STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675433	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Huntsville	1302 Nottingham St Huntsville, TX 77340

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents the right to be free from abuse and neglect for 1 of 7 (Resident #2) residents reviewed for abuse and neglect. The facility failed to protect Resident #2 from abuse from Resident #1 on 6/26/2025 when Resident #1 hit Resident #2 with his walker. This failure could place residents in the facility at risk for severe negative psychosocial outcomes which could prevent them from achieving their highest practicable physical, mental, and psychosocial well-being. Findings included: 1.Record review of the electronic face sheet for Resident #1 indicated Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] with the most recent readmission on [DATE]. Resident #1 discharged from the facility on 6/27/2025. Resident #1's diagnoses included: cerebral infarction (brain tissue dies due to lack of blood flow; stroke), bipolar disorder (extreme shifts in mood, energy, and activity levels), Alzheimer's disease (impairs memory, thinking and behavior), and major depressive disorder. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated a BIMS score of 06, which indicated severe cognitive impairment. Record review of Resident #1's care plan dated 6/27/2025 indicated: On 6/26/2025 Resident #1 had actual episode of aggression. Resident #1 was noted by CNA and a visitor that he hit one of the residents while they were in the lobby he was aggressive trying to pursue the CNA when he was being directed, he was also arguing to anyone redirecting him to his room with interventions that included: 1. Separate from other resident and redirect to room. 2. Physician and family notified. 3. Resident #1 was to be discharged to another facility 6/27/2025. Record review of facility incident report dated 6/26/2025 at 5:30 PM for Resident #1 indicated: Resident #1 was noted by CNA and a visitor that he hit one of the residents walkers causing her walker to hit her leg while they were in the lobby, he was aggressive trying to pursue the CNA when he was being directed, he was also arguing to anyone redirecting him to his room. The incident report further indicated that there were no injuries at the time of the incident. Record review of nursing progress notes dated 6/27/2025 written by LVN A indicated Resident #1 discharged from the facility at 6:40 PM to the behavioral hospital. 2. Record review of the electronic face sheet for Resident #2 indicated Resident #2 was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #2's diagnoses included: dementia (decline in mental ability), delusional disorders (false beliefs), and depression. Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated Resident #2's BIMS score of 15 which indicated no cognitive impairment. Record review of Resident #2's care plan dated 6/27/2025 indicated: on 6/26/2025 Resident #2 was struck by another resident with no injury, with interventions that included: 1. Separated from aggressive resident. 2. Head to toe physical assessment done. 3. Temporarily moved to a different room for the night for safety. Record review of facility incident report dated 6/26/2025 at 8:00 PM indicated: another resident (Resident #1) pushed his walker into this resident's (Resident #2) walker causing it to hit her leg, according to her, by one of the residents while they were in the living room watching TV. The incident report further indicated there were no injuries at the time of the incident. During an interview on 8/12/2025 at 1:18 PM, Hospitality Aide B said Resident #1 liked to go and lay on the couch in the TV room. She said on 6/26/2025, Resident #1 was walking into the TV room with his walker when Resident #2 told Resident #1 to watch her feet. She said Resident #1 then picked up his walker and hit Resident #2 on the knee. She said Resident #2 called out oh don't hit me, why are you hitting me. She said she told Resident #1 that was not nice, and Resident #1 picked up his walker and started chasing her and calling her names. She said the Administrator came and tried to calm Resident #1 down and he went ballistic on her. She said Resident #1 began going after the Administrator because she told him that he needed to go to his room. During an interview on 8/12/2025 at 1:34 PM, Resident #2 said the Administrator had told Resident #1 that he was not allowed to sleep on the couch in the TV room anymore. She said, on 6/26/2025, Resident #1 came into the TV room and was on the couch and she told him that he was not allowed to sleep on the couch anymore and he got up and hit her. She said he hit her across her waist where her [NAME] pack was, and across her quilted jacket and because she had on her [NAME] pack she did not get hurt. She said the Administrator came and tried to calm down Resident #1 and he went after her. She said the Administrator sent Resident #1 out of the facility and she had not seen him since. During an interview on 8/13/2025 at 10:14 AM, the Administrator said she had told Resident #1 that he could not sleep on the couch in the TV room anymore. She said Resident #1 came through the TV room, and when Resident #2 said something to Resident #1, he took his walker and pushed it in to Resident #2's walker