STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675089	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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** 44405 Based on observations, interviews, and records review, the facility failed to ensure the right to be free from misappropriation of resident property for 1 of 5 residents (Resident #1) reviewed for misappropriation of resident property. RN A used Resident #1's prescribed Fentanyl (an opioid pain medicine that is used to treat moderate to severe chronic pain around the clock) 100 mcg 72-hour transdermal (skin) patch for personal recreational use on 02/12/25. This failure placed residents at risk of not receiving timely pain management care which could result in prolonged pain and diminished quality of life. Findings included: Record review of Resident #1's Quarterly MDS assessment, dated 12/06/24, revealed an [AGE] year-old female, who admitted to the facility on [DATE] - most recent re-admission on 02/02/24, with the following diagnoses: Ankylosing Spondylitis (an inflammatory disease that can fuse the vertebrae in the spine and cause back pain, stiffness and hunched posture), lumbar region; Erosive Osteoarthritis ([EOA] a type of osteoarthritis that create deformities with a distinctive shape); and Chronic Pain Syndrome. Resident #1's BIMS score was 05, which indicated severe cognitive impairment. The Quarterly MDS, Section J - Health Conditions reflected Resident #1 received a scheduled pain medication regimen. Resident #1 admitted to hospice on 02/05/25. Record review of Resident #1's comprehensive care plan, admitted [DATE], reflected: [Resident #1] was at increased potential for pain due to chronic pain (Initiated 03/13/18; Revised 08/23/21) and included interventions to Assess characteristics of pain; administer pain medication as per orders; and monitor for potential side effects of pain medication. [Resident #1] was on pain medication therapy r/t disease process (Initiated 02/11/25; Revised 02/11/25) and included interventions to Administer analgesic medications as ordered; Monitor, document, report adverse side effects to medications; and review every shift for pain medication efficacy. (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
	675089	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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	[Resident #1] complained of increased pain/discomfort and was at Risk for Injury from decreased ADLs and Osteoarthritis (Initiated 02/14/25; Revised 02/14/25) and included interventions to Anticipated the resident's need for pain relief; Evaluate the effectiveness of pain relief interventions; Monitor, document, report non-verbal s/s of pain; adverse side effects to medications; and review every shift for pain medication efficacy. Resident #1's clinical physician's orders reflected: - Order date 10/06/22: Verify Fentanyl patch placement every shift. - Order date 11/29/24: Fentanyl Transdermal 72-hour Patch 100 mcg/hr. Apply one patch topically every 72 hours for pain and remove per schedule. - Order date 12/13/24: Monitor for side effects of opioid medications - Fentanyl every shift by indicating the corresponding number as follows: 0) None; 1) Constipation; 2) Nausea; 3) Dry Mouth; 4) Dizziness; 5) Drowsiness; 6) Confusion; 7) Withdrawn; 8) Itching; 9) Sweating; 10) Increased Tolerance; 11) Respiratory Depression. Notify MD with changes in condition every shift. Record review of Resident #1's February 2025 MAR reflected: - The orders were implemented as written to Fentanyl Transdermal 72-hour Patch 100 mcg/hr. Apply one patch topically every 72 hours for pain and remove per schedule. as evidenced by a checkmark and a nurse's initials. The patch was last replaced on 02/09/25. On 02/12/25 at 1211, RN A entered a 9 (See Progress Notes) and her initials. An attempt to review Resident #1's Fentanyl Patch narcotic count sheet revealed it was missing. Review of Resident #1's progress notes indicated: - Nurse's Note Effective Date: 02/12/25 at 7:10 AM, RN A entered, [Resident #1] refused to allow nurse to remove and replace her Fentanyl patch. Attempted to educate but [Resident #1] became very combative. During an observation and interview on 02/15/25 at 10:15 AM, LVN E removed a patch from Resident #1 upper back. The patch reflected the date 02/09/25 and LVN E's initials. LVN E placed a new Fentanyl 100 mcg/24-hour patch to Resident #1's left upper mid shoulder. The patch reflected 02/15/25 and LVN E's initials. Resident #1 could not participate in a meaningful interview. Resident #1 stated that she was always in pain when asked if she was in pain. Resident #1 could not rate her pain level. Resident #1 did not verbalize or demonstrate non-verbal cues suggestive of pain during removal and placement of patches. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675089	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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	During an interview on 02/15/25 at 3:35 PM, the DON stated she and LVN B discovered RN A unresponsive on the floor of the staff bathroom located on the secured unit on 02/12/25. The DON said that RN A worked 02/12/25 6A - 2P shift, on the hall Resident #1 resided. The DON said that RN A agreed to work part of the 2P - 10P shift on the secured unit until the on-coming nurse (LVN H) arrived. The DON said (on 02/12/25) she entered the secured unit around 5:00 PM to notify RN A that LVN H would arrive soon. The DON said that she did not see RN A on the unit and RCP C informed (the DON) that RN A was in the bathroom. The DON said that she exited the secured unit and tried calling RN A on the phone (at 5:05 PM), but the call was unanswered. The DON said that RN A did not reply to the text sent. The DON said that she became concerned because RN A would send a message if unable to answer a call or replied to a text within a timely manner. The DON said that she returned to the secured unit after 10 minutes and still could not locate RN A. The DON said that RCP C indicated RN A had not come out of the bathroom. The DON said that she knocked on the bathroom door and RN A did not answer. The DON said that she could hear the fan blowing in the bathroom and can see the light shine from under the door. The DON said that she knocked again and walked over to the nurses' station to see if the bathroom key was returned, it was not there. The DON said that she stepped out of the secured unit, not allowing the door to close completely, and asked LVN B to come to the secured unit. The DON said that she told LVN B about her concerns. The DON said that LVN B kneeled to look under the bathroom door and could see that someone was leaning against the door. The DON said that she and LVN B tried to force the door open. The DON said that LVN B left to try to find a tool to pry the door open. The DON said that LVN B used the tool to unlock the door and shoved on the door until they were able to enter. The DON said that she observed RN A sitting on the floor with her back against the wall, slumped to her left side. The DON said that RN A drooled foam from her mouth, her lips had a bluish tint, and presented with decreased respirations. The DON said that RN A's eyes were open with a blank stare, and RN A's fingertips and hands were colorless. The DON said that she and LVN B pulled RN A from the bathroom into the hall and placed [RN A] on her back. The DON said that RMP F entered the secured unit and the DON redirected [RMP F] to get the crash cart and AED. The DON told LVN B to call 911. The DON said that oxygen was applied to RN A and rescue breathing was initiated until EMS arrived. The DON said that EMS assessed RN A and transferred her onto a stretcher. The DON said as she started her car to follow behind the ambulance, LVN H approached and presented a Fentanyl patch that she found on the bathroom floor. LVN H informed EMS about the Fentanyl patch, a paramedic acknowledged, and indicated Narcan would be initiated for opioid overdose. The DON said when she returned to the facility (02/12/25) she conducted cart audits and initiated in-services. The DON said that RN A was suspended during investigation and terminated on 02/14/25. During an interview on 02/15/25 at 5:17 PM, LVN E said that Resident #1 would refuse the removal and placement of a Fentanyl patch at times. LVN E said that the patch was scheduled at 6:00 AM. LVN E said that he felt it was too early to try to remove and apply a patch when Resident #1 was just waking, and other care tasks were being performed. LVN E said that on days Resident #1 was irritated, he was often successful at a second try after breakfast. LVN E said that he never worked behind or alongside RN A to have concerns regarding drug diversion. During a phone interview on 02/16/25 at 12:51 PM, RCP C said that she worked 02/12/25. RCP C said that she arrived around 4:00 PM. RCP C said that she saw RN A briefly before she (RN A) went into the bathroom. RCP C said that she has worked with RN A in the past, but RN A seemed overly happy or was marked by an overwhelming pleasurable emotion on that day (02/12/25). RCP C said that it was different but did not think anything about it. RCP C said that she never suspected RN A was under the influence of drugs when worked together. