

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 02/12/2025
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on interviews, and record review the facility failed to ensure residents have the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives and to choose the option he or she prefers for 3 of 18 residents reviewed for the right to be informed. (Resident's #1, Resident #17, and Resident #18)</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident #1's psychoactive (substances that, when taken in or administered into one's system, affect mental processes) medication therapy consent was completed upon admission and prior to the administration for Sertraline (is an antidepressant). Resident #1's Sertraline was prescribed on 12/03/24. 2. The facility failed to ensure Resident #17's Consent for Antipsychotic (used to treat certain mental/mood disorders) or Neuroleptic (also known as Antipsychotic) Medication Treatment HHSC Form 3713 was correctly completed for Seroquel (Quetiapine) (antipsychotic medication used to treat certain mental/mood disorders) as evidenced by there was no written signature for signed consent. 3. The facility failed to ensure Resident #18's Consent for Antipsychotic or Neuroleptic Medication Treatment HHSC Form 3713 was correctly completed for Zyprexa (Olanzapine) (antipsychotic medication used to treat certain mental/mood disorders) as evidenced by there was no written signature for signed consent. <p>These failures could place residents at risk for treatment or services provided without their informed consent.</p> <p>The findings included:</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Record review of Resident #1's face sheet dated 1/10/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses including Asperger's syndrome (is a term sometimes used to describe a developmental disorder that's part of the autism spectrum disorder (ASD)), major depressive disorder (is a common mental health condition characterized by persistent low mood, loss of interest, and other symptoms that significantly interfere with daily life), anxiety disorder (are a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), and epilepsy (is a chronic brain disorder characterized by recurrent seizures, which are brief episodes of involuntary movements, loss of consciousness, or altered awareness). Resident #1's responsible party was a family member.</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 was understood and had the ability to understand others. Resident #1 had a BIMS of 09 which indicated moderate cognitive impairment. Resident #1 received an antidepressant during the last 7 days of the assessment period.</p> <p>Record review of Resident #1's care plan dated 12/15/24 indicated Resident #1 was at risk for adverse consequences related to receiving psychotropic medication. Resident #1 was currently taking psychotropic medication(s) for diagnosis of depression. Intervention included administer psychotropic medication as ordered.</p> <p>Record review of Resident #1's consolidated physician order dated active as of 2/10/25 indicated Sertraline Oral Tablet 100mg, give 1 tablet by mouth one time a day. Start 12/03/24.</p> <p>Record review of Resident #1's MAR dated 2/01/25-2/28/25 indicated Sertraline Oral Tablet 100mg, give 1 tablet by mouth one time a day. Start 12/03/24. Resident #1 received 10 of the 10 scheduled doses.</p> <p>Record review of Resident #1's medical record on 2/12/25 did not reflect a psychoactive consent form for Sertraline.</p> <p>On 2/12/25 at 10:13 AM, a copy of Resident #1's Sertraline psychoactive consent form was requested by email sent to the EDO.</p> <p>During an interview on 2/12/25 at 1:57 PM, LVN D said psychoactive consents should be done prior giving the resident a medication. She said the admitting nurse or the nurse who received the medication order should obtain consent. She said the consent should be obtained from the resident or responsible party. She said the consent should be done so the resident and family were aware of the risk and benefit of the medication.</p> <p>During an interview on 2/12/25 at 5:15 PM, the DCO P said the facility could not find a copy of Resident #1's Sertraline psychoactive consent form.</p> <p>On 2/12/25 at 5:45 PM, called Resident #1's responsible party and unable to leave message because the mailbox was full. No return call was received before or after exit.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 5:49 PM, the ADCO said a psychotropic medication consent should be completed with the admission paperwork. She said the consent form could be completed by any nurse that noticed one needed to be done. She said the psychotropic consents were important to educate the resident and/or family on the medication and make sure they wanted to receive it. She said the DCO was responsible to ensure the nursing staff was obtaining consent for psychotropic medications. She said monitoring should be done by chart audits. She said when a consent was not received for a psychotropic medication, it placed the resident and family at risk for not being informed. She said she did not know about Resident #1's Sertraline consent form.</p> <p>During an interview on 2/12/25 at 6:57 PM, the DCO P, from the facility's sister facility, said the admission nurse or the nurse putting in the psychotropic medication order was responsible for the consent form. She said the consent should be obtained prior to medication administration. She said obtaining a consent from the resident or responsible party was important, so they were aware of the side effects and know what they are getting. She said the nursing management including the IDT should be monitoring this process.</p> <p>During an interview on 2/12/25 at 7:34 PM, the EDO said the nursing staff who received the medication order was responsible for the psychotropic consent form. She said the consent should be obtained from the resident and/or responsible party. She said the consent should be given prior to the medication administration. She said it was important to get consent, so the resident and responsible party understood the risk and benefits of the medication. She said not getting consent risked the resident and responsible party not being informed of the benefits and risk of the medication.</p> <p>46062</p> <p>2. Record review of Resident #17's face sheet dated 2/12/25 revealed she was [AGE] years old and admitted to the facility initially on 3/02/17 and readmitted [DATE]. Resident #17 had diagnoses including Bipolar Disorder, Major Depressive Disorder, and anxiety disorder.</p> <p>Record review of Resident #17's quarterly MDS assessment dated [DATE] indicated she had a BIMS of 15, which indicated she was cognitively intact. The MDS indicated Resident #17 had active diagnoses of Anxiety Disorder, Depression, and Bipolar Disorder. The MDS indicated Resident #17 was taking an antipsychotic medication in Section N0415 High-Risk Drug Classes.</p> <p>Record review of Resident #17's undated Care Plan Report indicated she was at risk for adverse consequences related to receiving psychotropic medication for diagnoses of anxiety, depression, paranoia, and psychotic/psychosis with an initiated date of 5/12/23.</p> <p>Record review of Resident #17's Order Summary Report dated 2/12/25 reflected an order for Quetiapine Fumarate oral tablet 25 MG give one tablet by mouth at bedtime for schizoaffective disorder, bipolar type, with a start date of 1/10/25.</p> <p>Record review of Resident #17's Medication Administration Record dated 2/01/25-2/28/25 indicated she received Quetiapine Fumarate oral tablet 25 MG give one tablet by mouth at bedtime for schizoaffective disorder, bipolar type, with a start date of 1/10/25 and had received daily in February 2025.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 9:52 AM, LVN D said she had worked at the facility since August 2024. LVN D said she did admissions and she was not sure who was responsible for completing the HHSC Form 3713 antipsychotic consent. LVN D said they have had different nurse managers and they each want something different. LVN D said she would have to look at the HHSC Form 3713 to know how to complete and if she had questions, she would ask a nurse manager. LVN D said she knew the physician needed to sign the form. LVN D said she thought the HHSC Form 3713 must be signed by the RP or the resident and could not be a verbal consent. LVN D said the purpose of the HHSC Form 3713 form was to inform the RP and/or resident about the use, risks, and benefits of the medication. LVN D said the RP or the resident may not have wanted the medication if they were not informed of all the risks and benefits of the medication.</p> <p>During an interview on 2/12/25 at 1:33 PM, the ADCO said she had worked at the facility since 1/13/25. The ADCO said the DCO and SW were the ones that handled getting the consents signed and the HHSC Form 3713 had to be signed in person, a written signature, or a verbal could be obtained. The ADCO said the purpose of the consent was to inform the RP or resident of what the medication was used for, side effects, and benefits of the medication to choose whether they wanted to take the medication.</p> <p>During an interview on 2/12/25 at 2:18 PM, DCO P said she was covering the facility while DCO Q was out sick. DCO P said she worked at a sister facility as the DCO. DCO P said she was familiar with the HHSC Form 3713. DCO P said the psychotropic medications were not to be given without a consent. DCO P said the charge nurse would be responsible for ensuring consents were signed because they could not give antipsychotics without a consent. DCO P said then nurse management do the admission checks after admissions to ensure the consents for the medications and everything were correct. DCO P said the HHSC Form 3713 must have an in person written signature for the antipsychotics. DCO P said they could have verbal consents for anti-anxiety type medications, but a verbal consent must have two nurse signatures for verbal consents. DCO P said the purpose of the antipsychotics consent was to inform the RP and/or the resident of the side effects, risks, and benefits of the medications. DCO P said the side effects and risks were high with antipsychotics and had a black box warning. DCO P said the resident or RP needed to be able to make an informed decision about whether to take the medication or not. DCO P said the effect on the resident could be having side effects or adverse reactions that could be dangerous to the resident. DCO P said the resident may not want to take the medication if they knew what the side effects and risks of the medication were.</p> <p>During an interview on 2/12/25 at 5:46 PM, the EDO said the nurses were responsible for obtaining the antipsychotic medication consents because the nurses would be the best ones to educate the resident and/or the RP on benefits/risks of the medication. The EDO said the purpose of the consents were for the resident and/or family to understand the risks and benefits of the medication. The EDO said the HHSC Form 3713 had to have a written consent. The EDO said if proper antipsychotic consent was not obtained the resident or RP may not have all the information about the medication that they are taking.</p> <p>Record review of the facility's policy titled, Resident Rights, dated revised December 2016, reflected . Federal and state laws guarantee certain basic rights to all residents of the facility . these rights included the resident's right to . be informed of, and participate in, his or her care planning and treatment .</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled, Psychotropic Medication Review, dated 4/2020, reflected . IDT would emphasize the importance of seeking an appropriate dose and duration of each psychotropic medication, with careful assessment as to whether the medication was necessary and pharmacologically appropriate . the community would make every effort to comply with state and federal regulations related to the use of psychopharmacological medications, to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits .</p> <p>Record review of the Texas Administrative Code , Title 26, Rule 554.1207 (Texas Administrative Code (state.tx.us)) titled Prescription of Psychoactive Medication revealed . consent to the prescription of psychoactive medication given by a resident, or by a person authorized by law to consent on behalf of the resident, was valid only if . the person who prescribes the medication, that person's designee, or the facility's medical director provides the resident and, if applicable, the person authorized by law to consent of behalf of the resident, with a form containing the following information identified as being for the purpose of consent to treatment with psychoactive medications . the specific condition to be treated . beneficial effects on that condition expected from the medication . probable clinically significant side effects and risks associated with the medication . proposed course of the medication . consent was given in writing by a resident or by a person authorized by law to consent on behalf of the resident, on a form prescribed by HHSC, if the prescription was for antipsychotics or neuroleptics .</p> <p>Record review of Long-Term Care Regulatory Provider Letter, number PL 2022-11, titled Consent for Antipsychotic and Neuroleptic Medications and dated May 5, 2022 reflected . a resident receiving antipsychotic or neuroleptic medications must provide written consent . written consent could also be given by a person authorized by law to consent on the resident's behalf . consent for antipsychotic and neuroleptic medications must be documented on HHSC Form 3713 . the prescriber of the medication, the prescriber's designee, or the nursing facility's medical director must complete Section 1 of Form 3713 . the resident or the resident's legally authorized representative must sign Section 2 of Form 3713 . the person prescribing the medication, the prescriber's designee, or the NF's medical director must provide the resident, and if applicable, the person authorized to consent on behalf of the resident, the following information . condition being treated . beneficial effects on that condition expected from the medication . potential side effects of the medication . associated risks of the medication . proposed course of medication .</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 18 (Resident #18) residents reviewed for call lights.</p> <p>The facility failed to ensure Resident #18's call light button was within reach while Resident #18 was in her bed as evidenced by call light button was draped over the nightstand against the wall on her left side.</p> <p>This failure could place residents at risk for a delay in assistance and decreased quality of life, self-worth, and dignity.</p> <p>Findings included:</p> <p>Record review of Resident #18's face sheet dated 2/10/25 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #18 had diagnoses which included Severe Morbid Obesity (severely overweight), reduced mobility, history of Cerebrovascular Disease (disruption of blood supply to the brain), hemiplegia and hemiparesis following Cerebral Infarction affecting the left non-dominant side (unable to move and/or weakness of the left side of the body), contracture of left hand, muscle weakness, and Ataxia (impaired coordination).</p> <p>Record review of Resident #18's annual MDS assessment dated [DATE], indicated she had a BIMs score of 11, which indicated she had moderate cognitive impairment. Resident #18 required maximal assistance or was totally dependent on staff for most ADLs. The MDS indicated Resident #18 was frequently incontinent of bladder and was always incontinent of bowel. The MDS indicated Resident #18 had pain almost constantly.</p> <p>Record review of Resident #18's undated Care Plan Report reflected Resident #18 was incontinent and at risk for skin; she was at risk for increased falls and fractures as evidence by a history of falls, physical impairment/immobility with an intervention which included to ensure call light was within reach and answered promptly; she had limited physical mobility; she had anxiety related to cognitive deficit as evidenced by trouble concentrating, forgetfulness, episodes of confusion, poor impulse control, and feelings of discomfort, apprehension or helplessness; she had a contracture of left hand with an intervention which included anticipate and meet needs, be sure call light was within reach and respond promptly to all requests for assistance; and she had a cerebral vascular accident affecting her left side.</p> <p>During an observation and interview on 2/10/25 at 9:26 AM, Resident #18 was lying in bed. Resident #18 said the staff would frequently not give the call light to her. Resident #18's call light was laid across her nightstand against the wall on Resident #18's paralyzed left side out of her reach. Resident #18 said she had no use of her left side of her body.</p> <p>During an observation on 2/10/25 at 12:35 PM, Resident #18's call light continued to be laid across the nightstand against wall on Resident #18's paralyzed left side out of her reach.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 2/11/25 at 2:38 PM, Resident #18 was sitting up in a reclined wheelchair and her call light pad was draped across and laid on her chest. Resident #18 said the staff would not give the call light to her and surveyor showed Resident #18 the call light pad was on her chest. Resident #18 said she did not know the call light was there.</p> <p>During an interview on 2/12/25 at 8:34 AM, RCP X said the RCPs and nurses were responsible for keeping the residents' call lights within reach. RCP X said the call lights should be in reach and answered due to the resident could need assistance or something could be wrong. RCP X said Resident #18 was paralyzed on her left side and would not be able to reach her call light if it was laid across her nightstand on her left side. RCP X said Resident #18 would yell for assistance if she could not reach her call light or forgot she had it.</p> <p>During an interview on 2/12/25 at 9:52 AM, LVN D said the call lights should be within reach of the resident for dependent residents. LVN D said it would not be appropriate to have a call light draped over the nightstand against the wall on the resident's paralyzed side out of her reach. LVN D said the resident would not be able to call for assistance if they needed it if the resident could not reach their call light. LVN D said if the resident could not reach their call light, it could make the resident feel upset, helpless, and/or frustrated. LVN D said any staff member would be responsible for ensuring the resident's call light was within reach anytime they go into the room. LVN D said she thought staff sometimes forget to put the call light back within reach after providing care at times.</p> <p>During an interview on 2/12/25 at 10:31 AM, RCP M said it was everyone's responsibly to ensure the residents' call lights were within reach, so the resident could call for assistance if needed. RCP M said if a resident could not reach their call light, it could make the resident mad and feel like no one cared.</p> <p>During an interview on 2/12/25 at 10:44 AM, RCP O said staff were responsible for ensuring the call lights were within reach of the residents. RCP O said the call lights need to be within the resident's reach, so if they need anything, they can call for help. RCP O said she had not taken care of Resident #18, but the call light should be placed on the side of the resident that the resident could use within the resident's reach.</p> <p>During an interview on 2/12/25 at 1:33 PM, the ADCO said all staff were responsible for ensuring a resident's call light was within reach so they could call for assistance if needed. The ADCO said if a resident's call light was not within reach, it could place the resident at danger of falling and not be able to call for help and the resident could lay in urine or feces and not have basic needs met if the resident was not able to call for assistance.</p> <p>During an interview on 2/12/25 at 2:18 PM, DCO P said she was covering the facility while DCO Q was out sick. DCO P said she worked at a sister facility as the DCO. DCO P said the RCPs and the nurses would be responsible for ensuring call lights were in reach. DCO P said if a resident could not reach their call light, it could affect the resident emotionally and they would not be able to call for help. DCO P said the call light should have been within reach for Resident #18.</p> <p>On 2/12/25 at 4:30 PM, requested a policy related accommodation of needs related to the call light being in reach from the ADM and was provided a policy titled Bedrooms and it did not address resident accommodation of needs related to the call light being in reach.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 5:46 PM, the EDO said all staff that enter the resident's rooms should be ensuring the call light was in reach. The EDO said Resident #18 could and would holler out if she needed assistance and forgot she had a call light or if the call light was not in reach but there were other residents that could not do that. The EDO said she would expect the call lights to be in reach for the residents. The EDO said for the residents that could not call out there would be a delay in asking for assistance.</p> <p>Record review of the facility policy titled Bedrooms dated revised May 2017 indicated . all residents were provided with clean, comfortable and safe bedrooms that met federal and state requirements . all resident rooms were equipped with a resident call system that allowed residents to call for staff assistance .</p>		

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NAME OF PROVIDER OR SUPPLIER Focused Care at Linden		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W Houston St Linden, TX 75563	
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<p>F 0635</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide doctor's orders for the resident's immediate care at the time the resident was admitted.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on observation, interview, and record review the facility failed to ensure, at the time each resident was admitted, there were physician orders for the resident's immediate care for 1 of 7 residents reviewed for admission physician orders. (Resident #93)</p> <p>The facility failed to initiate wound care treatment after Resident #93 admitted on [DATE], with multiple areas of shearing.</p> <p>The facility failed to initiate Resident #93's wound care orders noted in the wound care doctor's progress notes on 02/08/25 until 02/10/25.</p> <p>An IJ was identified on 02/11/25. The IJ template was provided to the facility on [DATE] at 5:00 p.m. While the IJ was removed on 02/12/25, the facility remained out of compliance at a scope of pattern and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on the process of carrying out orders for residents admitted with wounds or obtaining orders if no orders accompanied the resident, completion of weekly skin assessments, wound care orders, skin management policy, and pressure ulcer prevention and interventions for residents with pressure ulcers.</p> <p>These failures could place residents at risk of not receiving appropriate care and treatment services.</p> <p>Findings included:</p> <p>1. Record review of Resident #93's face sheet dated 02/11/25 indicated Resident #93 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #93 had diagnoses including acute kidney failure (when the kidneys suddenly can't filter waste products from the blood), urinary tract infection (is an infection in any part of your urinary system: kidneys, bladder, ureters, and urethra), morbid obesity (is a medical condition characterized by excessive body weight that significantly impacts health and well-being), and pressure ulcer of right hip, left hip, and other sites, stage 3 (a full-thickness tissue loss where the subcutaneous fat layer is visible within the wound, but the bone, tendon, or muscle is not exposed).</p> <p>Record review of the MDS, on 02/10/25, indicated Resident #93 was admitted to the facility less than 21 days ago. No MDS for Resident #93 was completed prior to exit.</p> <p>Record review of Resident #93's care plan dated 02/03/25 indicated:</p> <p>*Resident #93 was admitted with stage 3 pressure ulcer to right thigh. Interventions included assess and document skin condition every week, pressure relieving appliances as ordered, reposition residents as indicated to relieve pressure and for comfort, and wound care per MD orders.</p> <p>(continued on next page)</p>		

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<p>F 0635</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>*Resident #93 was admitted with Stage 3 pressure ulcer to right hip. Interventions included assess and document skin condition every week, monitor nutritional intake, weight, lab values and report significant changes to MD, pressure relieving appliances as ordered, reposition residents as indicated to relieve pressure and for comfort, and wound care per MD orders.</p> <p>*Resident #93 was admitted with stage 3 pressure ulcer to left thigh. Intervention included administer treatments as ordered and monitor for effectiveness, monitor nutritional status, and obtain and monitor lab/diagnostic work as ordered.</p> <p>Record review of Resident #93's consolidated physician orders dated active as of 02/11/25 indicated the following:</p> <p>*Left thigh- cleanse with house wound cleanser. Apply Medi honey and collagen sheet. Cover with foam and border gauze dressing everyday shift. Start 02/11/25.</p> <p>*Nursing to perform weekly skin assessment. Ordered 02/09/25.</p> <p>*Right hip- cleanse with house wound cleanser and pat dry. Apply Medi honey and cover with collagen sheet and foam then secure with border dressing everyday shift. Start 02/11/25.</p> <p>*Right thigh- cleanse with house wound cleanser and pat dry. Apply Medi honey and collagen sheet. Cover with foam and secure with border dressing everyday shift. Start 02/11/25.</p> <p>The consolidated physician order did not reflect wound care orders for Resident #93's left thigh, right hip, and right thigh pressure ulcer on admission (02/01/25).</p> <p>Record review of Resident #93's MAR dated 02/01/25-02/28/25 indicated the following:</p> <p>*Left thigh- cleanse with house wound cleanser. Apply Medi honey and collagen sheet. Cover with foam and border gauze dressing everyday shift. Start 02/11/25.</p> <p>*Nursing to perform weekly skin assessment. Ordered 02/02/25. Discontinued 02/09/25. No documentation was noted on 02/02/25 and 02/09/25.</p> <p>*Right hip- cleanse with house wound cleanser and pat dry. Apply Medi honey and cover with collagen sheet and foam then secure with border dressing everyday shift. Start 02/11/25.</p> <p>*Right thigh- cleanse with house wound cleanser and pat dry. Apply Medi honey and collagen sheet. Cover with foam and secure with border dressing everyday shift. Start 02/11/25.</p> <p>Record review of Resident #93's progress note dated 01/12/25-02/12/25 indicated:</p> <p>(continued on next page)</p>		

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<p>F 0635</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>*02/01/25 at 7:47 p.m. by the ADCO, .new admission skin assessment .the following areas were all noted upon admission to the facility . Right Lateral thigh shearing 2cm x 5cm x0.1cm open area without exudate with surrounding scaring . Right gluteal area shearing 0.4cm x 0.4cm x 0.1 cm no exudate noted . Right lateral hip shearing with surrounding scaring 5.5cm x 1.4cm x 0.1cm no exudate noted . Right Posterior hip shearing 1.3cm x 0.9cm x 0.1cm no exudate noted . Right posterior thigh near gluteal fold 1.2cm x 0.1cm. Area is a hard area that appears to be healing . Left posterior thigh shearing 1.2cm x 1cm x 0.1cm area noted to have slight bleeding when dressing was removed . right medial posterior thigh near gluteal fold 1cm x 1cm. area is a hard area that appears to be healing .</p> <p>*02/08/25 at 7:33 p.m. by DNP S, .date of service: 02/07/25 .wound initial .Resident #93 . The following wounds were evaluated during today's visit . Wound 1 Right Hip, Pressure Injury, Stage 3 . Wound 2 Right Thigh, Pressure Injury, Stage 3 . Wound 3 Left Thigh, Pressure Injury, Stage 3 . Patient is admitted with multiple wounds . Per report from DON . WOUND ASSESSMENT: .Wound: 1 . Status: Present on Admission Location: Right Hip . Primary Etiology: Pressure Injury Severity: Stage 3 . Size: 6 cm x 1.5 cm x 0.1 cm. Actual area is 9 cm2. Actual volume is 0.9 cm3 Wound Base: , 100% granulation . Wound Edges: Attached . Periwound: Fragile, No erythema, No edema Exudate: Light Serous .Wound Odor: None . Signs of Wound Infection: No signs of infection Wound Pain at Rest: 0 . Wound: 2 . Status: Present on Admission Location: Right Thigh . Primary Etiology: Pressure Injury .Severity: Stage 3 . Size: 4 cm x 2 cm x 0.1 cm. Actual area is 8 cm2. Actual volume is 0.8 cm3 Wound Base: , 100% granulation . Wound Edges: Attached . Periwound: Fragile, No erythema, No edema, No maceration Exudate: Light Serous . Wound Odor: None . Signs of Wound Infection: No signs of infection Wound Pain at Rest: 0 . Wound: 3 . Status: Present on Admission Location: Left Thigh . Primary Etiology: Pressure Injury .Severity: Stage 3 . Size: 1.5 cm x 1 cm x 0.1 cm. Actual area is 1.5 cm2. Actual volume is 0.15 cm3 Wound Base: , 100% granulation . Wound Edges: Attached . Periwound: Fragile, No erythema, No edema, No maceration Exudate: Light Serous . Wound Odor: None .Signs of Wound Infection: No signs of infection Wound Pain at Rest: 0 . Recommendations consisting of: .We will re-evaluate this patient on our next visit (anticipated 1-2 weeks), Implement pressure relieving measures, offloading, and repositioning, as tolerated . Establish turning frequency based on the characteristics of the support surface and the patient's response . Protect skin from exposure to excessive moisture (periwound) with a barrier product. Use skin emollients to hydrate dry skin . Repositioning should be undertaken using the 30-degree tilted side-lying position (alternating right side, back, left side) . Plan of care discussed with facility staff .Wound# 1 Right Hip Pressure Injury Treatment Recommendations: .clean with Wound Cleanser . apply Collagen particles, Honey and Bordered foam dressing . change Daily and as needed if dislodged, saturated, or soiled Wound # 2 Right Thigh Pressure Injury .Treatment Recommendations: . clean with Wound Cleanser . apply Collagen particles, Honey and Bordered foam dressing . change Daily and as needed if dislodged, saturated, or soiled Wound # 3 Left Thigh Pressure Injury .Treatment Recommendations: . clean with Wound Cleanser . apply Collagen particles, Honey and Bordered foam dressing . change Daily and as needed if dislodged, saturated, or soiled .</p> <p>Record review of Resident #93's memorandum of transfer and physician certification dated 02/01/25 indicated emergency department diagnoses included pressure injury of contiguous region involving back, right buttock, and right hip, stage 2.</p> <p>Record review of Resident #93's hospital discharge summary dated 02/01/25 did not reflect wound care orders.</p> <p>Record review of Resident #93's Braden scale for predicting pressure sore risk dated 02/01/25 indicated score of 16 which was at risk.</p> <p>(continued on next page)</p>		

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<p>F 0635</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #93's weekly skin assessment dated [DATE] indicated .does the resident have a pressure, venous, arterial, diabetic, or surgical wound .yes .stage 2 PU, multiple shearing sites to right lateral thigh, right posterior thigh multiple, left posterior thigh, right buttocks, left posterior thigh . The facility's electronic medical record did not reflect a skin assessment on 02/08/25 or 02/09/25.</p> <p>Record review of Resident #93's wound assessment report dated 02/07/25 indicated .left thigh .Length: 1.50 cm .Width: 1.00 cm .Depth: 0.10 cm .left thigh .pressure injury .stage 3 .treatment: daily .wound cleanser . collagen particles and honey .bordered foam dressing .</p> <p>Record review of Resident #93's wound assessment report dated 02/07/25 indicated .right thigh .length: 4 cm .width: 2 cm .depth: 0.10 cm .right thigh .pressure injury .stage 3 . treatment: daily .wound cleanser . collagen particles and honey .bordered foam dressing .</p> <p>Record review of Resident #93's wound assessment report dated 02/07/25 indicated .right thigh .length: 6 cm .width: 1.5 cm .depth: 0.10cm .right hip .pressure injury .stage 3 . treatment: daily .wound cleanser . collagen particles and honey .bordered foam dressing .</p> <p>Record review of the facility's Skin Management: Prevention and Treatment of Wounds policy revised 10/06/22 indicated .specialty mattress will be implemented for residents with multiple stage 2 areas, stage 3, or stage 4 pressure injuries .</p> <p>During an observation and interview on 02/10/25 at 10:51 a.m., Resident #93 was lying in the bed on her back. Resident #93 was not on a specialty mattress. Resident #93 did not have any pressure relieving devices noted in her bed. Resident #93's legs were not offloaded. Resident #93 said staff did not turn her every 2 hours or prop her heels with pillows. She said she could turn herself with the assist rails but staff did not place pillows behind her back, underneath her buttocks or between her legs.</p> <p>During an observation and interview on 02/10/25 at 3:05 p.m., Resident #93 was lying in the bed on her back. Resident #93 was not on a specialty mattress. Resident #93 did not have any pressure relieving positioning devices noted in her bed. Resident #93's legs were not offloaded. Resident #93 said staff did not turn her every 2 hours or propped her heels with pillows.</p> <p>During an observation on 02/11/25 at 10:02 a.m., Resident #93 was lying in the bed on her back. Resident #93 was not on a specialty mattress. Resident #93 did not have any pressure relieving positioning devices noted in her bed. Resident #93's legs were not offloaded.</p> <p>During an observation and interview on 02/11/25 at 11:32 a.m., Resident #93 was lying in the bed on her back. Resident #93 was not on a specialty mattress. Resident #93 did not have any pressure relieving positioning devices noted in her bed. Resident #93's legs were not offloaded. Resident #93 said staff had not turn her every 2 hours or propped her heels with pillows. She said she had wounds on thighs, buttock, and hip. She said when she came from the hospital, there were dressings on two of the wounds. She said the facility did not do dressing changes every day. She said it depended on the staff as to what was done to her wounds. She said some staff did nothing and others would put cream on the wounds if they were closed.</p> <p>(continued on next page)</p>		

