STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675398	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care of Center	501 Timpson Center, TX 75935

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50818 Based on observations, interviews, and record review, the facility failed ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 8 residents (Resident #8) reviewed for accomodation of needs. The facility failed to ensure Resident #8's call light in the room was left within reach on 4/17/2024. This failure could place residents at risk of injury, pain, hospitalization , and a diminished quality of life. Findings included: Record review of an Admission Record dated 4/17/2025 for Resident #8 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of dementia (altered cognition) and secondary diagnoses of hemiplegia and hemiparesis (weakness or paralysis on one side of the body) and muscle weakness. Record review of an MDS assessment dated [DATE] for Resident #8 indicated he had a BIMS score of 12 which indicated moderate cognitive impairment. He was dependent on staff for most ADLs except for eating. He was always incontinent of bladder and had an ostomy. Record review of Resident #8's care plan dated 4/5/22 and revised on 2/25/24 indicated he had a history of falls and was at risk for future falls due to diagnosis of hemiplegia/hemiparesis. An intervention was in place to Ensure call light is in reach and answer promptly. During an observation and interview on 4/17/25 at 11:00 AM, Resident #8 was in his room lying in his bed in a semi-private room with no roommate. His call light was lying on the unoccupied bed in the room. Resident #8 said CNA B assisted him with personal care and left his call light lying out of reach. He said he used a trapeze bar (bed pull up assistance device) to sit up in bed and could not stand or walk independently. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/2025 at 11:30 AM, CNA B said she was assigned to hall 500 today, 4/17/2025, where Resident #8 resided. CNA B said she had recently rounded on Resident #8 and assisted him with personal care. She said CNAs were responsible for ensuring call lights were left accessible to residents before leaving the room. During an interview on 4/17/25 at 2:00 PM, the ADM said direct care staff were expected to round on every resident at least every two hours. She said direct care staff were expected to ensure call lights were left within reach before leaving the room. The ADM said the DON was responsible for ensuring all nursing staff and CNAs received required training and successfully completed skill competency checkoffs. During an interview on 4/17/2025 at 2:45 PM, the DON said she was responsible ensuring all CNAs and nursing staff successfully complete competency checkoffs. She said CNAs and nurses were expected to ensure call lights were accessible by residents before leaving the room. Record review of a facility policy titled Bedrooms revised in May 2017 indicated .All resident rooms are equipped with a resident call system that allows residents to call for staff assistance .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 4 of 7 residents (Resident #3, Resident #4, Resident #5 and Resident #6) reviewed for abuse and neglect. 1. The facility failed to prevent a Resident-to-Resident altercation when Resident #3 and Resident #4 began fighting and both residents fell to the ground in the smoking area on 11/30/2024. 2. The facility failed to protect Resident #6 from abuse from an Unidentified Resident on 1/5/2025 when an Unidentified Resident grabbed Resident #6 by the arm and threatened him. 3. The facility failed to prevent a Resident-to-Resident altercation when Resident #5 hit Resident #3 with a walker and then began fighting and both residents fell to the ground in the dining room on 2/15/2025. 4. The facility failed to protect Resident #6 from abuse from Resident #3 on 3/25/2025 when Resident #3 kicked Resident #6 in the dining room at breakfast. An Immediate Jeopardy (IJ) situation was identified on 4/16/2025. While the IJ was removed on 4/17/2025, the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for severe negative psychosocial outcomes which could prevent them from achieving their highest practicable physical, mental, and psychosocial well-being. Findings include: 1. Record review of the electronic face sheet for Resident #3 indicated the resident was admitted to the facility on [DATE] with the most recent readmission on 4/2/2025. Resident #3 had diagnoses which included: bipolar disorder (significant shifts in mood, energy, and activity levels, causing periods of intense highs and lows), impulse disorder (difficulty controlling impulses, urges, or behaviors, leading to harmful or inappropriate actions), Parkinson's (neurological disorder that primarily affects movement) and Wilson's disease (causes copper to build up in the liver, brain, and other organs). Record review of Resident #3's admission MDS assessment, dated 2/8/2025, indicated a BIMS of 15, which indicated no cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's care plan, dated 11/15/2024, indicated: I am exhibiting behavior of making flirtatious comments towards staff and some female residents. Interventions included: 1. [Counseling] services evaluate and treat. 2. Monitor/document/report PRN any signs/symptoms of resident posing danger to self and others. 3. Staff will monitor for safe environment and to ensure no unusual episodes occur. The care plan dated 3/4/2025, indicated I am exhibiting behavior of-verbal aggression to other residents, I like to 'stir the pot', boss people around and tell people what they can and can't do. I am often loud and obnoxious and often instigate arguments with staff and residents. Interventions included: 1. Monitor/document/report PRN and signs/symptoms of resident posing danger to self and others. 2. Psychological services evaluate and treat. 3. Staff will monitor for safe environment and to ensure no unusual episodes occur. 4. When the resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away and approach later. Record review of the facility's incident report for Resident #3, dated 2/15/2025 at 2:38 PM, completed by LVN A, indicated: Heard loud noises coming from dining room, when arrived to dining room, saw resident sitting on floor along with the other resident. Resident stated the CNA was in the way and [Resident #5] asked him to move and resident yelled back at him. Resident stated they both were going back and forth. [Resident #5] got angry and hit him on top of his head with walker. Staff member broke incident up. 2. Record review of the electronic face sheet for Resident #4 indicated the resident was admitted to the facility on [DATE] with the most recent admission on 3/27/2025. Resident #4 had diagnosis which included: vascular dementia (difficulty thinking, memory and behavior), Hemiplegia (paralysis on the left side of the body) and muscle weakness. Record review of Resident #4's admission MDS assessment, dated 4/4/2025, indicated a BIMS of 13, which indicated no cognitive impairment. It also indicated Resident #4 was independent with walking 150 feet. Record review of Resident #4's care plan, dated 11/15/2024, indicated: I have a ADL self-care performance deficits related to disease processes. I am mostly independent with ADLs with some assistance with set-up and supervision with locating thing. I have left side hemiplegia and walk with a cane. Interventions included: 1. Transfer: The resident requires supervision and set-up assistance by 1 staff to move between surfaces as necessary. Record review of the facility's incident report for Resident #4, dated 11/30/2024 at 6:45 PM, indicated: Resident stated he was outside smoking when he and another male resident started arguing, he stated he walked up to the other resident and the other resident pulled himself up out of his wheelchair using him they began hitting one another and fell to the ground. The notes section indicated: Resident involved in physical altercation with [Resident #3]. Resident had words with other resident and both decided to show who was boss. Few slaps back and forth, easily redirected by staff present. No injury noted or complaint of pain. Both residents redirected to their room and further smoke breaks this evening. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's progress note for Resident #4, dated 11/30/2024 at 7:31 PM, completed by LVN C, indicated: This nurse was at the medication cart when a dietary worker came in the hallway and stated 'hey they need some help out here.' Nurse went to the dining room and the door leading out to the smoke area was open. Resident was observed laying in the smoke area with the other male resident beside him and they were both arguing and still trying to engage physically. Nurse stepped between them and assisted this resident up. Resident was assisted back in the facility and sat in a chair. After he got his shoes back on he was assisted to his room. Resident described in his words what happened. DON was notified. Resident was instructed to stay away from the other male resident and there would be no other smoke breaks for him. Resident did not have any visible physical injuries after assessment. Denies any physical or emotional distress 3. Record review of the electronic face sheet for Resident #5 indicated the resident was admitted to the facility on [DATE]. Resident #5 had diagnoses which included: toxic encephalopathy (brain disorder caused by exposure to toxic substances), chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe) and type 2 diabetes (high blood sugar). Record review of Resident #5's quarterly MDS assessment, dated 2/5/2025, indicated a BIMS of 14, which indicated no cognitive impairment. It also indicated Resident #2 was independent with walking 150 feet. Record review of Resident #5's care plan, dated 2/21/2025, indicated: The resident was/has potential to be physically aggressive hit another resident with walker, related to anger, poor impulse control 2/15/25-became impatient with another resident and hit that resident with walker. Interventions included: 1. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document . 3. Monitor/document/report PRN any s/sx of resident posing danger to self and others. 4. Offer psych or psychology services as needed. 5. Social Worker to talk and evaluate resident after any incidents. 6. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Record review of the facility's progress notes for Resident #5, dated 2/15/2025 at 3:16 PM, completed by the LVN A indicated: Resident had a witnessed physical altercation with another resident. Resident was found sitting on the floor in front of his walker. Resident denies pain or discomfort at this time. Resident vital signs are stable. No injuries noted at this time. 4. Record review of the electronic face sheet for Resident #6 indicated the resident was admitted to the facility on [DATE]. Resident #6 had diagnoses which included: intracerebral hemorrhage (stroke), Hemiplegia (paralysis on the right side of the body), and muscle weakness. Record review of Resident #6's annual MDS assessment, dated 2/25/2025, indicated a BIMS of 03, which indicated severe cognitive impairment. It also indicated Resident #6 required substantial to maximal assistance with transfers. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #6's care plan, dated 1/5/2025, indicated: I received physical and verbal aggression from another resident when he was grabbed by the hand and another resident told him he would knock the hell out of him. I am still protective of other residents and may act aggressively towards others. Interventions included: 1. Resident will be assessed for emotional distress and physical injuries after incident and as needed. 2. Resident will be redirected when appropriate. 3. Resident will not go on the same smoke breaks as physically aggressive resident . 5. Staff will monitor for safe environment and to ensure no unusual episodes occur. Record review of the facility's incident report for Resident #6, dated 1/5/2025 at 8:30 am, indicated: Resident was in dining room near the smoking door with another resident when his w/c bumped into the other resident's chair. The other resident grabbed his and told him if he did it again he would knock the shit out of him. Residents were separated and no further physical contact was made. Resident was assessed for injuries with none observed. Resident showed no signs of emotional trauma. Residents will not go on the same smoke breaks together. 5. Record review of the electronic face sheet for Resident #7 indicated the resident admitted to the facility on [DATE] with the most recent admission on 10/31/2022. Resident #7 had diagnoses diagnosis which included: major depressive disorder (persistently low mood), chronic respiratory failure with hypoxia (lungs cannot adequately provide oxygen to the blood), and muscle weakness. Record review of Resident #7's quarterly MDS assessment, dated 2/18/2025, indicated a BIMS of 15, which indicated no cognitive impairment. It also indicated Resident #4 required supervision or touching assistance with walking 150 feet. Record review of Resident #7's care plan, dated 4/15/2022, indicated: I may have a potential for Coping Impaired related to situational and social factors including loss of autonomy or independence; disrupted family life, grief, loneliness, helplessness, or hopelessness. I am seeing counselor at facility and have visits with [Psychiatrist] as needed. Interventions included: Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing medication or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. During an interview on 4/15/2025 at 10:48 AM, Resident #5 said Resident #3 was in the way while he was trying to get out the door to the smoking area. He said he asked him to let him get by and he said Resident #3 talked noise and cussed him out. He said Resident #3 was agitated and spoke in Spanish. He said Resident #3 turned around and was raising up out of his chair like he was going to fight. He said he then hit him with his walker. He said they both fell on the floor in the dining room. He said Resident #3 called the police and they came and talked to him and told him the next time they would take him to jail. He said if Resident #3 acted that way again he would hit him again. He said that had been the only physical incident he had with Resident #3. He said there was another guy on the 300 hall, Resident #4 had a physical altercation with Resident #3. He said Resident #3 had problems with a lot of residents because he was always in other people's business and cussing other residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/15/2025 at 11:11 AM, Resident #7 said she called bingo when the activity director couldn't and said Resident #3 yelled out at her when she called bingo like a bully would. She said they sent Resident #3 to a behavioral hospital because he was physical with Resident #6. She said they initially put Resident #3 on another hall, but he was now back on her hall. She said Resident #3 would throw things. She said Resident #6 was really the only resident she had ever seen Resident #3 kick or get physical with. She said he kissed the older ladies', hands a lot and did not feel it was appropriate. She said one lady (unknown) finally yelled at him to stop and leave her alone. She said Resident #3 did a lot of cussing and calling people names. She said Resident #3 had asked her for sex, and she turned him down and he didn't like it. She said he asked a lot of the ladies and employees for sex. She said she was not afraid of him physically, but she was afraid of what he brought out in her and was afraid she would hit him. She said one time they got in an argument, and he tried to charge at her, and staff pulled him back. She said she felt so much better when he resided on a different hallway. She said he had just moved back to this hall yesterday 4/14/2025 because he got into an altercation with his roommate on the 300 hall and his roommate called the police. She said all altercations or arguments were always centered around Resident #3. During an interview on 4/15/2025 at 11:25 AM revealed Resident #6 could not answer questions due to a diagnosis of aphasia (language disorder that results from damage to the brain's language centers). During an interview on 4/15/2025 at 11:31 AM, CNA D said Resident #3 moved back to the 500 hall yesterday 4/14/2025. She said she did not know what prompted the move back to the 500 hall. She said Resident #3 was smart mouthed and disrespectful to staff and residents. She said a staff member would be talking to another resident and Resident #3 would chime in with his negative input. She said she had seen the arguing with Resident #3 but had never seen him get physical with anyone. During an interview on 4/15/2025 at 12:52 PM, the ADON said he was an instigator and liked to create tiffs until other residents went off on him. She had been employed at the facility since December 2024, Resident #3 was sent to a behavioral hospital and had 2 room changes, and medication changes. She said the SW was sending out referrals to discharge Resident #3, but no one would accept him. During an interview on 4/15/2025 at 1:13 pm, the DON said Resident #3 liked to stir the pot and instigate arguments with residents and staff. She said Resident #3 had been in a group home and multiple nursing homes prior to being at the facility. She said Resident #3 had issues when he was living at home with his mother and thought that adult protective services had been involved because Resident #3 had acted out and called the police many times while he was there. She said Resident #3 was sent to after he kicked Resident #6 at breakfast. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/16/2025 at 10:01 am, the SW said on 3/25/25 Resident #3 kicked Resident #6 during breakfast because he was making some noise and Resident #3 did not like it. She said he came to her office that morning and said he had kicked Resident #6 but did not know why he did it. She said on 2/15/25 the residents were going out to smoke and Resident #3 was in the doorway and Resident #5 was telling him to go go go and he said he couldn't go so he was cussing Resident #5, and Resident #5 picked up his walker and hit Resident #3, and both residents began fighting and fell on the floor. She said Resident #3's head was sore from being hit and he had an abrasion but otherwise there were no other injuries. She said she saw the video footage and could not tell if Resident #3 was hit on the head or shoulder area. She said on 11/30/2024 Resident #3 and Resident #4 were outside in the smoking area and were going back and forth arguing and both residents ended up on the ground. She said she couldn't remember if either one actually hit the other one. She said she couldn't remember any other physical altercations she was aware of. She said Resident #3 was referred to counseling services on 11/5/24 but refused. She said on 2/19/25 the order and consent were received for counseling services, and he was evaluated by the counselor on 2/26/25. She said he had a verbal altercation a few days earlier and if another incident happened then they needed to seek further help for him. She said the Resident #3 received counseling services on Wednesday and the Psych MD and saw him monthly. She said she sent out 6 referrals to seek alternate placement for Resident #3 between 4/1/2025 and 4/15/2025 and all had been denied. During an interview on 4/16/2025 at 11:50 am, the Administrator said Resident #3 had a history of behaviors. She said she knew Resident #3 had behaviors before the resident was admitted to the facility, but she accepted him anyway because she felt like they could help Resident #3. She said Resident #3 liked to instigate and stir the pot with other residents and staff. She said Resident #3 often inserted himself into conversations with staff and residents who were not about him. She said Resident #3 knew what he was doing and would often apologize after an altercation with staff or other residents. During an interview on 4/16/2025 at 1:21 PM, Resident #3 said when he was 28 he was in the hospital for 2 months and that's when he was diagnosed with the Wilson's disease. He said he is a sweet guy but when you him make him mad, he turns into the devil. He said he did not receive counseling services at the facility. He said he had only talked to a counselor 1 time since he had been at the facility. He said when he had the incidents with other residents he would go and apologize after the incident was over. He said he did not have control over his actions when he got mad and he got anxious. He said he told Resident #4 to tie his shoe and Resident #4 told him to shut up and for him to tie it and said he got up and started walking over to him and they just began fighting and fell to the ground in the smoking area. He said Resident #5 told him to go out the door and he said Resident #5 took his walker and put it over his head and jerked it back as if to choke him. He said he kicked Resident #6 because he was jealous the staff were feeding Resident #6 and not him. He said he went to the behavior hospital after he kicked Resident #6. He said he got kicked out of another nursing facility for trying to bite the medication aide's finger. During an interview on 4/17/2025 at 1:25 PM, Resident #4 said he did not like Resident #3 and said on the day in question he was in the smoking area. He said Resident #3 told him his shoe was untied and he told Resident #3 it was none of his business. He said Resident #3 would not leave him alone and he got mad and him and Resident #3 mutually began fighting and fell on the ground. He said after the incident he did not like Resident #3, but he just tried to stay away from him and stay out of trouble. