

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/08/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Humble		STREET ADDRESS, CITY, STATE, ZIP CODE 93 Isaacks Rd Humble, TX 77338	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free from abuse and neglect, for 5 of 5 residents (Resident #1, Resident #2, Resident #4, Resident #8 and Resident #10) reviewed for abuse. The facility failed to ensure Resident #1 was free from abuse when CNA D forcefully pushed the resident down into the couch as the resident attempted to stand, causing the resident to cry and experience distress on 05/20/2026. The facility failed to protect Resident #2 from physical abuse when CNA D slapped the resident on the right arm, then grabbed his left arm and forcefully pulled him into a standing position, causing the resident to become unsteady and cry on 05/20/2026. The facility failed to ensure Resident #4 was treated with dignity and free from verbal and physical abuse when CNA S used vulgar language toward the resident, then grabbed him by the shoulders and forcefully walked him down the hallway to his room on 05/20/2026. The facility failed to protect Resident #8 from verbal and physical abuse when CNA S grabbed the resident by the shoulder and forced her to walk out of the activities room while using vulgar language towards her on 05/20/2026. The facility failed to ensure Resident #10 was free from abuse when Laundry Aide A struck the resident in the face during a physical altercation on 05/02/2026. The non-compliance was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 05/20/2026 and ended on 05/21/2026. The facility corrected the non-compliance before the investigation began on 06/03/2026. These failures could place residents at risk for serious injury, trauma, and ongoing exposure to abuse. Findings included: Resident #1 Record review of Resident #1's admission record, undated revealed an [AGE] year-old female who admitted into the facility on [DATE] and readmitted on [DATE]. She had diagnosis of symbolic dysfunctions (a group of neurological and cognitive impairments that affect the brain's ability to comprehend, manipulate, or express abstract symbols such as gestures or environmental signs), memory deficit, dementia, major depressive disorder, and cerebrovascular disease (all conditions affecting blood flow and the blood vessels in the brain. Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 01 out of 15, which indicated severe cognitive impairment. Resident #1 is unable to demonstrate basic recall or orientation and requires extensive support, supervision, and cueing for safety and daily decision-making. Record review of Resident #1's Care Plan initiated interventions on 07/29/2025 read. to allow resident to verbalize feelings, encourage residents to be an active participant in decision making, encourage resident to be involved in activities of choice and preference, and provide care in a warm and caring manner. It also read. Resident resides in the secure unit and is at risk for injury from wandering in an unsafe environment R/T DX of dementia and altered cognition. Resident #1 has DX of Anxiety R/T cognitive deficit which could cause anxiousness, trouble concentrating, and episodes of confusion. The interventions involved staff to Observe/Monitor/Document/Report PRN any Adverse Reactions to ANTI-ANXIETY Therapy: Drowsiness, Lack of Energy, Clumsiness, Slow Reflexes, Slurred Speech, Confusion and Disorientation, Depression, Dizziness, Lightheadedness, Impaired Thinking and Judgment, Memory Loss, Forgetfulness, Nausea, Stomach Upset, Blurred or Double Vision. UNEXPECTED SIDE EFFECTS: Mania, Hostility, Rage, Aggressive or Impulsive (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	how it could have affected them:Resident #1 She stated they were unable to determine the resident's level of understanding but confirmed the resident's emotional response was affected.Residents #2 and #4 She stated they do not communicate effectively.Resident #8 was assessed; she apologized to her for what happened and noted the resident did not remember the incident.The Administrator stated she was disappointed in LVN W and initially believed he was unaware of what was occurring. The Administrator stated CNA D was described as nonchalant and distant. She stated CNA D did not remember pushing a resident but believed staff needed to be forceful for residents to comply. She stated CNA D admitted for cing a resident to replace a cushion despite knowing the resident did not understand. She stated CND D refused to participate in the final termination meeting and ended the investigation call. The Administrator stated CNA S initially interviewed but later stopped responding after viewing the video footage. The Administrator stated she believed CNA S was fired based on the in-service and planned to obtain an attorney. The Administrator stated that no staff outside the secured unit were aware that abuse was occurring or occurred. She also stated the facility is training a new nurse for the 6p-6a shift in the secured unit.Resident #10Record review of Resident #10's face sheet dated 6/3/26 revealed a [AGE] year-old female who admitted on [DATE]. Her diagnoses included dementia with psychotic and mood disturbance, delusional disorders, major depressive disorder, need for assistance with personal care, bipolar disorder with psychotic features, and anxiety.Record review of Resident #10's discharge assessment - return anticipated MDS assessment dated [DATE] revealed her cognitive skills for daily decision making was severely impaired. She had delusions and exhibited physical and verbal behavioral symptoms toward others for 4 to 6 days. She required ADL assistance from staff.Record review of Resident #10's care plan revised on 5/18/26 indicated she had potential to be physically aggressive toward staff and peers due to delusions of thinking this is her house. 