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	07/16/2025

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 0600 Level of Harm - Minimal harm or potential for 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the right to be free from abuse was provided for 1 of 7 reviewed for abuse. (Resident #1) The facility failed to ensure Resident #1 was free from abuse when RCP A told Resident #1, You better get out of my face and get back in your room. on 07/05/25 as witnessed by LVN B and LVN C. This failure could place residents at risk for verbal abuse and emotional harm.Findings included:Record review of a face sheet dated 07/14/25 revealed Resident #1 was [AGE] years old and was initially admitted on [DATE] with diagnoses including congestive heart failure (chronic condition where the heart cannot pump enough blood to meet the body's needs), bipolar disorder (a mental illness that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks), and anxiety disorder. Record review of an annual MDS dated [DATE] revealed Resident #1 had a BIMS score of 15 which indicated intact cognition. The MDS indicated Resident #1 required supervision to moderate assistance with most ADLs. Record review of a care plan last reviewed on 07/14/25 revealed Resident #1 had a behavior problem related to low frustration tolerance. The care plan indicated Resident #1 got angry with other residents and would yell at them or staff. The care plan indicated Resident #1 made false allegations against staff and other residents. There was an intervention for caregivers to provide opportunity for positive interaction and attention. Record review of a typed statement indicated Resident #1 was interviewed by the DCO and the EDO on 07/07/25. The statement indicated the date of the incident was 07/05/25. The statement indicated, .A while after lunch I had gone to my room and found my roommate, in bed with the lift pad pulled over her face and her left fingers in the straps on the side and she was pulling on them. I went to (RCP A) who was standing in the hallway and told her, and she said that she would come fix it. After a few minutes, I went to see where she was, and she was still standing in the hall. I went to the nurses' station and was telling (LVN B), but I was so upset I couldn't get my words out, so she pushed me down to my room. When we got back to my room, (RCP A) was in there. (LVN B) went into the room, and I stayed in the hallway. They both came out and started walking back towards the nurses station. (RCP A) got about halfway up the hall and turned around and smiled at me. I said loudly (RCP A) its not funny. And she said (Resident #1, that's why we don't get along. You need to shut up and let me do my job. (LVN B) came to my room later and told me that she reported (RCP A) to the DCO because she can't talk to me that way and that it was abuse. The statement was not signed. Record review of a typed statement indicated RCP A was interviewed by the DCO and ADCO on 07/07/25. The statement indicated the date of the incident was 07/05/25. The statement indicated, .After lunch I had put (Resident #1's roommate) in bed from her geri-chair and then walked out of the room to go get my resident out of the dining room and tend to their needs. (Resident #1) came to me while I was pushing another resident to her room and asked me to move (Resident #1's roommate's) chair and told me that (the roommate) had pulled her lift pad over her face and that her hand was tangled up in straps, so I went in there and took care of that then went and changed a couple more residents that were asking for help then came back to (the roommate's) room to change her. As I was finishing with her, (LVN B) came into the room and asked what was going on, being rude to me. So, I told her what happened, and she said I was rude, so I just walked out of the room. I stopped to get my linen barrel, and (Resident #1) was behind me talking about me and saying things under her breath and being confrontational, so I said, (Resident #1) go in your room and leave me alone. The statement was not signed. Record review of a typed statement indicated LVN B was interviewed by the DCO and ADCO on 07/07/25. The statement indicated the date of the incident was 07/05/25. The statement indicated, .After lunch I was sitting at the nurses' station with the other nurse and (Resident #1) came up to the nurses' station and told the other nurse she needed to report something. The other nurse told her that was sitting right there, and (Resident #1) said she wanted (LVN C) to be witness in case something didn't get done about it. She then started telling me that her roommate was in bed with a lift pad over her face. When we got there the door was closed and she said, Well I guess she is in there fixing it now. I entered the room, and (RCP A) was in there finishing her incontinent care. I asked her what was going on and she started telling me that the resident had pulled the lift pad over her face and that her hand was kind of tangle up in it but it was fixed now. As we walked out of the room, (RCP A) was behind me and I heard her say You need to get out of my face and go back to your room. I informed (RCP A) that she can not talk to residents like that. (RCP A) walked away and I spoke with (Resident #1) who was not in any distress afterwards and told her that I would

