

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221</p> <p>Based on interview and record review, the facility failed to notify the resident representative when the resident had a change in his psychosocial status for one (Resident #1) of four residents reviewed for changes in condition.</p> <p>The facility failed to inform Resident #1's responsible party when he ran out of the medication Risperidone or of his ongoing aggressive behavior.</p> <p>The facility failed to inform Resident#1's physician that when he ran out of the medication Risperidone and get a new order for the medication at the family's request.</p> <p>This failure could place residents at risk for not having their representative notified or not receiving relevant medical information when there is a change of condition.</p> <p>Findings included:</p> <p>Review of Resident #1's Admission Record, dated 5/16/24, revealed he was a [AGE] year-old male who was a respite resident originally admitted to the facility on [DATE] with a most recent admitted [DATE] with a diagnosis which included Traumatic Brain Injury and Quadriplegic Cerebral Palsy. Resident #1 was discharged on [DATE].</p> <p>Review of Resident #1's Order Summary Report, dated, 5/16/24, revealed orders including Risperidone 1 mg in liquid form twice a day for traumatic brain injury.</p> <p>Resident #1 was not in the facility long enough for a Minimum Data Set to be completed.</p> <p>Review of Resident #1's Care Plan revealed:</p> <p>Dated 9/2/21: Focus that Resident #1 may have adverse consequences from the use of psychotropic medications as evidenced by disease process Traumatic Brain Injury and take Risperidone as ordered. The identified goal was Resident #1 would remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension (low blood pressure), gait disturbance, constipation/impaction, or cognitive/behavioral impairment through the review date. Identified interventions included Administer psychotropic medications as ordered by physician.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dated 12/15/23: Focus The resident is on an antipsychotic medication Risperidone related to Traumatic Brain Injury. The goal was the resident will remain free from adverse reactions related to antipsychotic medication therapy. Interventions included: administer medications as ordered and obtain consent from resident or responsible party prior to medication use.</p> <p>Dated 12/17/23 The resident has a behavior problem. Hits/grabs staff or residents related to low frustration tolerance. The identified goal was: the resident will have fewer episodes of hitting or grabbing by review date. Identified interventions included: administer medications as ordered.</p> <p>Dated 4/14/24 Focus: The resident has the potential to be physically aggressive (hits, kicks, throws things) related to poor impulse control. The goal was the resident will demonstrate effective coping skills through the review date. Interventions included: Administer medications as ordered</p> <p>Dated 4/17/24 The resident has a psychosocial well-being problem related to Quadriplegic Cerebral Palsy. The identified goal was: the resident demonstrate adjustment to the nursing home placement through review date. Identified interventions included: increase communication between resident/ family/ caregivers about care and living environment. Explain all procedures and treatments, medications, condition, all changes, rules, options and provide opportunities for the resident and family to participate in care.</p> <p>Review of Resident #1's April 2024 MAR revealed:</p> <p>Saturday 4/13/24 at 8 p.m. = (Administration note Time 4:58 p.m. revealed: med aide approach resident for meds, he swung left arm and knock meds out of hand, spit, and hitting table with fist. Med aide informed nurse.</p> <p>Sunday 4/14/24 at 8 a.m. = (Administration note time 3:38 p.m. meds refused, resident very combative and informed nurse)</p> <p>4/14/24 at 8 p.m. = resident refused the medication</p> <p>Wednesday 4/17/24 at 8 p.m. = resident refused the medication</p> <p>Thursday 4/18/24 at 8 p.m. = resident refused the medication</p> <p>Sunday 4/21/24 at 8 am. = resident refused the medication</p> <p>Tuesday 4/23/24 at 8 a.m. = (administration note, time 8:54 a.m. administration note - notified family for meds)</p> <p>4/23/24 at 8 p.m. = 9</p> <p>Wednesday 4/24/24 at 8 a.m. = 9</p> <p>4/24/24 at 8 p.m. = (administration note, time 8:37 p.m. awaiting from family)</p> <p>Thursday 4/25/24 at 8 p.m. =9 (administration note, time 9:09 p.m. awaiting from the family)</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Friday 4/26/24 at 8 p.m. = (administration note, time 8:25 p.m. awaiting from the family)</p> <p>Sunday 4/28/24 at 8 a.m. = (administration note, time 1:45 resident not very cooperative not taking meds and combative, informed nurse)</p> <p>Monday 4/29/24 at 8 a.m. = resident refused the medication (administration note, time 8:16 p.m. awaiting from family)</p> <p>4/29/24 at 8 p.m. = (no note given for why resident did not get the medication)</p> <p>Review of Resident #1's Clinical Notes revealed:</p> <p>4/13/24 5:55 p.m. Behavior Note: Resident refused to eat all meals. Refused medications. Threw medications on MA. Slamming hand onto table and swing fist at staff.