STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455944	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Clarksville	2407 West Main Street Clarksville, TX 75426

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on interview, and record review, the facility failed to ensure the right to be free from misappropriation of resident property for 1 of 3 (Resident # 1) residents reviewed for misappropriation of resident property. The facility failed to prevent a drug diversion (misappropriation) of Resident #1's-controlled medications on [DATE], Hydrocodone-Acetaminophen 7XXX,d+[DATE]MG (narcotic pain reliever), Hydrocodone-Acetaminophen,d+[DATE]MG, and Lorazepam (controlled anti-anxiety medication) 0.5 MG, after she expired on [DATE]. The medications were not found. The non-compliance was identified as past non-compliance. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for decreased quality of life, misappropriation of property, misappropriation of physician ordered medications and dignity. Findings included: Record review of Resident #1's face sheet dated [DATE] indicated she was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE] diagnoses of dysphagia (difficulty swallowing), myalgia (muscle pain), muscle wasting, lack of coordination, major depressive order (persistent feeling of sadness or loss of interest that can lead to an arrange of behavioral and physical symptoms), anxiety (mental disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities), hypertension (high blood pressure), arthropathy (on going swelling and pain of joints). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was understood and had the ability to understand others. The MDS indicated Resident #1 had a BIMS score of 09 which indicated a moderate cognitive impairment. The MDS indicated Resident #1 required maximal assistance with toilet use, bathing, bed mobility, transfer, and dressing, and extensive assistance for personal hygiene. The MDS indicated Resident #1 received setup/supervision assistance for eating. The MDS indicated Resident #1 received scheduled pain medication regimen and received 7 days of opioid (powerful pain-reducing medications) during the assessment period. The MDS assessment indicated Resident #1 received anti-anxiety medication. (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated [DATE] indicated Resident #1 was at risk for alteration of discomfort of musculoskeletal status limited range of motion (happens when swelling and tenderness in one or more joints, causing joint pain or stiffness that often gets worse with age). Resident #1's care plan indicated she was at risk for anxiety (mental disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities) related to cognitive deficit with the intervention to administer Lorazepam (medication used to relieve anxiety) as ordered. Record review of Resident #1's consolidated physician orders active as of [DATE] indicated the following orders: *Hydrocodone-Acetaminophen 7XXX,d+[DATE] MG give one tablet by mouth every 4 hours as needed for pain with an order start date of [DATE]. *Hydrocodone-Acetaminophen ,d+[DATE] MG give one tablet by mouth every 4 hours for pain with an order start date of [DATE]. *Lorazepam Tablet 0.5 MG Give 1 tablet by mouth two times a day for anxiety, with a start date of [DATE]. Record review of Resident #1's MAR dated [DATE] - [DATE], indicated between this time Resident #1 received a total of: o 28 tablets of Hydrocodone-Acetaminophen 7.5mg-325mg, o 39 tablets of Hydrocodone-Acetaminophen ,d+[DATE]mg, o 20 tablets of Lorazepam 0.5mg. Record review of the Provider Investigation Report dated [DATE] indicated .incident date unknown. telephone call reporting drug diversion .alleged perpetrator .RN A stealing narcotics from the facility .denied . reporter stated received information from a reliable source .suspension of RN A pending investigation . reviewed all residents that RN A had given narcotic pain medications to from [DATE] to [DATE] .interviewed for any change in pain of residents and unexplained change in pain noted .during investigation the DON noted Resident #1's medications missing after compared to pharmacy manifest .reported to police interviews on all staff who had access to the medication carts associated with Resident 1's missing medications no one admitted to taking drugs or knew what happened to the missing medication .interview with RN A .offered drug screen positive for opiates .no confirmed perpetrator .RN A remained suspended until drug screen confirmed . investigation findings. Record review of staff schedules dated [DATE] - [DATE] indicated RN A had access to the two medication carts with Resident #1's routine and as needed Lorazepam and hydrocodone-acetaminophens. Record review of a progress note dated [DATE] at 12:36 AM indicated LVN D attempted to give Resident #1 pain medication (Resident was not swallowing, refused to open mouth and take medicine. Medication wasted with second nurse. