

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675849	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Focused Care at Burnet Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 3921 N. Main Street Baytown, TX 77521	
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 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, observation and record review, the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for 1 (Resident #1) of 8 residents reviewed for pharmacy services. The facility failed to ensure Resident #1 received scheduled alprazolam on 7/15/26 and 7/16/26 and scheduled Hydrocodone-Acetaminophen/Norco on 7/7/26 at 12:00 p.m. This failure could place residents at risk of not receiving medications as ordered by the physician and increased pain or anxiety. Findings included: Record review of Resident #1's face sheet, dated 7/21/26, revealed the resident was a [AGE] year-old male admitted on [DATE]. Resident #1 had diagnoses which included chronic pain syndrome (condition characterized by persistent pain that lasts beyond expected period of healing), unspecified low back pain, unspecified pain, and generalized anxiety disorder (mental health condition characterized by excessive, uncontrollable worry). Record review of Resident #1's quarterly MDS assessment, dated 6/25/26, section C (Cognitive Patterns) revealed a BIMS score of 13 which indicated cognition was intact. Section I (Active Diagnoses) revealed anxiety disorder. Section J (Health Conditions) revealed Resident #1 received scheduled pain medication regimen in the last 5 days prior to the assessment. Record review of Resident #1's physicians order summary report, dated 7/21/26, revealed physician orders for alprazolam 1 mg oral tablet with instructions to give 1 mg by mouth every 24 hours as needed for anxiety and may have 1 mg repeat dose if initial schedule dose was ineffective only during nighttime if Resident #1 woke up during the night with start a date of 7/17/26, alprazolam 1 mg oral tablet with instructions to give 2 tablets at bedtime with start date of 5/27/26, and hydrocodone-acetaminophen 10/325 mg oral tablet with instructions to give 1 tablet by mouth every four hours for pain with start date of 5/20/26. Record review of Resident #1's care plan, dated 7/22/26, revealed a focus regarding psychosocial well-being related to anxiety. Record review of Resident #1's July 2026 MAR revealed alprazolam oral tablet 1 mg with instructions to give 2 mg by mouth at bedtime had chart code 5 documented on 7/15/26 at 8:00 p.m. and 7/16/26 at 8:00 p.m. by Resident Medication Provider B. Hydrocodone-acetaminophen oral tablet 10/325 mg with instructions to give 1 tablet my mouth every 4 hours for pain had chart code 9 documented on 7/7/26 at 12 p.m. by LPN A. Record review of the chart code key revealed 5 indicated Hold/See Progress Notes and chart code 9 indicated Other/See Progress Notes. Alprazolam 1mg oral tablet with instructions to give 1 mg by mouth every 24 hours as needed and may have 1 mg repeat dose if initial scheduled dose ineffective was administered on 7/1/26, 7/2/26, 7/5/26, 7/6/26, 7/7/26, 7/8/26, 7/9/26, 7/11/26, 7/12/26 and 7/13/26. Alprazolam 1 mg with instructions to give one time only for anxiety was documented as being administered on 7/17/26 at 8:54 p.m. by Resident Medication Provider B. Record review of Resident #1's progress notes 7/7/26 and 7/15/26-7/16/26 did not (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 0755 Level of Harm - Actual harm Residents Affected - Few	reveal any associated progress notes related to the alprazolam administration on 7/15/26 at 8:00 p.m. and 7/16/26 at 8:00 p.m. or hydrocodone-acetaminophen administration on 7/7/26 at 12:00 p.m. Record review of Resident #1's 24 hour nurse reports, dated 7/1/26 to 7/9/26, revealed the following: a note on the 7/1/26-7/2/26 24 hour report sheet that as needed alprazolam 1 mg was administered at 12 a.m.; 7/2/26-7/3/26 24 hour report revealed a note that hydrocodone-acetaminophen was to be refilled soon and the doctor was aware; 7/6/26-7/7/26 24 hour report sheet revealed a note that a Norco prescription was needed per the pharmacy with 0 left and the doctor was aware. and note was crossed out with a check next to the note and the word completed. 7/8-7/9/26 24 hour report sheet revealed note Norco received. Record review of MD A practitioner's progress note for date of service 7/7/26 written by MD A revealed past medical history of chronic midline low back pain unspecified sciatica (pain that travels down the lower back through the buttocks and each leg). Progress notes also revealed diagnosis, assessment and plan for chronic pain syndrome and to continue hydrocodone-acetaminophen 10/325 and acceptable control (the state in which a condition, process, or measurement is managed or regulated within a predefined, safe, and effective range). Record review of Resident #1's hydrocodone-acetaminophen 10/325 mg controlled drug administration record, dated 6/23/26 through 7/7/26, revealed last documentation of administration on 7/7/26 at 4:00 a.m. with end count of 0 tablets left. Record review of Resident #1's alprazolam 1 mg controlled drug administration record revealed date received at the facility 7/2/26 and last administration on 7/14/26 at 8:00 p.m. with end count of 0 tablet left. Record review of Resident #1's alprazolam 1 mg controlled drug administration record on the medication cart revealed the first date of administration was 7/17/26. Record