</p> <p>4/20/24 10:47 a.m. Behavior Note: Staff approached this nurse voiced resident is being combative, instructed staff to sit resident alone this nurse approached resident with bilingual nurse the second nurse spoke to him in Spanish offered him breakfast and coffee. Resident took his hat off and began to swing at second nurse. Attempted to give him lorazepam (an anti-anxiety medication) as needed. Resident Refused and knocked cup out of the nurse's hand. At this time staff stepped back and allowed resident to sit alone in front of tv in common area. Other residents kept at a distant. (no documentation of family notified of behavior)</p> <p>4/26/24 7:38 a.m. Behavior Note: Resident being aggressive with staff. Hit CNA in the stomach as she walked by resident. When this nurse walked by punched cart with fist. When medication aide went to give medications, resident flipped off by resident.</p> <p>4/27/24 12:06 p.m. Nurse's Note: Resident admitted for respite care. Resident admitted with medication from home. Risperidone on hand depleted (facility out of medication). Attempted to notify parent. No answer. notified Care Giver of needed medication stated can't you order it? The pharmacy here closes at noon, we can't get it. Advised that typically respite residents supply their own meds and long-term care residents' medications are supplied by facility pharmacy. Also advised that resident will miss multiple doses until medication is able to be obtained which will be more difficult to obtain a liquid medication. replied, ok then.</p> <p>Review of the 24-hour report showed no documentation that the family was notified of Resident #1's ongoing behaviors or that he was running out of Risperidone. On 4/12/24 (day of admission) it documented he was admitted for respite care for three weeks.</p> <p>Review of the Discharge Summary dated 5/1/24 at 1:15 p.m. revealed Resident discharged home with family. Took belongings with resident and medications.</p> <p>Review of the CNA behavior monitoring Kardex revealed Resident #1 demonstrated multiple physical and/or disruptive behaviors daily.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Admission Contract signed by the Resident/Family revealed the family signed they gave consent for the Medical Director to be the resident's physician for the duration of the resident's stay and for the facility to be in charge of pharmacy service. (The family signed the same contract every other admitting resident signed.)</p> <p>Interview on 5/15/24 at 12:29 p.m. the Administrator stated Resident #1 was a private pay resident and there were issues with his medications. She stated his family was supposed to bring his Risperidone and they were not able to bring it. The Administrator stated Resident #1 used the liquid version of the medication and the facility's pharmacy did not provide that. The Administrator stated they explained to the family they would have to bill the family for the medication if they ordered it. The Administrator stated Resident #1 was frequently aggressive to staff and would not eat or drink. The Administrator said on the last day he was at the facility; Resident #1 tore the arm and tip back bar off his wheelchair. The Administrator said Resident #1 was a TBI and was a respite resident. She stated the facility had had him prior, but this visit was a bit longer than previous stays.</p> <p>During an interview on 5/16/24 at 1:42 p.m. CNA A said there was a resident on her hall that would hit them. She stated the expectation was for 2 people to go into the room to assist the resident and explain what you were doing. CNA A said if that did not work to step away and come back when the resident was calmer. CNA A said Resident #1 would refuse to take his medication and all the nurse would say was not to agitate him. She said he was only at the facility for a few weeks. CNA A said he was calmer with the girls who would speak Spanish to him and explain everything they were doing, every time they were doing it.</p> <p>During an interview on 5/16/24 at 2:45 p.m. MA B stated the ordering process for medications was the MA would make a list of medications they were running out of and give it to the nurse and the nurse would follow up with it. MA B stated the facility would usually get the medication the next day unless it was a narcotic they needed to go to the doctor for or the resident was hospice and hospice needed to bring the medication. MA B said she did not know why a resident would go without medication because she believed the pharmacy was open on the weekends. MA B said she did not know of any special circumstances that would prevent a resident from getting medications.