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<p>F 0635</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an observation on 02/11/25 at 1:25 p.m., Resident #93 was lying in the bed on her back. Resident #93 was not on a specialty mattress. Resident #93 did not have any pressure relieving positioning devices noted in her bed. Resident #93's legs were not offloaded.</p> <p>During an interview on 02/11/25 at 1:30 p.m., the ADCO said she was working the floor when Resident #93 was admitted . She said she was Resident #93's admitting nurse. She said if the admitting nurse was not a RN, then the nurse was only responsible for measuring and describing the wound. She said a RN, the DCO, or MD staged pressure wounds at the facility. She said upon admission the resident's MD should be notified and general wound care orders obtained. She said when the wound care doctor rounded on Fridays, the facility received specialized wound care orders. She said the wound care doctor came every Friday and the DCO notified him of who needed to be seen. She said after the wound care doctor rounded and made recommendations. She said the wound care doctor placed his recommendations in a progress note. She said the floor nurses or the DCO were responsible to place the recommendations in the facility's electronic medical record as an order. She said the DCO and ADCO were responsible for ensuring the wound care orders were followed through. She said the floor nurses were responsible for the resident's weekly skin assessments. She said the DON and DNP completed the weekly wound assessments when he rounded on Fridays. She said Resident #93 wounds on admission were shearing to her right hip, right buttocks, left thigh, and left buttocks. She said since she was not a RN, she did not stage Resident #93's wounds. She said Resident #93 arrived from the hospital with dressings over the wounds. She said she notified NP R by text or phone and let her know about Resident #93's shearing. She said she did not receive a response from NP R until shift change. She said she could not remember what NP R said about Resident #93's shearing. She said she knew she passed the message from NP R on to RN G when she gave report. She said she did not know what wound care treatment Resident #93 had been receiving since admission on 02/01/25. She said she did not know the facility's policy or criteria on specialty mattress because she just started January 13, 2025. She said she did not know if Resident #93 met the facility's criteria for a specialty mattress but she probably did. She said other interventions for Resident #93's pressure wounds should have been frequent repositioning and incontinent care and a dietary consult. She said the dietician would be at the facility this week. She said since Resident #93 had a skin assessment on 02/01/25, then she should have had one on 02/08/25. She said even though the skin assessment was a day after the wound care doctor came, it should have been done by the floor nurse. She said skin assessments were important to ensure skin issues were not missed and proper wound care orders were in place. She said following doctors' orders were important to prevent the wound from declining and promote healing. She said the facility provided Resident #93 assist rails and trapeze bar to help with her mobility.</p> <p>On 02/11/25 at 2:23 p.m., called NP R and left voicemail.</p> <p>On 02/11/25 at 2:25 p.m., called RN G and left voicemail.</p> <p>During an interview on 02/11/25 at 2:58 p.m., NP R said she received a text message from LVN A that Resident #93 was admitted . She said she was currently driving and could not remember if the ADCO contacted her on admission about Resident #93's wounds. She said normally the facility followed the hospital's wound care orders and did not need them to give any orders.</p> <p>During an interview on 02/11/25 at 4:41 p.m., NP R called back and said LVN A and the ADCO called her on 02/01/25 about Resident #93. She said she told LVN A and the ADCO to resume all hospital orders and she would see Resident #93 on Tuesday, 02/04/25.</p> <p>(continued on next page)</p>		

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<p>F 0635</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 02/11/25 at 6:01 p.m., RN G said she had worked at the facility for 6 years. She said she had taken care of Resident #93. She said she was texting with NP R on 02/05/05 about another resident lab work and NP R asked about Resident #93. She said NP R mentioned the hospital had not sent Resident #93 with wound care orders when she discharged. She said she told NP R that there were no wound care orders in Resident #93's hospital discharge paperwork. She said she told NP R, she did not know what the facility had been doing either for Resident #93's pressure wounds. She said NP R ordered collagen and a dry dressing and for the wound care doctor to see Resident #93. She said she did the ordered wound care on Resident #93 that night shift (02/05/25). She said she thought she placed the wound care orders NP R gave for Resident #93 in the facility's electronic medical records. She said Resident #93's wound care orders from NP R would be on her MAR if she did. She said it was important to have put in the wound care orders from NP R, so the next person knew what to do for Resident #93's wounds. She said not doing wound care treatments for Resident #93's wounds could cause further break down or increased stages. She said Resident #93's wounds would have been called stage 2's on admission. She said if the admission nurse was not a RN, then the next RN on duty was responsible for staging the pressure ulcer. She said if a wound needed to be staged by a RN, that information needed to be passed down by the next nurse or put on the 24-hour report. She said staging a pressure ulcer was important so the wound could be caught early and treated so it did not decline. She said she was not aware Resident #93's wounds were not staged until DNP S came on 02/07/25. She said a resident had to have pressure breakdown to be on a low air loss mattress. She said Resident #93 was on a bariatric pressure reduction mattress. She said she did not if they made bariatric specialty mattresses. She said if they made bariatric low air loss mattresses, Resident #93 would qualify for one because she had several areas of pressure breakdown.</p> <p>During an interview on 02/12/25 at 1:57 p.m., LVN D said nurses were responsible for resident's skin assessments. She said the skin assessments were due weekly and as needed. She said the weekly skin assessments should be charted in the resident medical records. She said a resident should be on a low air loss mattress if they have pressure ulcers or at the family request. She said heels should be floated for residents after hip surgery, residents who do not turn good, or residents with redness on their heels. She said residents should be repositioned every 2 hours. She said the RCP or LVN could do it but the RCP was primarily responsible. She said if a resident was able to turn themselves in the bed, the RCP should still encourage and help the resident turn every 2 hours. She said the RCP should be propping the resident with pillows to offload them when repositioning. She said the LVN should be ensuring the RCP are repositioning every 2 hours and offloading the residents by observation. She said a RN and LVN certified in wound care could stage pressure wounds. She said primarily RNs. She said if a resident needed a pressure wound staged, she would find a RN or contact the DCO. She said the facility had a telehealth option to stage wounds available now. She said the resident's doctor or the medical director was contacted for wound care orders. She said nursing management was responsible for taking the wound care doctor recommendations and making them orders. She said when the wound care doctor rounded on Fridays, he gave the DCO a copy of his recommendations on a piece of paper before he left. She said the wound care doctor left around 10 am. She said the bedside nurses were responsible for doing wound care treatments. She said the nurses documented on the MAR/TAR when wound care was completed. She said if wound care was not documented on the resident MAR/TAR, it could indicate it was not done. She said some residents did not show on the right screen to be done on the facility's computer system. She said skin assessments, wound care treatments, and repositioning/offloading were important to prevent skin breakdown and worsening of wound and not miss anything.</p> <p>(continued on next page)</p>		

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<p>F 0635</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 02/12/25 at 5:25 p.m., RCP H said she had worked at the facility for 2 years. She said she found out a resident had wounds when she changed them. She said she was not really made aware by nursing staff or during report which resident had wounds. She said it depended on the severity of the wound what type of treatment the resident required. She said some resident needed cream and other had dressing changes by the nursing staff. She said RCPs were responsible for repositioning the residents every 2 hours with rounds. She said the residents should be alternated side to side and propped with pillows. She said residents stuck in the bed should have their heels offloaded. She said Resident #93 was stuck in the bed unless PT got her up. She said when she had Resident #93, she went in her room every once in a while, to remind her to turn but not every 2 hours. She said turning and offloading were important to prevent skin breakdown. She said constant pressure caused skin breakdown.</p> <p>During an interview on 02/12/25 at 5:49 p.m., the ADCO said wound care was documented on the resident's TAR in the facility's charting system. She said if wound care was not documented in the facility's charting system, it could indicate it was not done. She said the charge nurses were responsible for the resident's wound care. She said the DCO and ADCO should ensure the charge nurses were doing the ordered wound care treatments and documenting wound care on the resident's MAR/TARs. She said doing the resident's ordered wound care treatment was important to prevent decline of the wound, infection, prevent pain and more wounds. She said it was also important to do wound care to monitor the wound and follow doctor's orders. She said completion of the resident's skin assessment was documented on the TAR/MAR and a skin assessment form was also done. She said when she first started, she did not know that a skin assessment form had to be done even if the resident had no skin changes. She said she documented she completed Resident #15's skin assessment on the MAR/TAR but she did not do a new skin assessment form. She said she and the DCO Q were in the process, of putting a process in place to do chart audits to monitor skin assessments and wound care orders.</p> <p>During an interview on 02/12/25 at 6:57 p.m., DCO P, who was covering for DCO Q, said she expected nursing staff to follow physician orders. She said she expected nursing staff to document wound care on the MAR/TAR and/or progress note in the facility's charting system. She said if the wound care was not documented on the MAR/TAR and/or progress note, it could indicate it was not done. She said she expected nursing staff to order skin assessment on admission. She said she expected nursing staff to complete skin assessment weekly and with skin changes. She said the DCO ordered the resident's specialty mattresses and the charge nurse should ensure it was on the correct settings. She said all resident benefited from having their heels floated. She said but immobile residents especially needed their heels floated. She said she expected residents to be repositioned and offloaded at least every 2 hours by the RCPs. She said she preferred staging pressure wounds be done by the telehealth system. She said a RN or DCO should stage the resident pressure wounds. She said the ADCO and DCO should be ensuring nursing staff were doing wound care and skin assessments. She said all of these were important for wound prevention and management.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0635</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 02/12/25 at 7:34 p.m., the EDO said skin assessment were to be completed every 7 days in the facility's charting system. She said Resident #93 met the criteria for a low air loss mattress. She said the facility had a few specialty mattresses in house and she also could order one if needed. She said the DCO or the nursing staff who rounded with the wound care doctor was responsible for inputting his orders. She said it was important to document wound care and skin assessments to have an adequate clinical record. She said it was important to do wound care and skin assessments to promote wound healing. She said nursing management was responsible for ensuring nursing staff completed skin assessment and wound care. She said nursing management should be doing chart audits to ensure it was happening.</p> <p>Record review of a facility's Skin Management: Prevention and Treatment of Wounds policy revised 10/06/22 indicated .the purpose of this procedure is for prevention and treatment of skin breakdown such as pressure injuries, diabetic ulcers, arterial ulcers, and skin wounds Skin assessments will be documented at a minimum of every 7 days on a Weekly Skin Assessment . Staging of wounds will be performed by a registered nurse or licensed nurse certified in wound care . Dependent residents will have heels floated while in bed and be turned and repositioned at a minimum of every 2 hours . A licensed nurse will obtain orders from physician for new skin wounds and transcribe onto resident's treatment record for follow up . Specialty mattresses will be implemented for residents with multiple stage II areas, stage III, or stage IV pressure injuries . Weekly skin assessments will be documented on the Weekly Skin Assessment every 7 days or less . Licensed nurse will initiate the schedule for the wound form in Point Click Care which automatically triggers every 7 days from day of completion .</p> <p>The EDO and DCE were notified of an IJ on 02/11/25 on 5:00 p.m., were given a copy of the IJ template, and a Plan of Removal (POR) was requested. The Plan of Removal was accepted on 02/12/25 at 9:40 a.m. and included the following:</p> <p>[F635]</p> <p>Plan of Action:</p> <p>Resident #93 had wound care orders written on 02/11/25. A weekly wound assessment was completed on 02/11/25. A specialty mattress was placed on Resident #93's bed on 02/11/25. Resident #93's heels were floated effective 02/11/25.</p> <p>Skin sweep competed on 02/11/25 to ensure all skin issues were identified and had current orders and interventions in place. Completed 02/11/25 by Director of Clinical Education and designees.</p> <p>Director of Clinical Education will educate Director of Clinical Services and Assistant Director of Clinical Services on the process of reviewing new resident admissions electronic health records for completion of order transcription as it relates to wound orders as well as carrying out those orders. Completed 2/11/25 If a RN or wound care certified LVN is not on duty at the time a resident admits, the admitting nurse on duty will utilize Advanced Wound Care Telehealth for a consult. Completed 02/12/25.</p> <p>(continued on next page)</p>		

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<p>F 0635</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>All licensed nurses will be educated by the ADCO or designee on the process of carrying out orders for residents admitted with wounds or obtaining orders if no order accompanies the resident when admitted . Education will also include the completion of weekly skin assessments per schedule. Completion 02/12/25 10:00 a.m. Anyone who is not on duty that we cannot reach by phone will be required to complete the in-service prior to working their next shift.</p> <p>All licensed nurses will receive in-service regarding wound care orders and weekly skin assessments prior to the beginning of their next shift to begin 02/11/25.</p> <p>Any newly hired nurses will receive the above education upon hire during orientation prior to taking a shift on the floor.</p> <p>Ad hoc QAPI meeting will be held with the Medical Director on 02/12/25 reviewing the policies and procedures for wound care.</p> <p>All licensed nurses will be educated on the Skin Management policy regarding general guidelines, prevention, notification, treatment, and documentation the Director of Clinical Education or designee. Completed 2/12/2025 2:00 p.m. Anyone who is not on duty that we cannot reach by phone will be required to complete the in-service prior to working their next shift.</p> <p>All C.N.A.'s will be educated by the Director of Clinical Education or designee regarding pressure ulcer prevention and interventions for residents with pressure ulcers. Completed 2/12/2025 3:00 p.m. Anyone who is not on duty or cannot come in or be reached by phone will be required to complete the in-service prior to working their next shift.?</p> <p>Validation/Monitoring Tools?</p> <p>Director of Clinical Operations or Assistant Director of Clinical Operations will review all orders for new admissions every day in the morning clinical meeting to ensure orders have been written and carried out for residents admitted with wounds. ?Beginning 02/12/25.</p> <p>Director of Clinical Operations or designee will review weekly skin assessments daily to ensure timely completion. Beginning 02/12/25.</p> <p>Director of Clinical Operations or designee will review wound physician documentation weekly to ensure any orders are carried out timely. Beginning 02/12/25.</p> <p>Director of Clinical Operations and/or designee will review all wound care patients orders, interventions, and skin assessments during Standards of Care Meeting weekly, Beginning 02/12/25.</p> <p>The Administrator, Director of Clinical Operations and/or designee will review the action plan developed related to obtaining wound care orders, implementing wound care interventions, and weekly skin assessments in QAPI meeting monthly during the next six months. Beginning 02-12-25.?</p> <p>This surveyor and team verification of the Plan of Removal from 02/12/25 was as follows:</p> <p>Record review of Resident #93's MAR dated 02/01/25-02/28/25 indicated wound care written on 02/11/25.</p> <p>(continued on next page)</p>		

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<p>F 0635</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #93's skin assessment dated [DATE] completed by DCO P, indicated, .stage 3 pressure injuries x3 (right lateral hip, right thigh and left inner thigh) seen by AWC MD .</p> <p>Record review of Resident #93's wound assessment dated [DATE] completed by DCO P, indicated, .right thigh .2.2cmx3cmx0.2cm .</p> <p>Record review of Resident #93's wound assessment dated [DATE] completed by DCO P, indicated, .left inner thigh .1cmx0.1cmx0.2cm .</p> <p>Record review of Resident #93's wound assessment dated [DATE] completed by DCO P, indicated, .right lateral hip .4.5cmx1.3cmx0.2cm .</p> <p>Record review of the facility's Residents with Pressure Injuries provided by the EDO on 02/11/25 indicated seven residents with pressure injuries. Five residents were included in finalized sample. Resident #11 and Resident #15 had missing documentation of wound care and skin assessments.</p> <p>Record review of the facility's weekly skin assessment dated [DATE] indicated all 40 resident skin assessments were completed.</p> <p>Record review of the QAPI Ad hoc meeting sign in sheet dated 02/12/25 at 8:00 a.m., indicated the EDO, Medical Director, [NAME], DFS, DLE, DCE, DPO, ADCO, and SSDD.</p> <p>During an observation on 02/12/25 at 4:00 p.m., a low air loss mattress, a type of specialty mattress, was noted in Resident #93's room. Several pillows were noted on Resident #93's bed used for offloading.</p> <p>Record review of an In-Service and Education Record for Chart Reviews for Admission and Readmitted d 02/11/25, was conducted by the DCE indicated the DCO Q (via phone) and ADCO were in attendance.</p> <p>Record review of an In-Service and Education Record for Wound Care Orders-Admission and Readmission and Wound Care Orders-Wound</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</p> <p>Based on interview, and record review, the facility failed to ensure individuals with mental health disorders were provided an accurate Preadmission Screening and Resident Review (PASRR) Screenings for 1 of 5 residents (Resident #7) reviewed for PASRR.</p> <p>The facility failed to refer Resident #7 for a PASRR review following a new mental illness diagnosis of Bipolar Disorder (mental illness associated with episodes of mood swings ranging from extreme sadness to excitement) on 05/23/23.</p> <p>This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs.</p> <p>Findings included:</p> <p>Record review of Resident #7's face sheet dated 2/10/25 indicated she was [AGE] years old and admitted initially to the facility on [DATE]. Resident #7 had diagnoses which included Bipolar Disorder with on onset date of 5/23/23.</p> <p>Record review of Resident #7's quarterly MDS assessment dated [DATE] indicated Resident #7 made herself understood and understood others. The MDS indicated Resident #7 had a BIMS score of 10, which indicated she had moderate cognitive impairment. The MDS indicated Resident #7 had psychological/mood disorders including anxiety, depression, and Bipolar.</p> <p>Record review of Resident #7's undated care plan indicated she was at risk for adverse consequences related to receiving psychotropic medication and had diagnoses of Bipolar disorder, depression, and a sleeping disorder. Resident #7 had a behavior problem related to low frustration tolerance, paranoia (distrust of others), and untrusting of staff.</p> <p>Record review of Resident #7's PL1 dated 2/10/22 indicated she had no evidence or indicators of mental illness, intellectual disability, or developmental disability. There was no other record of any other PL1s after 2/10/22.</p> <p>Record review of Resident #7's undated Mental Illness/Dementia Resident Review, Form 1012, completed by the MDS Coordinator and signed by the physician on 2/12/25, indicated Resident #7 did not have a primary diagnosis of dementia (loss of memory). The Form 1012 indicated Resident #7 did have a Mental Illness (MI) Indication or a mood disorder (Bipolar, Major Depression, or other mood disorder) with an onset date of 5/23/23. There was no other record of another Form 1012 being completed prior to 2/12/25.</p> <p>(continued on next page)</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/11/25 at 4:20 PM, the MDS Coordinator said she had been the MDS Coordinator since October 2024. The MDS Coordinator said Resident #7 did not have a PASRR level II assessment because it looked like in reviewing Resident #7's records, she had received a new diagnosis of Bipolar in 2023 and the PL1 was done in 2022. The MDS Coordinator said Resident #7 should have had a Form 1012 completed to capture the new mental illness diagnosis and sent to the local authority for a PASRR level 2 evaluation.</p> <p>During an interview on 2/12/25 at 9:28 AM, the ADCO said the MDS Coordinator was having surgery and would not be available, but the MDS Coordinator and sent her a message related to Resident #7's PL1. The ADCO said the MDS Coordinator said in 2023 the previous MDS nurse added the diagnosis of Bipolar, and the previous MDS nurse did not complete the Mental Illness/Dementia Resident Review, Form 1012, or update the PL1 to reflect the new diagnosis. The ADCO said the MDS Coordinator said she had completed the Form 1012, was getting the Form 1012 signed by the physician, and MDS Coordinator would submit another PL1 to reflect the mental illness of Bipolar when she returned to work.</p> <p>During an interview on 2/12/25 at 9:43 AM, the ADCO said Resident #7's new PL1 would be submitted to the local authority that day (2/12/25).</p> <p>During an interview on 2/12/25 at 1:33 PM, the ADCO said Resident #7's PL1 not being updated to reflect her new diagnosis of Bipolar in 2023, resulted in Resident #7 potentially not receiving services that she may have qualified for. The ADCO said it was also a notification issue to have the Local Authority come in to see if Resident #7 met the criteria and be a part of the care plan meetings.</p> <p>During an interview on 2/12/25 at 2:18 PM, DCO P said she was covering the facility while DCO Q was out sick. DCO P said she worked at a sister facility as the DCO. DCO P said she was not well versed in PASRR regulations, and she just sat in on meetings at her facility.</p> <p>During an interview on 2/12/25 at 5:46 PM, the EDO said she would expect the PASRR to be updated timely with any new mental illness diagnosis. The EDO said Resident #7 could have missed out on PASRR services that she may have qualified for.</p> <p>Record review of the facility's policy titled PASRR and revised on 11/15/23 indicated . the purpose of the policy was to ensure PASRRs were being obtained and completed timely and accurately . Follow Texas PASRR policy for all mandatory meetings and care coordination including any changes that may require a change in resident's PASRR status .</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643</p> <p>Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for 1 of 6 residents (Resident #9) reviewed for PASRR Level I screenings.</p> <p>The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #9. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnoses (Major Depressive Disorder, Schizoaffective Disorder, Bipolar Disorder) were present upon Resident #9's admitted on 12/30/22.</p> <p>This failure could place residents who had a mental illness at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs.</p> <p>Findings included:</p> <p>Record review of Resident #9's face sheet, dated 11/18/24, indicated he was a [AGE] year-old male, admitted to the facility on [DATE], and readmitted most recently on 04/20/23. His diagnoses included Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Schizoaffective Disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder), and Bipolar Disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration).</p> <p>Record review of Resident #9's annual MDS assessment, dated 1/4/25, indicated he had a BIMS score of 08, which indicated mildly impaired cognition. The MDS did not show he received an antipsychotic medication.</p> <p>Record review of Resident #9's PASRR Level 1 Screening, dated 12/29/22, indicated that in Section C, Mental Illness was marked as no, which indicated Resident #9 did not have a mental illness.</p> <p>During an interview on 2/11/25 at 8:33 a.m., the MDS Coordinator said Resident #9 was PASRR negative. She said that the PASRR provided to the survey was the only PASRR form available and competed prior to admission.</p> <p>During an interview on 2/12/25 at 1:44 p.m., the Director of Nurses said Schizophrenia, Major Depressive Disorder, and Bipolar Disorder all qualify for a positive PASRR level one evaluation. She said that the MDS nurse is responsible to ensure that the PASRR is completed correctly. She said that the residents can be placed at risk for not receiving the services they are qualified for if the PASRR is not filled out correctly.</p> <p>During an interview on 2/12/25 at 5:07 p.m., the Administrator said the MDS Coordinator is responsible for completing PASRR evaluations. She said the MDS Coordinator is not here today as she had a medical appointment. She said she expects that the PASRR is completed properly. She said that residents may not get the services they are eligible for if their PASRR is not completed properly.</p> <p>(continued on next page)</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy titled, PASRR dated 11/2023 indicated, The purpose of this policy is to ensure PASRRs are being obtained and completed timely and accurately PASRRs are obtained from referring entity by the admissions department PL 1 s are put in to Simple L TC by the facility CRC within 72hours of resident admitting to facility. The completed PL 1 must also be uploaded into the resident's EMR Communicate with LIDDA/LMHA to ensure all active positive PL 1 s have a completed PE and upload the PE into the resident's EMR Review recommended Specialized Services on the PE once the PE is submitted When discharging a resident to another Nursing Facility, the facility is responsible for completing a PASRR for the NF Follow Texas PASRR Policy for all mandatory meetings and care coordination including any changes that may require a change in resident's PASRR status.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on interview and record review, the facility failed to ensure the baseline care plan that included the instructions for resident care needed to provide effective and person-centered care was completed and provided to the resident and/or their representative for 1 of 6 residents reviewed for new admissions (Resident #93).</p> <p>The facility failed to provide Resident #93, a copy of the summary of the baseline care plan. Resident #93 was admitted on [DATE] and had not received a copy of the summary as of 02/10/25.</p> <p>This failure could place residents at risk of not receiving care and services to meet their needs.</p> <p>Findings included:</p> <p>Record review of Resident #93's face sheet dated 02/11/25 indicated Resident #93 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #93 had diagnoses including acute kidney failure (when the kidneys suddenly can't filter waste products from the blood), urinary tract infection (is an infection in any part of your urinary system: kidneys, bladder, ureters, and urethra), morbid obesity (is a medical condition characterized by excessive body weight that significantly impacts health and well-being), and pressure ulcer of right hip, left hip, and other sites, stage 3 (a full-thickness tissue loss where the subcutaneous fat layer is visible within the wound, but the bone, tendon, or muscle is not exposed).</p> <p>Record review of the MDS indicated Resident #93 was admitted to the facility less than 21 days ago. No MDS for Resident #93 was completed prior to exit.</p> <p>Record review of Resident #93's baseline care plan initiated by ADCO, on 02/01/25 did not reflect the signature of Resident #93. The baseline care did not reflect Resident #93 received a copy of the summary of the baseline care plan.</p> <p>During an interview on 02/10/25 at 10:36 a.m., Resident #93 said she was admitted from the hospital about 9 days ago. She said a staff member had started a baseline care plan when she admitted but had to stop because the staff member got busy. She said no one had been back to finish the baseline care plan. She said she did not receive a copy of the summary of the baseline care plan or any other type of care plan. She said she would have liked a copy of her care plan. She said she knew her goal was to start walking again.</p> <p>During an interview on 02/12/25 at 1:57 p.m., LVN D said she had recently started at the facility. She said she did not know who was responsible for providing a copy of the summary of the baseline care plan to the resident and/or responsible party.</p> <p>During an interview on 2/12/25 at 5:07 p.m., the EDO said the CRC was not here today as she had a medical appointment.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/12/25 at 5:49 p.m., the ADCO said the admitting nurse could start a baseline care plan. She said the ADCO, DCO Q, and CRC had to ensure the information on the baseline care plan was correct. She said the baseline care plan had to be completed within 48 hours of admission. She said the LVNs or nursing managers could provide a copy of the summary to the resident. She said she did not know if the facility had to give the copy of the summary to the resident or responsible party within 48 hours also. She said she did start and almost complete Resident #93's baseline care plan on admission. She said she was working the floor and got busy.</p> <p>During an interview on 02/12/25 at 6:57 p.m., the DCO P, from a sister facility, said the admitting nurse started the baseline care plan. She said a RN had to complete the baseline care plan. She said the baseline care plan had to be completed within 48 hours of admission. She said the DCO was supposed to review the baseline care plan with the resident and/or responsible party. She said she did not know who was responsible for giving the resident and/or responsible party a copy of the summary of the baseline care plan. She said it was important for the resident and/or responsible party to get a copy so they knew the plan of care.</p> <p>During an interview on 02/12/25 at 7:34 p.m., the EDO said the IDT was responsible for the baseline care plan. She said the baseline care plan had to be completed within 72 hours of admission. She said any staff member could open the baseline care plan. She said each department was responsible for their part on the baseline care plan. She said the SSDD was responsible of given the resident and/or responsible party a copy of the summary. She said it was important to give them a copy to see if everyone agreed with the plan of care. She said the responsible party could also add input to the plan of care when they received a copy of the summary of the baseline care plan.</p> <p>Record review of a facility's Baseline Care Plan policy dated 11/01/2019 indicated .a baseline care plan is required to be completed within 48 hours of admission .the facility must provide the resident and their representative with a summary of the baseline care plan .</p> <p>Record review of a facility's Comprehensive Care Plan revised 04/25/21 indicated .A Registered Nurse will complete the Baseline Care Plan in the RN's absence in the Clinical reimbursement role . An RN initiates all Care Plans .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on observation, interviews and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to ensure the comprehensive care plan described the services and interventions to be used to attain and maintain the resident's practicable physical, mental, and psychosocial well-being for 3 of 13 residents reviewed for care plans (Resident #1, Resident #11, and Resident #15).</p> <p>The facility failed to ensure Resident #1's history of a fall, with a fracture prior to admission, triggered on the 12/08/24 MDS and actual fall on 01/15/25 were care planned.</p> <p>The facility failed to ensure Resident #1's unplanned weight loss experienced on 01/07/25, was care planned.</p> <p>The facility failed to ensure Resident #1's risk of pressure ulcers (is a localized area of skin damage that develops when pressure on the skin cuts off blood flow to the area), triggered on the 12/08/24 MDS, was care planned.</p> <p>The facility failed to ensure Resident #1 experienced pain and received pain medication triggered on the 12/08/24 MDS, was care planned.</p> <p>The facility failed to ensure Resident #1 being on an antiplatelet medication (drugs that prevent platelets from clumping together and forming blood clots), triggered on the 12/08/24 MDS, was care planned.</p> <p>The facility failed to ensure Resident #11 being on an antiplatelet, started on 04/03/24, was care planned.</p> <p>The facility failed to ensure Resident #15 had a posted Enhanced Barrier Precaution (are a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs; are bacteria that are resistant to multiple antibiotics and antifungals)) sign, per her care plan intervention, on 01/10/25-01/12/25.</p> <p>These failures could place residents at risk of not having their individualized needs met, and a decline in their quality of care and life.</p> <p>Findings included:</p> <p>(continued on next page)</p>		

