STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455591	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care of Waxahachie	1413 W Main St Waxahachie, TX 75165

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interview and record review, the facility failed to ensure residents were informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he prefers for one (Resident #1) of four residents reviewed for consents. The facility failed to obtain a written consent from Resident #1 before administering the following psychoactive medications: Risperdal (anti-psychotic), Paroxetine (anti-depressant) , Depakote (mood stabilizer , Nudexta (anti-depressant), Quetiapine (antipsychotic), Lorazepam (anti-anxiety). This failure placed residents who received psychoactive medications at risk for not understanding the risks and dangerous side effects of psychoactive medications without their opportunity for informed consent and opportunity to refuse the drug. Findings included: Review of Resident #1's face sheet dated 9/23/2024 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (mood disorder) and Traumatic Brain Injury (injury to the brain). Resident #1 was his own responsible party. Review of Resident #1's quarterly MDS assessment, dated 08/12/2024, reflected a BIMS of 14, suggesting no cognitive impairment. Section D (Mood) reflected he had been feeling down, depressed, or hopeless for several days. Section E (Behavior) reflected he had not had any hallucinations, delusions, or physical or verbal altercations directed towards others. Review of Resident #1's current care plan, dated 09/23/2024, reflected he had a behavior problem related to schizoaffective disorder yelling, hitting himself, impulsiveness, racial slurs, name calling. Review of Resident #1's physician orders dated 12/14/2023 reflected an order for Depakote 500 mg tablet - give one tablet by mouth two times a day for mood at 9:00 am and 5:00 pm. Review of Resident #1's physician orders dated 03/07/2024 reflected an order for Depakote 500 mg tablet - give one tablet by mouth two times a day for mood at 9:00 am and 9:00 pm. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's MARs for December 2023, January 2024, February 2024, and March 2024 revealed resident was administered Depakote from 12/14/2023 until 3/7/2024; Then again from 3/7/2024 until 6/26/2024. Review of Resident #1's EMR dated 9/23/2024 reflected a signed consent for Depakote dated 3/14/2024 but no signed consent prior to 3/14/2024. Review of Resident #1's physician orders dated 12/14/2023 reflected an order for Risperidone, 1 mg tablet - give one tablet two times a day for mood. Review of Resident #1's MARs for December 2023, January 2024, February 2024, and March 2024 revealed resident was administered Risperidone from 12/14/2023 until 3/7/2024. Review of Resident #1's EMR dated 9/23/2024 reflected no signed consent form for Risperidone. Review of Resident #1's physician orders dated 12/15/2023 reflected an order for Paroxetine HCL, 40 mg tablet - give one tablet in the morning for depression. Review of Resident #1's MARs for December 2023 to September 2024 revealed resident was administered Paroxetine from 12/15/2023 until MAR review date of 9/24/2024. Review of Resident #1's EMR dated 9/23/2024 reflected a signed consent form for Paroxetine HCL dated 1/26/2024, but no signed consent when medication was started on 12/15/2024. Review of Resident #1's physician orders dated 9/9/2024 reflected an active order for Quetiapine 100 mg - give one tablet by mouth three times a day for schizophrenia. Review of Resident #1's MARs for August 2024 to current revealed resident was administered Quetiapine until MAR review date of 9/24/2024. Review of Resident #1's EMR dated 9/23/2024 reflected no signed consent form for Quetiapine. Review of Resident #1's physician orders dated 8/19/2024 reflected a PRN order for Lorazepam - give one tablet every 6 hours as needed for anxiety. Review of Resident #1's August and September 2024 MARs reflected he was administered Lorazepam on 8/27/2024 - 8/31/2024 and 9/19/2024. Review of Resident #1's EMR dated 9/23/2024 reflected no signed consent form for Lorazepam. Review of Resident #1's physician orders dated 4/20/2024 reflected an order for Nudexta 20-10 mg - give one capsule in the morning for Pseudobulbar affect. Review of Resident #1's physician orders dated 4/28/2024 reflected an order for Nudexta 20-10 mg - give one capsule in the morning for Pseudobulbar affect. Review of Resident #1's April [DATE] reflected he was administered Nudexta on 4/21/2024 - 4/26/2024 and 4/29/2024 and 4/30/2024. (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's EMR dated 9/23/2024 reflected no signed consent form for Nudexta. Review of progress notes for Resident #1 from 12/14/2023 to 9/24/2024 revealed no progress notes related to medication consent forms or education related to psychoactive medications. During an interview with Resident # 1's FM on 11/6/2024 at 11:24 am the FM revealed Resident #1 had been discharged and transferred to another facility. The FM stated the facility asked FM to sign a consent form for Depakote back in March of 2024, but to their knowledge no other consent forms had been signed by either FM or Resident #1 for any of the other psychoactive medications. The FM stated Resident #1 was his own RP, but due to his TBI he sometimes forgot things. The FM stated they were very upset that the facility did not explain the medications to Resident #1 prior to administering them so Resident #1 could understand