</p> <p>Interview on 5/17/24 at 12:47 p.m. Resident #1's family stated they used the facility for respite care for years without issue, so they continued that. She said the facility called one time to say he had behaviors and she said she told them to put him to bed with his cards and he would calm down. The family stated the facility dealt with it and Resident #1 started eating. The family member said the following day Resident #1 did fine and the family did not hear anything from the facility, so they thought things were fine. The family said the family visited to check on Resident #1 and he was happy, and they were fine and he was eating; then that Saturday they called and said he was out of his Risperidone. Resident #1's family member said they thought why was the facility calling the family now when the drug store was closed and the family lived several hours away. The family said when they went to pick up Resident #1 no one told them anything about how Resident #1 did at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 5/17/24 at 3:47 p.m. the Administrator stated the respite contract was different from the regular contract in that the facility did not provide the resident's medications. The DON said she did not know where it documented in the respite contract, only that was what she was told. The Administrator said if a resident was private pay they were still under their doctor's care so if they needed anything they would be seen by the doctor. The DON added the facility's doctor did see Resident #1 while he was at the facility. The DON said they facility did reorder Resident #1's Risperidone but the pharmacy did not provide the liquid. The DON said the facility could have got an order for the Risperidone and crushed the medication. The Administrator explained the family visited twice and Resident #1 was very happy they visited. The Administrator said Resident #1 said when the family came the second time Resident #1 thought he was going to go home and when he did not his behavior escalated. The DON said that Saturday they called the and notified the caregiver the facility was out of the Risperidone. The DON stated the said they lived in a town 3 hours away and the pharmacy there was closed so the facility needed to get the medication. The DON said if the family said if Resident #1 got combative to give him flash cards and put to bed. The DON said this did not work to calm him down. The DON stated the visited the first weekend and brought him a milkshake. The DON said Resident #1 drank all of it and they told the family he was not eating, was being aggressive, and not taking his medication, and the family said that was fine (there is no documentation of this communication). The DON stated the family visited a second time and Resident #1 became so excited because he thought he would be going home so when he did not go home he threw a fork at staff and that Saturday he was getting all out. The DON said the nurses called the said the city's pharmacy was closed so the facility needed to get the medication. The DON said the facility got the medication, but it took their pharmacy a while to get the medication which was not perfect. The DON stated there was no order to crush the Risperidone and Risperidone was not in the facility's emergency medication system. The DON said Resident #1 was not hurting himself or other so did not need the antipsychotic medication they did have in the emergency medication system. The DON said the nurses did not document they called the family. The DON said the nurses were encouraged to call the family and talked to them twice. The DON agreed the family should have been contacted more often and she did not know why they were not. She said the family should have been contacted when Resident #1 stopped eating again and when his behavior escalated. The Administrator stated she was not sure of the exact policy but the family should have been notified when the medication was low and not out and when Resident #1 stopped eating. The Administrator said there were a lot of behaviors, behaviors, he's a repeat respite, I don't know if it's continued decline. The Administrator added Resident #1 never got comfortable at the facility with the respite visits. The DON said nothing worked to calm Resident #1 down and the facility did not know the family was upset with the facility's care until the family contacted them two days after the discharge.</p> <p>Review of the facility's policy and procedure on Change in a Resident's Condition or Status, Revised May 2017, revealed:</p> <p>Policy Statement: our facility shall promptly notify the resident, his or her Attending Physician, an representative (sponsor)(of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, residents rights etc.)</p> <p>Policy Interpretation and Implementation</p> <p>The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): refusal of treatment or medications two (2) or more consecutive times.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: there is a significant change in the resident's physical, mental, or psychosocial status.</p> <p>Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.</p> <p>The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221</p> <p>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 one (Resident #1) of four residents reviewed for availability of medications.</p> <p>The facility failed to obtain and administer the antipsychotic Risperidone fifteen (15) times between 4/23/24 and 5/1/24 per physician's orders to Resident #1.