

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455900	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Focused Care at Mount Pleasant		STREET ADDRESS, CITY, STATE, ZIP CODE 1606 Memorial Ave Mount Pleasant, TX 75455	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49019</p> <p>Based on observation , interview and record review the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determine that drug records are in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 2 residents (Resident #12) reviewed for drug diversion.</p> <p>The facility failed to prevent the drug diversion of 55 tablets of Hydrocodone (Norco) (a combination medicine that is commonly taken for severe pain) for Resident #12 on 2/6/2025.</p> <p>This failure could place residents at risk for drug diversion of physician ordered medications which could result in residents not having medications/treatments available and a decline in health.</p> <p>Findings include:</p> <p>Record review of Resident #12's face sheet, dated 4/17/2025, indicated a [AGE] year-old male who was readmitted to the facility on [DATE]. Resident #12 had diagnoses which included Alzheimer's disease (a progressive disease that destroys memory), pain (a physical discomfort ranging from mild to severe, usually caused by injury, illness, or a nerve condition) and type II diabetes (a condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>Record review of Resident #12's quarterly MDS, dated [DATE], indicated he was usually able to make self-understood and usually understood others. Resident #12 had a BIMS score of 7, which indicated he had severe cognitive impairment. Resident #12 was dependent on toileting, bathing, required substantial assistance with personal hygiene, and dressing upper and lower body.</p> <p>Record review of Resident #12's care plan, initiated on 9/25/2025, indicated Resident #12 had potential for pain related to chronic pain, diabetes and recent healed hip fracture and was currently on palliative care. Interventions included:</p> <p>Assess characteristics of pain: location, severity, on a scale of 1-10, type and frequency.</p> <p>Discuss with resident factors that precipitated pain and what may reduce it.</p> <p>Administer medication as ordered.</p> <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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Discuss with resident the need to request pain medications before pain becomes severe.</p> <p>Discuss with physician that for maximum pain relief pain medication are best given around the clock, with PRNs for breakthrough pain.</p> <p>Monitor for potential side effects of pain medication.</p> <p>Record review of the pharmacy narcotic sheet, dated 12/27/2024, indicated Hydrocodone-Acetaminophen 10-325 mg was delivered with 55 tablets filled and was started on 1/11/2025 and completed on 2/7/2025. The NP's progress note correlated with the number of 5 tablets remaining on the medication card on 2/5/2025 .</p> <p>Record review of Resident #12's Medication Administration record, dated 2/1/2025-2/28/2025, indicated he was prescribed Hydrocodone-Acetaminophen 10-325 mg 1 tablet by mouth two times daily for pain starting on 11/1/2024.</p> <p>Record review of palliative progress note, dated 2/5/2025 at 3:00 PM, the NP indicated Resident #12 had 5 tablets remaining and the next refill would be due on 2/25/2025.</p> <p>Record review of Resident #12 's assessment, dated 2/7/2025 , titled Pain in Advanced Dementia indicated Resident #12 had a score of NA on his assessment. Resident #12 scored O on assessment questions, which indicated no pain.</p> <p>Record review of the pharmacy narcotic sheet, dated 2/8/2025, indicated Hydrocodone-Acetaminophen 10-325 mg was delivered with 58 tablets that started on 2/8/2025 and completed on 3/9/2025. The NP's progress note narcotic correlated with the number of 48 tablets remaining on the medication card on for 2/8/2025.</p> <p>Record review of palliative progress note, dated 2/13/2025 at 4:00 PM, the NP indicated Resident #12 had 48 tablets remaining during her visit.</p> <p>Record review of the facility's Provider Investigation Report, dated 2/14/2025, indicated .pharmacy would not fill medication stating it was too early . medication card and medication count sheet could not be located .it would appear the last delivery with 55 tablets .the facility searched for medication in all areas .all narcotics in the facility were accounted for by 2 licensed nurse .interviews conducted with staff and pain management . [Resident #12] did not go without medication .incident did not affect [Resident #12]. The PIR indicated the physician, police, management, and pharmacy were notified. Education conducted with staff on clear bag policy for nurses to add a level of security against theft and misappropriation. Education was conducted regarding abuse, to include medication misappropriation.