) The facility failed to keep Resident #2 free of injury after her bed rolled, hitting a wall, while LVN C provided incontinent care. This failure could place residents at risk of injury from accident and hazards. Findings included: Record review of the face sheet dated 04/09/25 revealed Resident #2 was [AGE] years old and admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (lung disease), peripheral vascular disease (a condition where blood vessels outside the heart and brain become narrowed or blocked, restricting blood flow, often to the legs and feet), and acquired absence of right leg above the knee. Record review of the quarterly MDS dated [DATE] revealed Resident #2 was understood and understood other. The MDS indicated Resident #2 had a BIMS of 8 which indicated moderate cognitive impairment. The MDS indicated Resident #2 dependent on staff for toileting hygiene and required moderate assistance with personal hygiene. The MDS indicated Resident #2 required substantial/maximal assistance with rolling left and right. Record review of the care plan last revised on 01/28/25 indicated Resident #2 had an ADL self-care performance deficit related to an acquired absence of right leg above the knee requiring extensive assistance. The care plan indicated the resident was able to turn with extensive assistance. The care plan indicated during incontinent care, nurse was assisting Resident #2 to turn to right side. While rolling the bed rolled into the wall causing resident to roll too far and hit the wall with foot, head, and left hand. The care plan indicated the resident had 2 metatarsal fractures. There was an intervention to send the resident to the emergency room for evaluation and for the resident to be a 2 person assist during incontinent care. The interventions were initiated on 03/24/25. Record review of an incident report dated 03/23/25 at 5:50 a.m. indicated, .During incontinent care, nurse was assisting resident to turn to right side. While rolling, the bed rolled into wall causing resident to roll too far and hit the wall with foot, head, and left hand. Resident states that when she was rolling she hit her foot on the food board and her knuckles on both hands on the wall .No injuries observed at time of the incident . Level of Pain: 0 . The incident report was completed by LVN C. Record review of a Nurses Note for Resident #2 dated 03/23/25 at 5:58 a.m. by LVN C indicated, During resident care was turning resident to change pull up and bed was not locked. When bed rolled to the wall resident ended up rolling over to fall hitting the wall. Assessed and not noted bruising at this time. Resident has no complaints of pain . (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	04/09/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of a report of an X-Ray of Resident #2's left hand dated 03/23/25 indicated, .Lucency (an area where the X-ray beam passes through more easily, appearing darker or less dense on the image) involving the distal (situated away from the center of the body) aspect of the ulna (one of the two bones in the forearm, located on the pinky side of the hand, and is the longer of the two), which may reflect a nondisplaced fracture . Record review of a report of an X-ray of Resident #2's left foot dated 03/23/25 indicated, Acute fractures involving the second and third metatarsal (bones of the toe) necks, relatively nondisplaced .Mineralization is decreased . Record review of hospital records for Resident #2 dated 03/23/25 indicated, Patient presents with .an injury to head while turning her in the bed .she is here for complaints of pain in both hands and pain in the left foot and toe area . Patient complaint of discomfort to palpation of both hands. Bruising and small abrasions to the hands are noted .examination of the left foot reveal tenderness along the foot into the toes . Patient's workup returned with fractures of the second and third metatarsals (bones of the toe. Degenerative changes are noted throughout the other x-ray .She will need orthopedic referral for treatment of her foot . Record review of a Nurses Note for Resident #2 dated 03/24/25 at 2:47 p.m. by the ADCO indicated, Resident up in w/c (wheelchair) .Resident has no complaint of pain or discomfort at this time. Continues with bruising to the top of bilateral hands with small skin tears to the left. Redness and light bruising noted to left side of forehead .continues ace wrap to left foot for comfort. Resident has two fractured toes . Record review of a Weekly Skin Assessment for Resident #2 dated 03/24/25 indicated bruising bilateral hands. The report indicated skin tears to left hand, right hand, and right elbow. The skin assessment was signed by the DCO. Record review of Orthopedic Surgeon notes dated 04/09/25 indicated second and third metatarsal (bones of the toes) neck fractures left foot and distal ulna (lower arm bone nearest the 5 finger) left wrist. There were orders to ace wrap left foot and for a Velcro splint to the left wrist. The notes were signed by the Orthopedic Surgeon. During an interview on 04/09/25 at 12:48 p.m., a