the affect and use of each mediation. The FM stated the nursing facility asked her to sign a consent for Depakote on 3/14/2024 but she had not signed any other medication consent forms. She stated, they gave {Resident #1} medications that he had no idea what they were for or understand the affects of use. During an interview with ADON on 11/6/2024 at 4:30 pm, she stated she was unable to find any medication consent forms for Resident #1 except for the Depakote consent form signed 3/14/2024 by FM. She stated there were no other signed medication consent forms signed by either the resident or FM. During an interview with the Medical Director on 11/7/2024 at 2:44 pm, he stated he was not aware that consent forms needed to be signed for psychoactive medications in the Nursing Facility setting. He stated he was coming from the acute clinical setting and worked in a pain clinic where consents are done in the clinic. He stated he will have to revisit education with psychiatric team - he was not aware they were missing or were done well after the fact of the medication being prescribed and given. He stated consent forms are important, so residents or RPs are aware of the medication uses and side effects. He stated residents have a right to make informed decisions. During an interview with ADON on 11/7/2024 at 3:00 pm she stated her expectation was that nurses would talk to the resident or the RP when starting a new psychoactive medication and educate them on the medication. She stated her concerns were if the resident or FM were not notified that education would not have been done and they could not be aware of side effects or the reason for the medication. During an interview with RVP on 11/7/2024 at 3:30 pm he stated his expectations were that consent forms were signed before starting medications. If they are not, residents were not fully informed of the care, and it was a resident right to be informed. He stated it was part of their process and it should have been done. He stated they were not able to find a facility policy specifically on the use pf psychoactive medications, but consent would fall under resident rights. Record Review of psychoactive medication consent for Depakote for Resident #1 reflected it was signed 3/14/2024 by Resident #'s FM. Review of facility Policy Resident Rights dated December 2016 reflected 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: e. self-determination. (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	j. be informed about his or her rights and responsibilities; o. be notified of his or her medical condition and of any changes to his or her condition; p. be informed of, and participate in, his or her care planning and treatment; s. choose an attending physician and participate in decision-making regarding his or her care. A facility policy on psychoactive medication and consents was requested but not provided prior to exit.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interview, and record review, the facility did not provide pharmaceutical services to meet the needs of each resident for one (Resident #1) of four residents reviewed for pharmaceutical services, in that: The facility failed to ensure they had enough Depakote medication (mood stabilizer medication) on hand from 3/20/2024 to 4/10/2024 for Resident #1. This deficient practice could place residents at risk of not receiving the intended therapeutic benefit of the medications and could result in worsening or exacerbation of chronic medical conditions, and hospitalization . Findings included: Review of Resident #1's face sheet dated 9/23/2024 reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (mood disorder), Traumatic Brain Injury (injury to the brain), malignant neoplasm of prostate (prostate cancer), ataxia (impaired coordination), and gout (form of arthritis which causes joint swelling and pain). Resident #1 was his own responsible party. Review of Resident #1's quarterly MDS assessment, dated 08/12/2024, reflected a BIMS of 14, suggesting no cognitive impairment. Section D (Mood) reflected he had been feeling down, depressed, or hopeless for several days. Section E (Behavior) reflected he had not had any hallucinations, delusions, or physical or verbal altercations directed towards others. Review of Resident #1's current care plan, dated 09/23/2024, reflected he had a behavior problem related to schizoaffective disorder yelling, hitting himself, impulsiveness, racial slurs, name calling. Review of Resident #1's physician orders dated 03/07/2024 reflected an order for Depakote 500 mg tablet - give one tablet by mouth two times a day for mood at 9:00 am and 9:00 pm. Review of Resident #1's MARs for March 2024 and April 2024 revealed resident MAR for Depakote was signed off as administered from 3/20/2024 until 4/10/2024. Review of Resident #1's progress note dated 3/18/2024 by the facility Social Worker revealed SW was informed about an altercation that happened this past weekend. Resident verbalized his side of the story. SW discussed conflict resolution to avoid altercations. Interventions in-used includes new room location, counseling as well as ongoing counseling from [facility], and resident was placed back on his medication, Depakote. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/23/2024 at 12:20 pm, the FM stated they believed Resident #1 was not getting his Depakote as ordered between January of 2024 and March of 2024. The FM stated the nursing facility had them sign a consent form in March 2024 for the Depakote and FM believed it was because he had been off his medications and the nursing facility was just then getting him back on the Depakote. During an interview on 10/22/2024 at 1:20 pm, the DON stated she reviewed the pharmacy orders for Resident t#1's Depakote and it showed an order was shipped on 12/16/2024 but they have no record of receiving it. She stated they noticed on 12/20/2023 that the Depakote was running out and called the pharmacy and an order for Depakote was delivered on 12/21/2023. The DON stated she had reviewed the pharmacy orders for Resident #1's Depakote and there was a gap in March of 2024 where they could not show a delivery had been received for Resident #1's Depakote. She stated she had reviewed Resident #1's MARs for March and April and the Depakote had been signed off as given during that time. She stated she spoke with multiple staff, and all stated they had given Resident #1 his medications. She stated she did not believe they were out of Resident #1's Depakote during that time, but she cannot show pharmacy receipts to indicate they had sufficient quantity on hand during that time period. During an interview on 11/6/2024 at 11:24 am the FM stated she had reviewed her insurance benefit records and it showed medication bills for December 2023, January 2024, February 2024, and April 2024. The FM stated there was no bill for any Depakote medication for Resident #1 in March of 2024. The FM stated Resident #1 would have been without his Depakote for a couple weeks from March until April when the next delivery came in. The FM stated they had reviewed Resident #1's progress notes and on 3/18/2024 the Social Worker put that Resident #1 would be placed back on his medications. The FM stated when they compared the insurance bills to Resident #1's order for Depakote, he would have been without Depakote from the end of March 2024 until the second week of April 2024. The FM stated during this time, Resident #1 had come home for a visit and Resident #1 had had a complete meltdown and escalating behaviors. The FM stated they believed Resident #1 may not have been getting his Depakote during this time. Record Review of FM's insurance receipts revealed insurance receipts for Depakote on 12/21/2023 for a 30-day supply, 1/13/2024 for a 30-day supply, 2/9/2024 for a 30-day supply, and 4/10/2024 for a 30-day supply. Review of FM insurance EOB for March 2024 reflected no Depakote had been billed or ordered. During an interview with the Medical Director on 11/6/2024 at 2:23 pm he stated he had not been aware of a gap in Resident #1's Depakote from March 2024 to April 20204. He stated Resident #1's Depakote level had been checked in January 2024, and he would not have requested another check unless Resident #1 had become symptomatic with escalating behaviors. He was not aware of any significant increase in behaviors from Resident #1's baseline during that time. The Medical Director further stated when Depakote was used as a mood stabilizer there was not a therapeutic level or range identified. He stated in general he does not monitor Depakote on a therapeutic level on a regular basis when used for mood stabilization. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the ADON on 11/6/2024 at 4:45 pm, she stated she had worked the floor passing medications to Resident #1 during the period of 3/20/2024 to 4/10/2024. She stated, I believe with all my heart that I gave him his meds. She stated she did not recall any time during March 2024 or April 2024 where Resident #1 did not have medications available. She stated if a medication wasn't available, she would not have signed off the MAR that it was given, instead she would mark it 'other' and put in a progress note and say it wasn't available. She stated if medications were not available, they could call the pharmacy or check the emergency kit. During an interview with MA 1 on 11/7/2024 at 12:52 pm she stated she worked as a MA passing medications to Resident #1 during the period of 3/20/2024 to 4/10/2024. She stated she did not remember any problems with Resident #1's Depakote during that time. She confirmed she had clicked off the MARs during that time and if I clicked it off that means I gave it to him. She stated she did not recall being out of any medications during that time, but if they had been she would have told the nurse. During an interview with LVN 2 on 11/7/2024 at 12:56 pm, she stated she had worked the floor passing medications to Resident #1 during the period of 3/20/2024 to 4/10/2024. She stated she did not remember any issues with Resident #1's Depakote during that time. She stated if my initials are on the MAR with a check mark, it means the med was given. She stated it a med was not available she would have checked the emergency kit and she does not recall using the emergency kit during those dates. An interview with Facility Social Worker was attempted on 11/6/2024 at 1:22 pm via text,11/6/2024 at 3:46 pm via phone (VM left), 11/6/2024 at 3:51 pm via text and 11/7/2024 at 12:37 pm by phone (VM left); calls, voicemails and texts were not returned. Record Review of Pharmacy delivery receipts from the NF for Resident #1's Depakote revealed deliveries as follows: 12/21/2023, 60 tablets (30-day supply); 1/13/2024, 60 tablets (30-day supply); 2/10/2024, 60 tablets (30-day supply); and 4/10/2024, 60 tablets (30-day supply). Review of facility policy from Pharmscript entitled Ordering and Receiving Non-controlled Medications reflected Medications and related products are received from the pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt.