

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675849	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/06/2025
NAME OF PROVIDER OR SUPPLIER  Focused Care at Burnet Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 3921 N Main Baytown, TX 77521	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38644</p> <p>Based on observation, interview and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 3 of 5 residents (Resident #39, #23, and CR #1) reviewed for abuse.</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure Resident #39 was free from abuse when CR #1 hit her and made her cry on 3/7/24.</li> <li>2. The facility failed to ensure Resident #23 was free from abuse when CR #1 screamed at her and made her cry on 1/16/24.</li> </ol> <p>These failures could place residents at risk for physical, mental, and psychosocial harm.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #39's face sheet, dated 3/14/24, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnosis included dementia, need for assistance with personal care, anxiety, recurrent depressive disorders, hypertension (high blood pressure) and peripheral vascular disease (a common condition in which narrowed arteries reduce blood flow to the arms or legs).</li> <li>Record review of Resident #39's incident report, dated 3/8/24, read in part, .nursing description: stated by another resident, that victim was on 200 hall and said assailant was passing and swung her arm and hit victim around chest and arm area No injuries observed at time of incident</li> <li>2. Record review of CR #1's face sheet, dated 3/6/25, revealed an [AGE] year-old female who was admitted to the facility on [DATE] and discharged to a psychiatric hospital on 3/8/24. Her diagnosis included cognitive communication deficit, bipolar disorder (a serious mental illness characterized by extreme mood swings), and atrial fibrillation (an irregular and often very rapid heart rhythm).</li> <li>Record review of CR #1's discharge-return anticipated MDS assessment, dated 3/8/24, revealed her cognitive skills for daily decision making was modified independence. The assessment indicated physical and verbal behavioral symptoms toward others were not exhibited. She was independent with eating and oral hygiene and required assistance from staff with toileting, dressing, and personal hygiene.</li> </ol> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of CR #1's care plan, dated 2/1/24, revealed she had the potential to be physically and verbally aggressive towards staff and residents related to anger. Interventions were to administer medications as ordered, assess and anticipate resident's needs, provide physical and verbal cues to alleviate anxiety, monitor every shift and document observed behavior, monitor/document/report as needed any s/sx of resident posing danger to self and others, psychiatric/psychogeriatric consult as indicated, and intervene before agitation escalates.</p> <p>Record review of CR #1's nursing note, dated 1/10/24 at 4:42 p.m., written by LVN R, read in part, Resident aggressive and hollering at another resident, telling her to shut up. ADCO and DCO made several attempts to redirect resident, but resident continued to display aggressive behavior. The DCO removed resident away from the other resident but while in route resident punched DCO in the face on the right side</p> <p>Record review of CR #1's nursing note, dated 1/10/24 at 9:45 p.m., written by LVN J, revealed the resident was discharged from the facility. No signs of distress noted at time of departure.</p> <p>Record review of CR #1's nursing note, dated 1/15/24 at 9:50 a.m., written by LVN M, read in part, Resident arrived via wheelchair by ambulance for (local hospital) for long term care</p> <p>Record review of CR #1's nursing note, dated 1/15/24 at 11:07 p.m., written by LVN C, read in part, Resident could be heard screaming, when walked in room she was screaming at her roommate, roommate was not doing anything [sic] other than laying in bed, she was standing over her screaming to turn off tv, her tv was not even on, it was her tv that was on, redirected resident to stop acting like that because she was scaring her she stated 'I don't give a dam, now get your black (expletive)(expletive) out of my room' . she continued to physically get out of bed and go over to roommate side and turn off her overhead light. [Resident #23] came out of room, I went back to room to turn light on and told her she cannot touch roommates things, she layed [sic] down and shut eyes, [Resident #23] went back to bed</p> <p>Record review of CR #1's nursing note, dated 1/16/24 at 12:45 a.m., written by LVN C, read in part, .while doing continuous checks on resident and her roommate she became aggitated [sic] that staff was in her room and started screaming more racial hate comments toward staff, then proceeded to chase CNA out of room running after her and hit her with cane, res finally went back to room and I went to room and removed [sic], RP called and message left, DON and Administrator notified</p> <p>Record review of CR #1's nursing note, dated 1/16/24 at 8:03 p.m., written by LVN R, read in part, Resident screaming and hollering at roommate telling her to shut her mouth. Resident then pulled TV cord out of the electric outlet. This narrator informed resident that room is for both of them and she cannot touch roommate's belongings. Resident called this narrator a witch and [expletive]. This narrator observed roommate crying and upset. Narrator attempted calmed [sic] roommate down while resident continues to scream and holler</p> <p>Record review of CR #1's nursing note, dated 1/17/24 at 11:59 a.m., written by the Social Worker, read in part, contacted (name and number) to inform of room change to (room number).