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's pharmacy manifest (tracks the waste to final disposal) dated [DATE] indicated Resident #1 received: o 115 pills of Hydrocodone-Acetaminophen ,d+[DATE] MG- dispensed on [DATE], o 90 pills of Hydrocodone-Acetaminophen 7XXX,d+[DATE] MG- dispensed on [DATE], o 60 Lorazepam Tablet 0.5 MG dispensed on [DATE]. Record review of the local police department report dated [DATE] at 12:38 PM, indicated .RN A took a drug test and awaiting results, test showed positive for opiates but sent off for specifics. Resident #1 passed on (died) [DATE] and Hydrocodone 10's, Hydrocodone 7.5's and Lorazepam came up missing. RN A was suspended on [DATE] . During an interview on [DATE] at 4:00 PM, the informant from the local police department, stated he could not reveal his reliable source of information regarding RN A stealing narcotics from the nursing facility. The informant from the local police department said he felt obligated to let the facility know this information because he would not want any resident to be in pain and go without medication. During an attempted phone interview on [DATE] at 4:30 PM, RN A did not answer the phone. During an attempted phone interview on [DATE] at 9:14 AM, RN A did not answer the phone. During an interview on [DATE] at 9:15 AM, LVN C said she had worked the night shift on [DATE], and she recalled the Hydrocodone ,d+[DATE] mg being on the cart. LVN C said she did not notice when the medication was no longer on the cart. LVN C said she had no discrepancies with the narcotic counts at the beginning or the end of her shifts. LVN C said routine procedure was to leave any discontinued medications on the medication cart and continue to count the medications against the Controlled Drug Administration Record when the DON was not in the building. Once the DON was in the building, the medications and Controlled Drug Administration Record were taken to the DON and verified by the DON and the nurse or MA. The nurses arrived for their shift at 6 am and 10 pm but the MA's shift started at 8 am. LVN C said she had not had any issues with her narcotic counts matching. LVN C said the facility started counting and recording all the cards in the narcotic box at the beginning and end of the shift during the summer. During an attempted phone interview on [DATE] at 12.32 PM, RN A did not answer the phone. A voice message was left to return call and phone number given. During an attempted phone interview on [DATE] at 2:15 PM, RN A did not answer the phone. A voice message was left to return call and phone number given. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:32 PM, RN F said she had worked approximately 6 months at the facility as the 2 PM to 10 PM charge nurse. RN F said she had been educated on the abuse policy on several occasions. RN F denied any abuse within the facility. RN F said the routine procedure was to leave discontinued medications on the medication cart and continue to count the controlled medications against the Controlled Drug Administration Record when the DON was not in the building. Once the DON was in the building, the medications and narcotic sign out sheets were taken to the DON and verified by the DON and nurse or MA. RN F said when she arrived for her shift, she ensured the narcotic count was correct by counting and recording all the cards in the narcotic box at the beginning and end of the shift and had been doing this for a few months now. RN F stated the oncoming nurse counts the medications while the off going shift nurse or MA verified totals on the Controlled Drug Administration Record. RN F said the nurse arrived at 6 am and 10 pm but the MAs arrived at 8 am. RN F said she had not had any issues with her narcotic counts matching. During an interview on [DATE] at 12:39 PM, MA B said she had been working at the facility for 1 and a half years and worked all the halls at some point and took over the routine medication cart. She said when she received the medication cart, the Controlled Drug Administration Record was correct, and she had not experienced any discrepancies. She said she could not recall when she last saw the medications for Resident #1 on the medication cart. MA B said over the last few months a new procedure was implemented and the facility started counting and recording the total amount of medication cards in stock in the narcotic locked box. MA B said she would leave any discontinued medications on the cart and continue to count the medications against the Controlled Drug Administration Record when the DON was not in the building. Once the DON was in the building, the medications and the Controlled Drug Administration Record were taken to the DON and verified by the DON and the nurse or MA. She said the keys and medication cart passed through a lot of hands because the nurse arrived at 6 am and 10 pm but the MAs arrived at 8 am. She said the morning LVN passed off to the morning MA then the morning MA passed off to the night LVN, then the night LVN passed off to the morning LVN. MA B said she had not had any issues when she worked with her narcotic counts matching. She said when she arrived for her shift, the narcotic count was correct. During an interview on [DATE] at 1:48 PM, the ADON said she was assigned to halls 4,5, and 6 as the charge nurse on [DATE] for the 6AM to 2PM shift. The ADON said she did not experience any drug discrepancies during this time but could not recall if Resident #1's medications were still on the cart that morning or not during the narcotic count down. The ADON said now the facility counted the total amount of cards in the locked narcotic box prior to doing the narcotic count down where the oncoming nurse counts the medications back to the going off shift nurse. The ADON said the routine procedure was to leave any discontinued medications on the cart and continue to count the medications against the Controlled Drug Administration Record when the DON was not in the building. Once the DON was in the building, the medications and narcotic sign out sheets were taken to the DON and verified by the DON and the nurse or MA. The ADON said she had been educated on abuse, neglect and misappropriation on several occasions at the facility. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:33 PM, the DON said she had been employed by the facility for approximately 2 years. During the investigation regarding the allegation of misappropriation with RN A, the DON said she reconciliated the pharmacy manifest to the Controlled Drug Administration Record and found the discrepancy between Resident #1's medications because there was no Controlled Drug Administration Record to match the received medications. The DON said the facility implemented adding and subtracting the amount of blister packs of medications added or removed from the narcotic locked boxes. The DON said the pharmacy reconciliation was done monthly now also. The DON said she was too new and was not aware to reconcile the narcotic sheets against the pharmacy manifest until the incident. The DON said the staff had been educated on abuse-misappropriation and reporting, the new implemented narcotic count down per shift counting the card and adding or subtracting. Staff surveys were completed regarding concerns of any residents not getting pain medications, and legal obligation to report those concerns. The DON said resident surveys were completed regarding pain/comfort levels. The DON and Administrator performed chart audits on residents receiving opioids given by RN A and the pain assessment notes were reviewed. The DON said it was important to ensure there was not misappropriation of medications, so the residents received medications appropriately and did not experience pain and or discomfort. During an interview on [DATE] at 2:45 PM, the Administrator said the facility could not find the missing medications, so the facility did have a drug diversion. She said if the drug was not available in the facility's emergency medication kit, then there was a potential for the resident to miss a dose and experience pain. The Administrator said the staff had been educated on abuse-misappropriation and reporting, they had now implemented narcotic count down per shift (counting the card and adding or subtracting) staff surveys were completed regarding concerns of any residents not getting pain medication, and legal obligation to report those concerns. The Administrator said resident surveys were completed regarding pain/comfort levels. The DON and Administrator performed chart audits on residents receiving opioids given by RN A and the pain assessment notes were reviewed. The Administrator said the medications belonged to the residents. The administrator said RN A had denied the allegations of taking narcotics from the facility. The DON said RN A volunteered to take a drug test when confronted with the allegations by the Administrator. The Administrator said the initial drug screen was positive for opioids. The Administrator said RN A stated, I eat lots of poppy seeds and take tons of Benadryl which would cause the positive drug screen result. The DON stated RN A remained suspended from [DATE] - [DATE] while the facility awaited the results of the sent-out drug screen. On [DATE], RN A was allowed to return to work when the final drug screen results were returned negative. Record review of a facility's Abuse, dated [DATE] indicated . the purpose of this policy is to ensure that each resident has the right to be free from any type of Abuse, Neglect, Intimidation, .misappropriation of resident property . The facility had corrected the noncompliance on [DATE] by the following: Suspension of RN A who the allegations involved for misappropriation. All staff educated by in-service on abuse and neglect/misappropriation and legal obligation of reporting of any suspicions per facility policy. Life Surveys completed on staff: (RN G, RN H, CNA K, CNA L). All staff educated by in-service on abuse, neglect, misappropriation and examples and legal obligation to report and suspicion of activity. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Self-Report completed to Health and Human Services and the local police department. Audits completed on narcotic locked boxes on all medication carts (inspected cards and verified counts). Residents prescribed with opioids reviewed for unexplained pain concerns. Life Surveys completed on residents to measure of pain and comfort levels (Resident #4 and Resident #5) Audit Report for computer system for as needed medications reviewed for trends administrated by RN A for [DATE] - [DATE]. Reconciliation of Controlled Drug Administration Record to the Pharmacy Manifest completed monthly from [DATE] to present - reviewed. Record Review and interviews of sampled residents (Resident #2, Resident #3, and Resident #4) indicated no misappropriation of property occurred. Record Review of sign in sheet dated [DATE] of all staff educated on abuse, neglect, misappropriation and examples and legal obligation to report and suspicion of activity. Record Review of sign in sheet dated [DATE] of all licensed staff educated utilizing the new narcotic count sheets to be filled out at each shift count. Parts include (addition, subtracting, when and who) to be completed on the new sheet. All medications should match the controlled narcotic sheets prior to any staff leaving the building, no blank spaces on the narcotic sheets, and the electronic computer system MAR should reflect when a medication was given and match the controlled narcotic sheets. All licensed staff interviewed (MA B, LVN C, LVN D, LVN E, RN F) verbalized any allegation of abuse/misappropriation should be reported to the administrator immediately. They verbalized understanding of the types of abuse and the facility's obligation to report abuse to HHS within 2 hours and removing the alleged perpetrator from the victim or any potential victims immediately. They verbalized the implementation of the card counting of the blister packs of the medications added to the narcotic count at the beginning and ending of each shift by utilizing the new narcotic count sheet each shift, no staff can leave prior to a count not being correct. The noncompliance was identified as PNC. The noncompliance began on [DATE] and ended on [DATE].