</p> <p>This failure puts residents at risk of not receiving prescribed medications and experiencing behaviors or other symptoms of diagnosed conditions.</p> <p>Findings included:</p> <p>Review of Resident #1's Admission Record, dated 5/16/24, revealed he was a [AGE] year-old male was originally admitted to the facility on [DATE] for respite services with a most recent admitted [DATE] with a diagnosis which included Traumatic Brain Injury and Quadriplegic Cerebral Palsy. Resident #1 was discharged on [DATE].</p> <p>Review of Resident #1's Order Summary Report, dated, 5/16/24, revealed orders including Risperidone 1 mg in liquid form twice a day for traumatic brain injury beginning 6/7/23.</p> <p>Review of Resident #1's Care Plan revealed:</p> <p>Dated 9/2/21: Focus that Resident #1 may have adverse consequences from the use of psychotropic medications as evidenced by disease process Traumatic Brain Injury and take Risperidone as ordered. The identified goal was Resident #1 would remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment through the review date. Identified interventions included Administer psychotropic medications as ordered by physician.</p> <p>Dated 12/15/23: Focus The resident is on an antipsychotic medication Risperidone related to Traumatic Brain Injury. The goal was the resident will remain free from adverse reactions related to antipsychotic medication therapy. Interventions included: administer medications as ordered and obtain consent from resident or responsible party prior to medication use.</p> <p>Review of Resident #1's April 2024 MAR revealed:</p> <p>Tuesday 4/23/24 at 8 a.m. = (administration note, time 8:54 a.m. administration note - notified family for meds)</p> <p>4/23/24 at 8 p.m. = (no explanation on why medication not given)</p> <p>Wednesday 4/24/24 at 8 a.m. = (no explanation on why medication not given)</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/24/24 at 8 p.m. = (administration note, time 8:37 p.m. awaiting from family)</p> <p>Thursday 4/25/24 at 8 p.m. = (administration note, time 9:09 p.m. awaiting from the family)</p> <p>Friday 4/26/24 at 8 p.m. = (administration note, time 8:25 p.m. awaiting from the family)</p> <p>Sunday 4/28/24 at 8 a.m. = (administration note, time 1:45 resident not very cooperative not taking meds and combative, informed nurse)</p> <p>Monday 4/29/24 at 8 a.m. = resident refused the medication (administration note, time 8:16 p.m. awaiting from family)</p> <p>4/29/24 at 8 p.m. = (no explanation on why medication not given)</p> <p>Review of Resident #1's Clinical Notes revealed:</p> <p>4/27/24 12:06 p.m. Nurse's Note: Resident admitted for respite care. Resident admitted with medication from home. Risperidone on had depleted (the facility ran out of medications). Attempted to notify the paren. No answer. Caregiver notified of needed medication. stated can't you order it? The pharmacy here closes at noon, we can't get it. Advised Caregiver that typically respite residents supply their own meds and long-term care residents' medications are supplied by facility pharmacy. Also advised caregiver that resident will miss multiple doses until medication is able to be obtained which will be more difficult to obtain a liquid medication. Caregiver replied, ok then.</p> <p>Review of the 24-hour report showed no documentation that the family was notified of Resident #1's running out of Risperidone. On 4/12/24 (day of admission) it documented he was admitted for respite care for three weeks.</p> <p>5/1/24 1:15 p.m. Discharge Summary Resident discharged home with family. Took belongings with resident and medications.</p> <p>Review of Resident #1's Admissions Contract signed by the Resident/Family on 9/2/21 revealed the family signed they gave consent for the Medical Director to be the resident's physician for the duration of the resident's stay and for the facility to be in charge of pharmacy service. (The family signed the same contract every other admitting resident signed.)</p> <p>Interview on 5/15/24 at 12:29 p.m. the Administrator stated Resident #1 was a private pay resident and there were issues with his medications. She stated his family was supposed to bring his Risperidone and they were not able to bring it. The Administrator stated Resident #1 used the liquid version of the medication and the facility's pharmacy did not provide that. The Administrator stated they explained to the family they would have to bill the family for the medication if they ordered it. The Administrator stated Resident #1 was frequently aggressive to staff and would not eat or drink. The Administrator said on the last day he was at the facility; Resident #1 tore the arm and tip back bar off his wheelchair. The Administrator said Resident #1 was a TBI and was a respite resident. She stated the facility had had him previously, but this visit was a bit longer than previous stays.