STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455333	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharpville Residence and Rehabilitation Center	7505 Bellerive Houston, TX 77036

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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. Based on observation, interview, and record review the facility failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1medication cart (200 Hall Nurse Cart) reviewed for pharmacy services . LVN A failed to ensure the 200 Hall Medication Nursing Cart was locked when not under direct supervision of authorized staff ON 5/27/26 at 10:26 AM. This failure could place residents at risk of adverse reactions to medications and misappropriation of medications.Findings included: Observation on 05/27/26 at 10:26 AM revealed the 200 Hall medication cart was unlocked and unattended. In an interview on 5/27/26 at 10:30 with CMA A, it was revealed that the unattended medication care was assigned to LVN A. CMA A initially thought LVN A was giving care to a resident in the area. However, after looking in several rooms, LVN A was not located on the floor. CMA A stated carts should be locked when unsupervised to prevent unauthorized access to the carts' contents. She said unlocked carts could place residents at risk of injury. In observation and interview on 05/27/26 at 10:40 AM, LVN A arrived back on the 2nd floor (200 Hall). LVN A stated she had to run downstairs (100 hall) and she thought she had locked her cart. LVN A stated she had in-service training two weeks ago on abuse and neglect, and on securing medication carts. LVN A stated the adverse effect of leaving a medical cart unattended and unlocked could have resulted in a resident accessing medication or other items that could result in serious harm or have an adverse drug reaction if they consumed medications from the cart. LVN A stated the medication cart had 4 drawers and contained a locked narcotics box inside. She stated needles were located in the top drawer of the cart and a resident could have opened it and harmed themselves. The medication cart contained the following items: Drawer 1- OTC medications, syringes, prescription medication, > 30 lancets (a device with a small needle used to prick fingers to collect blood for blood sugar monitoring.), >100 pen needles (needles attached to insulin pens).Drawer 2- liquid OTC and RX Only medications, solid form Resident prescription medications.Drawer 3- Inhalation solutions, inhalers, and topical creams An interview on 05/27/26 at 11:14am with the DON revealed that she made random rounds throughout day ensuring carts were locked and attended. She stated the nurse's medication cart should never have been unlocked. She stated she had never counseled LVN A because she was a good nurse, and typically very careful. The DON stated the adverse effect of an unlocked and unattended car was a resident could have gotten hold of the needles, vitamins, medication, which could have placed the resident at risk of harm. Record review of the undated facility policy Medication Storage revealed the following, General GuidelinesAll drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature and controls.C. During the medication pass, medications must be under the direct observation of the person administering medications or not in the medication storage area cart.

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