5/2/26 physical altercation between resident and staff. Interventions included altercation redirected by nursing staff, labs as ordered, medication review, family at bedside to provide one on one and encourage resident to take medications and have labs drawn. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. Provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated.Record review of the facility's provider investigation report dated 5/8/26 completed by the Administrator read in part, .Upon entrance to the secure unit (on 5/2/26) (Laundry aide A) was met with (Resident #10) cursing and calling her out of her name. (Laundry aide A) repeatedly tried to passing [sic] (Resident #10), without any issues. However, (Resident #10) continued to place her chair in (Laundry aide A's) path, as she called her many derogatory and very offensive names. As (Laundry aide A), proceeded down the hall (Resident #10) hit her multiple times and pulled a handful of hair, causing (Laundry aide A) to lean over forcefully and digging her nails in her arm. At this point (Laundry aide A) started trying to get herself a loose from (Resident #10), buy [sic] pulling, swinging, yelling, etc. During this entanglement, (Resident #10) was struck by (Laundry aide A), as she was trying to get her to loosen the grip of her hair. upon completion of the investigation, it was determined that (Laundry aide A) did strike (Resident #10), but it was in defense of her grabbing her hair and arm. (Laundry aide A) did attempt to avoid the altercation, but (Resident #10) was clearly having a Psychotic episode. (Resident #10) was admitted to (behavior hospital) for her behaviors.Employee was suspended pending investigation, then later terminated upon completion of investigation. The investigation findings were inconclusive.Record review of LVN P's witness statement dated 5/2/26 and signed by LVN P read in part, .(Laundry aide A) was coming down the hall to deliver clothes. (Resident #10) was blocking the path and she asked to have her moved. (Resident #10) was cussing and reached for (Laundry aide A's) hair at which point all staff members came to intervene. When I came around (CNA H's) left side I witnessed (Laundry aide A) strike her with an open hand to her face.In an interview on 6/3/26 at 11:07 a.m. Resident #10 said she was treated nicely and did not recall anyone hitting her.In an interview on 6/3/26 at 12:29 p.m. Laundry aide A said the incident with (continued on next page)		

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In an interview on 6/3/26 at 1:00 p.m. CNA B said on the day of the incident (5/2/26) Resident #10 was in a bad mood and put her nails into CNA H's skin and tried to hit other residents. She said Laundry aide A came to the hallway and Resident #10 blocked her path. The laundry aide asked Resident #10 to please move back and then walked past Resident #10. Resident #10 pulled the laundry aides hair and she and CNA H got in the middle of the altercation to separate them. She said while they were in between the altercation, the laundry aide swung and slapped the resident on the side of her face, the reaction appeared to be a reflex. After the laundry aide hit the resident, the CNAs isolated the resident, and the laundry aide left the secure unit. She said after the incident, Resident #10 called the laundry aide several expletives which lasted for approximately 5-10 minutes but then the resident forgot what happened. She said she was in-serviced on abuse incidents including types of abuse and who to report to. She was also in-serviced on behaviors and redirecting residents. In an interview on 6/3/26 at 1:20 p.m. CNA H said when Laundry aide A entered the secure unit (on 5/2/26) they told her to be careful around Resident #10. Resident #10 called the laundry aide names, kicked her, dug into her skin, and grabbed her by the hair. She said she intervened and tried to separate them and release the laundry aide's hair from Resident #10's grip. She said the laundry aide reached over and made contact with the resident's forehead and was unsure if she punched or slapped her. After the incident the resident sat in her wheelchair, crossed her legs, and called the laundry aide names. The resident did not remember the incident. She said she was in-serviced on abuse incidents including types of abuse and who to report to. She was also in-serviced on deescalating behaviors and what to do if a resident hits you. In an interview on 6/4/26 at 10:09 a.m. the Administrator said LVN P notified her of the incident between Laundry aide A and Resident #10 (on 5/2/26). She said the resident was irate and fighting all day. She was informed the resident pulled the laundry aide down and in self-defense the laundry aide hit the resident. She said the resident had a history of behaviors and