STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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 - 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 observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate administering of all drugs and biologicals, to meet the needs of 1 of 5 residents reviewed for pharmacy services. (Resident #1) The facility failed to accurately administer medications for Resident #1 when LVN A, Medication Aide B, and Medication Aide C administered a medication listed as an allergy. This failure could place residents at risk for inaccurate drug administration.Findings Included:Record review of a face sheet, dated 01/12/26, indicated Resident #1 was [AGE] years old and was admitted on [DATE] with diagnoses including traumatic brain injury (damage to the brain from an external force, like a blow, jolt, or penetrating object, leading to physical, cognitive, emotional, and behavioral changes, ranging from mild (concussion) to severe, affecting brain function, memory, movement, and more, with symptoms sometimes delayed), diabetes, and muscle weakness. The face sheet indicated Resident #1 had an allergy to Metformin (a widely prescribed oral medication used primarily to treat type 2 diabetes by controlling blood sugar levels). The face sheet indicated Resident #1 was discharged from the facility on 01/05/26.Record review of physician's orders, dated 01/12/26, indicated Resident #1 was allergic to Metformin. The orders indicated an order for Metformin HCL (hydrochloride) 500 milligrams by mouth twice a day with a start date of 12/19/25 and an end date of 12/23/25.Record review of an admission MDS, dated [DATE] indicated Resident #1 was understood and understood others. The MDS indicated a BIMS score of 11 which indicated moderately impaired cognition.Record review of a care plan, initiated 12/18/25, indicated Resident #1 had an allergy to Metformin. There was an intervention to not administer and/or come in contact with the allergen.Record review of hospital records for Resident #1, dated 12/17/25, indicated the resident was admitted to the hospital on [DATE]. The records indicated an allergy to Metformin was noted on 12/04/18.Record review of Resident #1's MAR, dated December 2025, indicated an allergy to Metformin. The record indicated LVN A administered an evening dose of Metformin on 12/19/25, MA B administered morning doses on 12/20/25, 12/21/25, and 12/22/25, and that MA C administered an evening dose on 12/20/25 and 12/21/25. The record indicated Metformin was placed on hold on 12/22/25 and was discontinued on 12/23/25.Record review of a nursing progress note for Resident #1, dated 12/19/25 at 8:46 p.m., indicated, The system has identified a possible drug allergy for the following order: Metformin HCL Oral Tablet 500 MG (milligrams). The author of this note was the ADON. There was no documentation of the allergy being discussed with the ordering provider or that there was a discussion between the ADON and Resident #1 to determine if this was a true allergy or not, prior to administration of the medication.Record review of a nursing progress note for Resident #1, dated 12/22/25 at 10:45 a.m., indicated, Spoke with (Resident #1) regarding her allergy to metformin, (Resident #1) verbalize she is not aware of any allergy to metformin, she stated, They just stop giving it to me. (Resident #1) denies s/sx (signs or symptoms) and no s/sx (signs or symptoms) or (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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NAME OF PROVIDER OR SUPPLIER Pleasant Springs Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 N Edwards St Mount Pleasant, TX 75455	

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(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 - Few	discomfort noted. The author of this note was the ADON.Record review of a nursing progress note for Resident #1, dated 12/22/25 at 10:54 a.m., indicated, Called and spoke with (Resident #1's) pcp (primary care physician) regarding allergies.metformin stop because it was not helping the blood sugar. The author of this note was the ADON.Record review of a nursing progress note for Resident #1, dated 12/22/25 at 5:45 p.m., indicated the ADON spoke with a family member regarding an allergy to Metformin. The family member told the ADON that Resident #1 would take her medication on an empty stomach and the medication made her sick. The note indicated that the Metformin was held by the ordering physician. The author of this note was the ADON.Record review of a nursing progress note for Resident #1, dated 12/23/25 at 8:10 a.m., indicated a family member called and stated the Metformin had a drug-to-drug interaction with another medication and that was why the metformin was stopped. The note indicated the ordering provider was notified. The author of this note was the ADON.During an attempted interview on 01/12/26 at 10:12 a.m., a call was placed to the telephone number on record for Resident #1. The number was not a working number.During an interview on 01/12/26 at 10:20 a.m., a family member said they only knew of Resident #1 receiving Metformin twice. The family member said they were told by the ADON that Resident #1 did not have a reaction to the Metformin. The family member said all they