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/16/24 at 2:45 p.m. MA B stated the ordering process for medications was the MA would make a list of medications they were running out of and give it to the nurse and the nurse would follow up with it. MA B stated the facility would usually get the medication the next day unless it was a narcotic they needed to go to the doctor for or the resident was hospice and hospice needed to bring the medication. MA B said she did not know why a resident would go without medication because she believed the pharmacy was open on the weekends. MA B said she did not know of any special circumstances that would prevent a resident from getting medications.</p> <p>Interview on 5/17/24 at 12:47 p.m. Resident #1's family stated they used the facility for respite care for years without issue, so they continued that. She said the facility called one time to say he had behaviors and she said she told them to put him to bed with his cards and he would calm down. The family stated the facility dealt with it and Resident #1 started eating. The family member said the following day Resident #1 did fine and the family did not hear anything from the facility, so they thought things were fine. The family said the family visited to check on Resident #1 and he was happy, and they were fine, and he was eating; then that Saturday they called and said he was out of his Risperidone. Resident #1's family member said they thought why was the facility calling the family now when the drug store was closed, and the family lived several hours away. The family said when they went to pick up Resident #1 no one told them anything about how Resident #1 did at the facility.</p> <p>Interview on 5/17/24 at 3:47 p.m. the Administrator stated the respite contract was different from the regular contract in that the facility did not provide the resident's medications. The DON said she did not know where it documented in the respite contract, only that was what she was told. The Administrator said if a resident was private pay, they were still under their doctor's care so if they needed anything they would be seen by the doctor. The DON added the facility's doctor did see Resident #1 while he was at the facility. The DON said they facility did reorder Resident #1's Risperidone but the pharmacy did not provide the liquid. The DON said the facility could have got an order for the Risperidone and crushed the medication. The DON said that Saturday they called the and notified the Caregiver the facility was out of the Risperidone. The DON stated the said they lived in a town 3 hours away and the pharmacy there was closed so the facility needed to get the medication. The DON said if the family said if Resident #1 got combative to give him flash cards and put him to bed. The DON said this did not work to calm him down. The DON stated the visited the first weekend and brought him a milkshake. The DON said Resident #1 drank all of it and they told the family he was not eating, was being aggressive, and not taking his medication, and the family said that was fine (there is no documentation of this communication). The DON said the nurses called the said the city's pharmacy was closed so the facility needed to get the medication. The DON said the facility got the medication, but it took their pharmacy a while to get the medication which was not perfect. The DON stated there was no order to crush the Risperidone and Risperidone was not in the facility's emergency medication system. The DON said Resident #1 was not hurting himself or others so did not need the antipsychotic medication they did have in the emergency medication system. The DON said the nurses did not document they called the family. The DON said the nurses were encourage to call the family and talked to them twice. The Administrator stated she was not sure of the exact policy but they family should have been notified when the medication was low and not out.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675927	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Focused Care at Crane		STREET ADDRESS, CITY, STATE, ZIP CODE 699 Campus Dr Crane, TX 79731	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy and procedure on Unavailable Medications, revised August 2020, documented: Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, or manufacturer's shortage of an ingredient, or may be a permanent situation due to the medication no longer being produced. The facility must make every effort to ensure that medications are available to meet the needs of each resident.</p> <p>Procedures:</p> <p>The pharmacy staff shall:</p> <p>Notify nursing staff that the order product(s) is/are unavailable.</p> <p>Notify nursing staff of when it is anticipated that the drug(s) will become available</p> <p>Suggest alternative, comparable drug(s) and dosage of drug(s) that is/are available.</p> <p>The nursing staff shall:</p> <p>Notify the attending physician (or on-call physician when applicable of the situation and explain the circumstance, expected availability, and alternative therapy(ies) available. If the facility nurse is unable to obtain a response from the attending physician or on-call physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction.</p> <p>Obtain a new order and cancel/discontinue the order for the non-available medication.</p> <p>Notify the pharmacy of the replacement order.</p>		