interventions included redirection, secure unit training, and only allowing specific people in the secure unit. She said she did not know why the laundry aide responded in that matter; it could have been a natural response. She said staff did not have the right to defend themselves against residents and the laundry aide should have walked away and let the nurse deal with Resident #10. She said the laundry aide informed her that everything moved so fast and if she hit the resident, that was not her intention, she was just trying to get herself loose. She said virtual dementia training was provided to the staff as well as abuse and neglect, resident rights, and redirecting resident. Record review of abuse/neglect in-service on 04/22/2026 for Night Shift/ Hall 200 (Secured-Unit, acknowledgement of in-service being completed before incidents) completed by the DON with the contents or summary of training session included: All forms of abuse must be reported to the abuse coordinator immediately. Immediate investigations must be conducted on all forms of abuse/neglect reported. The signature page revealed LVN W, CNA B, and CNA D signed. Record review of facility's Action Plan Agenda initiated on 05/21/2026 and followed up on 05/27/2026 read. Issue/Concern- Facility identified substantiated events of physical and verbal abuse towards residents from staff on 05/21/2026. The Measurable Goal: Nursing staff will be in-services on abuse/neglect, resident rights, forms of restraints, Senate [NAME] 9, transfers., secure unit competencies, incidents and accidents, changes of condition and following MD orders, dementia care and involuntary seclusions. Involved staff members will be suspended immediately pending investigations - 05/27/2026 all involves parties terminated. Skin assessment will be completed on all (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	residents residing on the secure unitSecure unit competencies to be completed by staff on paper and/or skilled nursing facility clinicSafe survey assessments completed for residents and staff - 05/27/2026 standard of care review of affected residents and safe survey resultsRecord review of facility's night shift supervisor schedule, effective 05/24/2026 and ongoing for three months revealed the name of the night shift supervisor with their signature of additional monitoring checks completed on the secured unit and throughout the facility. The addendum read. The Administrator and DON will conduct random night shift rounds throughout the schedule period to ensure compliance, support, and operational oversight.Record review of facility's resident safety survey was completed on 05/21/2026 for Resident #8 (Secured Unit), Resident #14 (Secured Unit), Resident #23, Resident #34 (Secured Unit), Resident #49, Resident #54, Resident #72 and Resident #94 who revealed the following:- They felt safe in the nursing home- They felt they were treated with respect and dignity by staff- They feel free from any form of abuse (physical, emotional, verbal, or financial)- Their personal needs are being met- They feel comfortable and can speak up with being heard by staff Record review of staff knowledge and responsibility survey completed on 05/21/2026 for ADOC M, CNA E, RN C, MA A, LVN S, LVN J, LVN L, Housekeeping M, Housekeeping G, Housekeeping J, PTA R, CNA Z, CNA C, and CNA F who revealed the following:- They are familiar with the facility's abuse and neglect policy- They understand the types of abuse and neglect and the signs to look for- They understand their responsibility to report suspected abuse or neglect immediately- They are aware of Senate [NAME] 9 and understand their legal responsibility to report abuse or neglect as required by this law- They feel confident in who to report suspected abuse or neglect in accordance with Senate [NAME] 9- With all marking they have not witnessed abuse or neglect in the facilityRecord review of abuse/neglect in-service, dementia care, and resident rights on 05/21/2026 for all staff completed by the DON with the contents or summary of training session included:All forms of abuse must be reported to the abuse coordinator immediatelyImmediate investigations must be conducted on all forms of abuse/neglect reported.In interview on 06/05/2026 during the times of 9a.m. -1:51p.m. with CNA Z, CNA T, CNA J who worked in the secured unit were interviewed and stated they have received abuse and neglect in-service training including types of abuse, resident rights, dementia care and their responsibility to report concerns. They identified verbal, physical, and neglect as forms of abuse. They were instructed to immediately report any witnessed or suspected abuse to the Administrator and understood that failure to report is a violation of facility policy and state regulations.Record review of the facility's 'Abuse Policy' revised on 01/01/2023 read.POLICYThe 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.Residents will not be subjected to abuse by anyone, including, but not limited to communitystaff, other residents, consultants, volunteers, staff of other agencies serving the residents,family members or legal guardians, care taker, friends, or other individuals.This includes physical, verbal, sexual, physical /chemical restraint.Training: All employees are required to be trained in issues related to abuse prohibitionpractices. Training