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 02/12/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's face sheet dated 01/10/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses including Asperger's syndrome (is a term sometimes used to describe a developmental disorder that's part of the autism spectrum disorder (ASD)), epilepsy (is a chronic brain disorder characterized by recurrent seizures, which are brief episodes of involuntary movements, loss of consciousness, or altered awareness), displaced bimalleolar fracture of left lower leg (is a severe injury to the ankle joint and bones of the lower leg), and osteoarthritis (is a chronic condition that causes joint pain, stiffness, and inflammation).</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 was understood and had the ability to understand others. Resident #1 had a BIMS of 09 which indicated moderate cognitive impairment. Resident #1 received as needed pain medication or was offered and declined. Resident #1 had a pain score of 04. Resident #1 had a fall in the last month prior to admission/entry or reentry. Resident #1 had a fracture related to a fall in the 6 months prior to admission/entry or reentry. Resident #1 required a major surgical procedure during the prior inpatient hospital stay. Resident #1 had a repair fracture of the pelvis, hip, leg, knee, or ankle. Resident #1 was at risk of developing pressure ulcers/injuries. Resident #1 received an antidepressant, antibiotic, opioid, antiplatelet, and anticonvulsant during the last 7 days of the assessment period.</p> <p>Record review of Resident #1's care plan dated 12/15/24 indicated Resident #1 had a history of seizures and was at risk for injury related to weakness, balancing difficulties, cognitive limitations or altered consciousness, loss of large or small muscle coordination. Resident #1 had a risk for ineffective airway clearance and at risk for the inability to clear secretions or obstructions for the respiratory tract to maintain a clear airway. Interventions included padded side rails on bed if required, remove objects from area that could cause injury, administer medications as prescribed, and monitor for side effects. Resident #1 care plan did not reflect history of a fall with a fracture, an actual fall, unplanned weight loss, risk of developing pressure ulcers/injuries, use of an antiplatelet, and experienced pain with opioid use.</p> <p>Record review of Resident #1's consolidated physician order dated active as of 02/10/25 indicated the following:</p> <p>*Health Shake (has protein, vitamins, and minerals to improve nutritional parameters) two times a day due to weight loss for 60 days. Take one by mouth between meals for 60 days. Start 02/04/25.</p> <p>*Aspirin (antiplatelet; can be effective at preventing heart attack or stroke) 81 mg, give 1 tablet by mouth one time a day for fracture. Start 12/03/24.</p> <p>*Hydrocodone-Acetaminophen (is used to relieve pain severe enough to require opioid treatment) Tablet 5-325mg, give 1 table by mouth every 6 hours as needed for pain scale 1-5. Start 12/04/24.</p> <p>Resident #1 received Health Shakes for weight loss supplement and Hydrocodone-Acetaminophen for pain management.</p> <p>Record review of Resident #1's MAR dated 01/01/25-01/31/25 indicated the following:</p> <p>*Aspirin 81 mg, give 1 tablet by mouth one time a day for fracture. Start 12/03/24. Received 30 of 31 doses.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Health Shake one time a day for 60 days. Start 12/17/24. Discontinued 02/04/25.</p> <p>*Hydrocodone-Acetaminophen Tablet 5-325mg, give 1 table by mouth every 6 hours as needed for pain scale 1-5. Start 12/04/24. Received doses on 01/03/25 (3 doses), 01/04/25 (2 doses), and 01/05/25 (1 dose).</p> <p>Record review of Resident #1's MAR dated 02/01/25-02/28/25 indicated:</p> <p>*Aspirin 81 mg, give 1 tablet by mouth one time a day for fracture. Start 12/03/24. Received 10 of 10 doses.</p> <p>*Health Shake one time a day for 60 days. Start 12/17/24. Discontinued 02/04/25.</p> <p>*Health Shake two times a day due to weight loss for 60 days. Take one by mouth between meals for 60 days. Start 02/04/25.</p> <p>*Hydrocodone-Acetaminophen Tablet 5-325mg, give 1 table by mouth every 6 hours as needed for pain scale 1-5. Start 12/04/24.</p> <p>Record review of Resident #1's Incident Report dated 01/15/25 indicated Resident #1 had an unwitnessed fall in her room.</p> <p>Record review of Resident #1's weight summary accessed on 02/11/25 indicated:</p> <p>*02/07/25 161.8 lbs.</p> <p>*01/07/25 162.2 lbs.</p> <p>*12/09/24 187 lbs.</p> <p>On 12/09/2024, the resident weighed 187 lbs. On 02/07/2025, the resident weighed 161.8 pounds which is a -13.48 % Loss.</p> <p>2. Record review of Resident #11's face sheet dated 02/11/25 indicated Resident #11 was an [AGE] year-old, female admitted to the facility on [DATE]. Resident #11 had diagnoses including cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced), type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), and muscle weakness.</p> <p>Record review of Resident #11's quarterly MDS assessment dated [DATE] indicated Resident #11 was understood and had the ability to understand others. Resident #11 had a BIMS of 06 which indicated moderate cognitive impairment. Resident #11 had received an antiplatelet during the last 7 days of the assessment period.</p> <p>Record review of Resident #11's care plan dated 12/13/24 did not reflect use of an antiplatelet.</p> <p>Record review of Resident #11's consolidated physician order dated active as of 02/11/25 indicated Aspirin 81 mg, give 1 tablet by mouth one time a day for antiplatelet. Start 04/03/24.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #11's MAR dated 02/01/25-02/28/25 indicated Aspirin 81 mg, give 1 tablet by mouth one time a day for antiplatelet. Start 04/03/24. Resident #11 received 11 of 11 doses.</p> <p>3. Record review of Resident #15's face sheet dated 02/10/25 indicated Resident #15 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #15 had diagnoses including type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), neuromuscular dysfunction of bladder (a condition where the nerves controlling bladder function are damaged, leading to impaired bladder control due to disrupted communication between the brain and the bladder muscles, causing issues like incontinence, difficulty urinating, or incomplete bladder emptying) and dementia (is a term used to describe a group of symptoms affecting memory, thinking and social abilities).</p> <p>Record review of Resident #15's admission MDS assessment dated [DATE] indicated Resident #15 was understood and had the ability to understand others. Resident #15 had a BIMS of 13 which indicated intact cognition. Resident #15 had an indwelling catheter and occasional bowel incontinence. Resident #15 had two stage 2 wounds.</p> <p>Record review of Resident #15's care plan dated 01/20/25 indicated Resident #15 was on Enhanced Barrier Precaution for an indwelling catheter. Intervention included Enhanced Barrier Precaution sign will be placed inside resident room within close proximity to resident to inform staff of resident specific needs.</p> <p>During an observation on 02/10/25 at 11:08 a.m., Resident #15 was lying askew in her bed. Resident #15 had an indwelling catheter hanging on the side of her bed. Resident #15 did not have a posted Enhanced Barrier Precaution sign in her room.</p> <p>During an observation on 02/11/25 at 10:13 a.m., Resident #15 was lying on her right side and the catheter bag was on the left side of the bed. Resident #15 did not have a posted Enhanced Barrier Precaution sign in her room. Near Resident #15's window, a plastic caddy was noted with personal protective equipment.</p> <p>During an observation on 02/12/25 at 1:35 p.m., Resident #15 was lying askew in her bed. Resident #15 had an indwelling catheter hanging on the side of her bed. Resident #15 did not have a posted Enhanced Barrier Precaution sign in her room.</p> <p>During an interview on 02/12/25 at 1:57 p.m., LVN D said she had just started at the facility. She said she knew LVNs could edit the resident's care plan but did not know who was responsible for them. She said Resident #15 should have had a Enhanced Barrier Precaution sign posted in her room. She said Resident #1 and Resident #11's care areas should have been care planned such as falls and medications. She said the care plans were important to know the resident's plan of care and how to properly care for them.</p> <p>During an interview on 2/12/25 at 5:07 p.m., the EDO said the CRC was not here today as she had a medical appointment.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 02/12/25 at 5:25 p.m., RCP H said she knew a resident was on Enhanced Barrier Precaution because the residents normally have a caddy with supplies and she thought a sign was posted. She said the RCPs did not have access to the resident's care plans. She said the nurse told the RCPs what interventions were in place for falls and things like that.</p> <p>During an interview on 02/12/25 at 5:49 p.m., the ADCO said she started at the facility on January 12, 2025. She said the CRC was responsible for comprehensive care plans. She said the CRC should have put up Resident #15's Enhance Barrier Precaution sign but the charge nurses were also responsible. She said the resident's falls should be updated after every incident by the floor nurses. She said resident's falls should be discussed in the morning meetings and the IDT should verify the care plan was updated. She said the CRC was responsible for Resident #1's weight loss care plan. She said care areas triggered on the resident's MDS should be care planned. She said medication orders or changes could be updated on the care plan by the nurses. She said the care plan was important because it was what the facility was doing to help the resident. She said the care plan helped everyone be on the same page on the resident's plan of care. She said it also helped the facility know what intervention were working and what was not. She said if the care plan was not developed or updated then the resident would not get the care they needed.</p> <p>During an interview on 02/12/25 at 6:57 p.m., the DCO P, from a sister facility, said the CRC was responsible for the comprehensive care plans. She said the resident's care areas triggered on the MDS should be care planned. She said resident's medications such as antiplatelets should be care planned. She said the ICP should have ensured Resident #15's Enhanced Barrier Precaution sign was posted. She said the CRC and the IDT should ensure resident's care plans were accurate. She said the care plans should be monitored and discussed at the daily morning meetings and weekly standard of care meetings.</p> <p>During an interview on 02/12/25 at 7:34 p.m., the EDO said, the nursing staff could do resident's care plans. She said not one person was responsible for comprehensive care plans. She said the CRC was responsible for care planning the care areas triggered on the MDS. She said nursing management should have ensured Resident #15 had an Enhanced Barrier Precaution sign posted in her room. She said acute care plans like the fall care plans, should be done by the nursing staff. She said the weight loss care plans should be done by the nursing staff and dietary. She said the care plans ensured the residents received the best individualized care. She said it was important to follow the resident's care plan because it was individualized. She said the IDT should review the resident's care plans to ensure they were comprehensive.</p> <p>Record review of a facility's Comprehensive Care Plan revised 04/25/21 indicated .Every resident will have an individualized interdisciplinary plan of care in place . The Interdisciplinary Team will continue to develop the plan in conjunction with the RAI (MOS 3.0) and CAAS, completing and conducting Comprehensive Care Plan Meeting and Reviews by day 21 after Admission . An RN initiates all Care Plan .The Interdisciplinary Team will review the healthcare practitioner's notes and orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a Comprehensive Care Plan to meet the residents' immediate care needs including but not limited to .Physician orders .Dietary orders .Skin prevention .Fall Prevention</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 1 of 13 residents (Resident #93) reviewed for ADL (activities of daily living) care.</p> <p>The facility failed to ensure Resident #93 was provided oral care on 02/10/25.</p> <p>The facility failed to ensure Resident #93 was provided bed baths on 02/10/25.</p> <p>Theses failures 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 feelings of poor self-esteem, decrease socialization and skin breakdown.</p> <p>Findings included:</p> <p>Record review of Resident #93's face sheet dated 02/11/25 indicated Resident #93 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #93 had diagnoses including acute kidney failure (when the kidneys suddenly can't filter waste products from the blood), urinary tract infection (is an infection in any part of your urinary system: kidneys, bladder, ureters, and urethra), morbid obesity (is a medical condition characterized by excessive body weight that significantly impacts health and well-being), and pressure ulcer of right hip, left hip, and other sites, stage 3 (a full-thickness tissue loss where the subcutaneous fat layer is visible within the wound, but the bone, tendon, or muscle is not exposed).</p> <p>Record review of the MDS indicated Resident #93 was admitted to the facility less than 21 days ago. No MDS for Resident #93 was completed prior to exit.</p> <p>Record review of Resident #93's care plan revised 02/10/25 indicated Resident #93 had an ADL self-care performance deficit related to disease processes. Diagnosis of obesity. Interventions included resident to wash all areas of body able to reach and staff assistance for areas unable to reach. Resident #93 able to perform oral and personal hygiene.</p> <p>During an interview and observation on 02/10/25 at 10:36 a.m., Resident #93 was lying the bed in a hospital gown. She said she was admitted from the hospital about 9 days ago. She said she had not received any bed baths nor had oral care been provided. She said staff gave her wet wipes or a towel with soap on it. She said she cleaned the areas she could reach but the staff did not clean the other areas out of reach. She said staff had not offered her a toothbrush and stuff to do oral care. On Resident #93's floor near the head of the bed was a wash basin. In Resident #93's wash basin was a toothbrush still wrapped, small, yellow basin for oral care, deodorant, and another small white bottle. All items in the wash basin appeared unused. Resident #93 said she had not used the items in the basin.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/11/25 at 11:32 a.m., Resident #93 said she still had not received a bed bath or oral care. She said staff gave her wet wipes during incontinence to clean her peri area. She said she would get more wet wipes and clean her arm pits. She said staff had not offered to wash her hair since admission.</p> <p>During an interview on 02/12/25 at 1:57 p.m., LVN D said if a resident could only reach certain areas of the body for cleaning, then they would be considered moderate to extensive assist. She said the RCPs should clean the rest of the resident's body. She said a resident's hair should be washed with showers or when the resident wanted. She said oral care should be offered or provided every shift by the RCPs. She said the LVNs should be ensuring RCPs were giving scheduled bed baths and showers and oral care to the residents. She said it was important for good hygiene. She said not providing the residents ADL care could cause poor hygiene, teeth issues, and infections.</p> <p>During an interview on 02/12/25 at 5:25 p.m., the RCP H, said the RCPs were responsible for bathing and oral care. She said she had not given Resident #93 a bed bath the times she had her. She said Resident #93 appeared to require limited assistance for bathing if she could clean from the neck down and peri area. She said the RCPs should clean all the areas Resident #93 could not reach. She said Resident #93 should receive three bed baths a week. She said Resident #93 was African American so she did not know how often her hair should be washed. She said she could not remember if she offered oral care to Resident #93. She said oral care was supposed to be provided every shift. She said Resident #93's wash basin should not have been on the floor. She said after ADL care was given the wash basin and personal hygiene items were stored in the bathroom or closet. She said not providing bathing and oral hygiene could lead to infections and skin breakdown. She said Resident #93 probably was not happy.</p> <p>During an interview on 02/12/25 at 5:49 p.m., the ADCO said, the RCPs were responsible for resident's ADL care. She said bed baths should be given as scheduled. She said oral care should be offered and provided every shift by the RCPs. She said RCPs should document when the ADL care was provided. She said it was important to provided oral care for oral hygiene. She said a bed bath was important for skin health, personal hygiene, and dignity. She said Resident #93 could feel depressed or down due to not getting a good bed bath and oral care.</p> <p>During an interview on 02/12/25 at 6:57 p.m., the DCO P said a bed bath should be provided three times a week. She said oral care should be provided to the residents every shift. She said Resident #93's wash basin should have been stored in the closet or bathroom. She said the RCPs was responsible for the resident's ADL care. She said the nurses should be ensuring it was happening. She said it was important to provide good hygiene care for odors, skin integrity, and quality of life.</p> <p>During an interview on 02/12/25 at 7:34 p.m., the EDO said the RCPs were responsible for the resident's ADL care. She said the charge nurse should ensure it was happening. She said bed baths and showers were scheduled three times a week or as needed. She said oral care should be provided every shift and as needed. She said ADL care was important for proper personal hygiene and dental health. She said a resident not receiving ADL care probably would not feel right.</p> <p>During an interview on 02/12/25 at 8:15 p.m., the DCE said the facility did not have a policy on ADL care related to bathing and oral care.</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on observation, interview, and record review, the facility failed to ensure treatment and services was provided, consistent with professional standards of practice, to promote healing and prevent new ulcers from developing for 3 of 7 residents reviewed for quality of care. (Resident #93, Resident #11, and Resident #15)</p> <p>The facility failed to initiate wound care treatment after Resident #93 admitted on [DATE], with multiple areas of shearing.</p> <p>The facility failed to perform a weekly skin assessment on Resident #93 that was due on 02/08/25.</p> <p>The facility failed to initiate Resident #93's wound care orders noted in the wound care doctor's progress notes on 02/08/25 until 02/10/25.</p> <p>The facility failed to implement a specialty mattress (use in the treatment and prevention of pressure ulcers) for Resident #93, per their policy, due to multiple stage 3 pressure injuries on 02/01/25.</p> <p>The facility failed to float Resident #93's heels on 02/10/25 and 02/11/25.</p> <p>The facility failed to offload and/or reposition Resident #93 every 2 hours on 02/10/25 and 02/11/25.</p> <p>An IJ was identified on 02/11/25. The IJ template was provided to the facility on [DATE] at 5:00 p.m. While the IJ was removed on 02/12/25, the facility remained out of compliance at a scope of pattern and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on the process of carrying out orders for residents admitted with wounds or obtaining orders if no orders accompanied the resident, completion of weekly skin assessments, wound care orders, skin management policy, and pressure ulcer prevention and interventions for residents with pressure ulcers.</p> <p>2.The facility failed to document wound care was performed on Resident #11, on 02/01/25, 02/02/25, 02/03/25, 02/05/25, and 02/10/25.</p> <p>The facility failed to document Resident #11's weekly skin assessments on 01/02/25, 01/15/25, 01/22/25, 01/29/25, and 02/04/25.</p> <p>3.The facility failed to document wound care was performed on Resident #15's right upper thigh wound on 01/17/25, 01/20/25, and 01/29/25.</p> <p>The facility failed to document Resident #15's weekly skin assessments on 01/19/25, 01/26/25, 02/02/25, and 02/09/25.</p> <p>Theses failures could place residents at risk for wound deteriorations and more WOUND development.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Findings included:</p> <p>1. Record review of Resident #93's face sheet dated 02/11/25 indicated Resident #93 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #93 had diagnoses including acute kidney failure (when the kidneys suddenly can't filter waste products from the blood), urinary tract infection (is an infection in any part of your urinary system: kidneys, bladder, ureters, and urethra), morbid obesity (is a medical condition characterized by excessive body weight that significantly impacts health and well-being), and pressure ulcer of right hip, left hip, and other sites, stage 3 (a full-thickness tissue loss where the subcutaneous fat layer is visible within the wound, but the bone, tendon, or muscle is not exposed).</p> <p>Record review of the MDS, on 02/10/25, indicated Resident #93 was admitted to the facility less than 21 days ago. No MDS for Resident #93 was completed prior to exit.</p> <p>Record review of Resident #93's care plan dated 02/03/25 indicated:</p> <p>*Resident #93 was admitted with stage 3 pressure ulcer to right thigh. Interventions included assess and document skin condition every week, pressure relieving appliances as ordered, reposition residents as indicated to relieve pressure and for comfort, and wound care per MD orders.</p> <p>*Resident #93 was admitted with Stage 3 pressure ulcer to right hip. Interventions included assess and document skin condition every week, monitor nutritional intake, weight, lab values and report significant changes to MD, pressure relieving appliances as ordered, reposition residents as indicated to relieve pressure and for comfort, and wound care per MD orders.</p> <p>*Resident #93 was admitted with stage 3 pressure ulcer to left thigh. Intervention included administer treatments as ordered and monitor for effectiveness, monitor nutritional status, and obtain and monitor lab/diagnostic work as ordered.</p> <p>Record review of Resident #93's consolidated physician orders dated active as of 02/11/25 indicated the following:</p> <p>*Left thigh- cleanse with house wound cleanser. Apply Medi honey and collagen sheet. Cover with foam and border gauze dressing everyday shift. Start 02/11/25.</p> <p>*Nursing to perform weekly skin assessment. Ordered 02/09/25.</p> <p>*Right hip- cleanse with house wound cleanser and pat dry. Apply Medi honey and cover with collagen sheet and foam then secure with border dressing everyday shift. Start 02/11/25.</p> <p>*Right thigh- cleanse with house wound cleanser and pat dry. Apply Medi honey and collagen sheet. Cover with foam and secure with border dressing everyday shift. Start 02/11/25.</p> <p>The consolidated physician order did not reflect wound care orders for Resident #93's left thigh, right hip, and right thigh pressure ulcer on admission (02/01/25).</p> <p>Record review of Resident #93's MAR dated 02/01/25-02/28/25 indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>*Left thigh- cleanse with house wound cleanser. Apply Medi honey and collagen sheet. Cover with foam and border gauze dressing everyday shift. Start 02/11/25.</p> <p>*Nursing to perform weekly skin assessment. Ordered 02/02/25. Discontinued 02/09/25. No documentation was noted on 02/02/25 and 02/09/25.</p> <p>*Right hip- cleanse with house wound cleanser and pat dry. Apply Medi honey and cover with collagen sheet and foam then secure with border dressing everyday shift. Start 02/11/25.</p> <p>*Right thigh- cleanse with house wound cleanser and pat dry. Apply Medi honey and collagen sheet. Cover with foam and secure with border dressing everyday shift. Start 02/11/25.</p> <p>Record review of Resident #93's progress note dated 01/12/25-02/12/25 indicated:</p> <p>*02/01/25 at 7:47 p.m. by the ADCO, .new admission skin assessment .the following areas were all noted upon admission to the facility . Right Lateral thigh shearing 2cm x 5cm x 0.1cm open area without exudate with surrounding scaring . Right gluteal area shearing 0.4cm x 0.4cm x 0.1 cm no exudate noted . Right lateral hip shearing with surrounding scaring 5.5cm x 1.4cm x 0.1cm no exudate noted . Right Posterior hip shearing 1.3cm x 0.9cm x 0.1cm no exudate noted . Right posterior thigh near gluteal fold 1.2cm x 0.1cm. Area is a hard area that appears to be healing . Left posterior thigh shearing 1.2cm x 1cm x 0.1cm area noted to have slight bleeding when dressing was removed . right medial posterior thigh near gluteal fold 1cm x 1cm. area is a hard area that appears to be healing .</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>*02/08/25 at 7:33 p.m. by DNP S, .date of service: 02/07/25 .wound initial .Resident #93 . The following wounds were evaluated during today's visit . Wound 1 Right Hip, Pressure Injury, Stage 3 . Wound 2 Right Thigh, Pressure Injury, Stage 3 . Wound 3 Left Thigh, Pressure Injury, Stage 3 . Patient is admitted with multiple wounds . Per report from DON . WOUND ASSESSMENT: .Wound: 1 . Status: Present on Admission Location: Right Hip . Primary Etiology: Pressure Injury Severity: Stage 3 . Size: 6 cm x 1.5 cm x 0.1 cm. Actual area is 9 cm2. Actual volume is 0.9 cm3 Wound Base: , 100% granulation . Wound Edges: Attached . Periwound: Fragile, No erythema, No edema Exudate: Light Serous .Wound Odor: None . Signs of Wound Infection: No signs of infection Wound Pain at Rest: 0 . Wound: 2 . Status: Present on Admission Location: Right Thigh . Primary Etiology: Pressure Injury .Severity: Stage 3 . Size: 4 cm x 2 cm x 0.1 cm. Actual area is 8 cm2. Actual volume is 0.8 cm3 Wound Base: , 100% granulation . Wound Edges: Attached . Periwound: Fragile, No erythema, No edema, No maceration Exudate: Light Serous . Wound Odor: None . Signs of Wound Infection: No signs of infection Wound Pain at Rest: 0 . Wound: 3 . Status: Present on Admission Location: Left Thigh . Primary Etiology: Pressure Injury .Severity: Stage 3 . Size: 1.5 cm x 1 cm x 0.1 cm. Actual area is 1.5 cm2. Actual volume is 0.15 cm3 Wound Base: , 100% granulation . Wound Edges: Attached . Periwound: Fragile, No erythema, No edema, No maceration Exudate: Light Serous . Wound Odor: None .Signs of Wound Infection: No signs of infection Wound Pain at Rest: 0 . Recommendations consisting of: .We will re-evaluate this patient on our next visit (anticipated 1-2 weeks), Implement pressure relieving measures, offloading, and repositioning, as tolerated . Establish turning frequency based on the characteristics of the support surface and the patient's response . Protect skin from exposure to excessive moisture (periwound) with a barrier product. Use skin emollients to hydrate dry skin . Repositioning should be undertaken using the 30-degree tilted side-lying position (alternating right side, back, left side) . Plan of care discussed with facility staff .Wound# 1 Right Hip Pressure Injury Treatment Recommendations: .clean with Wound Cleanser . apply Collagen particles, Honey and Bordered foam dressing . change Daily and as needed if dislodged, saturated, or soiled Wound # 2 Right Thigh Pressure Injury .Treatment Recommendations: . clean with Wound Cleanser . apply Collagen particles, Honey and Bordered foam dressing . change Daily and as needed if dislodged, saturated, or soiled Wound # 3 Left Thigh Pressure Injury .Treatment Recommendations: . clean with Wound Cleanser . apply Collagen particles, Honey and Bordered foam dressing . change Daily and as needed if dislodged, saturated, or soiled .</p> <p>Record review of Resident #93's memorandum of transfer and physician certification dated 02/01/25 indicated emergency department diagnoses included pressure injury of contiguous region involving back, right buttock, and right hip, stage 2.</p> <p>Record review of Resident #93's hospital discharge summary dated 02/01/25 did not reflect wound care orders.</p> <p>Record review of Resident #93's Braden scale for predicting pressure sore risk dated 02/01/25 indicated score of 16 which was at risk.</p> <p>Record review of Resident #93's weekly skin assessment dated [DATE] indicated .does the resident have a pressure, venous, arterial, diabetic, or surgical wound .yes .stage 2 PU, multiple shearing sites to right lateral thigh, right posterior thigh multiple, left posterior thigh, right buttocks, left posterior thigh . The facility's electronic medical record did not reflect a skin assessment on 02/08/25 or 02/09/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #93's wound assessment report dated 02/07/25 indicated .left thigh .Length: 1.50 cm .Width: 1.00 cm .Depth: 0.10 cm .left thigh .pressure injury .stage 3 .treatment: daily .wound cleanser . collagen particles and honey .bordered foam dressing .</p> <p>Record review of Resident #93's wound assessment report dated 02/07/25 indicated .right thigh .length: 4 cm .width: 2 cm .depth: 0.10 cm .right thigh .pressure injury .stage 3 . treatment: daily .wound cleanser . collagen particles and honey .bordered foam dressing .</p> <p>Record review of Resident #93's wound assessment report dated 02/07/25 indicated .right thigh .length: 6 cm .width: 1.5 cm .depth: 0.10cm .right hip .pressure injury .stage 3 . treatment: daily .wound cleanser . collagen particles and honey .bordered foam dressing .</p> <p>Record review of the facility's Skin Management: Prevention and Treatment of Wounds policy revised 10/06/22 indicated .specialty mattress will be implemented for residents with multiple stage 2 areas, stage 3, or stage 4 pressure injuries .</p> <p>During an observation and interview on 02/10/25 at 10:51 a.m., Resident #93 was lying in the bed on her back. Resident #93 was not on a specialty mattress. Resident #93 did not have any pressure relieving devices noted in her bed. Resident #93's legs were not offloaded. Resident #93 said staff did not turn her every 2 hours or prop her heels with pillows. She said she could turn herself with the assist rails but staff did not place pillows behind her back, underneath her buttocks or between her legs.</p> <p>During an observation and interview on 02/10/25 at 3:05 p.m., Resident #93 was lying in the bed on her back. Resident #93 was not on a specialty mattress. Resident #93 did not have any pressure relieving positioning devices noted in her bed. Resident #93's legs were not offloaded. Resident #93 said staff did not turn her every 2 hours or propped her heels with pillows.</p> <p>During an observation on 02/11/25 at 10:02 a.m., Resident #93 was lying in the bed on her back. Resident #93 was not on a specialty mattress. Resident #93 did not have any pressure relieving positioning devices noted in her bed. Resident #93's legs were not offloaded.</p> <p>During an observation and interview on 02/11/25 at 11:32 a.m., Resident #93 was lying in the bed on her back. Resident #93 was not on a specialty mattress. Resident #93 did not have any pressure relieving positioning devices noted in her bed. Resident #93's legs were not offloaded. Resident #93 said staff had not turn her every 2 hours or propped her heels with pillows. She said she had wounds on thighs, buttock, and hip. She said when she came from the hospital, there were dressings on two of the wounds. She said the facility did not do dressing changes every day. She said it depended on the staff as to what was done to her wounds. She said some staff did nothing and others would put cream on the wounds if they were closed.</p> <p>During an observation on 02/11/25 at 1:25 p.m., Resident #93 was lying in the bed on her back. Resident #93 was not on a specialty mattress. Resident #93 did not have any pressure relieving positioning devices noted in her bed. Resident #93's legs were not offloaded.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 02/11/25 at 1:30 p.m., the ADCO said she was working the floor when Resident #93 was admitted . She said she was Resident #93's admitting nurse. She said if the admitting nurse was not a RN, then the nurse was only responsible for measuring and describing the wound. She said a RN, the DCO, or MD staged pressure wounds at the facility. She said upon admission the resident's MD should be notified and general wound care orders obtained. She said when the wound care doctor rounded on Fridays, the facility received specialized wound care orders. She said the wound care doctor came every Friday and the DCO notified him of who needed to be seen. She said after the wound care doctor rounded and made recommendations. She said the wound care doctor placed his recommendations in a progress note. She said the floor nurses or the DCO were responsible to place the recommendations in the facility's electronic medical record as an order. She said the DCO and ADCO were responsible for ensuring the wound care orders were followed through. She said the floor nurses were responsible for the resident's weekly skin assessments. She said the DON and DNP completed the weekly wound assessments when he rounded on Fridays. She said Resident #93 wounds on admission were shearing to her right hip, right buttocks, left thigh, and left buttocks. She said since she was not a RN, she did not stage Resident #93's wounds. She said Resident #93 arrived from the hospital with dressings over the wounds. She said she notified NP R by text or phone and let her know about Resident #93's shearing. She said she did not receive a response from NP R until shift change. She said she could not remember what NP R said about Resident #93's shearing. She said she knew she passed the message from NP R on to RN G when she gave report. She said she did not know what wound care treatment Resident #93 had been receiving since admission on 02/01/25. She said she did not know the facility's policy or criteria on specialty mattress because she just started January 13, 2025. She said she did not know if Resident #93 met the facility's criteria for a specialty mattress but she probably did. She said other interventions for Resident #93's pressure wounds should have been frequent repositioning and incontinent care and a dietary consult. She said the dietician would be at the facility this week. She said since Resident #93 had a skin assessment on 02/01/25, then she should have had one on 02/08/25. She said even though the skin assessment was a day after the wound care doctor came, it should have been done by the floor nurse. She said skin assessments were important to ensure skin issues were not missed and proper wound care orders were in place. She said following doctors' orders were important to prevent the wound from declining and promote healing. She said the facility provided Resident #93 assist rails and trapeze bar to help with her mobility.</p> <p>On 02/11/25 at 2:23 p.m., called NP R and left voicemail.</p> <p>On 02/11/25 at 2:25 p.m., called RN G and left voicemail.</p> <p>During an interview on 02/11/25 at 2:58 p.m., NP R said she received a text message from LVN A that Resident #93 was admitted . She said she was currently driving and could not remember if the ADCO contacted her on admission about Resident #93's wounds. She said normally the facility followed the hospital's wound care orders and did not need them to give any orders.</p> <p>During an interview on 02/11/25 at 4:41 p.m., NP R called back and said LVN A and the ADCO called her on 02/01/25 about Resident #93. She said she told LVN A and the ADCO to resume all hospital orders and she would see Resident #93 on Tuesday, 02/04/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 02/11/25 at 6:01 p.m., RN G said she had worked at the facility for 6 years. She said she had taken care of Resident #93. She said she was texting with NP R on 02/05/05 about another resident lab work and NP R asked about Resident #93. She said NP R mentioned the hospital had not sent Resident #93 with wound care orders when she discharged. She said she told NP R that there were no wound care orders in Resident #93's hospital discharge paperwork. She said she told NP R, she did not know what the facility had been doing either for Resident #93's pressure wounds. She said NP R ordered collagen and a dry dressing and for the wound care doctor to see Resident #93. She said she did the ordered wound care on Resident #93 that night shift (02/05/25). She said she thought she placed the wound care orders NP R gave for Resident #93 in the facility's electronic medical records. She said Resident #93's wound care orders from NP R would be on her MAR if she did. She said it was important to have put in the wound care orders from NP R, so the next person knew what to do for Resident #93's wounds. She said not doing wound care treatments for Resident #93's wounds could cause further break down or increased stages. She said Resident #93's wounds would have been called stage 2's on admission. She said if the admission nurse was not a RN, then the next RN on duty was responsible for staging the pressure ulcer. She said if a wound needed to be staged by a RN, that information needed to be passed down by the next nurse or put on the 24-hour report. She said staging a pressure ulcer was important so the wound could be caught early and treated so it did not decline. She said she was not aware Resident #93's wounds were not staged until DNP S came on 02/07/25. She said a resident had to have pressure breakdown to be on a low air loss mattress. She said Resident #93 was on a bariatric pressure reduction mattress. She said she did not if they made bariatric specialty mattresses. She said if they made bariatric low air loss mattresses, Resident #93 would qualify for one because she had several areas of pressure breakdown.</p> <p>During an interview on 02/12/25 at 1:57 p.m., LVN D said nurses were responsible for resident's skin assessments. She said the skin assessments were due weekly and as needed. She said the weekly skin assessments should be charted in the resident medical records. She said a resident should be on a low air loss mattress if they have pressure ulcers or at the family request. She said heels should be floated for residents after hip surgery, residents who do not turn good, or residents with redness on their heels. She said residents should be repositioned every 2 hours. She said the RCP or LVN could do it but the RCP was primarily responsible. She said if a resident was able to turn themselves in the bed, the RCP should still encourage and help the resident turn every 2 hours. She said the RCP should be propping the resident with pillows to offload them when repositioning. She said the LVN should be ensuring the RCP are repositioning every 2 hours and offloading the residents by observation. She said a RN and LVN certified in wound care could stage pressure wounds. She said primarily RNs. She said if a resident needed a pressure wound staged, she would find a RN or contact the DCO. She said the facility had a telehealth option to stage wounds available now. She said the resident's doctor or the medical director was contacted for wound care orders. She said nursing management was responsible for taking the wound care doctor recommendations and making them orders. She said when the wound care doctor rounded on Fridays, he gave the DCO a copy of his recommendations on a piece of paper before he left. She said the wound care doctor left around 10 am. She said the bedside nurses were responsible for doing wound care treatments. She said the nurses documented on the MAR/TAR when wound care was completed. She said if wound care was not documented on the resident MAR/TAR, it could indicate it was not done. She said some residents did not show on the right screen to be done on the facility's computer system. She said skin assessments, wound care treatments, and repositioning/offloading were important to prevent skin breakdown and worsening of wound and not miss anything.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 02/12/25 at 5:25 p.m., RCP H said she had worked at the facility for 2 years. She said she found out a resident had wounds when she changed them. She said she was not really made aware by nursing staff or during report which resident had wounds. She said it depended on the severity of the wound what type of treatment the resident required. She said some resident needed cream and other had dressing changes by the nursing staff. She said RCPs were responsible for repositioning the residents every 2 hours with rounds. She said the residents should be alternated side to side and propped with pillows. She said residents stuck in the bed should have their heels offloaded. She said Resident #93 was stuck in the bed unless PT got her up. She said when she had Resident #93, she went in her room every once in a while, to remind her to turn but not every 2 hours. She said turning and offloading were important to prevent skin breakdown. She said constant pressure caused skin breakdown.</p> <p>During an interview on 02/12/25 at 5:49 p.m., the ADCO said wound care was documented on the resident's TAR in the facility's charting system. She said if wound care was not documented in the facility's charting system, it could indicate it was not done. She said the charge nurses were responsible for the resident's wound care. She said the DCO and ADCO should ensure the charge nurses were doing the ordered wound care treatments and documenting wound care on the resident's MAR/TARs. She said doing the resident's ordered wound care treatment was important to prevent decline of the wound, infection, prevent pain and more wounds. She said it was also important to do wound care to monitor the wound and follow doctor's orders. She said completion of the resident's skin assessment was documented on the TAR/MAR and a skin assessment form was also done. She said when she first started, she did not know that a skin assessment form had to be done even if the resident had no skin changes. She said she documented she completed Resident #15's skin assessment on the MAR/TAR but she did not do a new skin assessment form. She said she and the DCO Q were in the process, of putting a process in place to do chart audits to monitor skin assessments and wound care orders.</p> <p>During an interview on 02/12/25 at 6:57 p.m., DCO P, who was covering for DCO Q, said she expected nursing staff to follow physician orders. She said she expected nursing staff to document wound care on the MAR/TAR and/or progress note in the facility's charting system. She said if the wound care was not documented on the MAR/TAR and/or progress note, it could indicate it was not done. She said she expected nursing staff to order skin assessment on admission. She said she expected nursing staff to complete skin assessment weekly and with skin changes. She said the DCO ordered the resident's specialty mattresses and the charge nurse should ensure it was on the correct settings. She said all resident benefited from having their heels floated. She said but immobile residents especially needed their heels floated. She said she expected residents to be repositioned and offloaded at least every 2 hours by the RCPs. She said she preferred staging pressure wounds be done by the telehealth system. She said a RN or DCO should stage the resident pressure wounds. She said the ADCO and DCO should be ensuring nursing staff were doing wound care and skin assessments. She said all of these were important for wound prevention and management.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 02/12/25 at 7:34 p.m., the EDO said skin assessment were to be completed every 7 days in the facility's charting system. She said Resident #93 met the criteria for a low air loss mattress. She said the facility had a few specialty mattresses in house and she also could order one if needed. She said the DCO or the nursing staff who rounded with the wound care doctor was responsible for inputting his orders. She said it was important to document wound care and skin assessments to have an adequate clinical record. She said it was important to do wound care and skin assessments to promote wound healing. She said nursing management was responsible for ensuring nursing staff completed skin assessment and wound care. She said nursing management should be doing chart audits to ensure it was happening.</p> <p>Record review of a facility's Skin Management: Prevention and Treatment of Wounds policy revised 10/06/22 indicated .the purpose of this procedure is for prevention and treatment of skin breakdown such as pressure injuries, diabetic ulcers, arterial ulcers, and skin wounds Skin assessments will be documented at a minimum of every 7 days on a Weekly Skin Assessment . Staging of wounds will be performed by a registered nurse or licensed nurse certified in wound care . Dependent residents will have heels floated while in bed and be turned and repositioned at a minimum of every 2 hours . A licensed nurse will obtain orders from physician for new skin wounds and transcribe onto resident's treatment record for follow up . Specialty mattresses will be implemented for residents with multiple stage II areas, stage III, or stage IV pressure injuries . Weekly skin assessments will be documented on the Weekly Skin Assessment every 7 days or less . Licensed nurse will initiate the schedule for the wound form in Point Click Care which automatically triggers every 7 days from day of completion .</p> <p>The EDO and DCE were notified of an IJ on 02/11/25 on 5:00 p.m., were given a copy of the IJ template, and a Plan of Removal (POR) was requested. The Plan of Removal was accepted on 02/12/25 at 9:40 a.m. and included the following:</p> <p>F686- Skin Integrity/Pressure Ulcer</p> <p>Plan of Action:</p> <p>Resident #93 had wound care orders written on 02/11/25. A weekly wound assessment was completed on 02/11/25. A specialty mattress was placed on Resident #93's bed on 02/11/25. Resident #93's heels were floated effective 02/11/25.</p> <p>Skin sweep competed on 02/11/25 to ensure all skin issues were identified and had current orders and interventions in place. Completed 02/11/25 by Director of Clinical Education and designees.</p> <p>Director of Clinical Education will educate Director of Clinical Services and Assistant Director of Clinical Services on the process of reviewing new resident admissions electronic health records for completion of order transcription as it relates to wound orders as well as carrying out those orders. Completed 2/11/25 If a RN or wound care certified LVN is not on duty at the time a resident admits, the admitting nurse on duty will utilize Advanced Wound Care Telehealth for a consult. Completed 02/12/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>All licensed nurses will be educated by the ADCO or designee on the process of carrying out orders for residents admitted with wounds or obtaining orders if no order accompanies the resident when admitted . Education will also include the completion of weekly skin assessments per schedule. Completion 02/12/25 10:00 a.m. Anyone who is not on duty that we cannot reach by phone will be required to complete the in-service prior to working their next shift.</p> <p>All licensed nurses will receive in-service regarding wound care orders and weekly skin assessments prior to the beginning of their next shift to begin 02/11/25.</p> <p>Any newly hired nurses will receive the above education upon hire during orientation prior to taking a shift on the floor.</p> <p>Ad hoc QAPI meeting will be held with the Medical Director on 02/12/25 reviewing the policies and procedures for wound care.</p> <p>All licensed nurses will be educated on the Skin Management policy regarding general guidelines, prevention, notification, treatment, and documentation the Director of Clinical Education or designee. Completed 2/12/2025 2:00 p.m. Anyone who is not on duty that we cannot reach by phone will be required to complete the in-service prior to working their next shift.</p> <p>All C.N.A.'s will be educated by the Director of Clinical Education or designee regarding pressure ulcer prevention and interventions for residents with pressure ulcers. Completed 2/12/2025 3:00 p.m. Anyone who is not on duty or cannot come in or be reached by phone will be required to complete the in-service prior to working their next shift.?</p> <p>Validation/Monitoring Tools?</p> <p>Director of Clinical Operations or Assistant Director of Clinical Operations will review all orders for new admissions every day in the morning clinical meeting to ensure orders have been written and carried out for residents admitted with wounds. ?Beginning 02/12/25.</p> <p>Director of Clinical Operations or designee will review weekly skin assessments daily to ensure timely completion. Beginning 02/12/25.</p> <p>Director of Clinical Operations or designee will review wound physician documentation weekly to ensure any orders are carried out timely. Beginning 02/12/25.</p> <p>Director of Clinical Operations and/or designee will review all wound care patients orders, interventions, and skin assessments during Standards of Care Meeting weekly, Beginning 02/12/25.??</p> <p>The Administrator, Director of Clinical Operations and/or designee will review the action plan developed related to obtaining wound care orders, implementing wound care interventions, and weekly skin assessments in QAPI meeting monthly during the next six months. Beginning 02-12-25.?</p> <p>This surveyor and team verification of the Plan of Removal from 02/12/25 was as follows:</p> <p>Record review of Resident #93's MAR dated 02/01/25-02/28/25 indicated wound care written on 02/11/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #93's skin assessment dated [DATE] completed by DCO P, indicated, .stage 3 pressure injuries x3 (right lateral hip, right thigh and left inner thigh) seen by AWC MD .</p> <p>Record review of Resident #93's wound assessment dated [DATE] completed by DCO P, indicated, .right thigh .2.2cmx3cmx0.2cm .</p> <p>Record review of Resident #93's wound assessment dated [DATE] completed by DCO P, indicated, .left inner thigh .1cmx0.1cmx0.2cm .</p> <p>Record review of Resident #93's wound assessment dated [DATE] completed by DCO P, indicated, .right lateral hip .4.5cmx1.3cmx0.2cm .</p> <p>Record review of [TRUNCATED]</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45643</p> <p>Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 2 of 16 residents (Resident #12, Resident #35) reviewed for adequate supervision.</p> <p>The facility failed to prevent Resident #35 from having rubbing alcohol in his room.</p> <p>The facility failed to ensure that electrical wires were encased in their protective covering and not exposed for Resident #12</p> <p>These failures could place residents at risk for injury, harm, and impairment or death.</p> <p>Findings included:</p> <p>1. Record review of Resident #35's Admission Record indicated he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Acute and Chronic Respiratory Failure with Hypoxia (a medical condition where the lungs are unable to adequately exchange oxygen and carbon dioxide over a prolonged period, leading to persistently low levels of oxygen in the blood), Peripheral Vascular Disease (a condition that affects the blood vessels outside the heart and brain), Depression (a common mental health condition characterized by persistent low mood, loss of interest or pleasure in activities, and other symptoms that interfere with daily functioning).</p> <p>Record review of Resident #35's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 15 which indicated Resident #35 was cognitively intact. The MDS also revealed, Resident #35, was understood and understands others. Shows that Resident #35 requires partial assistance with activities of daily living.</p> <p>Record review of Resident #35's Care Plan revealed a problem initiation on 3/13/2023 Resident #35 has a self-care performance deficit related to cellulitis. Shows that Resident #35 required partial assistance with his activities of daily living.</p> <p>During an observation an interview on 2/10/25 at 9:50 a.m., Resident #35 had a bottle of isopropyl 91% rubbing alcohol in his room. He said that it was his alcohol. He said he did not know where he got it from. He said he used it on his skin to clean himself.</p> <p>During an interview on 2/12/25 at 1:32 p.m., DCO P said residents are not allowed to keep rubbing alcohol in their rooms. She said there was a risk to residents because they could accidentally drink the alcohol, it could poison them.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #12's Admission Record indicated he was an [AGE] year-old male admitted to the facility on [DATE]f4. His diagnoses included Bipolar Disorder (a chronic mental health condition characterized by extreme shifts in mood, energy, and activity levels), Depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities), Chronic Inflammatory Demyelinating Polyneuritis (a rare autoimmune disorder that affects the peripheral nervous system, causing inflammation and damage to the myelin sheath, the protective layer that insulates nerve fibers).</p> <p>Record review of Resident #12's significant change in status MDS dated [DATE] revealed that the resident had a BIMS score of 03 which indicates Resident #12 was severely cognitively impaired. The MDS also revealed, Resident #12, was understood and understands others. Shows that Resident #12 was dependent with activities of daily living.</p> <p>Record review of Resident #12's care plan revealed a problem initiation on 11/13/2024 shows he has an ADL self-care performance deficit related to disease processes. Shows that Resident #12 has an activity intolerance, confusion, impaired balance, limited mobility.</p> <p>During an interview on 2/12/25 at 1:32 p.m., DCO P said staff Report to the maintenance book if exposed wiring was found on an electronic item in room.</p> <p>During an interview on 2/12/25 at 1:44 p.m., the Director of Nurses said that residents should not have rubbing alcohol in their rooms as it was against facility policy and it could place the resident at risk of harm if they drank it. She said that if a resident's bed controls had exposed wiring, then it should be replaced or repaired. She said that anyone who spotted both issues would be responsible to remove the alcohol or report the bed control wiring.</p> <p>During an interview on 2/12/25 at 5:01 p.m., the Administrator said all staff and focused care partners who observe resident's rooms should keep them free of any potential hazards such as rubbing alcohol or exposed wiring. She said that residents could be placed at risk if they drank rubbing alcohol of harm. She said that electronics that have wiring should be properly maintained, and the inner wires should not be exposed for resident safety.</p> <p>Record review of the facility policy titled, Incident and Accident, dated 03/1/17 indicated, Accidents or incidents involving residents shall be investigated and reported to the Executive Director of Operations Licensed nurse will complete an incident and accident report when staff is aware that an incident occurred. Review each incident report at daily clinical meeting Incident reports are located in the electronic health record and are completed electronically.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</p> <p>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 3 of 6 residents (Residents #10, Resident #15, and Resident #22) reviewed for urinary catheters.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure RCP O performed hand hygiene and changed gloves appropriately while providing incontinent/urinary catheter care to Resident #10. 2. The facility failed to ensure RCP O performed proper incontinent/urinary catheter care to Resident #10. 3. The facility failed to ensure Resident #15 had an indwelling (foley) catheter securement device on 2/10/25 and 2/11/25. 4. The facility failed to ensure Resident #22 had an indwelling (foley) catheter securement device on 2/10/25 and 2/11/25. 5. The facility failed to document Resident #22's indwelling (foley) catheter care on 1/05/25 (6am and 6pm), 1/18/25 (6am), 1/26/25 (6am), 2/03/25 (6am), 2/07/25 (6am), and 2/08/25 (6am). <p>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.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #10's face sheet dated 2/11/25 indicated she was [AGE] years old and was admitted to the facility initially on 3/30/17 and readmitted on [DATE]. Resident #10 had diagnoses which included history of infection of amputation of right lower extremity, cognitive communication deficit, depression (persistent sadness), candidiasis of skin and nail (yeast infection of skin), lack of coordination, hypertension (high blood pressure), and dementia (loss of memory). <p>Record review of Resident #10's quarterly MDS assessment dated [DATE] indicated Resident #10 had a BIMS score of 10 which indicated she had moderate cognitive impairment. Resident #10 was dependent on staff for toileting hygiene. The MDS indicated Resident #10 had an indwelling catheter (urinary catheter) and was always incontinent of bowel. The MDS indicated Resident #10 had unstageable pressure ulcer and moisture associated skin damage (MASD) related to incontinence.