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/22/2025 at 9:28 AM, LVN A said on 2/15/2025 someone came and got her and let her know Resident #3 and Resident #5 were fighting in the kitchen. She said Resident #5 told her Resident #3 was talking bad to him. She said Resident #5 said he hit him. She said when she asked Resident #3 what happened he said Resident #5 was talking to someone else and Resident #3 got in their business and started the argument with Resident #5. She said both residents fell on the floor in the dining room. She said Resident #3 was always in someone else's business. She said she thought Resident #3 was just angry because he was in the nursing home. She said Resident #3 would wake up and just be mad at the world. During an interview on 4/22/2025 at 10:14 AM, CNA E said on 2/15/2025 she was taking the smokers out and stook in the doorway. She said she heard Resident #5 tell Resident #3 to go and he said don't you see CNA E in the way. She said she didn't hear him say anything else and then Resident #5 put his walker over Resident #3 like he was trying to choke him with it. She said then Resident #3 started shaking and fell on the floor. She said Resident #3 called the police. Said she thought both residents had been arguing prior to the incident. She said Resident #3 could not get along with anyone. Record review of the facility's policy titled Abuse, dated 2/1/2017, reflected: The purpose of this policy is to ensure that each resident has the right to be free from any type of Abuse, Neglect, Intimidation, Involuntary Seclusion/Confinement, and or Misappropriation of property . Residents will not be subjected to abuse by anyone, including, but not limited to community staff, other residents, consultants, volunteers, staff of other agencies serving the residents, family members or legal guardians, care taker, friends, or other individuals . This was determined to be an Immediate Jeopardy (IJ) on 04/16/2025 at 5:42 PM. The facility Administrator was notified. The Administrator was provided with the IJ template on 4/16/2025 at 5:42 PM. The following Plan of Removal submitted by the facility was accepted on 4/17/2025 at 2:07 PM: The following is a plan of removal, which has been immediately implemented at the facility, to remedy the immediate jeopardy as a result of alleged deficient practices, which was imposed on April 16, 2025, at 5:45 PM. F600 Abuse 11-30-24: Resident #3 was assessed on 11-30-24 after incident and had scratches to left arm that were treated in house. Resident #4 was assessed on 11-30-24 after incident and had no injuries or physical or emotional distress. DCO and LVNs redirected residents to their rooms and with no further smoke breaks for them that evening. Psych Services conducted a patient care call with Resident #3 on 12-2-24 with a new order for an increase to his Depakote ER to 1500 mg qhs. Psych Services conducted a patient care call with Resident #4 on 12-2-24 with no new orders. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2-15-25: Resident #3 was assessed on 2-15-25 after incident and had a small abrasion to right midback. Resident #5 was assessed on 2-15-25 after the incident and had no injuries. Police were called and they came and spoke to both residents and left. DRSS spoke with both residents individually on 2-17-25, and they reported no emotional effects from the incident and both residents were offered counseling services, which were refused. Psych services conducted a patient follow up visit on 2-18-25 on Resident #3 with no new orders or interventions. Resident #3 was reeducated on counseling services on 2-19-25 and agreed to the service and signed consent for treatment. Resident #5 refused counseling services again on 2-18-25. 3-25-25: Resident #3 was discharged to Behavioral Hospital on 3-25-25 for behaviors. Resident #6 was assessed on 3-25-25 after the incident with no injuries. Psych Services visited Resident #6 on 3-29-25 with no new orders. Immediate Action All staff in-serviced on April 16, 2025, by Executive Director of Operations (EDO)/Director of Clinical Operations (DCO) and/or designee on the following topics: Prevention, Identification and Reporting/Investigation of Abuse; How to Immediately Protect Residents when abuse is suspected; Possible Interventions to Assist with De-escalation after an Incident. All staff not present at time of in-service will not be permitted back to work until in-service is complete. 4-16-25: Resident #3 was placed on one-to-one monitoring at 7:20pm. Discharge Planning initiated to family. Family agreed by phone to discharge resident to their care on 4-16-25 at 9pm. Resident remained on one-to-one monitoring until discharge on [DATE] at 7:52am. 4-16-25: Safe Surveys were conducted by DRSS and/or designee with all residents cognitively able to participate. Results of and action after Safe Surveys are as follows: 3 residents expressed that Resident #3 was rude- Resident #3 was on one-on-one monitoring, 1 resident expressed that a nurse was unsure of what to do for his wound care-resident no longer in facility, 1 resident expressed a CNA was rough during her bed bath-the resident was reinterviewed by DCO to get details, the resident did not think the CNA had been abusive or intentionally rough, it was determined that due to her current clinical condition she requires 2 person assistance for bed mobility and personal care, the care plan and tasks were updated on 4-17-25, One-on-one in-service to be completed on 4-17-25 with CNA. 4-17-25: All residents identified as at risk for physically aggressive behaviors were reviewed by the CRC/ADCO to ensure they had an accurate care plan, appropriate interventions and appropriate Psych Services or Counseling Services The DCO/ADCO/EDO will monitor EMR documentation including the 24-hour report, incident reports and alerts, and Grievances to identify potential abuse or situations requiring further investigation during morning meeting. Abuse allegations will be reported and investigated according to company policy and THHS regulations. Potential abuse or situations requiring further investigation will be documented on a Grievance form with any investigation documentation attached. All staff in-serviced on April 17, 2025, on the Grievance process and utilizing the Grievance form to document the potential abuse or situation and the investigation. (continued on next page)

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	675398	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care of Center	501 Timpson Center, TX 75935

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Medical Director was initially made aware on April 16, 2025, of the immediate jeopardy, and has been involved in the development of the plan to remove during an abbreviated QA. These conversations are considered a part of the QA process. Next schedule QA meeting set for April 21, 2025 at 12pm. All in-servicing began on 4/16/2025. This plan was initially implemented on 4/16/2025 and will be monitored, through personal observation, through completion by Regional [NAME] President of Operation and Regional Director of Clinical Services. Monitoring of the Plan of Removal included the following: During interviews on 4/17/2025 between 3:56 PM and 4:32 PM the following staff across multiple shifts were able to appropriately describe abuse, ways to prevent abuse, de-escalation techniques of abuse, 1 to 1 monitoring and the grievance process: CNA F, LVN G, LVN H, CNA J, Floor Tech, CNA K, LVN L, CNA M, Activity Director, CNA N, Cook, Dietary Aide, and CNA E. Record review of skin assessment dated [DATE] for Resident #3. Record review of skin assessment dated [DATE] for Resident #3. Record review of behavioral hospital paperwork for Resident #3 dated 3/25/2025 through 4/2025. Record review of in-service, dated 4/16/2025, on the following topics: Prevention, Identification and Reporting/Investigation of Abuse; How to Immediately Protect Residents when abuse is suspected; Possible Interventions to Assist with De-escalation after an Incident with 39 staff signatures. Record review of every 15-minute monitoring for Resident #3 revealed 1 to 1 monitoring started on 4/16/2025 at 7:30PM and ended on 4/17/2025 at 7:52AM when Resident #3 discharged from the facility. Record review of 66 safe surveys conducted on 4/16/2025 with no noted concerns. Record review of inservice dated 4/17/2025 for completing grievance/complaint investigation report for with 11 staff signatures. The Administrator was informed the Immediate Jeopardy was removed on 4/17/2025 at 4:35 PM. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials, which included to the State Survey Agency, in accordance with State law through established procedures for 3 of 7 residents (Resident #3, Resident #4 and Resident #6) reviewed for abuse. 1. The facility failed to immediately report an allegation of resident-to-resident abuse to HHSC after the allegation was made on 11/30/2024. On 11/30/2024 at 6:45 PM Resident #4 and Resident #3 had a physical altercation while outside in the smoking area. 2. The facility failed to report immediately report an allegation of resident-to-resident abuse to HHSC after the allegation was made on 3/25/2025 at 8:09 AM. On 3/25/2025 Resident #3 kicked Resident #6 multiple times during breakfast. These failures could place residents at risk of further potential abuse. Findings include: 1. Record review of the electronic face sheet for Resident #3 indicated Resident #3 admitted to the facility on [DATE] with the most recent readmission on 4/2/2025 with diagnosis that included: bipolar disorder (significant shifts in mood, energy, and activity levels, causing periods of intense highs and lows), impulse disorder (difficulty controlling impulses, urges, or behaviors, leading to harmful or inappropriate actions), parkinsons (neurological disorder that primarily affects movement), wilsons disease (causes copper to build up in the liver, brain, and other organs). Record review of Resident #3's admission MDS assessment dated [DATE] indicated a BIMS of 15, which indicates no cognitive impairment. Record review of Resident #3's care plan dated 11/15/2024 indicated: I am exhibiting behavior of making flirtatious comments towards staff and some female residents. Interventions included: 1. [Counseling] services evaluate and treat. 2. Monitor/document/report PRN any signs/symptoms of resident posing danger to self and others. 3. Staff will monitor for safe environment and to ensure no unusual episodes occur. The care plan dated 3/4/2025 indicated I am exhibiting behavior of-verbal aggression to other residents, I like to stir the pot, boss people around and tell people what they can and can't do. I am often loud and obnoxious and often instigate arguments with staff and residents. Interventions included: 1. Monitor/document/report PRN and signs/symptoms of resident posing danger to self and others. 