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation, or mistreatment of residents for 1 of 7 residents reviewed for abuse and neglect.The facility failed to prevent Resident #1 from being abused when RCP A told Resident #1 You better get out of my face and get back in your room. on 07/05/25 as witnessed by LVN B and LVN C.The facility failed to immediately suspend RCP A. The facility staff failed to immediately interview Resident #1 concerning the allegations. These failures could place residents at risk for continued abuse and neglect due to inappropriate interventions and failure to report the allegations of abuse timely. Findings included:Record review of a face sheet dated 07/14/25 revealed Resident #1 was [AGE] years old and was initially admitted on [DATE] with diagnoses including congestive heart failure (chronic condition where the heart cannot pump enough blood to meet the body's needs), bipolar disorder (a mental illness that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks), and anxiety disorder. Record review of an annual MDS dated [DATE] revealed Resident #1 had a BIMS score of 15 which indicated intact cognition. The MDS indicated Resident #1 required supervision to moderate assistance with most ADLs. Record review of a care plan last reviewed on 07/14/25 revealed Resident #1 had a behavior problem related to low frustration tolerance. The care plan indicated Resident #1 got angry with other residents and would yell at them or staff. The care plan indicated Resident #1 made false allegations against staff and other residents. There was an intervention for caregivers to provide opportunity for positive interaction and attention. Record review of a typed statement indicated Resident #1 was interviewed by the DCO and the EDO on 07/07/25. The statement indicated the date of the incident was 07/05/25. The statement indicated, .A while after lunch I had gone to my room and found my roommate, in bed with the lift pad pulled over her face and her left fingers in the straps on the side and she was pulling on them. I went to (RCP A) who was standing in the hallway and told her, and she said that she would come fix it. After a few minutes, I went to see where she was, and she was still standing in the hall. I went to the nurses' station and was telling (LVN B), but I was so upset I couldn't get my words out, so she pushed me down to my room. When we got back to my room, (RCP A) was in there. (LVN B) went into the room, and I stayed in the hallway. They both came out and started walking back towards the nurses station. (RCP A) got about halfway up the hall and turned around and smiled at me. I said loudly (RCP A) its not funny. And she said (Resident #1, that's why we don't get along. You need to shut up and let me do my job. (LVN B) came to my room later and told me that she reported (RCP A) to the DCO because she can't talk to me that way and that it was abuse. The statement was not signed. Record review of a typed statement indicated RCP A was interviewed by the DCO and ADCO on 07/07/25. The statement indicated the date of the incident was 07/05/25. The statement indicated, .After lunch I had put (Resident #1's roommate) in bed from her geri-chair and then walked out of the room to go get my resident out of the dining room and tend to their needs. (Resident #1) came to me while I was pushing another resident to her room and asked me to move (Resident #1's roommate's) chair and told me that (the roommate) had pulled her lift pad over her face and that her hand was tangled up in straps, so I went in there and took care of that then went and changed a couple more residents that were asking for help then came back to (the roommate's) room to change her. As I was finishing with her, (LVN B) came into the room and asked what was going on, being rude to me. So, I told her what happened, and she said I was rude, so I just walked out of the room. I stopped to get my linen barrel, and (Resident #1) was behind me talking about me and saying things under her breath and being confrontational, so I said, (Resident #1) go in your room and leave me alone. The statement was not signed. Record review of a typed statement indicated LVN B was interviewed by the DCO and ADCO on 07/07/25. The statement indicated the date of the incident was 07/05/25. The statement indicated, .After lunch I was sitting at the nurses' station with the other nurse and (Resident #1) came up to the nurses' station and told the other nurse she needed to report something. The other nurse told her that was sitting right there, and (Resident #1) said she wanted (LVN C) to be witness in case something didn't get done about it. She then started telling me that her roommate was in bed with a lift pad over her face. When we got there the door was closed and she said, Well I guess she is in there fixing it now. I entered the room, and (RCP A) was in there finishing her incontinent care. I asked her what was going on and she started telling me that the resident had pulled the lift pad over her face and that her hand was kind of tangle up in it but it was fixed