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #10's Care Plan Report indicated she had a stage 3 pressure ulcer to right posterior above knee amputation stump, initiated on 1/24/25; she had MASD to left posterior thigh, initiated 1/24/25; she was at risk for skin breakdown, initiated 5/11/21; she had an indwelling catheter and was at risk for increased UTIs and skin breakdown, initiated 1/03/25; and she had an ADL self-care deficit related to absence of right leg above the knee and required extensive assistance with interventions that included the resident required extensive assistance of 2 staff for toileting, initiated 5/11/21 and revised on 1/27/25.</p> <p>Record review of Resident #10's Order Summary Report dated 2/10/25 revealed an order to check foley catheter placement, ensure foley was secured to reduce friction and pulling every shift with an order date of 1/03/25; foley catheter care every shift with an order date of 1/03/25; and foley catheter 18 FR 10 cc bulb to continuous drainage related to wound with an order date of 1/03/25.</p> <p>During an observation and interview on 2/10/25 at 10:24 AM, Resident #10 had a urinary catheter attached to the bed frame with a privacy bag. Resident #10 said she had a wound on her bottom and the facility was taking care of it. Resident #10 had a low air loss mattress and had an EBP sign on the wall by the top of her bed and an isolation cart outside of her room by the door .</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/11/25 at 11:18 AM, RCP O performed incontinent care and urinary catheter care on Resident #10. RCP O set up a basin of soapy water and a basin of clean water on the bedside table with washcloths and towels. RCP O washed her hands with soap and water in the bathroom and applied clean gloves. RCP O placed a plastic bag at the foot of Resident #10's bed directly on the air loss mattress that required no bed sheets. RCP O began by using a washcloth that had been dipped in the soapy water basin and cleansed Resident #10's skin under her overlapping stomach that had visible white creamy substance on the skin by using her left gloved hand to hold Resident #10's skin of her overlapping stomach up and her right gloved hand to wipe the skin under her overlapping stomach. RCP O said she was trying to get as much of the cream off as possible. RCP O tossed the soiled washcloth into the plastic bag at the end of Resident #10's bed. RCP O then changed her gloves (did not perform hand hygiene) and obtained a clean washcloth dipped in clean water and cleaned under Resident #10's overlapping stomach again. RCP O then wiped down between Resident #10's front right inner thigh area and then the left inner thigh without spreading the resident's legs/thighs to visualize the perineum area (female private area) to effectively clean the area and then tossed the soiled washcloth into the plastic bag at the end of the bed. RCP O then obtained a clean washcloth and held the urinary catheter tubing with her left gloved hand where it was visible on the outside of Resident #10's closed legs/thighs and wiped down the urinary catheter tubing going away from the resident's body. RCP O did not change gloves prior to holding the urinary catheter with the left same gloved hand used to hold the resident's skin of her overlapping stomach and right gloved hand used to clean her skin under her overlapping stomach and then wiped down between her closed inner thighs. RCP O tossed the used washcloths into the plastic bag sitting on the end of the bed and the plastic bag fell off the bed and onto the floor. RCP O picked the plastic bag with soiled washcloths up and placed the plastic bag directly back on the end of Resident #10's air loss mattress. RCP O did not clean Resident #10's perineum area or urinary catheter insertion site while performing incontinent care or urinary catheter care by not spreading the inner thighs to visualize the areas. RCP O changed her gloves (did not perform hand hygiene) and turned Resident #10 onto her right side and cleaned a small bowel movement with two washcloths and tossed soiled washcloths into the plastic bag sitting on end of the bed and the plastic bag fell on to floor. RCP O picked up the plastic bag off the floor and placed the plastic bag back directly on the air loss mattress at the end of the bed. RCP O then proceeded without changing gloves or performing hand hygiene to use a clean washcloth to wipe down Resident #10's back thigh areas and tossed the washcloth into the plastic bag and the plastic bag fell back onto the floor and all the soiled washcloths fell out of the plastic bag onto the floor. RCP O picked up the soiled washcloths and placed them back into the plastic bag and then tied the plastic bag and left it on the floor. RCP O changed her gloves (did not perform hand hygiene) and put a gown on Resident #10 and then removed her gloves and gown and placed them in the trash. RCP O then went and got a clean sheet and placed it over the resident and propped her left lower extremity up on a pillow without wearing a gown or gloves.</p> <p>During an interview on 2/12/25 at 9:20 AM, the Director of Resident Accounts said the CNAs (RCPs) on the personnel file review did not have their competency evaluations recorded, which included RCP O. The Director of Resident Accounts said she did not know if the competency evaluations were completed or not. The Director of Resident Accounts said it was the responsibility of the Director of Nursing (DCO) to complete the competency evaluations. The Director of Resident Accounts said since hiring a new Director of Nurses (DCO) they did not know where the previous Director of Nursing (DCO) kept the competency document files if they were completed.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 9:52 AM, LVN D said staff should change gloves after cleaning the resident up, like when going from dirty to clean. LVN D said the staff should clean the resident's perineum area, change gloves and washcloths prior to cleaning the urinary catheter to prevent the risk of infection to the resident. LVN D said staff should be cleaning the perineum area even if the resident had a foley catheter to prevent infection and it helped to have 2 staff members to assist in holding the legs during incontinent care.</p> <p>During an interview on 2/12/25 at 10:31 AM, RCP M said staff should perform hand hygiene and change their gloves any time they were going from a dirty area to a clean area during incontinent care and prior to performing urinary catheter care. RCP M said the purpose of urinary catheter care was to keep infection and germs away from the urinary catheter. RCP M said if the plastic bag fell on to the floor, the staff should get another plastic bag. RCP M said staff should not pick the plastic bag up off the floor and place it onto the resident's bed because it would contaminate the resident's bed. RCP M said it could place whatever potential germs that could have been on the floor onto the resident's bed and it's just gross. RCP M said the resident's bed would need to be stripped and the whole bed sanitized.</p> <p>During an interview on 2/12/25 at 10:44 AM, RCP O said she had worked at the facility since 12/05/24 and normally worked on the 6 AM-2 PM shift. RCP O said she changed gloves when she changed her water and she thought she changed gloves before cleaning Resident #10's urinary catheter. RCP O said she knew she changed her gloves at least three times while performing incontinent and urinary catheter care. RCP O said she did knock the plastic bag off on the floor several times and put it back on Resident #10's bed and it was an infection control issue. RCP O said Resident #10 was on EBP for her wound. RCP O said Resident #10 did not have bed sheets and she placed the plastic bag directly on Resident #10's mattress at the end of the bed after picking it up off the floor. RCP O said if she had help during Resident #10's incontinent/urinary catheter care, she could have cleaned her better. RCP O said if they were getting Resident #10 up then there would be 2 people and they would clean her up before getting her up. If Resident #10 was not getting up, she would perform incontinent/urinary catheter care in between by herself. RCP O said the facility had not provided her training in incontinent care or urinary catheter care, but she probably had training at her other facility. RCP O said the facility did not do a check off skills with her when she started.</p> <p>During an interview on 2/12/25 at 1:33 PM, the ADCO said she had worked at the facility since 1/13/25. The ADCO said she always cleaned a female from the inside out and changed gloves and performed hand hygiene when going from clean to dirty. The ADCO said from the scenario described by the state surveyor of the observation of RCP O performing incontinent care and urinary catheter care on Resident #10, RCP O did not perform incontinent/urinary catheter care to her standards. The ADCO said Resident #10 was more susceptible to UTIs due to having the urinary catheter. The ADCO said by RCP O placing the plastic bags back on the bed after they fell on the floor, it was an infection control issue. The ADCO said it should not have happened and if it did, the mattress should have been sanitized to prevent potential infections .</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 2:18 PM, DCO P said she was covering the facility while DCO Q was out sick. DCO P said she worked at a sister facility as the DCO. DCO P said RCP O should have changed her gloves and performed hand hygiene prior to cleaning the urinary catheter. DCO P said RCP O should have cleaned around the insertion site of the catheter and the perineum area of the Resident #10. DCO P said improper incontinent and/or urinary catheter care could cause UTIs in the residents. DCO P said RCP O should not have put the plastic bag back on the bed after it fell on to the floor twice. DCO P said it was cross-contamination and it was an infection control issue. DCO P said Resident #10 was at an enhanced risk of infection and was on EBP due to having a wound on her bottom and having a urinary catheter.</p> <p>During an interview on 2/12/25 at 5:46 PM, the EDO said RCP O putting the plastic bag from the floor back on Resident #10's bed was an infection control issue. The EDO said by RCP O not cleaning the urinary catheter properly or perineum area properly and by not changing gloves or performing hand hygiene appropriately placed the resident at risk of infection. The EDO said they have had some staffing issues and the previous DCO quit by text on Thanksgiving night. The EDO said RCP O's competency could have been missed because they had a gap of DCO coverage during the time of RCP O's hire. The EDO said RCP's orientation would have consisted of her going with another aide for a few days to show her around .</p> <p>44933</p> <p>2. Record review of Resident #15's face sheet dated 2/10/25 indicated Resident #15 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #15 had diagnoses including urinary tract infection (is an infection of the urinary tract, which includes the kidneys, ureters, bladder, and urethra) and neuromuscular dysfunction of bladder (a condition where the nerves controlling bladder function are damaged, leading to impaired bladder control due to disrupted communication between the brain and the bladder muscles, causing issues like incontinence, difficulty urinating, or incomplete bladder emptying).</p> <p>Record review of Resident #15's admission MDS assessment dated [DATE] indicated Resident #15 was understood and had the ability to understand others. Resident #15 had a BIMS score of 13 which indicated intact cognition. Resident #15 had an indwelling catheter and occasional bowel incontinence.</p> <p>Record review of Resident #15's care plan dated 1/21/25 indicated Resident #15 had an indwelling catheter related to neurogenic bladder and was at risk for increased urinary tract infection. Intervention included ensure foley was secured via Velcro strap to reduce friction/pulling.</p> <p>Record review of Resident #15's consolidated physician order dated active as of 02/10/25 indicated check foley catheter placement, ensure foley was secured via Velcro strap to reduce friction/pulling. Every shift. Start 1/04/25.</p> <p>Record review of Resident #15's TAR dated 2/01/25-2/28/25 indicated check foley catheter placement, ensure foley was secured via Velcro strap to reduce friction/pulling. Every shift. Start 1/04/25.</p> <p>During an interview and observation on 2/10/25 at 11:08 AM, Resident #15 was lying askew in her bed. Resident #15 had an indwelling catheter hanging on the side of her bed. She said she came from the hospital with the catheter. She said she did not have anything on her thigh holding the catheter tubing.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Focused Care at Linden		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W Houston St Linden, TX 75563	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 2/11/25 at 10:13 AM, Resident #15 was lying on her right side and the catheter bag was on the left side of the bed. Resident #15 said she did not have a strap holding the catheter tubing. Resident #15 lifted her gown and no securement device was noted to her left or right thigh.</p> <p>3. Record review of Resident #22's face sheet dated 2/10/25 indicated Resident #22 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #22 had diagnoses including irritant contact dermatitis (is a common skin condition caused by direct contact with irritants or allergens) due to friction or contact with body fluids and neuromuscular dysfunction of bladder (a condition where the nerves controlling bladder function are damaged, leading to impaired bladder control due to disrupted communication between the brain and the bladder muscles, causing issues like incontinence, difficulty urinating, or incomplete bladder emptying).</p> <p>Record review of Resident #22's quarterly MDS assessment dated [DATE] indicated Resident #22 was understood and had the ability to understand others. Resident #22 had a BIMS score of 15 which indicated intact cognition. Resident #22 had an indwelling catheter and was always incontinent of bowel.</p> <p>Record review of Resident #22's care plan dated 10/17/24 indicated Resident #22 had an indwelling catheter and was at risk for increases in urinary tract infections due to neurogenic bladder. Intervention included monitor/document for pain/discomfort due to catheter.</p> <p>Record review of Resident #22's consolidated physician order dated active as of 02/10/25 indicated:</p> <p>*Check foley catheter placement, ensure foley is secured via Velcro strap to reduce friction/pulling. Every shift for preventative. Start 11/04/24.</p> <p>*Foley catheter care every shift for preventative. Start 11/04/24.</p> <p>Record review of Resident #22's TAR dated 1/01/25-1/31/25 indicated:</p> <p>*Check foley catheter placement, ensure foley is secured via Velcro strap to reduce friction/pulling. Every shift for preventative. Start 11/04/24.</p> <p>*Foley catheter care every shift for preventative. Start 11/04/24.</p> <p>No documentation noted on 1/05/25 (6 AM and 6 PM), 1/18/25 (6 AM), and 1/26/25 (6 AM).</p> <p>Record review of Resident #22's TAR dated 2/01/25-2/28/25 indicated:</p> <p>*Check foley catheter placement, ensure foley is secured via Velcro strap to reduce friction/pulling. Every shift for preventative. Start 11/04/24.</p> <p>*Foley catheter care every shift for preventative. Start 11/04/24.</p> <p>No documentation noted on 2/03/25 (6 AM), 2/07/25 (6 AM), and 2/08/25 (6 AM).</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 2/10/25 at 2:35 PM, Resident #22 was lying in her bed. Resident #22 had an indwelling catheter on the right side of her bed with cloudy urine. She said the nursing staff did not provide catheter care daily and she did not feel like they did a good job.</p> <p>During an interview and observation on 2/11/25 at 3:34 PM, Resident #22 was sitting up in her bed. Resident #22 had an indwelling catheter on the right side of her bed with cloudy urine. Resident #22 said her adhesive securement device fell off two days ago. She said it did not stick on well after her bed baths. Resident #22 exposed both thighs and no securement device noted.</p> <p>During an interview on 2/12/25 at 1:57 PM, LVN D said the LVNs were responsible for ensuring the residents had catheter securement devices. She said the RCPs should notify the LVNs if they noticed a resident without one. She said the placement of a securement device was supposed to be checked daily. She said the LVNs documented on the MAR/TAR that the resident had a securement device in place. She said the securement devices were important, so the catheter did not fall out or became dislodged. She said Resident #22's securement device did not stay on that well. LVN D said the RCPs were responsible for foley catheter care. She said the LVNs were supposed to ensure catheter care was done. She said the LVNs, and RCPs documented in the facility's charting system when catheter care was done. She said the LVNs documented on the MAR/TAR. She said if catheter care was not documented on the MAR/TAR, it could indicate it was not done. She said the LVNs should also ensure catheter care was done and documented. She said catheter care was important for prevention of infections.</p> <p>During an interview on 2/12/25 at 5:25 PM, the RCP H said catheter securement devices were important, so the catheter did not pop out and mess up stuff inside the resident. She said the RCPs were responsible for letting the nurses know if a resident did not have a securement device. She said she thought Resident #15 had a securement device on.</p> <p>During an interview on 2/12/25 at 5:49 PM, the ADCO said the LVNs were responsible for ensuring the residents had a catheter securement device. She said placement was supposed to be checked by the LVNs every shift. She said the LVNs documented on the TAR verifying securement placement. She said the securement devices were important to keep the catheter tubing in place. She said if a resident did not have a securement device, it placed the resident at risk for physical injury, infection, and skin issues. She said the DCO Q and ADCO should be monitoring this process. She said chart audits should be done to monitor this process. The ADCO said the LVNs, and RCPs were responsible for foley catheter care. She said catheter care was supposed to be done every shift. She said the LVNs were supposed to document on the TAR every shift when catheter care was completed. She said when catheter care was not documented on the TAR, it could indicate it was not done. She said catheter care was important for infection, prevent skin issues, and dignity.</p> <p>During an interview on 2/12/25 at 6:57 PM, the DCO P, from the facility's sister facility, said LVNs were responsible for ensuring the residents had the catheter securement devices. She said placement was supposed to be checked by the LVNs every shift. She said the LVNs document on the MAR/TAR verifying securement placement. She said securement devices were important for safety and comfort. She said a resident not having a securement device, placed a resident at risk for displacement, trauma and injury, and bleeding. The DCO P said the RCPs performed catheter care on the residents. She said the LVNs document every shift, on the MAR/TAR, when catheter care was completed. She said when catheter care was not documented on the MAR/TAR, it could indicate failure of it being done. She said catheter care was important for infection control.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 7:34 PM, the EDO said the LVNs, and RCPs should ensure the residents with catheters had securement devices. She said the staff should check for placement every time they provided care. She said the securement device was important for comfort and to make sure the catheter did not accidentally dislodge. The EDO said the LVNs, and RCPs performed and charted catheter care. She said the LVNs documented catheter care on the MAR/TAR and RCPs also charted on the ADL task section in the facility's charting system. She said when catheter care was not documented on the MAR/TAR, it could indicate it potentially was not done. She said the charge nurses and nursing managers should ensure this process was occurring. She said this process should be monitored through chart audits and during morning stand up meetings.</p> <p>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 . instruct the resident to bend his/her knees and put his/her feet flat on the mattress, assist as necessary . for a female resident . a. use wipes and apply skin cleansing agent . b. wash perineal area, wiping from front to back . 1. Separate labia and wash area downward from front to back (Note: if the resident had an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches) . 2. Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. Do not reuse the same side of the disposable wipe, change the surface position of the disposable wipe and/or obtain a clean wipe to clean the urethra or labia . 3. Note: if resident had an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter . c. Instruct or assist the resident to turn on her side with her top leg slightly bent, if able . d. wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not use the same side of the disposable wipe, change the surface position of the disposable wipe and/or obtain a clean wipe to clean the labia . discard disposable items into designated containers .</p> <p>Record review of a facility's Catheters-Insertion and Care: Indwelling, Straight, Supra-Pubic, and External policy dated 04/2021 indicated . it is the policy of the community that the resident with a urinary catheter will 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 . general guidelines . document the date, time, procedure . indwelling catheter care . RN/LVN/CNA [RCP] to provide catheter care using the following procedure . 3. Wash perineum well with perineal cleanser, taking care to wash front to back . 5. Cleanse area well at catheter insertion . all debris must be removed from the catheter at insertion site . discard disposable equipment properly .</p> <p>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 .</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled Hand Hygiene dated last revised 10/24/22 indicated . hand hygiene was used to prevent the spread of pathogens in healthcare settings . you should always perform hand hygiene . before applying and after removing personal protective equipment (e.g. gloves, gown, mask, face shield/goggles) . before and after providing any type of care . after contact with intact skin . after contact with medical equipment or other environmental surfaces that may be contaminated . you must perform hand hygiene after contact with bodily fluids, such as urine .</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on interviews and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for 1 of 3 residents (Resident #1) reviewed for nutrition.</p> <p>The facility failed to obtain Resident #1's weekly weights times 4 on admission.</p> <p>The facility failed to obtain Resident #1's readmission weight after her hospital stay (12/26/24-12/31/24). Resident #1 was readmitted on [DATE].</p> <p>The facility failed to follow Resident #1's January 2025 dietary recommendation for the health shakes to be changed to house shakes (nutritional supplement for weight concerns) and given for 90 days.</p> <p>These failures could place residents at risk for malnourishment, weight loss, skin breakdown, and decreased quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 01/10/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses including Asperger's syndrome (is a term sometimes used to describe a developmental disorder that's part of the autism spectrum disorder (ASD)), epilepsy (is a chronic brain disorder characterized by recurrent seizures, which are brief episodes of involuntary movements, loss of consciousness, or altered awareness), displaced bimalleolar fracture of left lower leg (is a severe injury to the ankle joint and bones of the lower leg), and osteoarthritis (is a chronic condition that causes joint pain, stiffness, and inflammation).</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 was understood and had the ability to understand others. Resident #1 had a BIMS score of 09 which indicated moderate cognitive impairment. Resident #1 was 187 lbs. Resident #1 did not have a loss of 5% or more in the last month or loss of 10% or more in the last 6 months. Resident #1 was on a therapeutic diet.</p> <p>Record review of Resident #1's care plan dated 12/15/24 indicated Resident #1 was on a no added salt diet/therapeutic diet. Intervention included monitor and document intake. Resident #1 care plan did not reflect unplanned weight loss.</p> <p>Record review of Resident #1's consolidated physician order dated active as of 02/10/25 indicated:</p> <p>*Health Shake (has protein, vitamins, and minerals to improve nutritional parameters) two times a day due to weight loss for 60 days. Take one by mouth between meals for 60 days. Start 02/04/25.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1's current consolidated physician order did not reflect an order for weights. Resident #1's consolidated physician order did not reflect an order for house shake.</p> <p>Record review of Resident #1's MAR dated 12/01/24-12/31/24 indicated:</p> <p>*Obtain weight weekly times four weeks every shift, every Monday for four. Administrations weight resident weekly times four and follow facility guidelines on MD notification of weight loss or gain.</p> <p>The TAR indicated on 12/09/24 (187 lbs.). No documentation noted on 12/16/24, 12/23/24, and 12/30/24.</p> <p>*Health Shake one time a day for 60 days. Start 12/17/24. Discontinued 02/04/25.</p> <p>*Health Shake one time a day. Start 12/05/24. Discontinued 12/16/24. Received 12 of 12 doses.</p> <p>Record review of Resident #1's MAR dated 01/01/25-01/31/25 indicated:</p> <p>*Health Shake one time a day for 60 days. Start 12/17/24. Discontinued 02/04/25.</p> <p>* Obtain weight weekly times four weeks every shift, every Monday for four. Administrations weight resident weekly times four and follow facility guidelines on MD notification of weight loss or gain.</p> <p>No start date indicated, and no weights documented.</p> <p>Record review of Resident #1's MAR dated 02/01/25-02/28/25 indicated:</p> <p>*Health Shake one time a day for 60 days. Start 12/17/24. Discontinued 02/04/25.</p> <p>*Health Shake two times a day due to weight loss for 60 days. Take one by mouth between meals for 60 days. Start 02/04/25.</p> <p>Record review of Resident #1's hospital paperwork dated 12/30/24 indicated:</p> <p>*Recorded weight: 185lbs 3 oz (4 days ago (12/26/24))</p> <p>*Adjusted weight: 149lbs 7.6oz (12/28/24)</p> <p>Record review of Resident #1's weight summary accessed on 02/11/25 indicated:</p> <p>*02/07/25 161.8 lbs.</p> <p>*01/07/25 162.2 lbs.</p> <p>*12/09/24 187 lbs.</p> <p>*12/03/24 187.4 lbs.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1's weight summary did not reflect weekly weights times four after admission on 12/02/24, a weight on 12/31/24 when she was readmitted , weekly weights times for after readmission.</p> <p>Record review of Resident #1's weight variance report by completed by the Consultant Dietitian, dated January 2025 indicated .Resident #1 had -13.4% loss in 30 days . Comments .weight: 162.2 # .chg [change] health shake to house shake BID between meals x 90d [days] .</p> <p>During an observation on 02/10/25 at 10:51 a.m., Resident #1 was lying in her bed watching television. Resident #1 did not respond to greetings.</p> <p>During an observation on 02/11/25 at 10:06 a.m., Resident #1 was sitting up in her bed. Resident #1 still did not respond to greetings.</p> <p>During an interview on 02/12/25 at 1:57 p.m., LVN D said the nurses got the residents weights. She said the resident's weights were done weekly, monthly, or as ordered. She said the resident was supposed to be weighed on admission and readmission. She said obtaining resident's weights on admission times four and readmission established a baseline weight or started a new baseline for readmissions. She said the DCO and ADCO coordinated with the Dietitian regarding recommendations. She said only the nursing management received the dietary recommendation. She said nursing management was responsible for ensuring the dietary recommendations were adequately transcribed and followed. She said it was important to follow the dietary recommendations because it was a new intervention to help with weight loss.</p> <p>During an interview on 02/12/25 at 5:49 p.m., the ADCO said weights for new admissions and readmissions were supposed to be weekly times four then monthly. She said the resident's weight should be documented in the resident's electronic medical record. She said the nurses, the ADCO, or the DCO could weigh the residents. She said the admitting nurse should order weekly weight times four on new admissions and readmissions. She said she was not employed at the facility for Resident #1's admission or readmission. She said she did not know why it was not done. She said Resident #1 had been admitted to the hospital for a few days and returned with weight loss. She said it would have benefited the facility if a readmission weight had been obtained to get a new baseline. She said the DCO Q, and she had started at the facility together on January 13, 2025. She said they had not had a chance to really sit down and establish who was responsible for what. She said DCO Q was out sick, and she had to work the floor. She said for now, she was responsible for dietary recommendations. She said she just put in some of the dietary recommendation. She said she thought she had correctly entered Resident #1's recommendations. She said it was important to enter the resident's recommendations correctly because it was an intervention to maintain or increase the resident's weight.</p> <p>During an interview on 02/12/25 at 6:57 p.m., the DCO P, from a sister facility, said the facility's weight policy should be followed for admission and readmission. She said the charge nurse should be weighing the residents as ordered. She said admission and readmission weights were important to establish a baseline. She said the resident's dietary recommendation should be entered accurately and followed. She said the DCO or ADCO should be monitoring this process. She said she did not know who was responsible at the facility. She said the resident could experience continual weight loss if the recommendation was not followed.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/12/25 at 7:34 p.m., the EDO said, nursing management was responsible for resident's weights. She said it was important to track the resident's weights and hopefully the resident's weight stabilized. She said she expected the weight loss or gain to be addressed accordingly. She said she remembered in an IDT meeting discussing Resident #1's weight loss. She said she knew the facility addressed Resident #1's weight loss. She said the dietary recommendations were submitted to the ADCO and the DCO. She said nursing management should correctly transcribe the recommendations. She said the recommendations were important to ensure necessary weight loss or gain.</p> <p>Record review of a facility's Weight Surveillance Program policy revised 11/01/24 indicated .the purpose of this policy is to establish facility guidelines on how and when the facility obtains and documents residents weights .obtaining resident weights .the same staff members should weigh residents when possible . frequency of obtaining resident weights .new admission .the resident is then weighed at least weekly for at least 4 weeks .re-admission from hospital or other facility .the resident's weight should be obtained upon re-admission .the resident is then weighed at least weekly for at least 4 weeks .all residents will have a monthly weight obtained .any resident who experiences a significant weight loss or gain must be placed on the 'Weight Surveillance' program .dietitian recommendation should be implemented .</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 4 of 18 residents reviewed for respiratory care. (Resident #18, Resident #22, Resident #24, and Resident #38)</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident #18 had a filter (the air passes through a series of filters that remove impurities, ensuring that the oxygen delivered to the patient was of high quality) in the oxygen concentrator (takes air from the surroundings, extracts oxygen, and filters it into purified oxygen for resident to breathe). 2. The facility failed to ensure Resident #18's compartment that would have held the oxygen concentrator filter did not have gray fuzzy and hair-like particles covering the air intake area. 3. The facility failed to ensure Resident #24's oxygen concentrator filter was not covered in thick gray fuzzy and hair-like particles. 4. The facility failed to ensure Resident #22's oxygen concentrator filter was without white fuzzy particles. 5. The facility failed to ensure Resident #22 was on the ordered number of liters on 02/10/25 and 02/11/25. 6. The facility failed to ensure Resident #22's oxygen use was documented on her February 2025 MAR/TAR. 7. The facility failed to ensure Resident #22's nebulizer mask was stored in bag when not in use on 02/10/25 and 02/11/25. 8. The facility failed to ensure Resident #38 's oxygen concentrator filter was without white fuzzy particles. 9. The facility failed to ensure Resident #38's nasal cannula tubing was stored in bag when not in use on 02/10/25 and 02/11/25. 10. The facility failed to ensure Resident #38's oxygen use was documented on her February 2025 MAR/TAR. <p>These failures could place residents at risk of respiratory complications or respiratory infection.</p> <p>Findings included:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Record review of Resident #18's face sheet dated 2/10/25 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #18 had diagnoses which included diabetes (high blood sugar), history of pneumonia (lung infection), hypertension (high blood pressure), and cerebrovascular disease (disruption of blood flow to the brain).</p> <p>Record review of Resident #18's annual MDS assessment dated [DATE], indicated she had a BIMs score of 11, which indicated she had moderate cognitive impairment. The MDS indicated Resident #18 had shortness of breath or trouble breathing with exertion (movement). The MDS indicated Resident #18 was receiving oxygen therapy.</p> <p>Record review of Resident #18's undated Care Plan Report indicated she had oxygen therapy related to cerebral vascular accident (stroke) and obesity initiated on 4/10/23. Interventions included give medications as ordered by the physician.</p> <p>Record review of Resident #18's Order Summary Report dated 2/10/25 reflected an order to clean/change oxygen concentrator filters every night shift on Sunday with a start date of 3/19/23; an order for oxygen at 2 LPM by nasal cannula PRN to maintain oxygen saturation greater than 90 % with a start date of 8/16/24.</p> <p>Record review of Resident #18's Treatment Administration Record dated 2/01/25-2/28/25 indicated an order to clean/change oxygen concentrator filters every night shift every Sunday with a start date of 3/19/23. There was documentation on 2/09/25 by LVN F indicating the oxygen concentrator was clean/changed on 2/09/25.</p> <p>During an observation and interview on 2/10/25 beginning at 9:26 AM, Resident #18 was lying in bed and was not wearing her oxygen. Resident #18 had an oxygen concentrator in her room, and it was not turned on. Resident #18's oxygen tubing was dated 2/8/25. Resident #18's oxygen concentrator did not have a filter and there were gray fuzzy and hair-like particles covering the air intake area of the machine. Resident #18 said she used her oxygen daily.</p> <p>During an observation on 2/10/25 at 12:35 PM, Resident #18 was lying in bed and was not wearing her oxygen. Resident #18's oxygen concentrator continued to have no filter with gray fuzzy and hair-like particles covering the air intake area of the machine.</p> <p>During an observation on 2/10/25 at 1:54 PM, Resident #18 was lying in bed and was not wearing her oxygen. Resident #18's oxygen concentrator continued to have no filter with gray fuzzy and hair-like particles covering the air intake area of the machine.</p> <p>During an observation on 2/11/25 at 7:58 AM, Resident #18 was sitting up in bed feeding herself and wearing oxygen at 2 LPM by nasal cannula. Resident #18's oxygen concentrator continued to have no filter with gray fuzzy and hair-like particles covering the air intake area of the machine.</p> <p>During an observation on 2/12/25 at 9:17 AM, Resident #18 was lying in bed asleep, wearing oxygen at 2 LPM by a nasal cannula. Resident #18's oxygen concentrator continued to have no filter with gray fuzzy and hair-like particles covering the air intake area of the machine .</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Record review of Resident #24's face sheet dated 2/12/25 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #24 had diagnoses which included hypertensive (high blood pressure) heart disease with heart failure, dementia (memory loss), and paroxysmal atrial fibrillation (heart rhythm disorder that causes an irregular rapid heart rate for a short time).</p> <p>Record review of Resident #24's annual MDS assessment dated [DATE], indicated she had a BIMs score of 8, which indicated she had moderate cognitive impairment. The MDS indicated Resident #24 had shortness of breath or trouble breathing when lying flat. The MDS indicated Resident #24 was receiving oxygen therapy.</p> <p>Record review of Resident #24's undated Care Plan Report indicated she had heart failure and was at risk for activity intolerance related to cardiac insufficiency initiated on 12/31/21. Interventions included apply oxygen for complaints of chest pain as ordered.</p> <p>Record review of Resident #24's Order Summary Report dated 2/10/25 reflected an order for oxygen at 2 LPM by nasal cannula PRN to maintain oxygen saturation above 90 % with a start date of 11/21/24. There was no order to clean/change oxygen concentrator filters noted.</p> <p>Record review of Resident #24's Treatment Administration Record dated 2/01/25-2/28/25 indicated there was no order to clean/change oxygen concentrator filters.</p> <p>During an observation on 2/10/25 at 10:03 AM, Resident #24 was not in her room. There was an oxygen concentrator machine by the bed by the window and the oxygen concentrator filter was covered in gray fuzzy and hair-like particles. The oxygen tubing was dated 2/9/25.</p> <p>During an observation on 2/10/25 at 12:34 PM, Resident #24 was not in her room, but her oxygen concentrator filter continued to be covered in gray fuzzy and hair-like particles.</p> <p>During an observation on 2/10/25 at 1:57 PM, Resident #24 was not in her room, but her oxygen concentrator filter continued to be covered in gray fuzzy and hair-like particles.</p> <p>During an observation on 2/11/25 at 8:04 AM, Resident #24 was not in her room, but her oxygen concentrator filter continued to be covered in gray fuzzy and hair-like particles.</p> <p>During an observation and interview on 2/12/25 at 9:25 AM, Resident #24 was sitting up in her wheelchair in her room. Resident #24 said she only used her oxygen when she laid down in the bed to help her rest. Resident #24 said she did not know if staff ever changed the tubing or cleaned the oxygen concentrator filter. Resident #24 said she did not have any concerns with her care .</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 2/12/25 beginning at 9:52 AM, LVN D said the night shift nurses on Saturday or Sundays were responsible for changing oxygen tubing and cleaning oxygen filters. LVN D said when she rounded on the residents, she checked to see if the oxygen was in use, the date of the tubing, and if the resident was wearing the oxygen properly. LVN D said the oxygen concentrator machine should have a filter. LVN D said the oxygen concentrator filter needed to be kept clean because residents were at risk of pneumonia. LVN D said if the oxygen concentrator filter was dirty or it did not have an oxygen concentrator filter, it could place the resident at a higher risk of respiratory infection. LVN D accompanied the state surveyor to Resident #18's room. LVN D said Resident #18's oxygen concentrator filter was missing, and the oxygen concentrator's air intake area was dirty, and she would get the machine replaced. LVN D said no filter on the oxygen concentrator and a dirty air intake placed Resident #18 at risk for respiratory infections. LVN D said she did not check the oxygen concentrator filter that morning during her rounds and had only checked that Resident #18 was wearing the oxygen properly.</p> <p>During an observation and interview on 2/12/25 beginning at 12:49 PM, the ADCO accompanied the state surveyor to Resident #24's room and observed Resident #24's oxygen concentrator filter. The ADCO said there was an issue with Resident #24's oxygen filter not being clean, and she would get it resolved. The ADCO said the dirty oxygen concentrator filter placed the resident at risk for improper oxygenation and at risk of a respiratory infection. The ADCO said the purpose of the oxygen concentrator filter on the oxygen machine was to keep contaminants out of the system.</p> <p>During an interview on 2/12/25 at 2:18 PM, DCO P said she was covering the facility while DCO Q was out sick. DCO P said she worked at a sister facility as the DCO. DCO P said the purpose of the oxygen concentrator filter was to keep the dirt out and clean air going through the concentrator. DCO P said if there was no oxygen concentrator filter or the oxygen concentrator was dirty, it could cause a respiratory infection and it could affect the amount of oxygen the residents received.</p> <p>During an interview on 2/12/25 at 4:24 PM, LVN F said the nurses were responsible for changing oxygen tubing, cleaning the oxygen concentrator filters, and were done on the 6 PM-6 AM shift on Sundays. LVN F said if the oxygen concentrator filter was not clean the resident would not get adequate oxygen and could have trouble breathing. LVN F said she worked Sunday night 2/09/25. LVN F said she covered Hall 400 on 2/09/25. LVN F said she thought Resident #18 had that hard to take off filter and she just wiped the machine off. LVN F said she did not remember there not being a back or no oxygen concentrator filter on Resident #18's oxygen concentrator. LVN F said if she did not clean or check Resident's oxygen concentrator filter but documented that she had done it, that was an error on her part. LVN F said she could not remember if she cleaned Resident #18's oxygen concentrator filter or if it had a filter.</p> <p>During an interview on 2/12/25 at 5:46 PM, the EDO said the night nurses change out the tubing and humidifier bottles on Sundays. The EDO said they have a company that was supposed to take care of the maintenance of the oxygen concentrators. The EDO said they call the company as needed. The EDO said she did not know of any orders to clean the oxygen filters. The EDO said she would expect the physician's orders to be followed if there was an order to clean/change the oxygen filter. The EDO said the dirty oxygen concentrator filters, or no oxygen concentrator filter could affect the functioning of the oxygen concentrator machine.</p> <p>44933</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Record review of Resident #22's face sheet dated 02/10/25 indicated Resident #22 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #22 had diagnoses including acute respiratory failure (is a condition where there's not enough oxygen or too much carbon dioxide in your body), pneumonia (is an infection of one or both of the lungs caused by bacteria, viruses, or fungi), chronic obstructive pulmonary disease (is a group of lung diseases that cause ongoing inflammation and narrowing of the airways, making it difficult to breathe), and heart failure (is a serious condition that occurs when the heart can't pump enough blood and oxygen to the body).</p> <p>Record review of Resident #22's quarterly MDS assessment dated [DATE] indicated Resident #22 was understood and had the ability to understand others. Resident #22 had a BIMS score of 15 which indicated intact cognition. Resident #22 received oxygen therapy while a resident in the facility within the last 14 days.</p> <p>Record review of Resident #22's care plan dated 10/18/24 indicated Resident #22 had oxygen therapy related to chronic obstructive pulmonary disease and was at risk for ineffective breathing pattern. Intervention included give medication as ordered by the physician.</p> <p>Record review of Resident #22's consolidated physician order dated active as of 02/10/25 indicated:</p> <p>*Clean/change oxygen concentrator filters every night shift every Sunday for preventative. Start 11/03/24.</p> <p>*Oxygen at 2 liters nasal cannula to maintain oxygen saturation greater than 90 percent as needed. Indicate if oxygen was provided this shift by answering yes or no.</p> <p>*Budesonide Inhalation Suspension (is used to help prevent the symptoms of asthma) 0.5mg/2ml, 1 application orally two times a day for mix with Ipratropium. Start 11/04/24.</p> <p>*Ipratropium-Albuterol Solution (is a combination medication used to treat chronic obstructive pulmonary disease (COPD)) 0.5-2.5mg/3ml, 1 application inhale orally four times a day for shortness of breath and preventative. Start 11/04/24.</p> <p>Record review of Resident #22's MAR dated 02/01/25-02/28/25 indicated:</p> <p>*Oxygen at 2 liters nasal cannula to maintain oxygen saturation greater than 90 percent as needed. Indicate if oxygen was provided this shift by answering yes or no. Start 11/03/24.</p> <p>No documentation indicated of Yes noted.</p> <p>*Budesonide Inhalation Suspension (is used to help prevent the symptoms of asthma) 0.5mg/2ml, 1 application orally two times a day for mix with Ipratropium. Start 11/04/24.</p> <p>Resident #22 received 12 of 19 scheduled doses.</p> <p>*Ipratropium-Albuterol Solution (is a combination medication used to treat chronic obstructive pulmonary disease (COPD)) 0.5-2.5mg/3ml, 1 application inhale orally four times a day for shortness of breath and preventative. Start 11/04/24.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #22 received 19 of 38 scheduled doses.</p> <p>Record review of Resident #22's TAR dated 02/01/25-02/28/25 indicated:</p> <p>*Clean/change oxygen concentrator filters every night shift every Sunday for preventative. Start 11/03/24. The TAR indicated administration on 02/09/25 by LVN E.</p> <p>During an observation on 02/10/25 at 11:39 a.m., Resident #22 was lying in bed with a nasal cannula on her face. Resident #22's nasal cannula was connected to an oxygen concentrator. Resident #22's oxygen concentrator was on 3 liters. Resident #22's internal oxygen concentrator filter had moderate amount of white fuzzy particles. Resident #22's nebulizer mask was stored on a nightstand not in bag.</p> <p>During an observation and interview on 02/10/25 at 2:35 p.m., Resident #22 was lying in bed with a nasal cannula on her face. Resident #22's nasal cannula was connected to an oxygen concentrator. Resident #22's oxygen concentrator was on 3 liters. Resident #22's internal oxygen concentrator filter had moderate amount of white fuzzy particles. Resident #22's nebulizer mask was stored on a nightstand not in bag. She said she had been on oxygen all the time since her third hospital admission for pneumonia. She said she also had COPD and congestive heart failure and needed oxygen for that too. She said she was supposed to be on 3 or 4 liters of oxygen. She said staff changed her oxygen tubing every Saturday night but never cleaned her oxygen concentrator filter. She said she had the current oxygen concentrator for about 3 months now. She said her nebulizer mask was supposed to be placed back in the bag after her treatments. She said sometimes that did not happen.</p> <p>During an observation on 02/11/25 at 10:20 a.m., Resident #22 was lying in bed with a nasal cannula on her face. Resident #22's oxygen concentrator was on 3 liters.</p> <p>Resident #22's nebulizer mask was hanging from the machine, almost touching the floor, not stored in a bag. Resident #22's internal oxygen concentrator filter had moderate amount of white fuzzy particles.</p> <p>4. Record review of Resident #38's face sheet dated 02/12/25 indicated Resident #38 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #38 had diagnoses including down syndrome (is a genetic disorder caused by the presence of an extra copy of chromosome 21), nonrheumatic aortic valve stenosis (is a condition where the aortic valve, located between the heart's left ventricle and the aorta, becomes narrowed and restricts blood flow), and bradycardia (is a condition characterized by a slow heart rate, typically defined as a resting heart rate below 60 beats per minute (bpm)).</p> <p>Record review of Resident #38's annual MDS assessment dated [DATE] indicated Resident #38 was understood and had the ability to understand others. Resident #38 had a BIMS score of 08 which indicated moderate cognitive impairment. Resident #38's MDS did not reflect oxygen therapy.</p> <p>Record review of Resident #38's care plan 09/16/24 did not reflect oxygen therapy.</p> <p>Record review of Resident #38's consolidated physician order dated active as of 02/12/25 indicated:</p> <p>*Clean/change oxygen concentrator filters every night every Sunday. Start 02/04/24.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Oxygen at 2 liters per nasal cannula to maintain oxygen saturation greater than 90 percent. Indicate if oxygen was provided this shift by answering yes or no. Start 02/01/24.</p> <p>Record review of Resident #38's MAR dated 02/01/25-02/28/25 indicated:</p> <p>*Oxygen at 2 liters per nasal cannula to maintain oxygen saturation greater than 90 percent. Indicate if oxygen was provided this shift by answering yes or no. Start 02/01/24.</p> <p>No documentation indicated of Yes noted.</p> <p>Record review of Resident #38's TAR dated 02/01/25-02/28/25 indicated:</p> <p>*Clean/change oxygen concentrator filters every night every Sunday. Start 02/04/24.</p> <p>The TAR indicated administration on 02/09/25 by LVN E.</p> <p>During an observation on 02/10/25 at 11:35 a.m., Resident #38's oxygen concentrator filter had a moderate amount of gray, fuzzy particles. Resident #9's nasal cannula tubing was on the oxygen concentrator, not stored in a bag.</p> <p>During an observation on 02/11/25 at 10:19 a.m., Resident #38's oxygen concentrator filter had a moderate amount of gray, fuzzy particles. Resident #9's nasal cannula tubing was on the oxygen concentrator, not stored in a bag.</p> <p>During an interview on 02/12/25 at 1:57 p.m., LVN D said Resident #22 was supposed to be on the ordered number of liters. She said the LVNs were responsible for placing the residents on the ordered amount of oxygen. She said it was important to make sure the resident was not getting too little or too much oxygen. She said getting too little or too much oxygen affected the residents carbon dioxide levels and could cause confusion. She said the resident's liters of oxygen and oxygen saturation should be documented on the MAR. She said the resident may be getting oxygen and was not supposed to be. She said it was important to document when a resident used oxygen, so all staff were aware. She said staff may not know the resident was on oxygen from the lack of documentation. She said Resident #38 only wore oxygen at night, but it still should be documented on the MAR. She said the nebulizer masks and nasal cannulas, when not in use, were supposed to be stored in a bag. She said when the mask was not stored in a bag it was an infection control risk. She said the LVNs were responsible for storing the nebulizer masks in a bag, but an RCP also could do it. She said the DPO was responsible for cleaning the internal filters on the oxygen concentrators. She said the LVNs needed to notify the DPO when the internal filters needed to be cleaned.</p> <p>During an interview on 02/12/25 at 3:19 p.m., the DPO said the oxygen concentrators were contracted out to a company. He said the contracted company was responsible for the maintenance and cleaning of the resident's oxygen concentrators. He said he knew how to clean the internal filters. He said he did not mind cleaning the internal filters if the staff notified him. He said the facility nurses knew how to contact the contracting company for issues. He said the facility staff could also notify him to contact the contracting company for maintenance. He said the facility did not have a set process on who was solely responsible for the internal filters on the resident's oxygen concentrators.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 02/12/25 at 5:49 p.m. the ADCO said the physician order told the nurse how much oxygen the residents were supposed to be on. She said she expected the residents to be on the ordered amount of oxygen. She said the LVNs should be documenting on the resident MAR/TAR when the resident used oxygen. She said the nebulizer masks and nasal cannulas should be stored in a bag when not in use. She said the LVNs were responsible for storage of the resident's masks and cannulas. She said the cleaning of the internal filters was the responsibility of the oxygen company. She said the nurses contact the oxygen company when the filters needed to be cleaned. She said it was important for infection control.</p> <p>During an interview on 02/12/25 at 6:57 p.m., DCO P, from a sister facility, said she expected the nursing staff to place the resident on the ordered oxygen amount. She said she expected the nursing staff to document on the MAR/TAR when a resident was on oxygen. She said the nursing staff should be storing the resident nebulizer masks and nasal cannulas in a clear bag, when not in use. She said at her facility, the oxygen company came once a month to service the oxygen concentrators. She said she did not who was responsible for cleaning the internal filters on the oxygen concentrators at this facility.</p> <p>Review of the facility's Respiratory policy titled Oxygen Therapy dated 04/2021 indicated . policy of this community to ensure all oxygen administration was conducted in a safe manner . verify there was an order for oxygen administration to include . method of delivery, flow rate, oxygen saturation parameters if indicated . start oxygen flow of rate as ordered . document resident's response to PRN oxygen therapy . date and time of oxygen administration . type of delivery . oxygen rate . assessment of resident's respiration status to include oxygen saturation via pulse oximetry . change the reservoir, oxygen cannula and tubing every 7 days . keep oxygen cannula and tubing used PRN in a plastic bag when not in use . wash filters from oxygen concentrators every 7 days in warm soapy water . rinse and squeeze dry .</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on observations, interviews, and record review, the facility failed to attempt to use alternatives prior to installing a side or bed rail, obtain informed consent prior to installation, ensure correct installation, use and maintenance of bedrails for 1 of 10 residents (Resident #1) reviewed for bedrails.</p> <p>The facility failed to ensure informed consent for the use of Resident #1's bed rails were obtained prior to installation.</p> <p>The facility failed to obtain a bed rail assessment to assess the risk of entrapment for Resident #1's bed rails.</p> <p>These failures could place residents at risk of entrapment or injury.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 01/10/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses including Asperger's syndrome (is a term sometimes used to describe a developmental disorder that's part of the autism spectrum disorder (ASD)), epilepsy (is a chronic brain disorder characterized by recurrent seizures, which are brief episodes of involuntary movements, loss of consciousness, or altered awareness), displaced bimalleolar fracture of left lower leg (is a severe injury to the ankle joint and bones of the lower leg), and osteoarthritis (is a chronic condition that causes joint pain, stiffness, and inflammation).</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 was understood and had the ability to understand others. Resident #1 had a BIMS score of 09 which indicated moderate cognitive impairment. Resident #1 had lower extremity functional limitation in range of motion on one side. Resident #1 used a wheelchair for mobility. Resident #1 required supervision for sit to lying, roll left and right, and lying to sitting on side of the bed. Resident #1 required substantial/maximal assistance for sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Resident #1 had a fall in the last month prior to admission/entry or reentry. Resident #1 had a fracture related to a fall in the 6 months prior to admission/entry or reentry.</p> <p>Record review of Resident #1's care plan dated 12/15/24 indicated Resident #1 had a history of seizures and was at risk for injury related to weakness, balancing difficulties, cognitive limitations or altered consciousness, and loss of large or small muscle coordination. Resident #1 had a risk for ineffective airway clearance and was at risk for the inability to clear secretions or obstructions for the respiratory tract to maintain a clear airway. Interventions included padded side rails on bed if required. Resident #1 care plan did not reflect use of assist rails for bed mobility or repositioning.</p> <p>(continued on next page)</p>		