family member said when they left Resident #2 on 03/22/2025 and she was fine. She said Resident #2 called on 03/23/25 and told them she fell out of bed. The family member said they were told about the incident with the bed rolling and Resident #2 hitting the wall. The family member said they talked to LVN C, and he did seem very genuine about what happened. She said LVN C told her that he did not know the bed was not locked down and when he went to change Resident #2 the bed rolled, and the resident hit the wall. The family member said they did not feel like LVN C did anything intentionally. (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	04/09/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 04/09/25 at 12:55 p.m., Resident #2 was resting in bed. There was bruising to her left forehead, a brace on her left wrist, a healing abrasion to the back of her left hand, and an ace wrap to her left foot. The resident said there was nothing wrong with her head. A family member was at bedside and said all the bruising, abrasions, and injury to her left foot was from the incident when her bed rolled during incontinent care. Resident #2 said LVN C rolled her, and she hit the wall. She said she hit the wall hard. She said LVN C was not being rough with her. She said he was trying to assist her, and the bed rolled. She said she was not afraid of LVN C. She felt safe in the facility. During an interview on 04/09/25 at 1:18 p.m., LVN C said he went in Resident #2's room. LVN C said Resident #2 said she was wet and needed to be changed. He said the resident said he could change her. LVN C said he raised the bed up so he would not hurt his back. He said when he rolled Resident #2, he leaned against the bed and the bed rolled. He said the bed had appeared to be locked but the bed still rolled. He said Resident #2 hit the bed pretty hard. He said the bed was actually out from the wall and it hit the wall hard when it rolled. He said there was no bruising at the time of the incident and the resident had no complaints. He said he then finished changing Resident #2. He said all of this happened at the end of shift. He said he did an incident report and initiated neuro checks on the resident because she hit the wall so hard. He said the resident never complained of foot pain to him. He said there were no other staff in the room at the time of the incident. During an interview on 04/09/2025 at 2:03 p.m., the Director of Plant Operations said after the incident concerning Resident #2, he was called to check Resident #2's bed. He said the bed had six different brakes. He said one brake was loose but the other 5 were in good working order. He said there was not a mechanical reason the bed should have moved if the brakes were locked. During an interview on 04/09/2025 at 2:51 p.m., the DCO said LVN C told her he was performing incontinent care for Resident #2. LVN C told her he rolled Resident #2 onto her right side. He told her he thought the bed was locked but the brakes were not working. The DCO said his weight went against the bed and the bed rolled. She said Resident #2 was holding onto the assist bar with her hands. She said the resident had bruising to left side of her forehead. She said they were not sure what Resident #2's foot hit. She said it could have hit the foot board or even the hooks from the air mattress pump. She said she would have expected for LVN C to have made sure the bed was locked. She said a bed not being locked could cause injuries such as this. She said she was not sure where the wrist injury came from. She said the resident had not been complaining of wrist pain. During an interview on 04/09/25 at 3:28 p.m., the EDO said it was reported to her that the nurse went in to provide incontinent care for Resident #2 and when he went to roll her over the bed moved and the resident hit the wall. She said he was the only person in the room providing care. She said after this incident Resident #2 would require 2-person assistance. She said the resident did have osteoporosis. She said she had bruising to her forehead, she had a broken bones in her foot, she had a broken bone in her wrist. She said Resident #2 had abrasions to her hand and skin tears. She said they felt she was holding on to the handrail and hitting the wall caused the abrasions and skin tears. She said when Resident #2 returned from her orthopedic doctor visit on 04/09/25 the fracture to the wrist was listed. She said this was the first they had heard about the wrist fracture. She said she expected staff to make sure beds were locked while providing care to ensure safety of the resident. She said they completed audits on all of the beds to make sure they were in working order. (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	04/09/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of an undated Addressing Resident Safety in the Community facility policy did not address ensuring resident's beds were locked during incontinent care. Record review of a Bed Safety facility policy dated 04/2021 did not address ensuring resident's beds were locked during incontinent care.