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675089	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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	During a phone interview on 02/16/25 at 3:27 PM, RN A stated that she was the treatment nurse at the facility. RN A said that she had a history of substance abuse and had been sober for [AGE] years. RN A said that she had a relapse on 02/12/25. RN A said that she worked 6A - 2P as a floor nurse on 02/12/25 and was assigned to Resident #1. RN A said that Resident #1 refused when she (RN A) attempted to remove and place a new Fentanyl patch. RN A said that she had already signed the narcotic sheet that the patch was administered and did not know how to correct it after Resident #1 refused. RN A said that she kept the Fentanyl patch for personal recreational use and shredded the narcotic count sheet so she would not have to explain the missing patch. RN A said that it was the last Fentanyl patch and needed to be reordered. RN A said that she agreed to work the secured unit from 2:00 PM until the on-coming nurse arrived. RN A said that she went into the bathroom, cut a piece of the Fentanyl patch, and placed in her mouth to chew on it. RN A said that was all she remembered until she woke up in the hospital. RN A said that she did not expect a reaction. Record review of the Abuse Neglect and Exploitation policy, last revised 01/01/23, 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, 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 misappropriation of resident property included the diversion of a resident's medication(s), including, but not limited to, controlled substances for staff use or personal gain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675089	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44405 Based on observation, interview, and record review the facility failed to assure that medications were secure and inaccessible to unauthorized staff and residents for 2 (Medication Cart #1 and Medication Cart #2) of 2 medication carts observed for medication storage, in that: The facility failed to ensure controlled medications in unsecure bubble packaging cards were immediately removed from Medication Cart #1 and Medication Cart #2. These failures could place residents at risk of not having the medication available due to possible drug diversion and at risk of not receiving the intended therapeutic benefit of the medication. Findings Included: During an observation and record review of medication cart #1 on 02/15/25 at 2:09 PM revealed a pill bubble packaging card filled with Tramadol 50 mg tablets (controlled medication used to treat insomnia [trouble sleeping]). The seals that secured 3 pill bubbles (#6, #7, and #13) were not intact and covered with tape. A pink and blue capsule was noted inside each bubble. There were 14 pills remaining. The narcotic log count sheet reflected the appropriate count. During a continued observation of medication cart #1, a full pill bubble packaging card (30 pills) filled with Alprazolam 0.25 mg (controlled medication used to treat panic and anxiety disorders) had 1 seal (#16) that was not intact. A small white, oval tablet was inside the bubble. The narcotic log count sheet reflected the appropriate count. During an interview, observation, and record review of medication cart #2 on 02/15/25 at 2:20 PM revealed a pill bubble packaging card filled with Lorazepam 0.5 mg (a controlled substance used to relieve anxiety) with 1 seal (#6) not intact. A white, round tablet was noted inside the bubble. There were 11 pills remaining. The narcotic log count sheet reflected the appropriate count. During an interview, RMP D indicated that controlled medications were counted at the beginning and at the end of shift. RMP D said that controlled medications must be secured in a separately locked compartment within the medication cart. RMP D stated she did not see the broken seals during the count. RMP D stated she was unaware that the bubble seal was broken or when it happened. RMP D said that best practice would be to discard the pill with a second nurse. RMP D said the risk of an exposed pill was exposure, cross-contamination, the pill could be stolen, or replaced with a similar looking pill. RMP D stated the risk of a damaged bubble seal would be a potential for drug diversion. RMP D stated the RMP's, and nurses were responsible to check the medication bubble packs for broken seals during the count of narcotics at change of the shift. During an interview on 02/15/25 at 3:06 PM, the DON said that nurses were responsible for following the medication rights (the right resident, right medication, right dose, right form, right time) and review expiration dates. The DON said if a nurse discovered the seal of a medication bubble pack was altered (opened, torn, ripped) then the nurse should notify the DON and discard the pill with a second nurse. The DON said that the second nurse witnessed the pill disposal of controlled medications as a secure and safe method to prevent diversion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675089	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Sherman	817 W Center Sherman, TX 75090

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy Pharmacy Services, revised April 2007 reflected the following: . 4. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.