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 02/12/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Linden		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W Houston St Linden, TX 75563	
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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's consolidated physician orders, dated 02/10/25 did not reflect an order for assist rails.</p> <p>Record review of Resident #1's electronic medical records accessed on 02/11/25 did not reflect a side rail or entrapment assessment or informed consent documentation.</p> <p>During an observation on 02/10/25 at 10:51 a.m., Resident #1 was lying in her bed watching television. Resident #1 did not respond to greetings. Resident #1 had an assist bar on both sides of the bed.</p> <p>During an observation on 02/10/25 at 12:37 p.m., Resident #1 was asleep in her bed. Resident #1 was lying more toward the left side of the bed with her head resting on the assist bar.</p> <p>During an observation on 02/11/25 at 10:06 a.m., Resident #1 was sitting up in her bed. Resident #1 still did not respond to greetings. Resident #1 had an assist bar on both sides of the bed.</p> <p>During an interview on 02/12/25 at 1:15 p.m., the DOR, with the PTA present, said Resident #1 was no longer on therapy services. The PTA said Resident #1 refused to get out of bed to do therapy so she was discharged . The PTA said when Resident #1 was admitted she needed and used the assist rails. The PTA said Resident #1 currently did not need the assist rails because she refused to get out of the bed. The DOR said Resident #1 used the assist rails sometimes but not enough to keep them on her bed. The DOR said Resident #1 was currently a 1 person assist for bed mobility. The PTA said Resident #1 did not have good safety awareness. They said the nurses were responsible for putting in the orders for the assist rails. They said the DPO installed the assist rails on the resident's beds. They said when Resident #1 was on therapy services, they recommended assist rails. They said they normally assessed the residents on therapy services for assist rails. They said the staff could ask therapy to assess a resident for placement and removal of assist rails who was not on therapy services. They said they were not responsible for the facility's bed rail or entrapment assessment. They said Resident #1 could potentially hit her head or get an extremity stuck in the rails. The DOR said she would get Resident #1's assist rails removed today.</p> <p>During an interview on 02/12/25 at 1:57 a.m., LVN D said assist rails were supposed to help with repositioning. She said the bed rail assessments were done quarterly by the nurses. She said the nurses were responsible for getting an order for the assist rails. She said side rails required a consent from the resident or their family. She said when the assist rails became a safety risk to the resident, the nurse should notify the DPO to remove them. She said sometimes therapy coordinated with the DPO on the installation and removal of the assist rails. She said assist rails were removed after a bedrail assessment was completed or a therapy evaluation said the resident was no longer safe. She said the nurses should ensure the assist rails order and bed rail assessment were done. She said if a resident was no longer using the assist rails for bed mobility or repositioning, they could be considered a restraint. She said Resident #1 did not need the assist rails but because of her lack of motivation, she could benefit from them.</p> <p>On 2/12/25 at 5:45 PM, called Resident #1's responsible party and was unable to leave a message because the mailbox was full. No return call was received before or after exit.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/12/25 at 5:25 p.m., RCP H said Resident #1 was a one person assist with cues for bed mobility and transfers. She said Resident #1 liked to stay in the bed but would sometimes sit on the side of the bed to eat. She said Resident #1's assist rails used to help her with turning, getting out of the bed, and a feeling of securement. She said she felt Resident #1 had a pretty good safety awareness.</p> <p>During an interview on 02/12/25 at 5:49 p.m., the ADCO said the nurses were responsible for the resident's the assist/side rail order and assessment. She said the bed rail assessments were done on admission, quarterly, or with a condition change. She said for a resident to benefit from an assist/side rail, they must have the cognition to know how to use them. She said the residents should be using the rails for stabilization and turning. She said Resident #1 will use the assist rails when instructed to for repositioning. She said assist rails needed to be discontinued when the resident no longer used them. She said the DCO Q, and she should be monitoring this process by doing chart audits and rounds.</p> <p>During an interview on 02/12/25 at 6:57 p.m., the DCO P, from a sister facility, said the assist rails required an assessment prior to installation. She said the assessments were done by the nurses quarterly. She said the resident had to be able to reposition themselves to qualify for assist rails. She said she did not know if the facility required an order or consent for assist rails. She said a resident having assist rails without an assessment was a safety risk. She said if Resident #1 could harm herself then the assist rails needed to be removed.</p> <p>During an interview on 02/12/25 at 7:34 p.m., the EDO said, the therapy department and LVNs were responsible for bed rail assessments. She said bed rail assessment were supposed to be done quarterly and with a significant change in status. She said a resident needed an order for assist rails. She said the resident had to be able to utilize or reposition themselves to have assist rails. She said some days Resident #1 would not get out of the bed but other days she would. She said it depended on the staff how Resident #1 responded. She said the nursing staff and therapy department should be determining if a resident no longer needed assist rails. She said bed rail assessments and a physician's orders were important to make sure the assist rails were appropriate for the resident.</p> <p>Record review of a facility's Bed Safety policy dated 04/2021 indicated .The resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment . To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails .) . Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment . If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and/or legal representative . The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use . Side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified . Before using side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with side rails .</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>45643</p> <p>Based on interviews and record review the facility failed to complete a performance review of each Resident Care Provider (RCP) at least once every 12 months, for 5 of 5 (RCP L, RCP O, RCP U, RCP V, and RCP W) reviewed for annual competency evaluations.</p> <p>The facility failed to complete annual RCP (facility titles CNA as RCP) competency evaluations for RCP L, RCP O, RCP U, RCP V, and RCP W based on the personnel file review results.</p> <p>This failure could affect residents and place them at risk of not receiving consistent, appropriate interventions necessary to meet the residents' needs.</p> <p>Findings included:</p> <p>Record review of the Personnel File Review completed on 02/12/25, indicated RCP L, RCP O, RCP U, RCP V, and RCP W did not have a competency evaluation on file. The Personnel File Review indicated RCP L's date of hire was 01/07/25, RCP O 12/5/24, RCP U 12/5/24, RCP V 10/17/24, and RCP W 11/21/24.</p> <p>During an interview on 02/12/25 at 1:44 p.m., the Director of Nurses said that she did not know if the RCP (CNA) competencies had been completed. She said she could not find them. She said that the previous Director of Nurses did not file them or indicate where she placed them if she completed them. She said it was important for Resident Care Providers to have their annual competencies evaluated to ensure they were proficient in the areas of care they provide.</p> <p>During an interview on 02/12/25 at 5:09 p.m., the Administrator said she did not know if the RCP competencies were completed or not. She said she believed they were completed but they did not have documented proof to provide at the time the interview was conducted .</p> <p>Record review of the facility policy titles Competency of Nursing Staff dated 04/2020, indicated All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will participate in a facility-specific, competency-based staff development and training program demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on interviews and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs and biologicals, to meet the needs of 2 of 13 residents (Resident #1 and Resident #15) reviewed for pharmacy services.</p> <p>The facility failed to ensure Resident #1's Atorvastatin (is medication used to lower cholesterol and triglycerides (fats) levels to help prevent heart disease, angina (chest pain), strokes, and heart attacks) was available for administration on 01/28/25.</p> <p>The facility failed to ensure Resident #1's Cannabidiol (is an active cannabinoid used as an adjunctive treatment for the management of seizures) was available for administration on 01/10/25, 01/13/25, 01/14/25, 01/15/25, and 01/16/25.</p> <p>The facility failed to ensure Resident #1's Lamotrigine (is a medication used to treat epilepsy and stabilize mood in bipolar disorder) was available for administration on 01/15/25, 01/16/25, 01/17/25, 01/18/25, and 01/19/25.</p> <p>The facility failed to ensure Resident #1's Sertraline (is used to treat depression) was available for administration on 01/12/25, 01/15/25, 01/17/25, 01/20/25, 01/22/25, 01/23/25, 01/28/25, and 01/30/25.</p> <p>The facility failed to ensure Resident #1's Minocycline (is an antibiotic that treats bacterial infections) was available for administration on 01/06/25, 01/07/25, 01/08/25, 01/14/25, and 01/30/25.</p> <p>The facility failed to ensure Resident #1's Topiramate (is a medication that treats epilepsy, and it can also prevent migraine headaches) was available for administration on 01/16/25.</p> <p>The facility failed to ensure Resident #15's Amiodarone (is a medication that prevents and treats an irregular heartbeat (arrhythmia)) was available for administration on 01/07/25, 01/11/25, 01/12/25, 01/15/25, and 01/21/25.</p> <p>The facility failed to ensure Resident #15's Aricept (is commonly used to treat mild, moderate, and severe dementia related to Alzheimer's disease) was available for administration on 01/07/25, 01/10/25, 01/11/25, 01/12/25, 01/15/25, 01/17/25, and 01/18/25.</p> <p>The facility failed to ensure Resident #15's Aspirin (can be effective at preventing heart attack or stroke) was available for administration on 01/06/25 and 01/07/25.</p> <p>The facility failed to ensure Resident #15's Calcitriol (is a medication that treats low calcium levels caused by kidney disease) was available for administration on 01/05/25, 01/06/25, 01/07/25, 01/10/25, 01/11/25, 01/15/25, 01/17/25, 01/18/25, and 01/21/25.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility failed to ensure Resident #15's Cozaar (is used alone or together with other medicines to treat high blood pressure (hypertension)) was available for administration on 01/06/25, 01/07/25, 01/10/25, 01/11/25, 01/12/25, 01/15/25, and 01/21/25.</p> <p>The facility failed to ensure Resident #15's Lokelma (is indicated for the treatment of hyperkalemia in adults) was available for administration on 01/08/25 and 01/12/25.</p> <p>The facility failed to ensure Resident #15's Carvedilol was available for administration on 01/06/25, 01/07/25, 01/11/25, 01/12/25, and 01/15/25.</p> <p>The facility failed to ensure Resident #15's Macrobid (is an antibiotic that fights bacteria in the body) was available for administration on 01/05/25, 01/06/25, and 01/07/25.</p> <p>The facility failed to ensure Resident #15's Miconazole (is an antifungal skin cream that treats fungal or yeast infections) was available for administration on 01/04/25, 01/05/25, 01/06/25, 01/07/25, 01/08/25, 01/14/25, 01/17/25, 01/18/25, and 01/20/25.</p> <p>These failures could place residents at risk for inaccurate drug administration.</p> <p>1. Record review of Resident #1's face sheet dated 01/10/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses including Asperger's syndrome (is a term sometimes used to describe a developmental disorder that's part of the autism spectrum disorder (ASD)), epilepsy (is a chronic brain disorder characterized by recurrent seizures, which are brief episodes of involuntary movements, loss of consciousness, or altered awareness), major depressive disorder (is a common mental health condition characterized by persistent low mood, loss of interest, and other symptoms that significantly interfere with daily life), anxiety disorder (are a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), and hyperlipidemia (is an excess of lipids or fats in your blood).</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 was understood and had the ability to understand others. Resident #1 had a BIMS score of 09 which indicated moderate cognitive impairment. Resident #1 received an antidepressant, antibiotic, opioid, antiplatelet, and anticonvulsant during the last 7 days of the assessment period.</p> <p>Record review of Resident #1's care plan dated 12/15/24 indicated:</p> <p>*Resident #1 was at risk for adverse consequences related to receiving psychotropic medication. Intervention included administer psychotropic medication as ordered.</p> <p>*Resident #1 had potential for complications, signs and symptoms related to diagnosis of hyperlipidemia. Intervention included document any side effects in my clinical record and notify the MD.</p> <p>*Resident #1 had a history of seizures and was at risk for injury related to weakness, balancing difficulties, cognitive limitations or altered consciousness, and loss of large or small muscle coordination. Resident #1 had a risk for ineffective airway clearance and at risk for the inability to clear secretions or obstructions for the respiratory tract to maintain a clear airway. Interventions included administer medications as prescribed.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's consolidated physician order dated 02/10/25 indicated:</p> <ul style="list-style-type: none"> *Atorvastatin Calcium 20mg, give 1 tablet by mouth at bedtime for supplement. Start 12/02/24. *Cannabidiol Oral Solution 100mg/1ml, give 4 ml by mouth in the afternoon for epilepsy. Start 12/03/24. *Cannabidiol Oral Solution 100mg/1ml, give 5ml by mouth two times a day for seizures. Start 12/02/24. *Lamotrigine 100mg, give 1 tablet by mouth two times a day. Start 12/02/24. *Lamotrigine 100mg, give 1.5 tablet by mouth one time a day. Start 12/03/24. *Minocycline 100mg, give 1 capsule by mouth two times a day. Start 12/02/24. *Sertraline Oral Tablet 100mg, give 1 tablet by mouth one time a day. Start 12/03/24. *Topiramate Oral Tablet 100mg, give 1 tablet by mouth two times a day. Start 12/03/24. *Topiramate Oral tablet 100mg, give 2 tablets by mouth one time a day. Start 12/02/24. <p>Record review of Resident #1's MAR dated 01/01/25-01/31/25 indicated:</p> <ul style="list-style-type: none"> *Atorvastatin Calcium 20mg, give 1 tablet by mouth at bedtime for supplement. Start 12/02/24. The MAR indicated code 9 other/see progress notes on 01/28/25. *Cannabidiol Oral Solution 100mg/1ml, give 4 ml by mouth in the afternoon for epilepsy. Start 12/03/24. The MAR indicated code 9 other/see progress notes on 01/10/25, 01/13/25, 01/14/25, 01/15/25, and 01/16/25. *Cannabidiol Oral Solution 100mg/1ml, give 5ml by mouth two times a day for seizures. Start 12/02/24. The MAR indicated code 9 other/see progress notes on 01/10/25 (8am), 01/13/25 (8pm), 01/14/25 (8am and 8pm), and 01/15/25 (8am and 8pm). *Lamotrigine 100mg, give 1 tablet by mouth two times a day. Start 12/02/24. The MAR indicated code 9 other/see progress notes on 01/16/25 (2pm), 01/17/25 (2pm and 8pm), 01/18/25 (2pm and 8pm), and 01/19/25 (2pm). *Lamotrigine 100mg, give 1.5 tablet by mouth one time a day. Start 12/03/24. The MAR indicated code 9 other/see progress notes on 01/15/25, 01/17/25, and 01/18/25. *Minocycline 100mg, give 1 capsule by mouth two times a day. Start 12/02/24. The MAR indicated code 9 other/see progress notes on 01/06/25 (8pm), 01/07/25 (8pm), 01/08/25 (8pm), 01/14/25 (8pm), and 1/30/25 (8am). <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Sertraline Oral Tablet 100mg, give 1 tablet by mouth one time a day. Start 12/03/24. The MAR indicated code 9 other/see progress notes on 01/12/25, 01/15/25, 01/17/25, 01/20/25, 01/22/25, 01/23/25, 01/28/25, and 01/30/25.</p> <p>*Topiramate Oral Tablet 100mg, give 1 tablet by mouth two times a day. Start 12/03/24. The MAR indicated code 9 other/see progress notes on 01/16/25 (2pm).</p> <p>Record review of Resident #1's progress note dated 01/11/25-02/11/25 indicated:</p> <p>*01/12/25 at 8:50 a.m., Sertraline 1 tablet on order.</p> <p>*01/13/25 at 2:02 p.m., Cannabidiol 4ml awaiting pharmacy.</p> <p>*01/13/25 at 7:04 p.m., Cannabidiol 5ml awaiting pharmacy delivery.</p> <p>*01/14/25 at 10:35 a.m., Cannabidiol 5ml none available.</p> <p>*01/14/25 at 2:12 p.m., Cannabidiol 4ml awaiting pharmacy.</p> <p>*01/14/25 at 7:34 p.m., Cannabidiol 5ml awaiting delivery.</p> <p>*01/14/25 at 7:35 p.m., Minocycline 1 capsule awaiting delivery.</p> <p>*01/15/24 at 8:53 a.m., Cannabidiol 5ml on order.</p> <p>*01/15/25 at 8:56 a.m., Sertraline 1 tablet on order.</p> <p>*01/15/24 at 8:56 a.m., Lamotrigine 1.5 tablet on order.</p> <p>*01/15/25 at 3:14 p.m., Cannabidiol 4ml on order, waiting for delivery from family.</p> <p>*01/15/25 at 7:06 p.m., Cannabidiol 5ml not available.</p> <p>*01/16/25 at 5:21 p.m., Resident had times two seizures, nasal spray administered and effective.</p> <p>*01/17/25 at 10:49 a.m., Lamotrigine 1.5 tablet not available.</p> <p>*01/17/25 at 10:50 a.m., Sertraline 1 tablet not available.</p> <p>*01/17/25 at 2:06 p.m., Lamotrigine 1 tablet none available-on order.</p> <p>*01/17/25 at 8:58 p.m., Lamotrigine 1 tablet medication unavailable.</p> <p>*01/18/25 at 12:48 p.m., Lamotrigine 1.5 tablet medication on order waiting on pharmacy.</p> <p>*01/18/25 at 1:26 p.m., Lamotrigine 1 tablet medication on order.</p> <p>*01/18/25 at 8:30 p.m., Lamotrigine 1 tablet awaiting delivery of medication.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*01/19/25 at 1:46 p.m., Lamotrigine 1 tablet awaiting pharmacy arrival.</p> <p>*01/20/25 at 8:27 p.m., Sertraline 1 tablet on order.</p> <p>*01/22/25 at 7:07 a.m., Sertraline 1 tablet awaiting pharmacy delivery.</p> <p>*01/23/25 at 7:07 a.m., Sertraline 1 tablet awaiting on pharmacy.</p> <p>*01/28/25 at 7:17 a.m., Sertraline 1 tablet.</p> <p>*01/28/25 at 7:36 p.m., Atorvastatin 1 tablet awaiting delivery from pharmacy.</p> <p>*01/30/25 at 9:12 a.m., Minocycline 1 capsule awaiting pharmacy delivery.</p> <p>*01/30/25 at 9:12 a.m., Sertraline 1 tablet awaiting pharmacy delivery.</p> <p>On 2/12/25 at 5:45 PM, called Resident #1's responsible party and unable to leave message because the mailbox was full. No return call was received before or after exit.</p> <p>2. Record review of Resident #15's face sheet dated 02/10/25 indicated Resident #15 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #15 had diagnoses including type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), neuromuscular dysfunction of bladder (a condition where the nerves controlling bladder function are damaged, leading to impaired bladder control due to disrupted communication between the brain and the bladder muscles, causing issues like incontinence, difficulty urinating, or incomplete bladder emptying), dementia (is a term used to describe a group of symptoms affecting memory, thinking and social abilities), urinary tract infection (is an infection of the urinary system, which includes the kidneys, bladder, ureters, and urethra), hypocalcemia (is a condition where the level of calcium in the blood is below normal), and hypertension (high blood pressure).</p> <p>Record review of Resident #15's admission MDS assessment dated [DATE] indicated Resident #15 was understood and had the ability to understand others. Resident #15 had a BIMS score of 13 which indicated intact cognition. Resident #15 had an indwelling catheter and occasional bowel incontinence. Resident #15 received an antibiotic, diuretic, and antiplatelet during the last 7 days of the assessment period.</p> <p>Record review of Resident #15's care plan dated 01/21/25 indicated:</p> <p>*Resident #15 had potential complications, injury related to antiplatelet medication and hypertension. Intervention included administer medications as ordered.</p> <p>*Resident #15 had potential for complications, signs/symptoms related to diagnosis of hypertension. Resident #15 received anti-hypertensive and was at risk for side effects. Intervention included administer anti-hypertensive medications as ordered.</p> <p>*Resident #15 had an indwelling catheter related to neurogenic bladder and was at risk for increased urinary tract infection. Intervention included monitor/record/report to MD for signs/symptoms of UTI.</p> <p>(continued on next page)</p>		