review of Resident #1's hydrocodone-acetaminophen 10/325 mg controlled drug administration record revealed date received at the facility 7/7/26 and first administration on 7/8/26 at 1:22 a.m. Record review of Resident #1's practitioner's progress note, dated 7/17/26, written by Nurse Practitioner A, revealed Resident #1's medication list included alprazolam 1 mg tablet with instructions to take 2 tablets by mouth at bedtime and to take 1 tablet one time if Resident #1 awakens. Past medical history included general anxiety disorder and chronic midline low back pain unspecified sciatica (pain that travels down the lower back through the buttocks and each leg). Progress note revealed Resident #1 was seen for a follow up regarding his request regarding increased anxiety and depression for the past couple of days and the facility did not have the refill for alprazolam 2mg at bedtime and alprazolam 1 mg as needed. Progress note revealed Resident #1 stated he had not slept in two days because he relied on the alprazolam for sleep for the last ten years. Progress note revealed Resident #1 had gotten an alprazolam earlier that day as the pharmacy had refilled the prescription. During interview and observation on 7/21/26 at 9:59 a.m., Resident #1 said he had really bad PTSD that he took the antianxiety medication for. Resident #1 said he took two pills of the alprazolam before bedtime and he did not receive any alprazolam pills on Wednesday, 7/15/26, or Thursday, 7/16/26, and by the time he got the medication on Friday, 7/17/26, he had gone over 65 hours with no sleep. Resident #1 said staff said they were sending information to the doctor. Resident #1 said he had a panic attack for the first time in his life and cried for two days until he had no more tears. Resident #1 said the Administrator and someone else who he could not remember came Friday, 7/17/26, about 3:30-4:00 p.m. and told him something like the doctor had to send in a refill or there was a mix up with the pharmacy. Resident #1 said the CNAs kept telling him that the medication was coming on the next pharmacy delivery and the nurses would not come talk to him, but the night nurse was very concerned and said she did not know anything regarding the antianxiety medication. Resident #1 said he was seeing stuff crawling on the walls due to having withdrawals from the antianxiety medication, but he (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	the delay in the doctor writing the prescription. LPN A said the hydrocodone was delivered around shift change which was 2 p.m. on 7/7/26. LPN A said typically they documented regarding refills but unfortunately that was the first time I was made aware of the situation regarding Resident #1 running out of the hydrocodone and every nurse had the ability to refill the medication. LPN A said she would write information regarding medication refills on the 24 hour report sheet that the nurses used to report to each other. LPN A said typically they were supposed to write in the progress notes regarding refilling medications and that would be best. During interview on 7/22/26 at 11:58 a.m. the ADON said the process for reordering medication was when there were 6-8 pills of a scheduled medication left, the medication aide let the nurse know the medication needed to be refilled and the nurse reached out to the provider or their team members to let them know the medication needs to be refilled. The ADON said there were only certain medications in the automated medication dispensing system but not all medications. The ADON said both alprazolam and hydrocodone would have to have a prescription written first before they were able to pull the medication from the automated medication dispensing system. The ADON said they would call the pharmacy and verify they had received the prescription and then they would be able to pull the medication from the automated medication dispensing system. The ADON said all staff should be aware that the doctor needs to be notified to reorder medications. The ADON said if the medication was not coming in then they called the pharmacy. The ADON said if pain medication was not available the resident could be in more pain and could lead to a hospitalization. The ADON said if alprazolam was being taken for anxiety and was not available then the residents' anxiety symptoms could be increased unless we could find something for their anxiety symptoms. During interview on 7/22/26 at 12:14 p.m., the DON said the process for reordering medication was the staff should let the physician or the representative before 2 p.m. The DON said typically the staff try to notify the physician regarding a refill when the medication was around 4-5 doses. The DON said regarding Resident #1 it looked like he used up his order for the alprazolam because he had a scheduled order and a breakthrough dose and the pharmacist did not want to reorder the medication. The DON said he talked to the doctor to get the order for the alprazolam straightened out and they were able to get the medication the following day. The DON said they talked about the alprazolam for two straight days and the pharmacy said if the facility was able to pay for the alprazolam out of pocket that was the only other way. The DON said Resident #1's family came in on 7/17/26 and were upset regarding Resident #1 not receiving his medication and the DON said he told the family the facility had to get an order and depending on what time the order was called