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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676355	A. Building B. Wing	08/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Brenham	1303 Hwy 290 E Brenham, TX 77833

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 - Minimal harm or potential for actual harm Residents Affected - Some	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** 17141 Based on interview and record review, the facility did not provide pharmaceutical services to meet the needs of each resident for two (Resident #1 and Resident #3) of four residents reviewed for pharmaceutical services, in that: The facility failed to ensure Resident #1 was administered her prescribed carbidopa-levodopa (for Parkinson's/tremors) for three doses on 08/17/2024. This caused Resident #1 to feel as though her tremors were worsening after each dose missed. The facility failed to ensure Resident #3 was administered her prescribed pregabalin (for pain) and an as needed dose of diphenhydramine (antihistamine that causes sleepiness). This deficient practice could place residents at risk of not receiving the intended therapeutic benefit of the medications and supplements or could result in worsening or exacerbation of chronic medical conditions. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Parkinson's (brain disorder causing nerve degeneration which causes tremors, stiffness, and slowness in movements). Review of Resident #1's Quarterly MDS assessment, on 06/25/24, reflected a BIMS of 15 indicating her cognition was intact. Review of Resident #1's care plan, updated 04/21/24, reflected a focus area included for Resident #1's Parkinson's Disease. The goal of the focus includes Resident #1 will remain free of further signs and symptoms, discomfort, or complications of the disease. Review of Resident #1's Physician Orders revealed an order, revised on 08/17/24 for carbidopa-levodopa 25-250 mg, one tablet six times a day at three-hour intervals, starting at 5am. Review of Resident #1's MAR, dated August of 2024 on 08/18/24, reflected she had not received her 11 am, 2 pm and 5 pm doses of Carbidopa-Levodopa during the day on 08/17/24. LVN A marked 9, which was defined as Other/See Progress Notes . (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 - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/17/24 at 4:18 pm, LVN A stated she works at the facility as needed, and she has only worked here about ten times. When she came in this morning (8/17/24), she was asked to pass medications as the medication technician was not available. LVN A stated she is uncertain of the facility's process to reorder medications but there had been a problem with getting Resident #1 her Carbidopa-Levodopa today. When she gave the 8 am dose it was the last pill available. LVN A stated she ordered the medication from the pharmacy , but it had not arrived yet. She stated Resident #1 had missed two doses so far today and another will be due at 5. During an interview on 08/17/24 at 4:45 pm, Resident #1 stated she has missed three doses of her medication for tremors. She stated she is now having tremors more often than she does when she takes the medication as she should. Resident #1 stated it has not happened before that she missed doses or that the medication was not available. 2. Review of Resident #3's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including chronic pain. Review of Resident #3's Quarterly MDS assessment, dated 06/25/24, reflected a BIMS of 13 indicating her cognition was intact. Review of Resident #3's care plan, updated 01/15/23, reflected a focus area included for Resident #3's bone pain in her left knee. The goal of the focus includes Resident #3 will experience pain relief within an hour after intervention. The interventions include Administer pain medications as ordered. Review of Resident #3's Physician Orders revealed an order, revised on for pregabalin 150 mg, one capsule three times a day for neuropathic pain (nerve pain). Diphenhydramine 25mg is ordered as a PRN one tablet every 6 hours as needed for itching. Review of Resident #3's MAR, dated August of 2024 on 08/18/24, reflected she had not received her 2 pm and 8 pm doses of pregabalin on 08/11/24 and did not receive any of the three doses scheduled for 08/12/24 and 08/13/24. The MAR is initially marked 9, which was defined as Other/See Progress Notes on 08/10/24, then with an H , which is not defined. Continued review reflected diphenhydramine had no initials indicating the medication had been given during the month . Review of Resident #3's Progress Notes reflected the following: - 08/09/24 at 4:18 pm nurse documents pregabalin was ordered. -08/10/24 at 4:25 pm nurse documents physician notified regarding needing a new script for pregabalin. -08/11/24 at 8:24 am nurse documents physician notified regarding new script; resident is out. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility Medication Incident Report dated 08/12/24, reflected the pharmacy was notified on 8/10/24 and 8/11/24 for Medication order of Pregabalin 150 mg TID. The report indicates that the Physician was notified on 8/10/24 and 8/11/24 that a triplicate order was needed to obtain a refill of Resident #3's pregabalin. The DON noted on the report that a pain assessment with no signs of pain was conducted, and Resident #3 was being monitored for pain. Resident #3 had scheduled tramadol for pain as well as acetaminophen every 8 hours. During an interview on 8/17/24 at 11:10 am with Resident #3 revealed she did not currently have concerns of medications not being available but days ago there was a mix up with one of her medications. Resident #3 stated the medication was for pain, but it also helped her sleep. She does not recall being in pain, but she wanted diphenhydramine to help her sleep one night, since she was not taking the pain medication, and there was none. Resident #3 stated her family went to the drugstore and bought her some diphenhydramine so that she could take one. During an interview on 8/17/24 at 2:50 pm with LVN B revealed she is new to working at the facility. She stated she has not had any problems of prescription medications being available, but she did recently have a resident ask for a diphenhydramine, which is an over-the-counter medication, and there were none in stock. She reported to the DON that they were out. During an interview on 08/18/24 at 8:49 am, with the facility Physician he stated it was possible that Resident #1 was experiencing increased tremors because of her missed doses of Carbidopa-Levodopa yesterday. The intent of the medication is to decrease the tremors and the spacing of the doses was intended when the order was written. Resident #3's medication ordering issues were due to miscommunication. The ordering should have a system in place to ensure medications are ordered prior to running out. The Physician stated he was the Medical Director of the facility. He is at the facility in person about twice a month and has a nurse practitioner who visits more frequently. There has not been a pattern of residents missing medications. During an interview on 08/18/24 at 10:20 am with the facility DON revealed she has been at the facility about two weeks. She had recognized there was a problem with medications being ordered in a timely manner. She has looked through every medication yesterday and today and has ordered herself if there is a 7-day supply or less. She and an ADON she has worked with previously, who was hired and will be starting at the facility in a few days, will alternate checking the medications weekly. There had been a system in place prior to her being here but when the previous DON left, and a couple of the nurses followed her medication reordering was affected. The DON stated she came in early this morning to provide in-service to the overnight shift and oncoming day shift explaining medication reordering. It is the responsibility of all nursing staff to order a medication if needed. She described to them that the blister packs of medications have a different color, blue, on the card when they are entering a 7-day supply. The medication is to be ordered then and noted that the order had been placed. The DON stated it was her responsibility to order over the counter medications and she had ordered the diphenhydramine, but it was not delivered with the order received. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/18/24 at 12:16 pm with the facility Administrator revealed she had not been aware that medications were not being given until after it had already started. She stated they did drop the ball. The Administrator stated it should not have taken so long to get Resident #3's medication from the pharmacy and Resident #1's medication should have been ordered prior to her running out. The Administrator stated this has not happened before, but the new DON is addressing the problem and reeducating nursing staff. Her expectation is that residents receive their medications as ordered. Review of the facility policy titled Ordering and Receiving Non-Controlled Medications, revised 8/2020, reflected the procedure for ordering medications includes: Reorder medications based on the estimated refill date ([NAME]) on the pharmacy Rx label, or at least three days in advance to ensure an adequate supply is on hand.