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 10 residents reviewed for ADLs. (Resident #2)The facility failed to provide Resident #2 with his scheduled showers.This failure could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs which could result in poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity and health.Findings included:Record review of a face sheet dated 07/14/25 revealed Resident #2 was a [AGE] year-old male and was initially admitted to the facility on [DATE] with diagnoses including cerebral palsy (a group of disorders that affect movement and posture, impacting motor skills and muscle tone), personal history of traumatic brain injury (a brain injury that occurs when a sudden trauma to the head disrupts normal brain function), and reduced mobility. Record review of a quarterly MDS dated [DATE] revealed Resident #2 had no speech. The MDS indicated Resident #2 was rarely to never understood and sometimes understood others. The MDS did not indicate a BIMS score. The MDS indicated Resident #2 was dependent on staff for all ADLs, including bathing. Record review of a care plan dated 04/22/25 revealed Resident #2 had a diagnosis of depression. The care plan indicated Resident #2 had an ADL self-care performance deficit related to disease process. The care plan indicated Resident #2 had limited mobility, range of motion, inability to sit unsupported related to cerebral palsy and was dependent on staff for ADLs. There was an intervention that Resident #2 was totally dependent on 2 staff members to provide bath/shower per facility policy and as necessary. Record review of Resident #2's electronic medical record accessed on 07/14/25 - 07/16/25 indicated Resident #2 preferred showers on Monday and Thursday on day shift. Record review of ADL - Bathing documentation for Resident #2 from 06/19/25 - 07/16/25 revealed no documentation for a bath or a shower on Thursday - 06/26/25, Thursday - 07/03/25, Monday - 07/07/25, and Monday - 07/14/25. During an interview on 07/15/25 at 8:22 a.m., Family Member A said Resident #2 had recently missed some of his showers due to the facility not having the appropriate lift pad for the mechanical lift. During an interview on 07/16/2025 at 8:15 a.m., the Activity Director said she helped out on the floor as an RCP. She said she had known Resident #2 to have missed one shower because they did not have a lift pad. She said the facility had ordered new lift pads. She said family told her about him missing other showers.During an interview on 07/16/25 at 9:29 a.m., Family Member B said Resident #2 was supposed to be bathed three times a week. Family Member B said he was only showered on Mondays and Thursdays. She said they had to bath him once themselves because he had missed his shower because the facility did not have a shower lift pad. Family Member B said they ended up bringing one from home. Family Member B said this was approximately 3 weeks ago. Family Member B said the wound care doctor had wanted Resident #2 bathed three times a week. Family Member B said it depended on what staff was working if he got his showers. During an interview 07/16/25 at 12:58 p.m., RCP D said Resident #2 had never missed a shower on her shift. She said she could not speak for other aides. She said all of the showers were charted in the resident's electronic medical record. She it was her understanding the family wanted him showered two days a week. She felt some aides were maybe not charting the showers. She said if the family wanted him to be bathed three times a week, he should be bathed three times a week. She said it had always been 2 times a week.During an interview on 07/16/25 at 1:40 p.m., LVN E said she had known Resident #2 to have missed his showers because of not having shower pads. She said he had missed maybe 5 showers. She said his showers had always been two days a week. She said she thought that was what the family wanted. She said when he had missed his showers, she felt like he at least got a bed bath. She said bed baths or showers should have been charted in the Resident's electronic medical record. She said if there was no documentation, he did not receive a bath or shower. She said she felt like it was a charting issue. She said a resident not receiving their baths could lead to poor hygiene and infection. She said it was a dignity issue too.During an interview on 07/16/25 at 12:06 p.m., the ADOC said it was never presented to her that family wanted Resident #2 bathed three times a week. She said she felt he did not miss any showers. She felt it was just failure of the staff to document. She said this was an on-going education with the aides. During an interview on 07/16/25 at 2:09 p.m., the DCO said the family had wanted Resident #2 to be bathed only two times a week. She said this was the first she heard of them wanting him bathed three times a week. She said it had not been brought up in care plan meetings. She said she would expect all showers to be documented in the electronic medical record. She said she felt