in depended on when the medication was delivered. The DON said possibly the prescription did not get called in timely for the doctor. The DON said the doctor called the pharmacy because he said Resident #1 had three refills for the alprazolam and the pharmacy was saying he should not get another dose until the July 19th, he thought. The DON said they received the Xanax on the 7/17/26. The DON said he talked to Resident #1 on the 7/17/26 because he was under the impression everything was taken care of until the family came on 7/17/26. The DON said if a resident did not get their pain medication they could have increased pain, higher anxiety, decreased trust in the facility, and overall bad state. The DON said if a resident did not get anxiety medication, that in Resident #1's situation he could not sleep. The DON said other effects could include decreased mentation, being sleep deprived, delirious, or could affect the resident's overall care because they would not be feeling well, could raise the heart rate and put the resident at more risk due to comorbidities. The DON said Resident #1 did not report seeing things and only reported increased anxiety and not sleeping and being upset regarding the financial part of the issue. The DON said I told Resident #1 it was an issue with the pharmacy and the way the order was written. The DON said the (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	pharmacy was only going off the scheduled dose and not the breakthrough doses. During interview on 7/22/26 at 1:14 p.m., LPN A said Resident #1 did not report any hallucinations to her during 7/15/26-7/16/26. LPN A said on 7/17/26 the off going medication aide told her Resident #1 needed the alprazolam refilled and, even though she was not the nurse during the time the medication was scheduled, she called the doctor and got an order for a one time dose of the medication. During interview on 7/22/26 at 1:24 p.m., MD A said Resident #1's alprazolam order was 1 mg to take two tablets at bedtime and to take another tablet when he woke at night. MD A said apparently an order was put in for alprazolam 1 mg once a day and when the facility sent the refill they sent the alprazolam 1 mg once a day so that meant when the pharmacy tried to run the alprazolam 2 mg the pharmacy denied it saying they had already run the alprazolam. MD A said he called the pharmacy to see what the issue was and they said they had already filled the 1 mg alprazolam so it took some time to get it corrected. MD A said the orders had to be written how the facility could implement them. MD A said the problem with getting the alprazolam refilled was due to poor communication between him, the facility, the pharmacy and the insurance. MD A said Resident #1 had went into full mode panic attack when he did not receive the alprazolam and he did not recall Resident #1 reporting any hallucinations. During interview on 7/22/26 at 1:45 p.m., regarding Resident #1 alprazolam administration from 7/15/26-7/16/26 LPN B said she knew the alprazolam was not there and she sent the request to pharmacy to see if they could get some and sent a notification to the doctor to get refills. LPN B said the pharmacy said it was too soon to get refills and she got in touch with the doctor and he said he would call the pharmacy, and she was assuming that was the during the time frame of 7/15/26-7/16/26. LPN B said she believed they received the medication the following day, 7/17/26, but could not say most definitely. LPN B said she typically did not document in the progress notes regarding refills and she just called the pharmacy that they need a refill. LPN B said the pharmacy would say ok they had refills left or they need a new prescription. LPN B denied Resident #1 reporting any hallucinations during the time he did not receive the alprazolam she did not think Resident #1 had any increased anxiety. During interview on 7/22/26 at 2:54 p.m., the Administrator said the problem with Resident #1's alprazolam prescription was that the insurance was not going to pay to refill the medication until 7/19/26. During interview on 7/22/26 at 2:54 p.m., the ADON said Resident #1 had two alprazolam orders with one scheduled and one if he was awake during the night. The ADON said when the alprazolam order got switched, they did not call in more medication and that same card was still being used instead of two cards, one for the scheduled order and one for the breakthrough order, so he ran out sooner. The ADON said the PRN order was only to be given at night if Resident #1 woke up. The ADON said they spoke to the physician to get the order fixed so Resident #1 could get the medication that he needs. During interview on 7/22/26 at 4:12 p.m., the Senior Pharmacy Technician said he showed a paid claim for alprazolam 1 mg for 60 tablets on 7/17/26. The Senior Pharmacy Technician said the prescription for the alprazolam was phoned in on 7/16/26 by MD A so it would have gone out on the next day. The Senior Pharmacy Technician said the 7/17/26 alprazolam prescription was originally rejected by insurance but got an approval or someone notified us to reprocess the prescription and it was approved. Record review of facility's policy Administration Procedures for All Medications with effective date 9/2018 revealed medications will be administered in a safe and effective manner and review the 5 rights at each of the following steps of medication administration.