includes orientation, and on-going sessions. Training will include appropriate interventions on how to deal with residents with aggression or combative behavior.Reporting/Investigation: The law requires the abuse coordinator/designee, or employee of the facility who believes that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect or exploitation caused by another person to report the abuse, neglect or exploitation.All events that involve an allegation of abuse or involve a suspicious serious bodily injury of unknown origin must be reported immediately or not later than 2 hours of alleged violation.Protection: It is utmost important that residents(s) suspected of being abused, and all other residents must be protected during the initial identification, and investigation process. The facility will initiate immediate procedures to ensure that these residents are protected fully from any further harm or potential harm, upon notification of allegation, the Abuse Coordinator or designee will perform the foll		

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NAME OF PROVIDER OR SUPPLIER Focused Care at Humble		STREET ADDRESS, CITY, STATE, ZIP CODE 93 Isaacks Rd Humble, TX 77338	
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F 0755 Level of Harm - Actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #4) of 5 residents reviewed for pharmacy services. The facility failed to administer 4 doses of Clonazepam (medication used to treat seizures and anxiety) to Resident #4 between 05/8/26 - 05/10/26 because it was unavailable in the facility. Resident #4 had 3 back-to-back seizures and was sent to the hospital for treatment. This failure could place residents at risk of worsening of conditions and hospitalization. Findings included: Record review of Resident #4's face sheet dated 6/3/26 revealed a [AGE] year-old male who admitted on [DATE]. His diagnoses included other seizures (5/10/25), epilepsy (seizures), anxiety, Parkinson's disease, mild cognitive impairment, and autistic disorder. Record review of Resident #4's discharge-return anticipated MDS assessment dated [DATE] revealed his cognitive skills for daily decision making were moderately impaired. He required assistance from staff with ADL care. The assessment indicated he was taking an anticonvulsant and an indication was noted. Record review of Resident #4's care plan revised on 5/27/26 revealed he had a history of seizures and was at risk for injury related to weakness, balancing difficulties, cognitive limitations or altered consciousness, revised 10/7/25. His interventions were to administer medications (Clonazepam) as ordered by Physician; observe/monitor for side effects and effectiveness every shift. Record review of Resident #4's physician orders revealed an order for Clonazepam 2 mg give 1 tablet via PEG-tube two times a day for anti-seizure, order date 5/5/26. Record review of Resident #4's Psychoactive medication therapy informed consent form dated 5/6/25 revealed Clonazepam was prescribed to treat the resident's anxiety disorder and seizures. Record review of Resident #4's Medication Administration Record for May 2026 revealed Clonazepam 2 mg was documented with a 9 (other/see progress notes) on the following dates: *5/8/26 at 8:00 p.m., *5/9/26 at 8:00 a.m., *5/9/26 at 8:00 p.m., and *5/10/26 at 8:00 p.m. Record review of Resident #4's nursing note dated 5/8/26 at 7:29 p.m. by LVN K read in part, Clonazepam 2 mg. ordered. Record review of Resident #4's nursing note dated 5/9/26 at 9:18 a.m. by LVN R read in part, Clonazepam 2 mg. on order. Record review of Resident #4's nursing note dated 5/9/26 at 8:46 p.m. by LVN K read in part, Clonazepam 2 mg. (no documentation). Record review of Resident #4's nursing note dated 5/10/26 at 8:12 p.m. by the ADCO read in part, Clonazepam 2 mg. med on hold until avail from pharmacy md made aware. Record review of Resident #4's nursing note dated 5/11/26 at 10:39 a.m. by LVN B read in part, Resident noted to have seizure activity with altered responsiveness. Resident experienced 3 episodes with no periods of conscious between episodes. EMS activated and resident sent out to ER for further evaluation and treatment. Vital signs monitored. MD/NP notified and gave order to send out to ER. family contacted no answer, left message. Resident transferred in stable position. Record review of Resident #4's hospital records dated 5/12/26 read in part, 5/11/26 at 2:20 p.m. Patient presents with seizures. Patient brought to ED from (facility name). Patient reportedly had 3 seizure episodes today. History of autism, seizure, Parkinson's, HTN, PEG tube. HPI: the patient is a [AGE] year-old male with autism, seizure disorder, Parkinson's disease, and HTN, who arrives via EMS presenting for reported seizure activity. History is primarily obtained from EMS and the nursing facility. Per report from (facility name) the patient had 3 seizures back-to-back without returning to baseline alertness between episodes. Facility staff described the events as violent seizures lasting about 30 seconds each and stated they did not appear consistent with his baseline dyskinesias/tardive movements. The facility also reported a fever earlier today but did not provide a temperature and did not perform any testing/swabs. EMS temperature was reported as 98 F. at time of ED evaluation he appeared at