</p> <p>Record review of a police report, dated 2/7/2025 at 10:10 AM, indicated the Administrator reported missing medications. The police report stated a card of medicine for a resident went missing while the resident was being transferred to one part of the facility to the other. The police officer contacted the Administrator and were made aware of the transfer to [NAME] Hall to North Hall. The Administrator indicated to the police officer the facility would implement new protocols when it came to handling medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Performance Improvement Plan (PIP), dated 2/6/2025, indicated an issue of prescription for 55 Hydrocodone administered by the pharmacy on 1/22/2025 had been identified as missing. The facility developed a goal to ensure future incident did not occur by initiating an intervention of a card count and a random weekly audit to ensure card counts were complete and control log was signed with no gaps. The facility initiated an in-service which included card count, individualized card counts at the beginning of each shift. The facility-initiated documentation of received and removed cards during each shift and report card count at each shift with ongoing staff nurse. The facility educated staff on clear bag policy.</p> <p>Record review of the facility's form titled Medication Cart/Card Count Audit indicated the audit was completed which started on 2/7/2025 at 11:45 AM. The audit form indicated 100 % of narcotics were accounted for North, [NAME] and Women's unit. The audit indicated 2 cards were unaccounted for Resident #12. The facility audit started on 2/6/2025 and remained in place. The audit did not indicate any current issues or missing medications.</p> <p>During an observation round on 4/16/2025 at 1:35 PM, the ADON was working the men's secure unit. The ADON performed a narcotic count with surveyor which indicated there were 26 cards locked in the narcotic box. During the review of the cards and counts, the men's unit counts were correct, and no gaps were identified with the counts.</p> <p>During an observation and interview on 4/16/2025 at 1:44 PM, revealed RN G, located on the Northeast Hall, counted 52 cards in the narcotic lock box on the medication cart and 1 card of Marinol locked and attached securely in the refrigerator. RN G said the nurses were counting all the cards at the beginning of each shift. She said the nurse for the cart would document the number of narcotic cards used or received during their shift. RN G said the nurse was to review what they started with and add to the count if a resident was transferred from another unit. RN G said Resident # 12's nurse had come to the unit with all his medication cards and sat them down and left. She said she could not recall who received the medications that shift and did not observe if a count had occurred for Resident #12 when he was transferred to the new unit. RN G said the nurse who was assigned to the cart was responsible for the medication cart and narcotic counts at the beginning and the end of the shift.</p> <p>During an interview on 4/15/2025 at 11:00 AM, Resident #12 said his pain had been managed and he did not recall missing any medications. He said he received his medication timely.</p> <p>Attempted interview with LVN K on 4/15/2025 at 1:33 PM was unsuccessful. No return call received by the end of the survey.</p> <p>During an interview on 4/15/2025 at 2:02 PM, the DON said LVN E originally received the medication on 1/22/2025 with 55 tablets of Hydrocodone and LVN B received the medication from LVN K in one stack at shift change. The DON said all medications were placed on the cart, narcotics were counted, dated, and placed cards in the locked box according to LVN B's statement.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/15/2025 at 2:41 PM, LVN C said she was unable to recall that far back, if there was a narcotic sheet for Resident #12. LVN C said there should always be a narcotic sheet if a resident was prescribed a narcotic. She said if she received a narcotic medication for a resident, she would put the narcotic count sheet in the count book and place the narcotic in the box and lock it up. LVN C said the facility staff were now counting the cards. LVN C said no one else had access to the medication carts. She said a resident's narcotic was kept together and the overflow of narcotics were not stored in a separate area. LVN C said she would report a missing medication card and sheet if she was aware.</p> <p>During an interview on 4/15/2025 at 3:10 PM, LVN F said all the narcotics were to be stored on the locked cart. LVN F said she did not have any narcotic sheets or narcotics come up missing. LVN F said she would know if a card or sheet came up missing during narcotic counts.</p> <p>During an interview on 4/15/2025 at 3:16 PM, the ADON, who was working a unit, said he would verify the paper that came with the narcotics from the pharmacy . He said then he would add the medication to the cart and place the narcotic count in the book. The ADON said he searched the facility with the DON after she was made aware the Hydrocodone was missing. There was no verified paper for the delivery and only the electronic signature for the delivery on January 22, 2025. The ADON said part of the action plan was to count the number of cards along with the number of tablets at the beginning and end of each shift. There was a new form implemented to account for each card completed and added to the cart.