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 7 residents (Resident #2) reviewed for pharmacy services. The facility failed to ensure that medication was not left unattended at Resident #2's bedside on 7/21/26 at 9:43 a.m. This failure could place residents at risk for obtaining medications that were not ordered for them and potential adverse reactions or side effects. Findings included: Record review of Resident #2's face sheet, dated 7/21/26, revealed the resident was a [AGE] year-old female admitted on [DATE]. Resident #2 had diagnoses which included end stage renal disease (final stage of chronic kidney disease characterized by a permanent loss of kidney function). Record review of Resident #2's quarterly MDS assessment, dated 4/24/26, section C (Cognitive Patterns) revealed a BIMS score of 15 that indicated cognition was intact. Record review of Resident #2's physicians order summary report, dated 7/21/26, revealed physician's order for Renvela oral tablet 800 mg (Sevelamer Carbonate) with instructions to give 2 tablets by mouth three times a day for end stage renal disease to take with meals/food with start date 3/27/26. Record review of Resident #2's physicians order summary report, dated 7/22/26, revealed physician's order that resident may take Renvela oral tablet 800 mg (Sevelamer Carbonate) at bedside with start date of 7/21/26. Record review of Resident #2's July 2026 MAR revealed Renvela oral tablet (Sevelamer Carbonate) with instructions to give 2 tablets by mouth three times a day was administered on 7/21/26 at 6 a.m. by Resident Medication Provider A. Record review of Resident #2's care plan, dated 7/21/26, did not reveal any focus related to self-administration of medications. Record review of Resident #2's care plan, dated 7/22/26, revealed focus that Resident #2 had a physician's order for self-administration of Renvela oral tablet 800 mg (Sevelamer Carbonate). During interview and observation on 7/21/26 at 9:43 a.m., two white oval pills were in a medication cup sitting on top of a water cup on the bedside table of Resident #2's room and no staff were in the room. Resident #2 said the pills were her Sevelamer (Renvela) which were a phosphate binder and she was supposed to take them before breakfast, but she had forgotten. Resident #2 took the two pills at 9:43 a.m. Resident #2 said facility staff usually watched her take her pills. Resident #2 said the only medication she did not take immediately was the Sevelamer (Renvela) because she was supposed to take it immediately before meals and she did not always get her pills immediately before meals. During interview on 7/21/26 at 9:51 a.m., the Resident Medication Provider A was informed that pills were found on Resident #2's bedside table that Resident #2 identified as Sevelamer. Resident Medication Provider A said she had not given Resident #2 any medications yet today. Resident Medication Provider A said Resident #2 was particular about those pills that were at bedside and normally takes them before breakfast, lunch and dinner and was not sure who gave Resident #2 the pills. Resident Medication Provider A said Resident #2 was very adamant about not telling her how to take her medications. Resident Medication Provider A said she normally watched Resident #2 take her medication and they had to give them to her. Resident Medication Provider A said she stayed with the residents while they took their medications other than the medications Resident #2 took with her to dialysis. Resident Medication Provider A said she had never experienced medications left at bedside because she stayed with the resident. Resident Medication Provider A said she would have said something to (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 if she saw the pills at bedside. During interview on 7/21/26 at 3:12 p.m., the DON was informed that two Renvela (Sevelamer) tablets were found at Resident #2's bedside. The DON said there should not be medications left at bedside and staff should always observe the resident taking the medication. The DON said if medications were left at bedside another resident could come and take the medication, the medication could fall on the floor and become contaminated, could be a risk of poisoning or a risk of aspiration if the resident had swallowing issues and was not observed while taking the medication. During interview on 7/21/26 at 3:25 p.m., the ADON was informed that two Renvela (Sevelamer) tablets were found at Resident #2's bedside. The ADON said medications should not be left at the resident's bedside and staff were supposed to watch the resident take the medication. The ADON said if medications were left at the bedside the patient could possibly not take the medication or another resident could possibly take the medication. During a record review of an email received on 7/22/26 at 6:58 a.m. from the Administrator revealed Resident #2 had a BIMS score of 15 and was fully competent to self-administer medications. Also, that Resident #2 was capable of appropriately redirecting another resident if one were to enter the room and they had gotten an order from the doctor saying it was ok for Resident #2 to have medication at bedside. During interview on 7/22/26 at 10:47 a.m., Resident #2 said the Sevelamer (Renvela) tablets she got directly from the dialysis clinic and gave the medication aide as a matter of courtesy. Record review of facility's policy titled, Storage of Medications, dated 9/2018 revealed, Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access.		