

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Linden		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.</p> <p>(continued on next page)</p>

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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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to provide or obtain radiology and other diagnostic services to meet the needs of its residents for 1 of 4 (Resident #1) residents reviewed for radiology services. The facility failed to ensure Resident #1's STAT x-ray results were obtained and reported to the physician in a timely manner. Resident #1's x-ray results were not reviewed by the facility until 10/20/25, which was 4 days after the STAT x-ray was performed. This failure could result in a delay in treatment of broken bones, increased pain, and a decreased quality of life. The findings included: Record review of the face sheet, dated 10/30/25, reflected Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of dementia (memory loss) without behaviors, pressure ulcer of sacral region, stage 4 (wound that exposes muscle, bone, or tendon to the sacrum [triangular bone in the lower back formed from fused vertebrae and situated between the two hip bones of the pelvis] caused from pressure), Multiple Sclerosis (a progressive disease that damages the protective cover around nerves called myelin in your central nervous system, which can cause muscle weakness, vision changes, numbness and memory issues), and Arnold Chiari Syndrome (a condition in which brain tissue extends into the spinal canal). Record review of the quarterly MDS assessment, dated 05/03/25, reflected Resident #1 had clear speech, was understood by others, and was able to understand others. Resident #1 had a BIMS score of 8, which indicated moderately impaired cognition. Resident #1 had no behaviors or refusal of care. The MDS reflected Resident #1 had an impairment to both sides of her lower extremities that interfered with daily functions or placed resident at risk of injury. Record review of the comprehensive care plan, initiated on 10/15/25, reflected Resident #1 complained of pain to her right knee. Resident #1 denied falling or injuries. Resident #1 had a nondisplaced lateral plateau fracture (break or crack in the shin bone or tibia). The interventions were as follows:1. On 10/15/25 - Obtain x-ray to right knee per the physician's orders.2. On 10/15/25 - Mechanical lift when transferred.3. On 10/22/25 - Administer pain medication per physician orders. 4. On 10/22/25 - Check skin every shift under brace for redness, irritation, or breakdown.5. On 10/22/25 - May remove brace for showers.6. On 10/22/25 - Referral to the orthopedic (specialist bone doctor).7. On 10/22/25 - Straight leg brace to right lower extremity as the resident allows. Record review of Resident #1's progress notes, dated 10/15/25 at 10:32 PM, RN A documented While moving [Resident #1] from room [ROOM NUMBER] to 116, [Resident #1] complained of knee pain and swelling. Upon assessment, [Resident #1's] knee was very swollen. No redness or warmth noted. Contacted NP about getting [x-ray] for right knee. Awaiting response. [Resident #1] in bed at this time. [Call light] and [by mouth] fluids at bedside. Record review of the SBAR Communication Form, dated 10/16/25, reflected Resident #1 had new onset pain, swelling, and warmth of the right knee. Orders were obtained for a STAT x-ray for the right lower extremity. Record review of Resident #1's order details, dated 10/16/25, reflected the Nurse Practitioner ordered the following x-rays with an urgency of STAT:1. Left femur (upper leg), 2 views2. Right knee, 2 views3. Right Tibia and fibula (lower leg), 2 viewsThe order details reflected it was sent to the radiology provider. Record review of Resident #1's radiology report reflected the right knee x-ray was completed on 10/16/25 at 12:24 PM and was read by the radiologist and reported to the facility on [DATE] at 5:25 PM. The impression was findings concerning for a nondisplaced lateral plateau fracture [break or crack in the shin bone or tibia] Record review of Resident #1's radiology report reflected the right tibia and fibula x-ray was completed on 10/16/25 at 12:22 PM and was read by the radiologist and reported to the facility on [DATE] at 5:26 PM. The impression was findings of an age-indeterminate distal fibular fracture [fracture of the fibula bone near the ankle, unable to determine the age of the injury] . Record review of Resident #1's radiology report reflected the right femur x-ray was completed on 10/16/25 at 12:26 PM and was read by the radiologist and reported to the facility on [DATE] at 5:27 PM. The impression was no acute osseous abnormality [bone structure changes]. Record review of the follow-up note, dated 10/19/25, reflected Resident #1 had pain in her right knee with swelling and pain during movement. The follow-up note did not reflect any information on the x-ray results. Record review of Resident #1's radiology report reflected a right ankle x-ray was completed on 10/20/25 at 1:09 PM and was read by the radiologist and reported to the facility on [DATE] at 2:18 AM. The impression was osteopenia (bones are weaker than normal) and no fracture noted. Record review of the in-service education record, dated 10/20/25, reflected education was provided on osteopenia for nurses only. There were 4 nurse signatures. Record review of the in-service education record, dated 10/20/25, reflected</p>		