knew was Metformin was listed as an allergy, and the system alerted the facility of the allergy. The family member said Resident #1 had not had the medication in years. The family member said they did not know why Resident #1 was given the medication. The family member said Resident #1 now lived at home and there was not a telephone number where she could be reached. The family member said, Thank God she didn't have a reaction.During an interview on 01/12/26 at 11:13 a.m., LVN A said she remembered giving the initial dose of Metformin to Resident #1. She said she could not remember if it was listed as an allergy. She said if an allergy was listed there should be a pop-up warning that there was a possible allergy. She said she did not remember if a warning popped up or not. She said she did talk to the resident about her allergies, and Resident #1 told her she did not have any allergies that she could think of. She said the resident did not have a reaction to the medication. She said she did not know when it was listed in the chart as an allergy. She said she did not place the metformin allergy in Resident #1's electronic medical record. She said a resident who received a medication they were allergic to could cause a severe allergic reaction and different symptoms.During an interview 01/12/26 at 11:28 a.m., MA B said she had administered Metformin to Resident #1. She said the medication was not listed in her allergy list. She said she could not recall when it was added to her allergy list. She said Resident #1 did not have a reaction to any medications while she was at the facility. She said she was unaware that the resident was allergic to metformin. She said if it had been on Resident #1's list of allergies the system should have warned her or the nurse should have told her. She said some of the nurses communicated with them and some did not. She said a resident receiving a medication they were allergic to could cause a reaction and she would report it to the nurse immediately.During an attempted interview on 01/12/26 at 11:39 a.m., a call was placed to the telephone number on record for MA C. The number had restrictions, and the call could not be completed.During an interview on 01/12/26 at 11:46 a.m., the ADON said the nurse practitioner called on 12/19/22 and wanted Resident #1 to start on Metformin. She said it was already listed as an allergy in Resident #1's electronic medical record. She said the nurse practitioner asked her to go talk to the resident and see what her reaction was to the Metformin. She said the resident told her that it just made her sick to her stomach. She said she went through a list of symptoms with Resident #1 including difficulty breathing and itching. She said the resident denied Metformin causing any of those symptoms. She said she reported this back to the nurse practitioner, and they still wanted to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	start the medication. She said the resident was ok with the taking the medication. She said she talked to the family member about the medication. She said the family member told her it made Resident #1 sick to her stomach. The ADON said the family member said Resident #1 took her medications on an empty stomach. She said she called the nurse practitioner about the about the family member's concern and the Metformin was put on hold and eventually discontinued. She said the resident had no reaction to the medication. She said she checked on Resident #1, and she had no complaints. She said she talked to Resident #1 prior to the medication being administered. She said she did not know why she had not documented that conversation.During an interview on 01/12/26 at 12:21 p.m., the DON said her understanding was that somewhere in Resident #1's paperwork it said she had an allergy to Metformin. She said the physician for the facility wanted to give Resident #1 Metformin. She said the ADON told them it was listed as an allergy. She said Resident #1 said a previous physician stopped giving it to her and she did not know why. Resident #1 said when she took the medication it made her sick to her stomach. She said Resident #1 had no reaction to the medication. She said she would have expected the ADON to have documented the conversation with the resident stating the medication only made her sick to her stomach on the day she had the conversation. She said a resident could have an anaphylactic reaction (a severe, rapid, potentially fatal allergic reaction where the immune system releases a flood of chemicals, causing airways to narrow and blood pressure to drop, leading to shock) if they were given a medication, they had a true allergy to.During an interview on 01/26/26 at 12:36 p.m., the Administrator said he expected nurses to follow physician's orders. He said if the ADON had a conversation with the resident prior to the Metformin being administered, clarifying if she had a true allergy to the medication, he expected the conversation to have been documented. He said a resident receiving a medication they were allergic to could cause them to have an adverse reaction.Record review of an undated Admission/readmission facility policy indicated, .Notify the appropriate departments of the admission to include applicable allergies, isolation status and special needs.