</p> <p>During an interview on 4/15/2025 at 3:46 PM, the Chief Operating Officer with Palliative Care services said a triplicate (a 3-part form for the prescription of a controlled narcotics and other psychotropic substance to help reduce the abuse, misuse, and diversion of a controlled substance) order was received on 1/21/2025. She said the pharmacy filled 55 tablets of Hydrocodone which was 27 days' worth. The Chief Operating Officer said the NP had Resident #12 on an auto prescription (an automatic prescription refilled at regular intervals) indicated in the plan on her progress note.</p> <p>During an interview on 4/16/2025 at 1:30 PM, the DON said there were 4 medication carts located on the men's secure unit, the women's secure unit and the Northeast and North Hall .</p> <p>During an interview and observation on 4/16/2025 at 2:11 PM, RN B said there was a new process implemented due to Resident #12's medication card of Hydrocodone disappearance . She said she was working the day the Hydrocodone medications came up missing. She said Resident #12 transferred from the men's unit to the North Hall during shift change. She said she did count with the 2-10 PM nurse coming on shift but did not count with the nurse who brought over the medications. RN B said Resident #12 had remaining Hydrocodone on a card when he arrived at her unit. RN B said she could not recall how many tablets Resident #12 had left. She said she was never looking for an additional card on the cart because she did not know any were missing. RN B said a drug diversion could be bad and result in an overdose of a person who may have taken them. RN B completed narcotic counts with the oncoming nurse and surveyor at the end of her shift with no discrepancies or gaps in narcotic sheet.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/16/2025 at 2:55 PM, the Administrator said she had 2 staff members resign who were from the unit the medications were transferred. The Administrator said the facility put a performance improvement plan (PIP) in place on 2/6/2025. She stated the DON was performing weekly audits of narcotic counts and staff were in-serviced. The Administrator said it was not a suitable time to have transferred Resident #12 during a shift change and the facility was reviewing ways to prevent medication from coming up missing in the future. The Administrator said 2 staff members who worked the shift were drug tested and were negative.</p> <p>During an interview on 4/16/2025 at 3:39 PM, the DON said she went over the requirements for narcotic count and provided a copy of the new form for card counts. She said she expected the staff to follow the clear bag policy but was made aware during observations, clear bags were not observed. The DON said she had been reminding staff about the policy.</p> <p>During an interview on 4/16/2025 at 3:43 PM, LVN E said she had been in-serviced on counting the actual narcotic cards with narcotic counts each shift .</p> <p>During an interview on 4/17/2025 at 8:21 AM, RN B said she took care of Resident #12. She said he did not miss any of his medications and did not report any pain. She said she reordered the Hydrocodone and that was when it was identified by the pharmacy as missing. RN B said the staff was in-serviced after the incident occurred. She said the facility implemented a card counting system and was advised to report if any medication came up missing. RN B said she did not think the clear bag policy was in-serviced on and she said the staff continued to bring their regular bags and the clear bags were not being enforced.</p> <p>During an interview on 4/17/2025 at 8:29 AM, RN G said the nurses were counting the cards at the beginning and end of each shift. She said the nurses made sure they were signing out narcotics at time of administration and she said she was starting to see more clear bags coming in with staff. RN G said the staff were documenting on the new form which indicated a medication was received during the shift. She said she would notify the DON if the counts were off or missing a medication card.</p> <p>During an interview on 4/17/2025 at 8:38 AM, LVN A said the nurses were to sign out narcotics and count the cards at the beginning of the shift. She said if a medication was wasted, there would need to be a witness. LVN A said if the pharmacy brought a medication, the nurses would have to add the medication to the new form. She said the staff would report to the DON if a card was missing and she would also let the Administrator know. LVN A said she had not seen any gaps in her narcotics, and she was not aware of a clear bag policy. LVN A said she had a regular bag.