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 02/12/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Linden		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W Houston St Linden, TX 75563	

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Resident #15 had potential for complications, signs/symptoms related to diagnosis of hyperlipidemia. Intervention included document any side effects in my clinical record and notify the MD.</p> <p>Record review of Resident #15's consolidated physician order dated 02/10/25 indicated:</p> <p>*Amiodarone 200mg, give 1 tablet by mouth one time a day for abnormal heart rhythm. Start 01/05/25.</p> <p>*Aricept 10mg, give 1 tablet by mouth one time a day for dementia. Start 01/05/25.</p> <p>*Aspirin 81 mg, give 1 tablet by mouth one time a day for hypertension. Start 01/05/25.</p> <p>*Atorvastatin 20mg, give 1 tablet by mouth at bedtime for hyperlipidemia. Start 01/04/25.</p> <p>*Calcitriol 6.25mcg, give 1 capsule by mouth one time a day for hypocalcemia. Start 01/05/25.</p> <p>*Carvedilol 6.25mg, give 1 tablet by mouth two times a day for hypertension. Hold for SBP less than 100 or DBP less than 60 or HR less than 55. Start 01/04/25.</p> <p>*Cozaar 25mg, give 1 tablet by mouth one time a day for hypertension, Hold SBP less than 100 or DBP less than 60.</p> <p>*Miconazole-Zinc Oxide-Petrolate External Ointment 0.25-15-81.35%, apply to arms and feet topically every shift for moisture barrier. Start 01/04/25.</p> <p>Record review of Resident #15's MAR dated 01/01/25-01/31/25 indicated:</p> <p>*Amiodarone 200mg, give 1 tablet by mouth one time a day for abnormal heart rhythm. Start 01/05/25. The MAR indicated code 5 hold/see progress notes on 01/06/25. The MAR indicated code 9 other/see progress notes on 01/07/25, 01/11/25, 01/12/25, 01/15/25, and 01/21/25.</p> <p>*Aricept 10mg, give 1 tablet by mouth one time a day for dementia. Start 01/05/25. The MAR indicated code 5 hold/see progress notes on 01/06/25. The MAR indicated code 9 other/see progress notes on 01/07/25, 01/10/25, 01/11/25, 01/12/25, 01/15/25, 01/17/25, and 01/18/25.</p> <p>*Aspirin 81 mg, give 1 tablet by mouth one time a day for hypertension. Start 01/05/25. The MAR indicated code 5 hold/see progress notes on 01/06/25. The MAR indicated code 9 other/see progress notes on 01/07/25.</p> <p>*Atorvastatin 20mg, give 1 tablet by mouth at bedtime for hyperlipidemia. Start 01/04/25. The MAR indicated code 9 other/see progress notes on 01/05/25.</p> <p>*Calcitriol 6.25mcg, give 1 capsule by mouth one time a day for hypocalcemia. Start 01/05/25. The MAR indicated code 5 hold/see progress notes on 01/05/25 and 01/06/25. The MAR indicated code 9 other/see progress notes on 01/07/25, 01/10/25, 01/11/25, 01/15/25, 01/17/25, 01/18/25, 01/21/25.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Carvedilol 6.25mg, give 1 tablet by mouth two times a day for hypertension. Hold for SBP less than 100 or DBP less than 60 or HR less than 55. Start 01/04/25. The MAR indicated code 5 hold/see progress notes on 01/06/25. The MAR indicated code 9 other/see progress notes on 01/07/25, 01/11/25, and 01/15/25.</p> <p>*Cozaar 25mg, give 1 tablet by mouth one time a day for hypertension, Hold SBP less than 100 or DBP less than 60. The MAR indicated code 5 hold/see progress notes on 01/06/25. The MAR indicated code 9 other/see progress notes on 01/07/25, 01/10/25, 01/11/25, 01/12/25, 01/15/25, and 01/21/25.</p> <p>*Macrobid 100mg, give 1 capsule by mouth two times a day for UTI for 7 days. Start 01/06/25. The MAR indicated code 9 other/see progress notes on 01/06/25 (8pm) and 01/07/25 (8am and 8pm).</p> <p>*Macrobid 100mg, give 1 capsule by mouth two times a day for UTI. Start 01/04/25. Discontinued 01/06/25. The MAR indicated code 5 hold/see progress notes on 01/05/25 (9pm) and 01/06/25 (9pm). The MAR indicated code 9 other/see progress notes on 01/05/25 (9pm).</p> <p>*Miconazole-Zinc Oxide-Petrolate External Ointment 0.25-15-81.35%, apply to arms and feet topically every shift for moisture barrier. Start 01/04/25. The MAR indicated code 9 other/see progress notes on 01/04/25 (6p), 01/06/25 (6a), 01/07/25 (6a), 01/08/25 (6a), 01/14/25 (6a), and 01/18/25 (6a). No documentation of administration on 01/05/25 (6a), 01/17/25 (6a), and 01/20/25 (6a).</p> <p>*Lokelma 5GM, give 1 packet by mouth one time a day for hyperkalemia. Start 01/08/25. The MAR indicated code 9 other/see progress notes on 01/08/25 and 01/12/25.</p> <p>Record review of Resident #15's progress note date 01/11/25-02/11/25 indicated:</p> <p>*01/11/25 at 9:38 a.m. by LVN Y, Carvedilol 6.25mg, give 1 tablet by mouth two times a day for hypertension. Hold for SBP less than 100 or DBP less than 60 or HR less than 55. No documented indication of why code 9 was selected.</p> <p>*01/11/25 at 9:39 a.m. by LVN Y, Amiodarone 200mg, give 1 tablet by mouth one time a day for abnormal heart rhythm. No documented indication of why code 9 was selected.</p> <p>*01/11/25 at 9:39 a.m. by LVN Y, Aricept 10mg, give 1 tablet by mouth one time a day for dementia. No documented indication of why code 9 was selected.</p> <p>*01/11/25 at 9:39 a.m. by LVN Y, Calcitriol 6.25mcg, give 1 capsule by mouth one time a day for hypocalcemia. No documented indication of why code 9 was selected.</p> <p>*01/11/25 at 9:40 a.m. by LVN Y, Cozaar 25mg, give 1 tablet by mouth one time a day for hypertension, Hold SBP less than 100 or DBP less than 60. No documented indication of why code 9 was selected.</p> <p>*01/12/25 at 9:33 a.m. by LVN Y, Aricept 10mg, give 1 tablet by mouth one time a day for dementia. On order.</p> <p>*01/12/25 at 9:35 a.m. by LVN T, Lokelma 5GM, give 1 packet by mouth one time a day for hyperkalemia. On order.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*01/14/25 at 5:44 p.m. by RN Z, Miconazole-Zinc Oxide-Petrolate External Ointment 0.25-15-81.35%, apply to arms and feet topically every shift for moisture barrier. On order- not available.</p> <p>*01/15/25 at 10:01 a.m. by LVN Y, Aricept 10mg, give 1 tablet by mouth one time a day for dementia. On order, will call pharmacy.</p> <p>*01/15/25 at 10:02 a.m. by LVN Y, Calcitriol 6.25mcg, give 1 capsule by mouth one time a day for hypocalcemia. On order, will call pharmacy.</p> <p>*01/21/25 at 9:33 a.m. by LVN Y, Amiodarone 200mg, give 1 tablet by mouth one time a day for abnormal heart rhythm. Called pharmacy and medication cannot be filled until [DATE]th. Pharmacy will call insurance company for possible override due to resident never receiving medication while here.</p> <p>*01/21/25 at 9:35 a.m. by LVN Y, Calcitriol 6.25mcg, give 1 capsule by mouth one time a day for hypocalcemia. Called pharmacy and medication cannot be filled until [DATE]th. Pharmacy will call insurance company for possible override due to resident never receiving medication while here.</p> <p>*01/21/25 at 9:35 a.m. by LVN Y, Cozaar 25mg, give 1 tablet by mouth one time a day for hypertension, Hold SBP less than 100 or DBP less than 60. Called pharmacy and medication cannot be filled until [DATE]th. Pharmacy will call insurance company for possible override due to resident never receiving medication while here.</p> <p>During an interview on 02/12/25 at 1:57 p.m., LVN D said new admission medication orders were done through the facility's electronic chart system. She said if new admission orders were done before 7pm, the medications were normally filled the same day. She said the cutoff time for same day delivery was 2 pm on the weekends. She said refills needed to be ordered when the only pills left, on the blister packet, were in the blue section. She said refills normally took about a day to be delivered. She said Resident #1's family was providing Resident #1's Cannabidiol prescription. She said Resident #1's prescription was through a neurologist not in town and a local chain pharmacy filled it. She said Resident #1's family was filling and picking up the Cannabidiol. She said she finally calculated the amount Resident #1 needed for the week. She said she tried to notify Resident #1's family in enough time so Resident #1 did not run out of the Cannabidiol. She said the facility had a backup Pyxis machine that had medications in it. She said most of the resident's prescribed medications were in the backup Pyxis machine. She said the pharmacy could also be contacted to refill the backup Pyxis, so the residents did not miss a dose. She said code 9 on the resident's MAR/TAR typically meant see the progress note for why the medication was not given or held. She said the nurses were responsible for ensuring the residents did not miss doses of medications. She said if a resident did not receive their anticonvulsant medication, they could have seizures. She said if a resident did not receive their antidepressant medication for an extended period, they could experience depression and anxiety. She said Resident #11 and Resident #15 had a lot of missed medication doses. She said Resident #15 used a different pharmacy. She said Resident #15's medications could not be filled electronically. She said Resident #15's prescriptions had to be faxed or called in to the pharmacy. She said it was recently discovered Resident #15's pharmacy turned the fax machine off at night. She said a lot of staff probably thought the resident's orders were going through but they were not. She said she did not know if all the staff knew about Resident #15's pharmacy company turning off the fax machine at night. She said it depended on why the resident was prescribed the medication, how the missed doses would affect them.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 02/12/25 at 5:49 p.m., the ADCO said the floor nurses were responsible for ordering the residents medications. She said the medications should be ordered 7 to 8 days before the medication was going to run out. She said some resident's medications could be ordered through the facility's charting system. She said other residents, the physician order, or refill paperwork had to be faxed or called in. She said the facility should be notifying Resident #1's family in enough time so she did not run out. She said the family needed to be notified before, a quarter or half of the bottle was empty. She said Resident #1's Cannabidiol bottle normally came with 98 ml in it. She said Resident #1's family needed to be called when there was about 35-40 ml was left. She said the emergency Pyxis could be utilized so the resident did not miss doses. She said she had found several of Resident #1 and Resident #15's medications in the medication room when staff had been documenting it was unavailable. She said LVN Y no longer worked at the facility. She said she was not aware the other pharmacy company Resident #15 used, turned off the fax machine a night. She said it depended on the type of medication, for how it would affect the resident. She said a resident seizure medication was important. She said the DCO and ADCO should ensure the resident's medication were ordered timely by the nursing staff.</p> <p>During an interview on 02/12/25 at 6:57 p.m., the DCO P, from a sister facility, said the nurses were responsible for ordering resident's medications. She said the resident's medications should be ordered at least a week before they ran out. She said the medications were ordered in the facility's chart system. She said it was important for the resident's medication to be given because it was a doctor's order. She said the doctor prescribed the medication for a reason to manage a diagnosis. She said missed doses caused the illness to not be managed. She said the DCO and ADCO should be overseeing this process.</p> <p>During an interview on 02/12/25 at 7:34 p.m., the EDO said she expected the nurses to order the resident's medication timely. She said the resident's medication should be ordered through the facility's chart system. She said it was an electronically process. She said the resident's medication needed to be ordered as need or within 7 days of the medications running out. She said it depended on what diagnosis the medication was treating, how the missed does affected them. She said the nursing management should be monitoring this process.</p> <p>Record review of a facility's Ordering and Receiving Non-Controlled Medications dated 06/2024 indicated . medications and related products are received from the pharmacy on a timely basis .ordering medications from the pharmacy . Medications orders are written on a physician order form, telephone order sheet, or reorder form provided by the pharmacy, written in the chart by the physician, or entered into the facility's EHR system and transmitted to the pharmacy . Repeat medications (refills) are written on a medication reorder form or by peeling the reorder tab from the prescription label and placing it in the appropriate area on the medication reorder form provided by the pharmacy for that purpose, or requested via the facility's EHR system .</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on interviews and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (is a medication used: in excessive doses (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued) for 2 of 5 residents (Resident #1 and Resident #11) reviewed for unnecessary medications.</p> <p>The facility failed to ensure Resident #1, and Resident #11 had monitoring for being on an antiplatelet.</p> <p>The facility failed to ensure Resident #1 had side effect monitoring for her anticonvulsant use.</p> <p>The facility failed to ensure Resident #1 had documented diagnoses entered for use of Lamotrigine (is a medication used to treat epilepsy and stabilize mood in bipolar disorder), Levothyroxine (is used to treat hypothyroidism), Minocycline (is an antibiotic that treats bacterial infections, Ondansetron (is used to prevent nausea and vomiting), Sertraline (is used to treat depression), and Topiramate (is a medication that treats epilepsy and it can also prevent migraine headaches).</p> <p>The facility failed to ensure Resident #11 had correct diagnoses on entered orders for Aricept (is commonly used to treat mild, moderate, and severe dementia related to Alzheimer's disease) and Aspirin (can be effective at preventing heart attack or stroke).</p> <p>These failures could place residents at risk for adverse drug reactions (unintended, harmful events attributed to the use of medicines) and receiving unnecessary medications.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's face sheet dated 01/10/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses including Asperger's syndrome (is a term sometimes used to describe a developmental disorder that's part of the autism spectrum disorder (ASD)), epilepsy (is a chronic brain disorder characterized by recurrent seizures, which are brief episodes of involuntary movements, loss of consciousness, or altered awareness), major depressive disorder (is a common mental health condition characterized by persistent low mood, loss of interest, and other symptoms that significantly interfere with daily life), anxiety disorder (are a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), and hypothyroidism (is a condition that happens when your thyroid gland doesn't make or release enough hormone into your bloodstream).</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 was understood and had the ability to understand others. Resident #1 had a BIMS score of 09 which indicated moderate cognitive impairment. Resident #1 received an antidepressant, antibiotic, opioid, antiplatelet, and anticonvulsant during the last 7 days of the assessment period.</p> <p>Record review of Resident #1's care plan dated 12/15/24 indicated:</p> <p>(continued on next page)</p>		

