STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675927	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Crane	699 Campus Dr Crane, TX 79731

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46641 Based on interview and record review the facility failed to ensure allegation of abuse, the facility had evidence that alleged violation was thoroughly investigated but failed to report the results of investigation to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident for 1 resident (Residents #1) reviewed for investigating alleged violation of abuse. The facility failed to report evidence that a thorough investigation was conducted, failed to complete a provider investigative report (Form 3613A), and failed to report the results of the investigation when Resident #1 alleged abuse from CNA A which did not result in injury to Resident #1. These failures could place residents at risk for allegations of abuse and neglect not being thoroughly investigated by the facility and reported as required. Findings include: Record review of Resident #1's face sheet, dated 6/25/24, revealed Resident #1 was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included Acute Respiratory Failure with Hypercapnia (arterial oxygen, carbon dioxide, or both cannot be kept at normal levels), Ventricular Fibrillation (abnormal heart rhythm), Opioid dependence, Schizophrenia (mental disorder), Muscle Weakness, Muscle Wasting and Atrophy (wasting away of body part or tissue). Record review of Resident #1's MDS, dated [DATE], revealed Resident #1 had a BIMS score of 11 (moderate cognitively impaired), impaired visual functioning, fall risk, un-aware of safety risks. Record review of Resident #1's Care Plan, dated 4/7/24, revealed Resident #1 had impaired visual functioning and is at risk for decrease in ADLs and injuries. Resident #1 has behavior problems (refuses to listen to staff about smoke break times, redirection unsuccessful, low frustration tolerance. Schizoaffective disorder, Depression, high risk for falls and fractures, requires assistance with decision making, potential to be verbally aggressive towards staff, poor impulse control, limited physical mobility, elopement risk. Record review of Resident #1's progress notes, dated 5/26/24 at 2:40pm revealed, LVN B documented, this nurse witnessed resident verbally aggressive with CNA due to his smoke break. This resident bad-mouthing CNA because (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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident demanding to be taken out for a smoke CNA stated he would take him out to give him a minute to finish doing what he was doing resident then became loud demanding to be taken out, came around nurse's station and grabbed his cigarettes' and stated he would take himself. This nurse heard door alarm from smoking door, upon walking down hallway noted residents and staff down the hallway, this resident noted to be in the middle of the hallway, when he noticed this nurse he came towards me, upset, stating he wanted to report the male CNA A because he had put his hands on him, this nurse and resident continued on to the nurses station where resident stating he wanted to call the police, resident taken aside and assessment done, no bruising, no redness, no swelling noted to resident, then proceeded to report what had occurred, this nurse notified abuse coordinator and DON, resident then noted to go up to the CNA stating he would make sure and take his job from him, resident redirected and relocated, assisted outside by this nurse to take a smoke break and calm down, attempted to notify resident's family member of incident, no answer, resident stated he is on a cruise but that he does not want his family to know of incident. Record review of facility incident intake #506758, reported to HHSC on 5/26/24 by facility Administrator, incident category: Abuse. Narrative of incident intake #506758, 'Resident #1 asked to be taken out to smoke break, CNA A told Resident #1 that he would, but he needed to finish his charting before he went, and he would need a couple of minutes to finish it. CNA A turned and asked LVN C to take the smokers out to smoke. LVN C began to take the smokers down the hall while CNA A finished his charting. When CNA A was finished, he went down the smoker's hallway and Resident #1 stands up on his scooter to confront CNA A. Resident #1 told CNA A I will get our license and When I get done with you won't have anything left. CNA A said that he saw Resident #1 stand up on his scooter and become unsteady on his feet. CNA A put his hand under Resident #1's elbow to support him in sitting down in his chair. Resident #1 then began to say that CNA A had abused him. During an interview on 6/25/24 at 1:00pm with Resident #1 stated the facility and staff were good this was a good place, and they take care of them. Resident #1 did re-call incident on 5/26/24 at 2:30pm, Resident #1 stated he was ready to go smoke, and CNA A told him that he was not taking resident outside to smoke with the other residents. Resident #1 stated he had no idea why CNA A was not letting him go with them. Resident #1 stated for no reason CNA A pushed him back into his wheelchair, Resident #1 denied yelling or cussing at CNA A. Resident stated that CNA A was in front of him and grabbed him under his arms and pushed him. Resident #1 stated he was not hurt but was angry. Resident #1 stated he told the charge nurse, and the nurse checked him out and he was fine, he did not get hurt. Resident #1 stated he has never had any problems with CNA A before and has never seen or heard of any problems in the facility, Resident #1 stated this was a good facility and staff. Resident #1 stated that the DON and Administrator sent CNA A home and he has not come back. On 6/25/24 at 4:10pm Resident #1 approached surveyor and stated he (Resident #1) went a little overboard on 5/26/24 and acted out, Resident #1 stated sometimes he can't control his anger and yells at people. Record review of CNA A's statement dated 5/26/24 (CNA A did not return to facility after incident and self-terminated and did not reply to phone calls by surveyor). CNA A stated he told Resident #1 that he will take out residents to smoke in a few minutes. CNA A stated Resident #1 started yelling and calling him names, then Resident #1 stood up in his scooter and yelling at CNA A and began to fall forward, and CNA A grabbed Resident #1 and put him back in his scooter. LVN B came down hall, Resident #1 stated I pushed him, and he want to file abuse charges. CNA A denied allegations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/26/24 at 10:30am LVN B stated she witnessed Resident #1 yelling at CNA A to take them out to smoke. LVN B stated she was walking down hall towards CNA A and Resident #1, they were by the smoking exit door, LVN B stated she did not see CNA A grab or touch Resident #1. LVN stated Resident #1 came rolling up towards LVN stating CNA had pushed him and he wants to report abuse. LVN B stated she assessed resident found no redness or bruising, no injuries, Resident #1 stated he was not injured. LVN B stated she called Administrator and DON to report incident, notified resident's physician and tried to contact resident's family member but had no answer, resident stated they were on a cruise. Record review on 6/25/24 at 2:25pm Resident #2, [AGE] year-old male, BIMS of 11 (moderately cognitive impaired) stated he witnessed the incident. He stated Resident #1 stood up and got in CNA A's face saying you don't know who you are missing with. Resident #2 stated CNA A did not put his hands on Resident #1, Resident #1 did almost fall, and CNA A grabbed him and kept him from falling. Resident #2 did not know why Resident #1 was upset. Resident #2 stated he has never seen or heard of CNA being disrespectful to anyone, all the staff were nice. Interview on 6/25/24 at 1:55pm Administrator stated she self-reported incident on 5/26/24 to HHSC. In-service was conducted by DON on 5/26/24 over Abuse and who to report it to. The Administrator stated she did the investigation, took statements but did not know why she did not complete and turn in the 3613A Provider Investigation Report form as required in 5 days. The Administrator stated she and the DON discussed and decided the incident was inconclusive, but CNA A did not come back to facility, self-terminated. Record review of facility's Abuse/ Neglect Policy for Reporting: Abuse Reporting Policy date 1/1/23 Page 4, 'The abuse coordinator with the Director of Nursing/designee will investigate all allegations and use the appropriate forms to document the investigation and turn it into HHS within 5 calendar days.'