his baseline per collateral history. Home medication list provided included amlodipine and clonazepam 2 (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	mg BID (used for seizures).Assessment: .Lactate 5 supports recent seizures. Head CT showed no acute intracranial process. Overall presentation most consistent with breakthrough seizures in a patient without a dedicated antiepileptic regimen aside from scheduled clonazepam.History of Present Illness:.at this moment MPOA.states at this moment patient is at baseline and in good spirits.says last seizure was many months ago.In an interview on 6/3/26 at 5:01 p.m. with LVN K, she said Resident #4 missed Clonazepam one or two days and then it came in. She said he did not have any complications such as a seizure or hospitalization from missing it that she knew of. In an interview 6/3/26 at 5:13 p.m. LVN R said Resident #4 was on Clonazepam for seizures, but he never exhibited anything like that. Resident #4 did not normally run out of his Clonazepam and had not had any seizures since September 2025. When he saw Resident #4's Clonazepam was missing he sent the ADCO a picture of the triplicate and said it needed to be redone. He was informed to notify Staff A. He said he could not recall if he notified Staff A but said it would be on the MAR if the medication came in the next day. He said if a medication was not on the cart or in the medication room staff could try to emergency pharmacy kit. He said he did not remember if he tried to pull the Clonazepam from the ekit but said the last time he tried to use it the system was offline or updating. He said Clonazepam was a narcotic and all narcotics required a triplicate (a triplicate prescription was a three-part carbon copy form used to track controlled substances, with one copy for the prescriber, one for the pharmacy, and one for a state agency.) He said on the day he worked with the resident (5/9/26) the resident was ok and at his baseline. In an interview on 6/4/26 at 8:27 a.m. the NP said Resident #4 displayed seizure like symptoms, and she instructed staff to send him out to the hospital. She said he had never had a seizure since summer of 2025. She said the resident was on Clonazepam for anxiety, but the medication could also be used for seizures. She said it was possible that he might have had a history of seizures but did not recall seeing seizures in his history. She said the facility called her for refills all the time. She said there was no effect from the resident missing his Clonazepam 2 mg because he was not on it for seizures. She said if he was on it for seizures there would be an effect, such as him having a seizure.In an interview on 6/4/26 at 9:18 a.m. Resident #4's family member said the resident previously sustained two seizures while at the hospital in March 2025 and was unsure if he had anymore until now. She said he recently went to the hospital (May 2026) and had 3 back-to-back seizures and was unresponsive between them. She said when she arrived at the hospital, he was perfectly fine. She said the hospital did not say how or why the seizures occurred. He was referred to a neurologist. In an interview on 6/4/26 at 9:39 a.m. the ADCO said she was informed Resident #4 had a history of seizures from his family member, but the hospital removed him from the medication. She said his Clonazepam was prescribed for anxiety and people who have seizures also use it. She said she completed his consent form for Clonazepam, and it did indicate it was for seizure and anxiety. She said she worked as his floor nurse on 5/10/26 evening shift and the facility did not have the Clonazepam, so she documented a 9 and documented why it was not given. She said she would have informed the MD and notated what she did. She said every Wednesday the staff were supposed to review the narcotic supply, but it had been so short staffed she was unsure if that was done. She said Clonazepam would need to be called into the pharmacy by the provider. If the medication had not arrived to the facility, staff should call the pharmacy to inquire where it is and call the NP again. In an interview on 6/4/26 at 11:02 a.m. the pharmacy representative said Resident #4's Clonazepam prescription order was received on 5/11/26 and sent to the facility on 5/11/26. She said the pharmacy was waiting for the prescription to be sent to them and there were no issues noted with insurance or anything else.In an interview on 6/4/26 at 11:10 a.m. LVN B said on the day Resident #4 had the seizure (5/11/26) he did not look like himself. She said he began to seizure when she sat him up, was flush, red and was shaking involuntary, and jerking around with his eyes closed. She said he would come out the seizure and was not alert displayed heavy breathing and then went into another seizure. She said he experienced 2-3 back-to-back seizures. She turned him on the side and called for help. She notified the MD who said to send him to the hospital. She said Resident #4 had not had any (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	seizures when she worked with him before. She said he was on seizure medication and could not recall him being out of that medication while she worked. In an interview on 6/4/26 at 12:06 p.m. the DON said Resident #4 had a diagnosis of other seizures but was not on any medication for it when he admitted to