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of CR #1's nursing note, dated 1/31/24 at 3:08 p.m., written by the previous Activities Director, read in part, .on 1/30/24 at 2:30 p.m. resident was in the dinning [sic] room with other residents and she was snatching items from the residents and one of the dietary staff came and tried to separate the two residents once I noticed the commotion, I quickly went and tried to defuse the situation, once (CR #1) became non-complanate [sic] I proceeded to get her nurse once she came into the dining room she tried to get (CR #1) out of the dining room and she started to resist. I started to explain to the nurse what had just transpired and (CR #1) started to exit out of the dinning room trying to go to her room, and once she passed the nurse &amp; I she stated get out of my way then she proceeded to punch me in my stomach. I the activities director told the ADON, DON and the Admin as well as the nurse who also witnessed it. No incident report was done nor asked to be done</p> <p>Record review of CR #1's nursing note, dated 2/1/24, written by LVN J, read in part, Screaming heard on hall, upon reaching room, roommate reported to nurse that resident kicked her leg. Roommate transferred to another room. No further incidents by end of shift.</p> <p>Record review of CR #1's nursing note, dated 2/1/24, written by the Social Worker, read in part, Resident was observed rolling toward another resident's wheelchair hitting that resident's wheelchair in the dining hall and cursing at that resident. Resident was redirected by (staff); onset of repeated verbal aggression. Resident yelled out You lying (expletive)! Resident redirected again.</p> <p>Record review of CR #1's incident report, dated 3/8/24, read in part, .stated by another resident, Resident approached another resident hit her in the around chest area. Removed immediately from another resident and placed on 1:1</p> <p>Record review of an, undated, witness statement for Staff Member H read in part, .the incident happened on 3/7/24 stated it happened coming out on [sic] the dining room when [CR #1] hit [Resident #39]. She [Staff Member H] reported it to staff on 3/8/24.</p> <p>Record review of CR #1's nursing note, dated 3/8/24, written by the Social Worker read in part, .Another resident notified DRSS that resident hit another resident. While attempting to redirect resident, resident stated 'that [expletive] hit me first' and 'that [expletive] had it coming!' Redirected again, and resident rolled her eyes, and stormed off in the dining room area. Other resident was observed crying</p> <p>Record review of CR #1's nursing note, dated 3/8/24, written by LVN J, read in part, Transportation set up with [EMS company] to transfer resident to [Behavioral hospital] in [city]</p> <p>Record review of CR #1's nursing note, dated 3/12/24 at 9:23 a.m., written by the DON, read in part, . Late entry for 3/8/24 Resident was accused by another hit another [sic] resident in the dining room. Resident placed on 1:1 immediately and (hospital) notified of needed behavioral management with the expectation of not be able [sic] to return as I am unable to meet needs and keep other residents safe.</p> <p>In an observation on 3/4/25 at 10:03 a.m. revealed Resident #39 was lying in bed. She did not respond completely to the state surveyor's questions. There was no distress noted.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 3/6/25 at 3:33 p.m., the DON said in the event of a resident-to-resident altercation staff were instructed to separate residents immediately, assess both residents and obtain statements from witnesses. Notification should be made to the MD, family, psych services and an incident report should be done. She said Resident #39's family visited her every other day and there was no more abuse to the resident.</p> <p>In an interview on 3/6/25 at 5:53 p.m., the Administrator said the facility sent CR #1 out to the behavioral hospital when it got bad. She said CR #1 mainly wanted to go home and was triggered by certain family members. She said she was on psych services, was quite alert, and had previously lived by herself. She said the facility kept the residents isolated from her and CR #1's behavior was not an everyday thing. She said CR #1 was not being abusive to residents but then said it was abusive to the resident but a lot of it was because of anger. She said she was pretty sure the facility care planned her behaviors.</p> <p>In an interview on 3/6/25 at 6:12 p.m., the DON said she could not recall all of the interventions she put in place with CR #1 but she had psych services on board, medication, and was sure she made referrals. She said CR #1 was not abusive to the residents but had incidents of containable aggression where she lashed out. She said examples of abuse were mental, physical, emotional and misappropriation. She said physical abuse included hitting and kicking someone. She said CR #1 kicked someone but could not say if she knew what she was doing because she had cognition issues. She said verbal abuse included calling someone out of their name and insulting them. She said abuse was subjective. She said she was positive she protected the residents from abuse because that was her main goal.</p> <p>In an interview on 3/6/25 at approximately 6:45 p.m. Resident #23 was sitting in the living area near the front entrance with no distress noted. She said she did not have any problems from her previous roommates.</p> <p>Record review of the facility's Abuse policy, last revised 1/1/23, read in part, .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. The facility staff will adhere to the policies and procedures and will follow the guidelines in the written policy and procedure. The facility administrator is the appointed Abuse Coordinator, and in his/her absence a designee will be appointed . 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 includes physical, verbal, sexual, physical /chemical restraint . In the event of resident-to-resident abuse, the facility will immediately protect the resident being abused and all other residents in the facility. If the initial determination is that the perpetrator is a threat to the health and safety of the residents in the facility, as determined by the attending physician/or other physician, the resident will be discharged as soon as possible. During the time that the perpetrator has not been discharged , the facility will monitor this resident one-on-one to protect all other residents. The Director of Nursing will coordinate this and set up monitoring. If a threat does not exist then an assessment will be completed, and behavior will be care planned to meet resident's needs and protect others .</p>		