2. Psychological services evaluate and treat. 3. Staff will monitor for safe environment and to ensure no unusual episodes occur. 4. When the resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away and approach later. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of nursing progress notes, dated 3/25/2025 at 8:09 AM, written by the LVN A, indicated: It was reported to this nurse that [Resident #3] kicked another resident for no reason this morning at breakfast time. CNA E was feeding another resident and [Resident #3] decided to kick him multiple times. Resident is aware of possible consequences of his actions. Notified [DON]. 2. Record review of the electronic face sheet for Resident #4 indicated Resident #4 admitted to the facility on [DATE] with the most recent admission on 3/27/2025 with diagnosis that included: vascular dementia (difficulty thinking, memory and behavior), Hemiplegia (paralysis on the left side of the body), and muscle weakness. Record review of Resident #4's admission MDS assessment dated [DATE] indicated a BIMS of 13, which indicates no cognitive impairment. It also indicated Resident #4 was independent with walking 150 feet. Record review of Resident #4's care plan dated 11/15/2024 indicated: I have a ADL self-care performance deficits related to disease processes. I am mostly independent with ADLs with some assistance with set-up and supervision with locating thing. I have left side hemiplegia and walk with a cane. Interventions included: 1. Transfer: The resident requires supervision and set-up assistance by 1 staff to move between surfaces as necessary. Record review of facility incident report for Resident #4 dated 11/30/2024 at 6:45pm indicated: Resident stated he was outside smoking when he and another male resident started arguing, he stated he walked up to the other resident and the other resident pulled himself up out of his wheelchair using him they began hitting one another and fell to the ground. The notes section indicated: Resident involved in physical altercation with [Resident #3]. Resident had words with another resident and both decided to show who was boss. Few slaps back and forth, easily redirected by staff present. No injury noted or complaint of pain. Both residents redirected to their room and further smoke breaks this evening. Record review of facility progress note for Resident #4 dated 11/30/2024 at 7:31pm completed by the LVN C indicated: This nurse was at the medication cart when a dietary worker came in the hallway and stated, hey they need some help out here. Nurse went to the dining room and the door leading out to the smoke area was open. Resident was observed laying in the smoke area with the other male resident beside him and they were both arguing and still trying to engage physically. Nurse stepped between them and assisted this resident up. Resident was assisted back in the facility and sat in a chair. After he got his shoes back on he was assisted to his room. Resident described in his words what happened. DON was notified. Resident was instructed to stay away from the other male resident and there would be no other smoke breaks for him. Resident did not have any visible physical injuries after assessment. Denies any physical or emotional distress. 3. Record review of the electronic face sheet for Resident #6 indicated Resident #6 admitted to the facility on [DATE] with diagnosis that included: intracerebral hemorrhage (stroke), Hemiplegia (paralysis on the right side of the body), and muscle weakness. Record review of Resident #6's annual MDS assessment dated [DATE] indicated a BIMS of 03, which indicates severe cognitive impairment. It also indicated Resident #6 required substantial to maximal assistance with transfers. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's care plan dated 1/5/2025 indicated: I received physical and verbal aggression from another resident when he was grabbed by the hand and another resident told him he would knock the hell out of him. I am still protective of other residents and may act aggressively towards others. Interventions included: 1. Resident will be assessed for emotional distress and physical injuries after incident and as needed. 2. Resident will be redirected when appropriate. 3. Resident will not go on the same smoke breaks as physically aggressive resident . 5. Staff will monitor for safe environment and to ensure no unusual episodes occur. Record review of facility incident report for Resident #6 dated 1/5/2025 at 8:30am indicated: Resident was in dining room near the smoking door with another resident when his w/c bumped into the other resident's chair. The other resident grabbed his and told him if he did it again, he would knock the shit out of him. Residents were separated and no further physical contact was made. Resident was assessed for injuries with none observed. Resident showed no signs of emotional trauma. Residents will not go on the same smoke breaks together. During an interview on 4/15/2025 at 11:25 AM revealed Resident #6 could not answer questions due to diagnosis of aphasia (language disorder that results from damage to the brain's language centers). During an interview on 4/15/2025 at 11:31am CNA D said Resident #3 moved back to the 500 hall yesterday 4/14/2025. She said she did not know what prompted the move back to the 500 hall. She said Resident #3 was smart mouthed and disrespectful to staff and residents. She said a staff member would be talking to another resident and Resident #3 will chime in with his negative input. She said she had seen the arguing with Resident #3 but had never seen him get physical with anyone. During an interview on 4/15/2025 at 12:52pm the ADON said he was an instigator and liked to create tiffs until other residents go off on him. She she had been employed at the facility since December 2024, Resident #3 had been sent to a behavioral hospital and had 2 room changes, and medication changes. She said the SW had been sending out referrals to discharge Resident #3, but no one would accept him. During an interview on 4/15/2025 at 1:13pm the DON said Resident #3 liked to stir the pot and instigate arguments with residents and staff. She said Resident #3 had been in a group home and multiple nursing homes prior to being at the facility. She said Resident #3 had issues when he was living at home with his mother and thought that APS had been involved because Resident #3 had acted out and called the police many times while he was there. She said Resident #3 was sent to Brentwood after he kicked Resident #6 at breakfast. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/2025 at 10:01am the SW said on 3/25/25 Resident #3 kicked Resident #6 during breakfast because he was making some noise and Resident #3 did not like it. She said he came to her office that morning and said he had kicked Resident #6 but did not know why he did it. She said on 11/30/2024 Resident #3 and Resident #4 were outside in the smoking area and were going back and forth arguing and both residents ended up on the ground. She said she couldn't remember if either one actually hit the other one. She said she couldn't remember any other physical altercations that she was aware of. She said Resident #3 was referred to counseling services on 11/5/24 but refused. She said on 2/19/25 the order and consent were received for counseling services, and he was evaluated by the counselor on 2/26/25. She said he had a verbal altercation a few days earlier and if another incident happened then they needed to seek further help for him. She said the Resident #3 received counseling services on Wednesday and the Psych MD and sees him monthly. She said she sent out 6 referrals to seek alternate placement for Resident #3 between 4/1/2025 and 4/15/2025 and all had been denied. During an interview on 4/16/2025 at 11:50am the Administrator said had a history of behaviors. She said she knew that the Resident #3 had behaviors before Resident #3 admitted to the facility, but she accepted him anyway because she felt like they could help Resident #3. She said Resident #3 liked to instigate and stir the pot with other residents and staff. She said Resident #3 often inserted himself into conversations with staff and residents that were not about him. She said Resident #3 knew what he was doing and would often apologize after an altercation with staff or other residents. She said her expectation was to do their best to prevent abuse and if something did happen they reported and took action. During an interview on 4/16/2025 at 1:21pm Resident #3 said when he was 28, he was in the hospital for 2 months and that's when he was diagnosed with the Wilson's disease. He said he is a sweet guy but when you him make him mad, he turns into the devil. He said he did not receive counseling services at the facility. He said he had only talked to a counselor 1 time since he had been at the facility. He said when he has the incidents with other residents, he will go an apologize after the incident was over. He said he did not have control over his actions when he gets mad, and he gets anxious. He said he told Resident #4 to tie his shoe and Resident #4 told him to shut up and for him to tie it and said he got up and started walking over to him and they just began fighting and fell to the ground in the smoking area. He said he kicked Resident #6 because he was jealous the staff were feeding Resident #6 and not him. He said he went to the behavior hospital after he kicked Resident #6. He said he got kicked out of another nursing facility for trying to bite the medication aide's finger. During an interview on 4/17/2025 at 1:25pm Resident #4 said he did not like Resident #3 and said on the day in question he was in the smoking area. He said Resident #3 told him his shoe was untied and he told Resident #3 it was none of his business. He said Resident #3 would not leave him alone and he got mad and him and Resident #3 mutually began fighting and fell on the ground. He said after the incident he did not like Resident #3 but he just tried to stay away from him and stay out of trouble. Record review of the facility's policy titled Abuse, dated 2/1/2017, reflected: . All events that involve an allegation of abuse or involve a suspicious serious bodily injury of unknown origin must be reported immediately or not later than 2 hours of alleged violation