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 02/12/2025
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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Resident #1 was at risk for adverse consequences related to receiving psychotropic medication. Intervention included administer psychotropic medication as ordered.</p> <p>*Resident #1 had a history of seizures and was at risk for injury related to weakness, balancing difficulties, cognitive limitations or altered consciousness, loss of large or small muscle coordination. Resident #1 had a risk for ineffective airway clearance and at risk for the inability to clear secretions or obstructions for the respiratory tract to maintain a clear airway. Interventions included administer medications as prescribed.</p> <p>*Resident #1 had a potential for complications, signs/symptoms related to diagnosis of hypothyroidism. Intervention included administer medication as ordered.</p> <p>Record review of Resident #1's consolidated physician order dated 02/10/25 indicated:</p> <p>*Lamotrigine 100mg, give 1 tablet by mouth two times a day. Start 12/02/24.</p> <p>*Lamotrigine 100mg, give 1.5 tablet by mouth one time a day. Start 12/03/24.</p> <p>*Minocycline 100mg, give 1 capsule by mouth two times a day. Start 12/02/24.</p> <p>*Sertraline Oral Tablet 100mg, give 1 tablet by mouth one time a day. Start 12/03/24.</p> <p>*Topiramate Oral Tablet 100mg, give 1 tablet by mouth two times a day. Start 12/03/24.</p> <p>*Topiramate Oral tablet 100mg, give 2 tablets by mouth one time a day. Start 12/02/24.</p> <p>*Levothyroxine 150 mcg, give 1 tablet by mouth in the morning. Start 12/03/24.</p> <p>*Ondansetron 8mg, give 1 tablet by mouth two times a day. Start 12/02/24.</p> <p>Resident #1 consolidated physician order did not reflect diagnoses for the prescribed medications. The consolidated physician order did not reflect monitoring for use of an antiplatelet. The consolidated physician order did not reflect side effect monitoring for anticonvulsant use.</p> <p>Record review of Resident #1's MAR dated 02/01/25-02/28/25 indicated:</p> <p>*Lamotrigine 100mg, give 1.5 tablet by mouth one time a day. Start 12/03/24. Resident #1 received 10 of 10 doses.</p> <p>*Levothyroxine 150 mcg, give 1 tablet by mouth in the morning. Start 12/03/24. Resident #1 received 10 of 10 doses.</p> <p>*Sertraline Oral Tablet 100mg, give 1 tablet by mouth one time a day. Start 12/03/24. Resident #1 received 10 of 10 doses.</p> <p>*Topiramate Oral Tablet 100mg, give 1 tablet by mouth two times a day. Start 12/03/24. Resident #1 received 10 of 10 doses.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Lamotrigine 100mg, give 1 tablet by mouth two times a day. Start 12/02/24. Resident #1 received 19 of 19 doses.</p> <p>*Minocycline 100mg, give 1 capsule by mouth two times a day. Start 12/02/24. Resident #1 received 19 of 19 doses.</p> <p>*Ondansetron 8mg, give 1 tablet by mouth two times a day. Start 12/02/24. Resident #1 received 19 of 19 doses.</p> <p>*Topiramate Oral Tablet 100mg, give 1 tablet by mouth two times a day. Start 12/03/24. Resident #1 received 19 of 19 doses.</p> <p>Resident #1 MAR did not reflect diagnoses for the prescribed medications. The MAR did not reflect monitoring for use of an antiplatelet. The MAR did not reflect side effect monitoring for anticonvulsant use.</p> <p>2. Record review of Resident #11's face sheet dated 02/11/25 indicated Resident #11 was an [AGE] year-old, female admitted to the facility on [DATE]. Resident #11 had diagnoses including cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced), type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), and muscle weakness. The face sheet did not reflect diagnoses of dementia or Alzheimer's.</p> <p>Record review of Resident #11's quarterly MDS assessment dated [DATE] indicated Resident #11 was understood and had the ability to understand others. Resident #11 had a BIMS score of 06 which indicated severe cognitive impairment. Resident #11 had received an antiplatelet during the last 7 days of the assessment period.</p> <p>Record review of Resident #11's care plan dated 08/28/23 indicated Resident #1 had impaired cognitive function or impaired thought process related to recent CVA, impaired decision-making abilities, was not always understood or able to understand verbal and non-verbal expression. Intervention included administer medication as ordered.</p> <p>Record review of Resident #11's care plan dated 12/13/24 did not reflect use of an antiplatelet.</p> <p>Record review of Resident #11's consolidated physician order dated active as of 02/11/25 indicated:</p> <p>*Aspirin 81 mg, give 1 tablet by mouth one time a day for antiplatelet. Start 04/03/24.</p> <p>*Aricept 10mg, give 1 tablet by mouth at bedtime for cognitive awareness. Start 02/03/24.</p> <p>Resident #11's consolidated physician orders did not reflect monitoring for use of an anticoagulant.</p> <p>Record review of Resident #11's MAR dated 02/01/25-02/28/25 indicated:</p> <p>*Aspirin 81 mg, give 1 tablet by mouth one time a day for antiplatelet. Start 04/03/24. Resident #11 received 11 of 11 doses.</p> <p>(continued on next page)</p>		