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/17/2025 at 8:53 AM, the DON said Resident #12 transferred to the general population from the men's secure unit. She said the triplicate request form was sent to palliative care and they were notified it was rejected due to 55 tablets of Hydrocodone had already been dispensed on 1/22/2025 and that was when the investigation started. The DON said the facility completed an individual card count on narcotics and educated staff on the clear bag policy. The DON said they could tell staff to bring a clear bag, but they could not enforce or make them bring one. She said the facility could offer them clear bags and was discussing further with corporate. The DON said the pharmacy came in and the NP and Medical Director were notified. She said a suspect could not be identified. The DON said the police report was made. She said a new card count was in place and the facility had no further issues. She said she expected the nurses to count narcotics at each shift change and completed the new form which indicated if they received new medication cards or if a medication card was completed during their shift which was being completed by staff. The DON said the resident could miss medications and not get their pain treated which could affect their quality of life. She said Resident #12 did not miss any doses and was not affected in any way. She said the nurse receiving the medications were responsible for ensuring medications were properly reconciled and responsible for the medication cart.</p> <p>During an interview on 4/17/2025 at 9:03 AM, the Administrator said the police were contacted. She said 1 nurse was interviewed onsite and the other contact information was provided to the police officer. The nurse interviewed was not named on the police report. The Administrator said the police told her the medication may never be found and they would put the medication on their database. The Administrator said she made rounds with the ADON and the DON to count and search for the missing medication. She said they checked every cart, medication storage and narcotic boxes in the building. She also indicated nurse's bags were also checked. The Administrator said she expected the nurses to complete the card count form implemented. She said she was not sure the facility ever had the medications. She said the pharmacy delivered a box of medications with multiple prescriptions in the box that were signed when medication was delivered . The Administrator said now the facility must have 2 nurses upon transfer of a resident from a unit to check medications. She said medications delivered must be checked in by the nurse and notify the DON if there were any discrepancies. The Administrator said they were not requiring 2 nurses to check in the medications delivered to the facility. She said the DON and ADON were to complete an audit of every cart daily and weekly for QAPI . The Administrator said she felt the clear bag would be difficult to enforce but the facility was going to implement. The Administrator said she went out and bought clear bags and tags to label with names of staff and start enforcing the clear bag policy even though it was previously instructed on an in-service and staff not following. She said the bags and tags would be labeled today. The Administrator said she expected nurses to be carrying and following the clear bag policy. She said she expected the nurses to follow the new forms and complete the narcotic counts on each shift and for narcotics to be signed off on the electronic medical record and narcotic sheet when medication was administered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy, revised 8-2020, titled: Storage of Controlled Substances indicated . medication classified by the Drug Enforcement Administration (DEA) as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal, state, and other applicable laws and regulations. Procedures .1. The Director of Nursing, in collaboration with the consultant pharmacist, maintains the facilities compliance .only licensed nursing personnel and pharmacy personnel have access to controlled substances. 2. Schedule II through V medications and other medications subject to abuse or diversion are stored in a permanently affixed, double locked compartment separates from the other medications .if a key system is used, the medication nurse on duty maintains possession of the key .3. Controlled substances that require refrigeration are stored within a locked box within refrigerator .4. A controlled substance accountability records is prepared by the pharmacy/facility for all schedule II, III. IV and IV medications a. at each shift change, or when keys are transferred, a physical inventory of all controlled substances .6. Any discrepancy in controlled substance counts is reported to the Director of nursing immediately .a. the administrator, consultant pharmacist, determine whether other actions are needed .The medication regimen of residents using medication that have such discrepancies are reviewed to assure the resident received .7. Controlled substance inventory is regularly reconciled to medication administration record .8. Current controlled substance accountability records are kept in the MAR</p>		