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on interview and record review the facility failed to have evidence that all alleged violations were thoroughly investigated and prevented further abuse, neglect, exploitation, or mistreatment while the investigation was in progress for 3 of 7 residents (Residents #3, Resident #4 and Resident #6) reviewed for abuse/neglect. The facility failed to prevent further potential abuse and mistreatment of Resident #4 and Resident #6 by allowing the alleged perpetrator Resident #3 to remain in the facility and to have direct contact with the residents. An Immediate Jeopardy (IJ) situation was identified on 4/16/2025. While the IJ was removed on 4/17/2025, the facility remained out of compliance at a scope of a pattern with the potential for more than minimal harm due to the facility need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for abuse, physical harm, psychosocial harm, trauma, unrecognized abuse and emotional distress. The findings include: 1. Record review of the electronic face sheet for Resident #3 indicated Resident #3 admitted to the facility on [DATE] with the most recent readmission on 4/2/2025 with diagnosis that included: bipolar disorder (significant shifts in mood, energy, and activity levels, causing periods of intense highs and lows), impulse disorder (difficulty controlling impulses, urges, or behaviors, leading to harmful or inappropriate actions), parkinsons (neurological disorder that primarily affects movement), wilsons disease (causes copper to build up in the liver, brain, and other organs). Record review of Resident #3's admission MDS assessment dated [DATE] indicated a BIMS of 15, which indicates no cognitive impairment. Record review of Resident #3's care plan dated 11/15/2024 indicated: I am exhibiting behavior of making flirtatious comments towards staff and some female residents. Interventions included: 1.[Counseling] services evaluate and treat. 2. Monitor/document/report PRN any signs/symptoms of resident posing danger to self and others. 3. Staff will monitor for safe environment and to ensure no unusual episodes occur. The care plan dated 3/4/2025 indicated I am exhibiting behavior of-verbal aggression to other residents, I like to stir the pot, boss people around and tell people what they can and can't do. I am often loud and obnoxious and often instigate arguments with staff and residents. Interventions included: 1. Monitor/document/report PRN and signs/symptoms of resident posing danger to self and others. 2. Psychological services evaluate and treat. 3. Staff will monitor for safe environment and to ensure no unusual episodes occur. 4. When the resident becomes agitated: intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away and approach later. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility incident report for Resident #3 dated 2/15/2025 at 2:38pm completed by the LVN A indicated: Heard loud noises coming from dining room, when arrived to dining room, saw resident sitting on floor along with the other resident. Resident stated the CNA was in the way and [Resident #5] asked him to move and resident yelled back at him. Resident stated they both were going back and forth. [Resident #5] got angry and hit him on top of his head with walker. Staff member broke incident up. Record review of nursing progress notes, dated 1/1/2025 at 4:30 PM, written by the LVN P, indicated: [Resident #3] is verbally aggressive towards another resident. Intervened at this time and DON aware. Record review of nursing progress notes, dated 1/6/2025 at 12:38 PM, written by the SW, indicated: Spoke to [Resident #3] about an incident that occurred during a smoke break on 01/05/25. [Resident #3] stated that a male resident was hollering, cussing and calling his friend/another resident racial slurs. [Resident #3] said that he started to holler back at the male resident since his friend could not defend himself. [Resident #3] stated he was fine with the other resident now and that he just puts his headphones in his ears during smoke breaks to avoid the other resident. [Resident #3] was encouraged to keep doing that and to avoid any other future conflicts with the male resident. Record review of nursing progress notes, dated 1/24/2025 at 9:59 AM ,written by the SW, indicated: Spoke to [Resident #3] about the way he talks to other residents in the facility. [Resident #3] stated he cares for some of the residents and wants to teach them and keep them from getting into things they are not supposed to. Educated [Resident #3] that when he cusses, hollers and tells other residents what to do - it is not helping them. Informed [Resident #3] to let the staff redirect other residents. [Resident #3] understood and stated he would stop 'getting onto' and hollering at residents. Record review of nursing progress notes, dated 2/19/2025 at 3:25 PM, written by the SW, indicated: Spoke with [Resident #3] with EDO regarding comments that resident was making towards staff, and reports of him touching female staff inappropriately. Education was provided to resident on why the statements he was making, and his actions were not appropriate. Also educated [Resident #3] that the facility cannot tolerate him touching the female staff on the bottoms or anywhere else [Resident #3] stated he understood and would not do those things anymore. [Resident #3] was educated on [counseling] clinical services to help with these behaviors and [Resident #3] agreed to these services. Record review of nursing progress notes, dated 2/20/2025 at 3:46 PM, written by the SW, indicated: Spoke with [Resident #3] with EDO regarding behaviors that were observed by staff today. Educated [Resident #3] again on the expectations that the facility has for him on his treatment towards staff and other residents. [Resident #3] stated that he is 'trying to remember when we talked last, and to do better.' [Resident #3] stated he understood that he is not supposed to touching staff inappropriately, other residents or cursing towards staff and residents. Educated [Resident #3] again on reporting to nursing staff if he has a concern with other residents - that he should not try and 'help' the resident himself. [Resident #3] stated he understood and that he wants to stay at the facility. [Resident #3] was informed that alternate placement would be considered if resident's behaviors continued. [Resident #3] is now receiving services from Psychiatry and [counseling] Clinical Services to help with behaviors. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of nursing progress notes, dated 3/16/2025 at 3:03 PM, written by the RN O, indicated: [Resident #3] was heard yelling at another resident to pull his pants up. Both residents were yelling at each other. Resident was redirected to the dining area. Record review of nursing progress notes, dated 3/24/2025, written by the SW, indicated: Care Plan meeting with resident, Ombudsman, DCO, ADCO and DRSS. Discussed residents behavior towards staff and how the facility will not tolerate them. Ombudsman educated resident on his rights and other residents rights and education on the facility discharging him if behaviors continue. Resident stated he understood and that he wanted to stay at the facility. Resident also stated that he understands that he should not holler and 'pick on' other residents. DCO and ADCO educated resident on all interventions the facility have made to improve behaviors and resident stated he understood. Resident stated he would limit behaviors. Record review of nursing progress notes, dated 3/25/2025 at 8:09 AM, written by LVN A indicated: It was reported to this nurse that [Resident #3] kicked another resident for no reason this morning at breakfast time. Staff CNA was feeding another resident and [Resident #3] decided to kick him multiple times. Resident is aware of possible consequences of his actions. Notified [DON]. Record review of nursing progress notes, dated 3/25/2025 at 8:16 AM, written by the SW, indicated: [Resident #3 came into DRSS office stating, 'I have to tell you something before anyone else does.' [Resident #3] stated that he 'kicked' another male resident during breakfast and that he did it for no real reason. [Resident #3] stated he knew it was wrong and that he would apologize to male resident. [Resident #3] went to doorway of my office and said 'I'm sorry' to male resident then asked if this SW heard him apologize. Reminded [Resident #3] that we just had a meeting yesterday with the ombudsman about his behaviors towards other residents. [Resident #3] stated he remembered the meeting and that is why he wanted to tell me and apologize. Record review of nursing progress notes, dated 4/14/2025 at 7:28 AM, written by the ADON, indicated: This nurse was in office when a verbal altercation between this [Resident #3] and roommate. [Resident #3] states that his roommate was on the phone and 'he was lying to whoever he was talking, all he does is lie when what he needs to do is get his fat ass up. But I never threatened him' This nurse informed resident that the phone conversation that roommate is having has nothing to do with [Resident #3]. [Resident #3] states 'well, I am sick of him lying all the time.' [Resident #3] was assisted in getting dressed and was taken from room. Roommate called police department over altercation, officer was dispatched, where it was determined that no offense occurred. Administrator notified of situation. Record review of nursing progress notes, dated 4/14/2025 at 11:30 AM, written by the SW, indicated: Spoke to [Resident #3] regarding an altercation he had with his roommate. [Resident #3] stated he 'didn't meant to holler' towards roommate and that his roommate 'lies to people' on the phone all the time. Educated [Resident #3] that he did not need to intervene in other resident's business. Educated resident that if he had any concerns to come to staff - [Resident #3] understood that hollering towards resident was inappropriate and that he would not do that again. [Resident #3] agreed to room change as well. (continued on next page)

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	675398	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care of Center	501 Timpson Center, TX 75935

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Record review of the electronic face sheet for Resident #4 indicated Resident #4 admitted to the facility on [DATE] with the most recent admission on 3/27/2025 with diagnosis that included: vascular dementia (difficulty thinking, memory and behavior), Hemiplegia (paralysis on the left side of the body), and muscle weakness. Record review of Resident #4's admission MDS assessment dated [DATE] indicated a BIMS of 13, which indicates no cognitive impairment. It also indicated Resident #4 was independent with walking 150 feet. Record review of Resident #4's care plan dated 11/15/2024 indicated: I have a ADL self-care performance deficits related to disease processes. I am mostly independent with ADLs with some assistance with set-up and supervision with locating thing. I have left side hemiplegia and walk with a cane. Interventions included: 1. Transfer: The resident requires supervision and set-up assistance by 1 staff to move between surfaces as necessary. Record review of facility incident report for Resident #4 dated 11/30/2024 at 6:45pm indicated: Resident stated he was outside smoking when he and another male resident started arguing, he stated he walked up to the other resident and the other resident pulled himself up out of his wheelchair using him they began hitting one another and fell to the ground. The notes section indicated: Resident involved in physical altercation with [Resident #3]. Resident had words with other resident and both decided to show who was boss. Few slaps back and forth, easily redirected by staff present. No injury noted or complaint of pain. Both residents redirected to their room and further smoke breaks this evening. Record review of facility progress note for Resident #4 dated 11/30/2024 at 7:31pm completed by the LVN C indicated: This nurse was at the medication cart when a dietary worker came in the hallway and stated hey they need some help out here. Nurse went to the dining room and the door leading out to the smoke area was open. Resident was observed laying in the smoke area with the other male resident beside him and they were both arguing and still trying to engage physically. Nurse stepped between them and assisted this resident up. Resident was assisted back in the facility and sat in a chair. After he got his shoes back on he was assisted to his room. Resident described in his words what happened. DON was notified. Resident was instructed to stay away from the other male resident and there would be no other smoke breaks for him. Resident did not have any visible physical injuries after assessment. Denies any physical or emotional distress. 3. Record review of the electronic face sheet for Resident #5 indicated Resident #5 admitted to the facility on [DATE] with diagnosis that included: toxic encephalopathy (brain disorder caused by exposure to toxic substances), chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe), type 2 diabetes (high blood sugar). Record review of Resident #5's quarterly MDS assessment dated [DATE] indicated a BIMS of 14, which indicates no cognitive impairment. It also indicated Resident #2 was independent with walking 150 feet. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #5's care plan dated 2/21/2025 indicated: The resident was/has potential to be physically aggressive hit another resident with walker, related to anger, poor impulse control 2/15/25-became impatient with another resident and hit that resident with walker. Interventions included: 1. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document . 3. Monitor/document/report PRN any s/sx of resident posing danger to self and others. 4. Offer psych or psychology services as needed. 5. Social Worker to talk and evaluate resident after any incidents. 6. When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Record review of facility progress notes for Resident #5 dated 2/15/2025 at 3:16pm completed by the LVN A indicated: Resident had an witnessed physical altercation with another resident. Resident was found sitting on the floor in front of his walker. Resident denies pain or discomfort at this time. Resident vital signs are stable. No injuries noted at this time. 4. Record review of the electronic face sheet for Resident #6 indicated Resident #6 admitted to the facility on [DATE] with diagnosis that included: intracerebral hemorrhage (stroke), Hemiplegia (paralysis on the right side of the body), and muscle weakness. Record review of Resident #6's annual MDS assessment dated [DATE] indicated a BIMS of 03, which indicates severe cognitive impairment. It also indicated Resident #6 required substantial to maximal assistance with transfers. Record review of Resident #6's care plan dated 1/5/2025 indicated: I received physical and verbal aggression from another resident when he was grabbed by the hand and another resident told him he would knock the hell out of him. I am still protective of other residents and may act aggressively towards others. Interventions included: 1. Resident will be assessed for emotional distress and physical injuries after incident and as needed. 2. Resident will be redirected when appropriate. 3. Resident will not go on the same smoke breaks as physically aggressive resident . 5. Staff will monitor for safe environment and to ensure no unusual episodes occur. Record review of facility incident report for Resident #6 dated 1/5/2025 at 8:30am indicated: Resident was in dining room near the smoking door with another resident when his w/c bumped into the other resident's chair. The other resident grabbed his and and told him if he did it again he would knock the shit out of him. Residents were separated and no further physical contact was made. Resident was assessed for injuries with none observed. Resident showed no signs of emotional trauma. Residents will not go on the same smoke breaks together. 5. Record review of the electronic face sheet for Resident #7 indicated Resident #7 admitted to the facility on [DATE] with the most recent admission on 10/31/2022 with diagnosis that included: major depressive disorder (persistently low mood), chronic respiratory failure with hypoxia (lungs cannot adequately provide oxygen to the blood), and muscle weakness. Record review of Resident #7's quarterly MDS assessment dated [DATE] indicated a BIMS of 15, which indicates no cognitive impairment. It also indicated Resident #4 required supervision or touching assistance with walking 150 feet. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #7's care plan dated 4/15/2022 indicated: I may have a potential for Coping Impaired related to situational and social factors including loss of autonomy or independence; disrupted family life, grief, loneliness, helplessness, or hopelessness. I am seeing counselor at facility and have visits with [Psychiatrist] as needed. Interventions included: Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. During an interview on 4/15/2025 at 10:48am Resident #5 said Resident #3 was in the way while he was trying to get out the door to the smoking area. He said he asked him to let him get by and he said Resident #3 talked noise and cussed him out. He said Resident #3 was agitated and speaking in Spanish. He said Resident #3 turned around and was raising up out of his chair like he was going to fight. He said he then hit him with his walker. He said they both fell on the floor in the dining room. He said Resident #3 called the police and they came and talked to him and told him the next time they would take him to jail. He said if Resident #3 acted that way again he would hit him again. He said that had been the only physical incident he had with Resident #3. He said there was another guy on the 300 hall Resident #4 that had a physical altercation with Resident #3. He said Resident #3 had problems with a lot of residents because he was always in other peoples business and cussing other residents. During an interview on 4/15/2025 at 11:11am Resident #7 Said she calls bingo when the activity director can't and said Resident #3 yells out at her when she calls bingo like a bully would. She said they sent Resident #3 to a behavioral hospital because he was physical with Resident #6. She said they initially put Resident #3 on another hall, but he is now back on her hall. She said Resident #3 will throw things. She said Resident #6 is really the only resident she had ever seen Resident #3 kick or get physical with. She said he kissed the older ladies' hands a lot and did not feel it was appropriate. She said one lady (unknown) finally yelled at him to stop and leave her alone. She said Resident #3 did a lot of cussing and calling people names. She said Resident #3 had asked her for sex, and she turned him down and he didn't like it. She said he asked a lot of the ladies and employees for sex. She said she was not afraid of him physically, but she was afraid of what he brought out in her and was afraid she would hit him. She said one time they got in an argument, and he tried to charge at her, and staff pulled him back. She said she felt so much better when he resided on a different hallway. She said he had just moved back to this hall yesterday 4/14/2025 because he got into an altercation with his roommate on the 300 hall and his roommate called the police. She said all altercations or arguments is always centered around Resident #3. During an interview on 4/15/2025 at 11:25am Resident #6 could not answer questions due to diagnosis of aphasia (language disorder that results from damage to the brain's language centers). During an interview on 4/15/2025 at 11:31am CNA D said Resident #3 moved back to the 500 hall yesterday 4/14/2025. She said she did not know what prompted the move back to the 500 hall. She said Resident #3 was smart mouthed and disrespectful to staff and residents. She said a staff member would be talking to another resident and Resident #3 will chime in with his negative input. She said she had seen the arguing with Resident #3 but had never seen him get physical with anyone. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/16/2025 at 1:21pm Resident #3 said when he was 28 he was in the hospital for 2 months and that's when he was diagnosed with the Wilson's disease. He said he is a sweet guy but when you him make him mad, he turns into the devil. He said he did not receive counseling services at the facility. He said he had only talked to a counselor 1 time since he had been at the facility. He said when he has the incidents with other residents he will go an apologize after the incident was over. He said he did not have control over his actions when he gets mad and he gets anxious. He said he told Resident #4 to tie his shoe and Resident #4 told him to shut up and for him to tie it and said he got up and started walking over to him and they just began fighting and fell to the ground in the smoking area. He said Resident #5 told him to go out the door and he said Resident #5 took his walker and put it over his head and jerked it back as if to choke him. He said he kicked Resident #6 because he was jealous the staff were feeding Resident #6 and not him. He said he went to the behavior hospital after he kicked Resident #6. He said he got kicked out of another nursing facility for trying to bite the medication aide's finger. During an interview on 4/17/2025 at 1:25pm Resident #4 said he did not like Resident #3 and said on the day in question he was in the smoking area. He said Resident #3 told him his shoe was untied and he told Resident #3 it was none of his business. He said Resident #3 would not leave him alone and he got mad and him and Resident #3 mutually began fighting and fell on the ground. He said after the incident he did