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 02/12/2025
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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Aricept 10mg, give 1 tablet by mouth at bedtime for cognitive awareness. Start 02/03/24. Resident #11 received 10 of 10 doses.</p> <p>Resident #11's MAR did not reflect monitoring for use of an anticoagulant.</p> <p>During an interview on 02/12/25 at 1:57 p.m., LVN D said Aspirin 81 mg was considered an antiplatelet if ordered for a heart condition. She said if a resident was on an antiplatelet, bruise monitoring needed to be ordered. She said the LVNs were responsible for ordering bruise monitoring for the resident on an antiplatelet or anticoagulants. She said the monitoring should pop up in the facility's charting system when an antiplatelet was ordered. She said it was important to assess and monitor the resident on an antiplatelet for abnormal bruising. She said the residents on an anticonvulsant should have side effect monitoring. She said side effect monitoring was important, so the nursing staff knew what side effect to look for. She said the LVNs were responsible for ensuring the physician orders had an appropriate diagnosis. She said it helped the staff know why the medications were being used and what it was treating. She said Aricept was normally ordered for a resident with a dementia diagnosis. She said she would call and clarify with Resident #11's MD about Aricept being used for cognitive awareness. She said an antiplatelet was a drug classification and should not be used as a diagnosis for Aspirin 81mg use. She said Resident #11's Aspirin ordered also needed to be clarified with the MD. She said she felt like the LVNs were overall responsible for ensuring the resident had appropriate diagnoses for their medications.</p> <p>During an interview on 02/12/25 at 5:49 p.m., the ADCO said when the LVNs entered the physician orders, they should be ensuring an appropriate diagnosis or indication for use was added to the order. She said the nurse should be ordering bruise monitoring for the resident on an antiplatelet. She said it was important to monitor the resident on an antiplatelet for bleeding and abnormal bruising. She said the nurses should order side effect monitoring on an anticonvulsant. She said she did not know if cognitive awareness was an appropriate diagnosis for the use of Aricept. She said Aricept was prescribed for residents with dementia. She said Aspirin 81mg was an antiplatelet but the diagnosis or indication for use should not be antiplatelet. She said the ADCO should be monitoring the LVN to ensure they were ordering monitoring and orders had appropriate diagnoses.</p> <p>During an interview on 02/12/25 at 7:34 p.m., the EDO said, the LVNs were responsible for inputting correct diagnoses with the resident ordered medications. She said the LVNs should also be ordering side effect and bruise monitoring. She said the IDT should be monitoring the LVNs to ensure this process was being followed. She said the monitoring should be done by chart audits and during clinical stand-up meeting.</p> <p>Record review of a facility's General Guidelines for Medication Administration revised 08/2020 indicated . Medications are administered as prescribed in accordance with good nursing principles and practices . Monitoring of side effects or medication-related problems occurs continually .</p> <p>Record review of a facility's Ordering and Receiving Non-Controlled Medications dated 06/2024 indicated . Medications orders are written on a physician order form, telephone order sheet, or reorder form provided by the pharmacy, written in the chart by the physician, or entered into the facility's EHR system and transmitted to the pharmacy. The written entry includes . Indication for use .</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on interviews and record review, the facility failed to ensure each residents' drug regimen was free from unnecessary psychotropic drugs (without adequate behavior monitoring) for 2 of 5 residents (Resident #1, Resident #11) reviewed for unnecessary medications.</p> <p>The facility failed to ensure Resident #1 had behavior (monitor activities and mood) and side effect (are defined as unintended responses to approved pharmaceuticals (is any kind of drug used for medicinal purposes) given in appropriate dosages) monitoring for her prescribed Sertraline (antidepressant; is used to treat depression).</p> <p>The facility failed to ensure Resident #11 had behavior monitoring for her prescribed Buspirone (antianxiety; is used to treat anxiety disorders or in the short-term treatment of symptoms of anxiety) and Venlafaxine (antidepressant; is used to treat major depressive disorder, anxiety, and panic disorder).</p> <p>These failures could place residents at risk of not receiving the intended therapeutic benefits of their psychotropic medications.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's face sheet dated 01/10/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses including Asperger's syndrome (is a term sometimes used to describe a developmental disorder that's part of the autism spectrum disorder (ASD)), epilepsy (is a chronic brain disorder characterized by recurrent seizures, which are brief episodes of involuntary movements, loss of consciousness, or altered awareness), major depressive disorder (is a common mental health condition characterized by persistent low mood, loss of interest, and other symptoms that significantly interfere with daily life), and anxiety disorder (are a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life).</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 was understood and had the ability to understand others. Resident #1 had a BIMS score of 09 which indicated moderate cognitive impairment. Resident #1 received an antidepressant during the last 7 days of the assessment period.</p> <p>Record review of Resident #1's care plan dated 12/15/24 indicated Resident #1 was at risk for adverse consequences related to receiving psychotropic medication. Intervention included administer psychotropic medication as ordered.</p> <p>Record review of Resident #1's consolidated physician order dated 02/10/25 indicated Sertraline Oral Tablet 100mg, give 1 tablet by mouth one time a day. Start 12/03/24. Resident #1's consolidated physician order did not reflect behavior and side effect monitoring for her AD.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's MAR dated 02/01/25-02/28/25 indicated Sertraline Oral Tablet 100mg, give 1 tablet by mouth one time a day. Start 12/03/24. Resident #1 received 10 of 10 doses. Resident #1's MAR did not reflect behavior and side effect monitoring for her AD.</p> <p>2. Record review of Resident #11's face sheet dated 02/11/25 indicated Resident #11 was an [AGE] year-old, female admitted to the facility on [DATE]. Resident #11 had diagnoses including cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced), type 2 diabetes (is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), depression (is a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities once enjoyed), and anxiety disorder (a group of mental health conditions characterized by excessive worry, fear, and nervousness that can interfere with daily life).</p> <p>Record review of Resident #11's quarterly MDS assessment dated [DATE] indicated Resident #11 was understood and had the ability to understand others. Resident #11 had a BIMS score of 06 which indicated severe cognitive impairment. Resident #11 had received an antianxiety and antidepressant during the last 7 days of the assessment period.</p> <p>Record review of Resident #11's care plan dated 12/13/24 indicated Resident #11 was at risk for adverse consequences related to receiving psychotropic medication. Resident #11 was currently taking psychotropic medication for diagnoses of anxiety and depression. Interventions included monitor resident for SE of antianxiety medication including but not limited to hypotension, sedation, and increase anxiety and monitor resident for SE of antidepressant including but not limited to increased confusion, changes in appetite/weight, and change in sleep pattern.</p> <p>Record review of Resident #11's consolidated physician order dated 02/01/25 indicated:</p> <p>*Buspirone 5mg, give 1 tablet by mouth three times a day for anxiety. Start 12/18/24.</p> <p>*Venlafaxine 75mg, give 1 tablet by mouth two times a day for depression. Start 09/16/24.</p> <p>Resident #11's consolidated physician order did not reflect an order for behavior monitoring for her AA and AD.</p> <p>Record review of Resident #11's MAR dated 02/01/25-02/28/25 indicated:</p> <p>*Buspirone 5mg, give 1 tablet by mouth three times a day for anxiety. Start 12/18/24. Resident #11 received 32 out of 32 doses.</p> <p>*Venlafaxine 75mg, give 1 tablet by mouth two times a day for depression. Start 09/16/24. Resident #11 received 21 out of 21 doses.</p> <p>Resident #11's MAR did not reflect an order for behavior monitoring for her AA and AD.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/12/25 at 1:57 p.m., LVN D said the LVNs were responsible for behavior and side effect monitoring. She said the behavior and side effect monitoring was documented on the resident's MAR/TAR on each shift. She said if a resident was on a psychotropic medication, then the resident's behaviors and any side effects needed to be documented. She said if the resident behaviors were not documented then they could not get treatment for the behaviors. She said if the medication side effects were not assessed and documented, then the resident could have side effects no one addressed.</p> <p>During an interview on 02/12/25 at 5:49 p.m., the ADCO said all psychotropic medications required behavior and side effect monitoring. She said the nurses should add the BM and SE monitoring when they ordered the psychotropic medication. She said the behavior monitoring ensured the prescribed medication was effective and justified the use of the medication. She said side effect monitoring helped the staff know what side effects to look for. She said BM and SE monitoring was information used to determine if the medication was necessary, able to be weaned, and safe for continued use. She said the DCO and ADCO should perform chart audit to ensure this process was occurring. She said the IDT was also involved in this process.</p> <p>During an interview on 02/12/25 at 7:34 p.m., the EDO said the nurses were responsible for BM and SE monitoring. She said the nurses should order the monitoring and document every shift. She said the DCO and ADCO should ensure the LVN's were doing it. She said BM and SE monitoring were important to ensure the residents did not experience ill effects and the desired outcome was achieved. She said this process should be monitored through chart audits by the DCO and ADCO.</p> <p>Record review of the facility's Psychotropic Medication Review policy dated 04/2020 indicated .IDT will emphasize the importance of seeking an appropriate dose and duration of each psychotropic medication, with careful assessment as to whether the medication is necessary and pharmacologically appropriate . Reviews of the use of the medications with IDT on monthly basis, during Standard of Care Meeting to determine the continued presence of target behaviors and or the presence of any adverse effects of the medications . Monitor GDR for success or failure, related to targeted behaviors . Monitors psychotropic drug use noting any adverse effects .</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44933</p> <p>Based on interviews, and record review, the facility failed to ensure that residents were free of significant medication errors for 2 of 13 residents (Residents #1 and Resident #93) reviewed for medication administration.</p> <p>The facility failed to ensure Resident #1's Protonix (is used to treat certain conditions in which there is too much acid in the stomach) was scheduled before meals for optimal desired results.</p> <p>The facility failed to ensure Resident #93's prescribed Midodrine (is used to treat low blood pressure (hypotension)) was not administered when her blood pressure was outside of the ordered parameters 2/6/25, 2/7/25, 2/8/25, 2/9/25, 2/10/25, and 2/11/25.</p> <p>The facility failed to ensure Resident #93 was administered Midodrine with meals per the physician's order.</p> <p>These failures could place residents at risk of medical complications and not receiving the therapeutic effects of their medications.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's face sheet dated 01/10/25 indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses including Asperger's syndrome (is a term sometimes used to describe a developmental disorder that's part of the autism spectrum disorder (ASD)), muscle weakness, and constipation.</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] indicated Resident #1 was understood and had the ability to understand others. Resident #1 had a BIMS score of 09 which indicated moderate cognitive impairment.</p> <p>Record review of Resident #1's care plan dated 12/15/24 indicated Resident #1 had potential for complications, discomfort, related to GERD (is a common condition in which the stomach contents move up into the esophagus). Intervention included administer medications per MD orders and monitor for effectiveness.</p> <p>Record review of Resident #1's consolidated physician order dated 2/10/25 indicated Protonix Tablet Delayed Release 40 MG, 1 tablet by mouth one time a day for GERD. Start 01/24/25.</p> <p>Record review of Resident#1's MAR dated 01/01/25-01/31/25 indicated Protonix Tablet Delayed Release 40 MG, 1 tablet by mouth one time a day for GERD. Start 01/24/25. Resident #1 had 7 doses scheduled for 8am (1/24/25-1/30/25) and 1 dose scheduled for 9am (1/31/25).</p> <p>Record review of Resident #1's MAR dated 02/01/25-02/28/25 indicated Protonix Tablet Delayed Release 40 MG, 1 tablet by mouth one time a day for GERD. Start 01/24/25. Resident #1 had 10 of 10 doses scheduled for 9am (2/1/25-2/10/25).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 02/10/25 at 10:51 a.m., Resident #1 was lying in her bed watching television. Resident #1 did not respond to greetings.</p> <p>During an observation on 02/11/25 at 10:06 a.m., Resident #1 was sitting up in her bed. Resident #1 still did not respond to greetings.</p> <p>On 2/12/25 at 5:45 PM, called Resident #1's responsible party and unable to leave message because the mailbox was full. No return call was received before or after exit.</p> <p>2. Record review of Resident #93's face sheet dated 02/11/25 indicated Resident #93 was a [AGE] year-old female admitted to the facility on [DATE]. Resident #93 had diagnoses including acute kidney failure (when the kidneys suddenly can't filter waste products from the blood) and hypotension (low blood pressure).</p> <p>Record review of the MDS indicated Resident #93 was admitted to the facility less than 21 days ago. No MDS for Resident #93 was completed prior to exit.</p> <p>Record review of Resident #93's care plan dated 02/10/25 indicated Resident #93 had hypotension. Intervention included check blood pressure as ordered by the MD.</p> <p>Record review of Resident #93's consolidated physician order dated 02/11/25 indicated Midodrine Tablet 10MG, give 1 tablet by mouth three times a day for treat hypotension. Hold for SBP (is the pressure in your arteries when your heart beats and pumps blood throughout your body) greater than 110 or DBP (is the pressure in the arteries when the heart rests between beats) greater than 80 and give with meals. Start 2/5/25.</p> <p>Record review of Resident #93 MAR dated 2/1/25 and 2/28/25 indicated Midodrine Tablet 10MG, give 1 tablet by mouth three times a day to treat hypotension. Hold for SBP greater than 110 or DBP greater than 80 and give with meals. Start 2/5/25. Administration documented on 2/6/25 at 7am: 138/72 (ADCO), 2/7/25 at 7am: 130/65 (LVN A), 2/7/25 at 7pm: 116/72 (LVN E), 2/8/25 at 7am: 119/49(RN C), 2/8/25 at 1pm: 122/54 (RN C), 2/8/25 at 7pm: 119/67 (LVN E), 2/9/25 at 7pm: 120/70 (LVN E), 2/10/25 at 7am: 128/72(ADCO), 2/10/25 at 1pm: 132/78 (ADCO), and 2/11/25 at 7am: 152/86.</p> <p>During an interview on 2/12/25 at 1:57 p.m., LVN D said Protonix should be scheduled to be given on an empty stomach, in the morning. She said the medications worked better on an empty stomach and before meals. She said Resident #1's Protonix should be scheduled at 6am. She said 9am was not a good time to administer Protonix. She said Resident #93's Midodrine was ordered to raise her blood pressure for hypotension. She said if Resident #93 was administered Midodrine and her blood pressure was greater than the ordered parameters, it placed her at risk for hypertension or stroke. She said the nurse should look at the physician order and follow the hold parameters and administration instructions before giving a medication.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 5:49 p.m., the ADCO said Protonix should be given before breakfast or at least 30 minutes before a meal. She said Resident #1's Protonix should be scheduled for 6am. She said it should not be schedule for 9am. She said for the medication to work and prevent GERD it needed to administer before breakfast. She said Resident #93's Midodrine administration instruction said for it to be given with meals. She said Resident #93's current Midodrine schedule did not follow those instructions. She said she did not know why the doctor wanted it given with meals, but the facility should follow the orders. She said she already knew about the medication errors for Resident #93's Midodrine. She said she was embarrassed about not following Resident #93's Midodrine hold parameters. She said the medication administration order and parameters were supposed to be read before administration. She said she should have read the physician order more carefully. She said most blood pressure parameters are hold for less than the SBP or DBP not greater than. She said giving Resident #93 the Midodrine when her blood pressure was not low placed her at risk for a stroke.</p> <p>During an interview on 2/12/25 at 6:57 p.m., the DCO P, from a sister facility, said Protonix should be given on an empty stomach, before breakfast. She said the medication was not effective or therapeutic when it was taken with food. She said she expected the nursing staff to read the physician's order and follow the hold parameters. She said Midodrine was for hypotension. She said if the resident was not experiencing hypotension and was still given the medication, it was not good. She said Resident #93 could have experienced hypertension. She said the ADCO, DCO Q, and pharmacy consult should be ensuring medications were timed correctly, and physician orders and hold parameters were followed. She said monitoring should be done with chart audits.</p> <p>During an interview on 2/12/25 at 7:34 p.m., the EDO said she expected physician's orders to be followed by the nursing staff. She said the nursing management should be monitoring this process.</p> <p>Record review of a facility's General Guidelines for Medication Administration policy dated 08/2020 indicated . Medications are administered as prescribed in accordance with good nursing principles and practices . Medications are administered in accordance with written orders of the prescriber . Medications are administered within 60 minutes of the scheduled administration time, except before, with, or after meal orders, which are administered based on mealtimes .</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</p> <p>Based on observations, interviews, and record review the facility failed to ensure each resident receives and the facility provides food that accommodates residents' food preferences for 1 of 18 residents (Resident #17) reviewed for food preferences and the accommodation of resident's meal choices.</p> <p>The facility failed to honor Resident #17's request for an alternate meal choice for lunch service on 2/12/25 without state surveyor intervention.</p> <p>This failure could result in a decrease in resident choices, diminished interest in meals, and weight loss.</p> <p>Findings included:</p> <p>Record review of Resident #17's face sheet dated 2/12/25 revealed she was [AGE] years old and admitted to the facility initially on 3/02/17 and readmitted [DATE]. Resident #17 had diagnoses including bipolar disorder, major depressive disorder, and anxiety disorder.</p> <p>Record review of Resident #17's quarterly MDS assessment dated [DATE] indicated she had a BIMS score of 15, which indicated she was cognitively intact. The MDS indicated Resident #17 had active diagnoses of anxiety disorder, depression, and bipolar disorder.</p> <p>Record review of Resident #17's undated Care Plan Report indicated she had requested to not have an evening meal brought to her room unless requested, the resident would also like to be asked if she wished to have anything else and had interventions which included to monitor if the resident wanted other foods or evening meal back and to remind the resident she could request foods as she wished, revised on 11/27/20; resident was on a regular diet, she filled out her menus and would request items off the cycle, staff would try and meet her needs, as much as possible and had interventions which included the Dietary Manager to monitor/discuss food preferences, serve diet as ordered and offer substitutes if less than 50% was eaten, revised on 8/31/23; she was at risk for malnutritional issues due to regular diet, food choices, malabsorption disease process, metabolic needs higher than intake, psychological factors hinder eating with interventions including to encourage resident to take small frequent meals, revised on 7/24/24.</p> <p>Record review of Resident #17's Selective Menu dated 2/12/25 reflected she had circled winter mix vegetables, chocolate eclair, and iced tea for the noon meal.</p> <p>During an observation and interview on 2/12/25 at 12:29 PM, Resident #17 had just been served lunch. Resident #17 said she was served spaghetti and she did not like spaghetti. Resident #17 said she had forgotten to circle the deli sandwich on her menu for lunch and said she had told a staff member to let dietary know she wanted the sandwich. Resident #17 did not remember what staff member she had asked to let dietary know she wanted a sandwich.</p> <p>(continued on next page)</p>		

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 02/12/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Linden		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W Houston St Linden, TX 75563	
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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 12:35 PM, RCP M said Resident #17 had not asked her about letting dietary know she wanted a deli sandwich because she did not like spaghetti, but she would go let dietary know.</p> <p>During an interview on 2/12/25 at 12:40 PM, RCP M informed the state surveyor in the hallway that she had talked to the Dietary Manager and the Dietary Manager said Resident #17 had only circled the vegetables on the list. RCP M asked the state surveyor to accompany her to talk to talk to the Dietary Manager.</p> <p>During an interview on 2/12/25 at 12:43 PM, the Dietary Manager said Resident #17 did her this way all the time and Resident #17 could have anything she circled on the menu list and Resident #17 had only circled vegetables and a dessert. The Dietary Manager said she did not ask Resident #17 if she had not circled a main meal item by accident and did she have a preference of a main meal item. The Dietary Manager said she did look to see what Resident #17 ate last week and she had spaghetti, so she gave her spaghetti so she would have more than vegetables and dessert for lunch. The Dietary Manager said residents could have something else on the menu if they did not like what they had chosen if the dietary staff had time and the food was available. The Dietary Manager said she would get Resident #17 a sandwich, but it might take a little bit .</p> <p>During an interview on 2/12/25 at 1:13 PM, RCP M informed the state surveyor in the hallway that she was glad the state surveyor went with her to talk to the Dietary Manager because if the state surveyor had not gone with her, the Dietary Manager would not have given Resident #17 a sandwich. RCP M said the residents usually were only allowed to get what was marked on their menus. RCP M said the Dietary Manager acted like it was her money she was spending to feed the residents. RCP M said the residents paid to live at the facility and it was their right to choose what they wanted to eat .</p> <p>During an interview on 2/12/25 at 1:10 PM, Resident #17 said staff had brought her a sandwich and it was so good that she ate all of it. Resident #17 was asked if she had asked for something different to eat before and told she could not have it. Resident #17 said one morning she was in the dining room before they started serving breakfast and thought to herself that oatmeal sure sounded good. Resident #17 said she knew she had not marked it on her menu, but she said she asked the cook if she could get some oatmeal before they started serving and the cook told her yes. Resident #17 said she was headed back to her table and the Dietary Manager came over to her and had her menu in hand and said this was what you ordered, and the Dietary Manager told her she could not have oatmeal. Resident #17 said they did bring her some oatmeal later. Resident #17 said she did not remember what date it was on, but it had been in the last week or two. Resident #17 said the Dietary Manager did not like her.</p> <p>During an interview on 2/12/25 at 1:33 PM, the ADCO said the residents had the right to choose to eat something else, regardless of what they marked on their menus. The ADCO said if residents were not served what they wanted to eat, the resident could have decreased intake of food, which could lead to weight loss, malnutrition, or even depression. The ADCO said she knew if she did not get what she wanted to eat, she would be depressed, and if the Dietary Manager was argumentative or rude, it would make residents not want to ask for anything different.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 2:18 PM, DCO P said she was covering the facility while DCO Q was out sick. DCO P said the resident had the right to choose or change their mind on what they wanted to eat. DCO P said if residents were not allowed to choose what they wanted to eat, it could cause a weight loss issue for one thing, and it affected the resident's rights to choose preferences of food.</p> <p>During an interview on 2/12/25 at 5:46 PM, the EDO said the Dietary Manager cooked the meals from the menu based off the residents' menu choices circled on the forms. The EDO said she would have expected Resident #17 to have been served a sandwich after everyone had been served based on what had been circled on the menus, then be served from the always available menu of her preference.</p> <p>Record review of the facility's policy titled Resident Food Preferences revised July 2017 indicated . Individual food preferences would be assessed upon admission and communicated to the interdisciplinary team . when possible, staff would interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes . if the resident refuses or was unhappy with his or her diet, the staff would create a care plan that the resident was satisfied with . the Food Services Department would offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062</p> <p>Based on observations, interviews, 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 1 of 18 residents (Residents #10) reviewed for infection control practices.</p> <ol style="list-style-type: none"> The facility failed to ensure RCP O performed hand hygiene and changed gloves appropriately while providing incontinent care/indwelling urinary catheter care to Resident #10. The facility failed to ensure RCP O did not place a plastic bag onto Resident #10's low air loss mattress (that required no bed sheets) twice that fallen onto the floor twice while RCP O performed incontinent/urinary catheter care. <p>These failures could place residents at risk for cross contamination and the spread of infection.</p> <p>Findings included:</p> <p>Record review of Resident #10's face sheet dated 2/11/25 indicated she was [AGE] years old and was admitted to the facility initially on 3/30/17 and readmitted on [DATE]. Resident #10 had diagnoses which included history of infection of amputation of right lower extremity, cognitive communication deficit, depression (persistent sadness), candidiasis of skin and nail (yeast infection of skin), lack of coordination, hypertension (high blood pressure), and dementia (loss of memory).</p> <p>Record review of Resident #10's quarterly MDS assessment dated [DATE] indicated Resident #10 had a BIMS score of 10 which indicated she had moderate cognitive impairment. Resident #10 was dependent on staff for toileting hygiene. The MDS indicated Resident #10 had an indwelling catheter (urinary catheter) and was always incontinent of bowel. The MDS indicated Resident #10 had unstageable pressure ulcer and moisture associated skin damage (MASD) related to incontinence.</p> <p>Record review of Resident #10's Care Plan Report indicated she had a stage 3 pressure ulcer to right posterior above knee amputation stump, initiated on 1/24/25; she had MASD to left posterior thigh, initiated 1/24/25; she was at risk for skin breakdown, initiated 5/11/21; she had an indwelling catheter and was at risk for increased UTIs and skin breakdown, initiated 1/03/25; and she had an ADL self-care deficit related to absence of right leg above the knee and required extensive assistance with interventions that included the resident required extensive assistance of 2 staff for toileting, initiated 5/11/21 and revised on 1/27/25.</p> <p>Record review of Resident #10's Order Summary Report dated 2/10/25 revealed an order to check foley catheter placement, ensure foley was secured to reduce friction and pulling every shift with an order date of 1/03/25; foley catheter care every shift with an order date of 1/03/25; and foley catheter 18 FR 10 cc bulb to continuous drainage related to wound with an order date of 1/03/25.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 2/10/25 at 10:24 AM, Resident #10 had a urinary catheter attached to the bed frame with a privacy bag. Resident #10 said she had a wound on her bottom and the facility was taking care of it. Resident #10 had a low air loss mattress and had an EBP sign on the wall by the top of her bed and an isolation cart outside of her room by the door.</p> <p>During an observation on 2/11/25 at 11:18 AM, RCP O performed incontinent care and urinary catheter care on Resident #10. RCP O set up a basin of soapy water and a basin of clean water on the bedside table with washcloths and towels. RCP O washed her hands with soap and water in the bathroom and applied clean gloves. RCP O placed a plastic bag at the foot of Resident #10's bed directly on the air loss mattress that required no bed sheets. RCP O began by using a washcloth that had been dipped in the soapy water basin and cleansed Resident #10's skin under her overlapping stomach that had visible white creamy substance on the skin by using her left gloved hand to hold Resident #10's skin of her overlapping stomach up and her right gloved hand to wipe the skin under her overlapping stomach. RCP O said she was trying to get as much of the cream off as possible. RCP O tossed the soiled washcloth into the plastic bag at the end of Resident #10's bed. RCP O then changed her gloves (did not perform hand hygiene) and obtained a clean washcloth dipped in clean water and cleaned under Resident #10's overlapping stomach again. RCP O then wiped down between Resident #10's front right inner thigh area and then the left inner thigh without spreading the resident's legs/thighs to visualize the perineum area (female private area) to effectively clean the area and then tossed the soiled washcloth into the plastic bag at the end of the bed. RCP O then obtained a clean washcloth and held the urinary catheter tubing with her left gloved hand where it was visible on the outside of Resident #10's closed legs/thighs and wiped down the urinary catheter tubing going away from the resident's body. RCP O did not change gloves prior to holding the urinary catheter with the left same gloved hand used to hold the resident's skin of her overlapping stomach and right gloved hand used to clean her skin under her overlapping stomach and then wiped down between her closed inner thighs. RCP O tossed the used washcloths into the plastic bag sitting on the end of the bed and the plastic bag fell off the bed and onto the floor. RCP O picked the plastic bag with soiled washcloths up and placed the plastic bag directly back on the end of Resident #10's air loss mattress. RCP O did not clean Resident #10's perineum area or urinary catheter insertion site while performing incontinent care or urinary catheter care by not spreading the inner thighs to visualize the areas. RCP O changed her gloves (did not perform hand hygiene) and turned Resident #10 onto her right side and cleaned a small bowel movement with two washcloths and tossed soiled washcloths into the plastic bag sitting on end of the bed and the plastic bag fell on to floor. RCP O picked up the plastic bag off the floor and placed the plastic bag back directly on the air loss mattress at the end of the bed. RCP O then proceeded without changing gloves or performing hand hygiene to use a clean washcloth to wipe down Resident #10's back thigh areas and tossed the washcloth into the plastic bag and the plastic bag fell back onto the floor and all the soiled washcloths fell out of the plastic bag onto the floor. RCP O picked up the soiled washcloths and placed them back into the plastic bag and then tied the plastic bag and left it on the floor. RCP O changed her gloves (did not perform hand hygiene) and put a gown on Resident #10 and then removed her gloves and gown and placed them in the trash. RCP O then went and got a clean sheet and placed it over the resident and propped her left lower extremity up on a pillow without wearing a gown or gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 9:20 AM, the Director of Resident Accounts said the CNAs (RCPs) on the personnel file review did not have their competency evaluations recorded, which included RCP O. The Director of Resident Accounts said she did not know if the competency evaluations were completed or not. The Director of Resident Accounts said it was the responsibility of the Director of Nursing (DCO) to complete the competency evaluations. The Director of Resident Accounts said since hiring a new Director of Nurses (DCO) they did not know where the previous Director of Nursing (DCO) kept the competency document files if they were completed .</p> <p>During an interview on 2/12/25 at 9:52 AM, LVN D said staff should change gloves after cleaning the resident up, like when going from dirty to clean. LVN D said the staff should clean the resident's perineum area, change gloves and washcloths prior to cleaning the urinary catheter to prevent the risk of infection to the resident. LVN D said staff should be cleaning the perineum area even if the resident had a foley catheter to prevent infection and it helped to have 2 staff members to assist in holding the legs during incontinent care .</p> <p>During an interview on 2/12/25 at 10:31 AM, RCP M said staff should perform hand hygiene and change their gloves any time they were going from a dirty area to a clean area during incontinent care and prior to performing urinary catheter care. RCP M said the purpose of urinary catheter care was to keep infection and germs away from the urinary catheter. RCP M said if the plastic bag fell on to the floor, the staff should get another plastic bag. RCP M said staff should not pick the plastic bag up off the floor and place it onto the resident's bed because it would contaminate the resident's bed. RCP M said it could place whatever potential germs that could have been on the floor onto the resident's bed and it's just gross. RCP M said the resident's bed would need to be stripped and the whole bed sanitized.</p> <p>During an interview on 2/12/25 at 10:44 AM, RCP O said she had worked at the facility since 12/05/24 and normally worked on the 6 AM-2 PM shift. RCP O said she changed gloves when she changed her water and she thought she changed gloves before cleaning Resident #10's urinary catheter. RCP O said she knew she changed her gloves at least three times while performing incontinent and urinary catheter care. RCP O said she did knock the plastic bag off in the floor several times and put it back on Resident #10's bed and it was an infection control issue. RCP O said Resident #10 was on EBP for her wound. RCP O said Resident #10 did not have bed sheets and she placed the plastic bag directly on Resident #10's mattress at the end of the bed after picking it up off the floor. RCP O said the facility had not provided her training in incontinent care or urinary catheter care, but she probably had training at her other facility. RCP O said the facility did not do a check off skills with her when she started.</p> <p>During an interview on 2/12/25 at 1:33 PM, the ADCO said she had worked at the facility since 1/13/25. The ADCO said she always cleaned a female from the inside out and changed gloves and performed hand hygiene when going from clean to dirty. The ADCO said from the scenario described by the state surveyor of the observation of RCP O performing incontinent care and urinary catheter care on Resident #10, RCP O did not perform incontinent/urinary catheter care to her standards. The ADCO said Resident #10 was more susceptible to UTIs due to having the urinary catheter. The ADCO said by RCP O placing the plastic bags back on the bed after they fell in the floor, it was an infection control issue. The ADCO said it should not have happened and if it did, the mattress should have been sanitized to prevent potential infections.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/25 at 2:18 PM, DCO P said she was covering the facility while DCO Q was out sick. DCO P said she worked at a sister facility as the DCO. DCO P said RCP O should have changed her gloves and performed hand hygiene prior to cleaning the urinary catheter. DCO P said RCP O should have cleaned around the insertion site of the catheter and the perineum area of the Resident #10. DCO P said improper incontinent and/or urinary catheter care could cause UTIs in the residents. DCO P said RCP O should not have put the plastic bag back on the bed after it fell on to the floor twice. DCO P said it was cross-contamination and it was an infection control issue. DCO P said Resident #10 was at an enhanced risk of infection and was on EBP due to having a wound on her bottom and having a urinary catheter.</p> <p>During an interview on 2/12/25 at 5:46 PM, the EDO said RCP O sitting the plastic bag off floor back on the Resident #10's bed was an infection control issue. The EDO said by RCP O not cleaning the urinary catheter properly or perineum area properly and by not changing gloves or performing hand hygiene appropriately placed the resident at risk of infection. The EDO said they have had some staffing issues and the previous DCO quit by text on Thanksgiving night. The EDO said RCP O's competency could have been missed because they had a gap of DCO coverage during the time of RCP O's hire. The EDO said RCP's orientation would have consisted of her going with another aide for a few days to show her around.</p> <p>Record review of the facility's policy titled Hand Hygiene dated last revised 10/24/22 indicated . hand hygiene was used to prevent the spread of pathogens in healthcare settings . you should always perform hand hygiene . before applying and after removing personal protective equipment (e.g. gloves, gown, mask, face shield/goggles) . before and after providing any type of care . after contact with intact skin . after contact with medical equipment or other environmental surfaces that may be contaminated . you must perform hand hygiene after contact with bodily fluids, such as urine .</p> <p>Record review of the facility's policy titled Bedrooms dated revised May 2017 indicated . All residents were provided with clean, comfortable, and safe bedrooms . each resident was provided with . a clean, comfortable mattress . bedding that was clean .</p> <p>Record review of the facility's policy and procedure Enhanced Barrier Precautions, dated April 1, 2024, indicated . Enhanced Barrier Precautions (EBP) were a CDC guidance to reduce the transmission of multi-drug resistant organisms (MDRO) in healthcare settings, including nursing homes . EBP require team members to wear a gown and gloves while performing high-contact care activities with residents . who have open wounds or indwelling medical device . high contact resident care activities . providing hygiene . changing linens . changing briefs or assisting with toileting . device care . urinary catheter .</p>		