the facility. She said she was unsure why the Clonazepam order had for anti-seizure on it and that they nurse would have had to see the diagnosis from the paperwork. She said Clonazepam was also used for anxiety. She noticed he missed his Clonazepam doses before he left for the hospital and inquired about the status with the nurses. She said the nursing staff called the pharmacy and it was supposed to be delivered to the facility. In an interview on 6/4/26 at 12:17 p.m. the DON said Resident #4 missed 4 doses of Clonazepam but said it would take about a week for the medication to get out of his system, which she learned from school. She said she did not think he had a seizure because of the missed doses. She said Resident #4 had other medication for anxiety. To ensure medications are available to administer to the resident the nursing staff review the 24-hour report, conduct a cart and medication room audit checks, and monitor the MARs and TARs. She said nursing staff should notify the charge nurse or nurse manager of a short supply of medication. If the medication is still not available after 3 days call the NP. She said on Wednesdays nurses conduct a triplicate request form and send them to the doctor. She said they might have been out of the Clonazepam in the emergency pharmacy kit. In an interview on 6/4/26 at 3:05 p.m. Administrator said the facility had no challenges with getting medications in on time and there were systems in place to keep the medications from running out. In an interview on 6/4/26 at 3:28 p.m. the DON said the pharmacy and NP were aware the Clonazepam was out for Resident #4. She said the facility staff notified everyone. She said on 5/9/26 a nurse notified the nurse manager, and on 5/10/26 another nurse notified the NP about not having the medication. In an interview on 6/4/26 at 3:37 p.m. the NP said the ADCO sent her a text message about a refill for Resident #4's Clonazepam on the evening of 5/10/26 and the NP called it in to the pharmacy on the morning of 5/11/26. In an interview on 6/4/26 at 9:45 a.m. LVN K said Resident #4 had a history of seizures and anxiety, but the facility did not say much about seizures and the Clonazepam was more for anxiety. She said the indication for the medication would be located on the MAR, but she could not remember what diagnosis was listed. She did not hear anything about the medication being for seizures. When she worked with Resident #4 (on 5/8/26 and 5/9/26) she remembered the Clonazepam being out. She looked for it in the medication room and overflow, but did not see it. She said she probably called the day shift nurse to see if the medication was ordered and was sure it was ordered. She could not say if she called the MD or told the next shift, but said if she did not order it, she saw where someone else ordered it. She said the process for reordering controlled medication would be to notify the physician. She said you could not get in contact with the MD after hours and sometimes MDs and NPs did not respond over the weekend. She said someone ended up reaching out to the MD because the medicine arrived at the facility. In an interview on 6/5/26 at 10:15 a.m. LVN B said she could not remember what Resident #4 was on Clonazepam for. When she called 911, she saw he had a diagnosis of other seizures. She said he should have had another blister pack of Clonazepam 2 mg in the building. She said the nurses on the floor were responsible for notifying the DON and the pharmacy when the medication supply got low around 6-8-day supply remaining. She said she did not remember anyone saying they reordered the Clonazepam and honestly thought it was in the building. She said the nurses had to ensure the medication was available and for the most part nursing staff understood the reordering process and never had medication run out. In an interview on 6/5/26 at 4:38 p.m. ADCO L said Resident #4 was on Clonazepam 2 mg for anxiety and seizures. She had not seen him have a seizure at the facility before. She said LVN R informed her that Resident #4 was running low on Clonazepam. She informed him to reach out to the resident's NP. She said she did not hear anything back from the nurse. She said she normally filled out the triplicates and reminded nursing staff on Wednesdays to send the triplicates to the MD. She said she constantly checked to ensure a 7 day or more supply was available. She said floor nurses provided oversight of the narcotic availability and the providers were responsive to (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	medication request. She said she also never had an issue with LVN R not contacting a provider for medication. Record review of the facility's General Guidelines for Medication Administration policy dated 8-2020 read in part, .Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer. Preparation. 11. If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility. are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit.Documentation. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at a scheduled time or a starter dose of an antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record. If 3 consecutive doses, or in accordance with facility policy, of a vital medication are withheld, refused, or not available, the physician is notified. Nursing documents the notification and physician response .		