not like Resident #3 but he just tried to stay away from him and stay out of trouble. During an interview on 4/22/2025 at 9:28am LVN A said on 2/15/2025 someone came and got her and let her know Resident #3 and Resident #5 were fighting in the kitchen. She said Resident #5 told her that Resident #3 was talking bad to him. She said Resident #5 said he hit him. She said when she asked Resident #3 what happened he said Resident #5 was talking to someone else and Resident #3 got in their business and started the argument with Resident #5. She said both residents fell on the floor in the dining room. She said Resident #3 was always in someone else's business. She said she thought Resident #3 was just angry because he was in the nursing home. She said Resident #3 would wake up and just be mad at the world. During an interview on 4/22/2025 at 10:14am CNA E said on 2/15/2025 she was taking the smokers out and was standing in the doorway. She said she heard Resident #5 tell Resident #3 to go and he said don't you see CNA E in the way. She said she didn't hear him say anything else and then Resident #5 put his walker over Resident #3 like he was trying to choke him with it. She said then Resident #3 started shaking and fell on the floor. She said Resident #3 called the police. Said she thought both residents had been arguing prior to the incident. She said Resident #3 could not get along with anyone. Record review of the facility's policy titled Abuse, dated 2/1/2017, reflected: . Residents will not be subjected to abuse by anyone, including, but not limited to community staff, other residents, consultants, volunteers, staff of other agencies serving the residents, family members or legal guardians, care taker, friends, or other individuals .Upon notification of an allegation of physical or mental abuse, neglect or involuntary seclusion, the facility will conduct interviews that include documented statement summaries from the alleged perpetrator, the alleged victim, family members, visitors who may have made observations, roommate, and any staff who worked prior to and during the time of the incident. Investigations will focus on determining if the abuse occurred, the extent of the abuse and potential causes . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339 Based on observation, interview, and record review the facility failed to ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents for 2 of 7 (Resident #1 and Resident #2) residents reviewed for supervision. The facility failed to ensure the secured unit courtyard gates were locked after lawn care services on [DATE]. On [DATE] Resident #1 eloped from the facility grounds through an unlocked gate in the courtyard of the secured unit. A good Samaritan encountered Resident #1 at a nearby doctor's office and Resident #1 was returned to the facility. The facility failed to provide adequate supervision for Resident #2. On [DATE] Resident #2 eloped from the facility through the front door. A good Samaritan encountered Resident #2 at a nearby roadway intersection and returned Resident #2 to the facility. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 4:51 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm because (e.g.) all staff had not been trained on the facilities elopement policy. This failure could place residents at risk of not being properly supervised resulting in injury or death. Findings included: 1.Record review of the electronic face sheet for Resident #1 indicated Resident #1 admitted to the facility on [DATE] with diagnosis that included: dementia (decline in cognitive function), muscle weakness, type 2 diabetes (high blood sugar). Record review of Resident #1's annual MDS assessment dated [DATE] indicated a BIMS of 03, which indicates severe cognitive impairment. It also indicated Resident #1 was independent with walking 150 feet. Record review of Resident #1's care plan dated [DATE] indicated: I am exhibiting behavior of wandering. I have dementia and may wander or pace. I may enter other's rooms uninvited. I respond well to redirection at this time. I have been moved to secured unit for safety. Interventions included: Staff will monitor for safe environment and to ensure no unusual episodes occur. Record review of Resident #1's elopement risk assessment dated [DATE] indicated an elopement score of 15 which was of high risk category. Record review of Resident #1's elopement risk assessment dated [DATE] indicated an elopement score of 3 which was of medium risk category. (continued on next page)

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	675398	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care of Center	501 Timpson Center, TX 75935

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility incident report for Resident #1 dated [DATE] at 3:31pm completed by the DON indicated: Resident had finished eating lunch and asked to go outside in the courtyard, approximately, 12:55pm. At 1:08pm a family member of a staff member, [family member] called facility asking if we were missing one of our residents. Staff immediately left facility, where [family member] had resident and brought him back to facility at approximately 1:13pm just smiling. When SW interviewed resident, he remembers leaving facility on foot but doesn't know where he was going. 2. Record review of the electronic face sheet for Resident #2 indicated Resident #2 admitted to the facility on [DATE] with diagnosis that included: anxiety (feelings of worry or unease), metabolic encephalopathy (brain dysfunction), type 2 diabetes (high blood sugar). Record review of Resident #2's admission MDS assessment dated [DATE] indicated a BIMS of 01, which indicates severe cognitive impairment. It also indicated Resident #2 partial to moderate assistance with walking 150 feet. Record review of Resident #2's care plan dated [DATE] indicated: I will reside on the facility secured care unit due to wander/elopement risks. Related to disoriented to place, history of attempts to leave facility unattended, impaired safety awareness. Interventions included: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Record review of Resident #2's elopement risk assessment dated [DATE] indicated an elopement score of 3 which was of medium risk category. Record review of Resident #2's elopement risk assessment dated [DATE] indicated an elopement score of 9 which was of high risk category. Record review of facility incident report for Resident #2 dated [DATE] at 8:30am completed by the ADON indicated: A community member knocked on front entrance door with resident noted to be sitting in wheelchair, stating he was down there in the road Resident assessed with no noted distress. Resident #2 said I just want to go home. Record review of facility incident report for Resident #2 dated [DATE] at 8:30am notes completed by the DON indicated: from review of cameras-resident left building behind [family member] family member who did not close the door after him. Per staff-they saw resident on 400 hall approximately, 8 am as they went into a staff meeting, when they came out at approximately 8:10 he was out of facility and in process of being returned. Record review of Resident #2's electronic medical record indicated Resident #2 expired in the facility on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:44am CNA Q said they document once a shift to check the outside doors and gates to make sure they are locked. She said for the back door you have to put in the door code and that unlocks the door and the outside gate. She said you have to be fast to go down to the gate because it locks back pretty fast. She said the dining room door is unlocked and residents can come and go as they want. She said they have to push the emergency exit button that unlocks all doors in the secured unit to unlock the gate in the dining room courtyard. She said they have to push and turn the emergency exit button again to lock the gate back. She said when the [NAME] come the button releases the gate and one of them goes and opens the gate and then the other pushes the button to lock all the doors back. She said when the lawn care service was at the facility, they had to watch the residents in the secure unit to ensure no one got out of the locked doors. She said the staff had to remember to relock the doors and gates after the lawn care service was finished. During and observation and interview on [DATE] at 11:44am CNA R said that all gates are checked once a shift and CNA Q usually already checked them prior to him getting to work so he typically did not check them. CNA R put in the code on the back door of the secured unit. CNA R said the code would release the back door and also the gate outside of the back hallway door. Surveyor observed the gate being released and the gate required being pushed back so the magnets on the gate would reattach and lock the gate. If the gate was not pushed back together the gate would not lock. The secured unit dining room door was observed with no lock and residents could come and go freely to the outside courtyard. CNA Q pushed the emergency exit button which then released all locked doors of the secured unit. CNA Q then pushed and turned the emergency exit button in the dining room to relock the secured unit doors and gates. The Surveyor observed the courtyard gate had to be physically pushed back together in order for the magnets to reattach and lock the gate. Resident #1 was sitting outside during this observation and got up and went and checked to see if the gate was locked. CNA R said they had to keep a closer watch on the residents when the lawn care service was there and then had to remember to relock the doors and gates once they were finished. During an interview on [DATE] at 12:52pm the ADON said she started in [DATE] right before the Resident #2's elopement. She said a passerby came and knocked on the door and said Resident #2 was out and had brought him back to the door. She said she didn't know where she had encountered Resident #2 and did not have contact with anyone at the facility and was just driving by. She said they took Resident #2 to the unit and assessed Resident #2 and then checked the door locks and alarms. She said she saw Resident #2 at around 8:00am and she didn't know how long Resident #2 was out before being brought back to the facility. During an interview on [DATE] at 1:13pm the DON said Resident #1 got out the gate and went to a nearby doctor's office. She said Resident #1 was brought back to the facility at 1:13pm. She said at 12:55pm Resident #1 was last seen after he had just finished lunch and then was returned to the facility at 1:13pm. She said they believed there was an issue with the magnetic lock but when the lock was checked it was fine. She said the lawn care service had been there the day before but is not sure if that was the cause. She said staff were supposed to do 4-hour checks on the gates that was started prior to the elopement. She said they had a monitoring sheet for the gate checks but was not able to find any monitoring sheets since [DATE]. She said Resident #2 admitted on [DATE] and eloped on [DATE]. She said Resident #2 went to the door and wheeled out the door right behind another family member. She said a passerby brought the resident back from down the street on the corner at the redlight. She said Resident #2 went out at 8:10am and was brought back to the facility at 8:26am. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:28am LVN A said she was here the day Resident #2 eloped but said all she remembered was that Resident #2 kept saying he wanted to go home. She said Resident #2 kept going to the doors trying to get out and someone would redirect him and then he eloped. During an interview on [DATE] at 9:50am LVN H said Resident #1 had gotten out of the secured unit before the elopement. He said Resident #1 liked standing by the doors and one day he didn't close the door soon enough and Resident #1 got out of the secured unit and was walking around the nurse's station. He said he had eyes on Resident #1 the whole time and was easy to get back into the secured unit. He said he didn't remember the day he got out of the gate. He said he was here the day Resident #2 eloped but by the time he knew anything about it they had already gotten Resident #2 back in the facility. During an interview on [DATE] at 10:48am with the Administrator via phone, she said her expectation was to prevent elopements. She said if a resident were to elope that resident was in danger of being hurt. Record review of the facilities Elopement policy dated [DATE] indicated: To safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing . This was determined to be an Immediate Jeopardy (IJ) on [Date] at [Time]. The [Titles of people identified] were notified. The [Name of person given the IJ template] was provide with the IJ template on [Date] at [Time]. I . The facility's plan of removal was accepted on [DATE] at 9:16 am and included: The following is a plan of removal, which has been immediately implemented at the facility to remedy the immediate jeopardy as a result of alleged deficient practices, which was imposed on [DATE] at 5:26pm. Resident #1 was assessed and interviewed upon return on [DATE]. The resident was not injured and was not in distress. The Maintenance Director checked the functioning of the magnetic locks on the doors and gates on the secured unit, all were in working order. Secured Unit staff were educated on [DATE] on the required gate lock checks every 4 hours and to complete the Secured Unit Gate Monitoring Log. Resident #2 was assessed upon return on [DATE]. The resident was not injured and was not in distress. The Maintenance Director and EDO checked all exit doors for functioning of key pads and alarms, all were in working order. Video footage revealed the resident exited the front door behind another resident's family member. The resident was moved to the secured unit due to the new elopement risk on [DATE]. The front door code was changed on [DATE], and a staff in-service was completed on [DATE] on keeping the code confidential. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All staff in-serviced on Elopement/Missing Resident on [DATE] by Executive Director of Operations (EDO)/Director of Clinical Operations(DCO) and/or designee. All staff not present at time of in-service will not be permitted back to work until in-service is complete. All staff in-serviced on magnetic lock reset function during power disruption on [DATE] by EDO and DCO. All staff not present at time of in-service will not be permitted back to work until in-service and competency test is complete. implemented and educated all staff on new process during lawn care services on [DATE]. New process adopted by facility is as follows: Facility staff will bring residents inside during lawn care and monitor all exit doors to not allow residents to leave secured unit hallway. Staff will then reengage the magnetic locks when lawncare is completed and verify that each door and gate are secured. Lawn vendor contacted on [DATE] at 8:45 pm by EDO and educated on communication with EDO and/or DCO about exiting the property and verifying the gate is secured. All staff in-serviced on facility door code confidentiality and who to contact if he/she feels the code has been compromised on [DATE] by EDO and DCO. All staff not present at time of in-service will not be permitted back to work until in-service is completed. Facility EDO reviewed and in-serviced on facility policy to door code changes. All resident with risk of elopement have the potential to be affected by the this alleged deficient practice. An audit was completed on [DATE] by the CRC to ensure all residents had a current elopement risk assessment and accurate care plan. The Medical Director was initially made aware on [DATE] of the immediate jeopardy, and has been involved in the development of the plan to remove during an abbreviated QA. These conversations are considered a part of the QA process. Next schedule QA meeting set for [DATE] at 12pm. All in-servicing began [DATE]. This plan was initially implemented [DATE] and will be monitored, through personal observation, through completion by Regional [NAME] President of Operation and Regional Director of Clinical Services. On [DATE] the Surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Record review of skin assessment completed [DATE] on Resident #1. Record review of inservice record dated [DATE] regarding required gate lock checks on secured unit every 4 hours and check the courtyard gate to ensure the lock is secure and complete the log attached. 18 staff signatures on inservice. Record review confirmed Resident #2 was moved to the secured unit on [DATE]. Record review of an untitled document dated [DATE] revealed maintenance director and ADO together checked all exit doors for functioning of keypads and alarms, and all were in working order. Record review of inservice record dated [DATE] titled Do not give the door codes to anyone other than staff. Staff are to let visitors out of the doors. 34 staff signatures on inservice. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of inservice dated [DATE] at 7:00pm titled 1. All staff inservices on the elopement/missing resident protocol. With 33 employee signatures. Record review of inservice dated [DATE] at 7:00pm titled 2. All staff inservices on the magnetic lock reset function. 3. All staff inservices on process during lawn care visits. With 33 employee signatures. Record review of inservice dated [DATE] at 8:45pm titled Lawn vendors to communicate with ADM/DCO each time they need to enter and exit the secured unit patio/lawn care areas. Doors and Gates must be secured before they leave the area lawn care service inserviced via phone. Record review of inservice dated [DATE] at 7:00pm titled 4. Door codes-are confidential and are never to be given to residents/family members or vendors at any time With 33 employee signatures. Record review of residents with risk of elopement audit completed by the CRC on [DATE]. Record review of Ad Hoc Qapi meeting held on [DATE] at 7:15pm attended by the medical director, Administrator and DON. During interviews conducted on [DATE] between 8:45 am - 9:15 am CNA M, PTA, CNA B, CNA F, CNA N, Activity Director, HSK, Floor Tech, Laundry U, Laundry V, Receptionist, BOM, CNA K, ADON, CNA S, LVN H, LVN T, LVN A, and LVN G all verbalized if a resident is missing a code pink is called. They all said the codes to the doors are never to be shared with visitors and if a visitor is observed entering a code the Administrator was to be notified so it can be changed. They all said the gates on the unit must be checked every 4 hours and the inside buttons to be checked to make sure the light was green. They said if the lawn care service was present, they were to be let in and then back out when they were finished. On [DATE] at 9:55am, the Administrator was notified the IJ was removed. However, the facility remained out of compliance at a level of no actual harm with the potential for more than minimal harm with a scope identified as isolated due to the facility's need to monitor the implementation and effectiveness of its POR.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 50818 Based on observation, interview, and record review, the facility failed to provide an effective pest control program to ensure the facility is free of pests and rodents in 1 of 1 facility kitchens. The facility failed to address the roaches in the facility kitchen, which staff was aware of and had reported to the Dietary Manager and ADM. This failure could place all residents who eat meals prepared in the facility kitchen at risk of food borne illness and cross contamination. Findings included: An observation on 4/17/25 at 12:30 p.m. in the facility kitchen revealed dead insects on top of dry-food storage shelves and stuck to the walls below a food preparation area. During an interview on 4/17/2025 at 12:40 p.m., the Dietary Aide said there had been roaches in the kitchen for at least a month. She said had reported the roaches to the Dietary Manager and ADM, but the issue had not been addressed. During an interview on 4/17/2025 at 12:45 p.m., the [NAME] said there had been roaches in the kitchen off and on since December of 2024. She said she had reported the issue to both Dietary Manager and ADM but there were still roaches in the kitchen. During an interview on 4/17/2025 at 1:00 p.m., the Dietary Manager said she had worked at the facility for 4 months and there had been an issue with roaches in the facility kitchen. She said pest control had come out today to spray for pests. During an interview on 4/17/25 at 2:00 p.m., the ADM said the facility had roaches in the walls in the kitchen since December of 2024. She said facility maintenance staff saw roaches in the walls in the kitchen while repairing a leak on or around 4/11/25. She said facility staff sprayed the area with a can of pesticide, but she did not call pest control because they were coming out next week for a scheduled monthly visit. She said there was no risk to residents from roaches in the kitchen. Review of the Pest Control service visits revealed a Service Order for a visit on 4/16/25. The service order instructions indicated there were reports of roaches in the dining room cabinets and kitchen. Pest control products were applied in the kitchen, dish pit, dining room, break room, and common area targeting pests American Roaches and German Roaches with a follow-up visit recommended to be scheduled in a week. Review of a facility policy titled Pest Control last revised in May 2008 indicated .This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents .