STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455915	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granbury Care Center	301 S Park St Granbury, TX 76048

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free of any significant medication error reviewed 5 of 5 (LVN E, LVN I, LVN J, LVN K and ADON A) staff reviewed for Insulin use. The facility failed to ensure LVN E held Resident #102's Lantus 100 Units/ML two (2) times when his blood glucose was under 120 for a two (2)-month review period. The facility failed to ensure LVN I held Resident #102's Lantus 100 Units/ML thirteen (13) times when his blood glucose was under 120 for a two (2)-month review period. The facility failed to ensure LVN J held Resident #102's Lantus 100 Units/ML three (3) times when his blood glucose was under 120 for a two (2)-month review period. The facility failed to ensure LVN K held Resident #102's Lantus 100 Units/ML six (6) times when his blood glucose was under 120 for a two (2)-month review period. The facility failed to ensure ADON A held Resident #102's Lantus 100 Units/ML six (1) times when his blood glucose was under 120 for a two (2)-month review period. These failures could place residents at risk of not receiving care and services to meet their needs. Findings include: Record review of Resident #102's face sheet, dated 02/19/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #102's medical diagnoses included dementia, psychotic disturbance, mood disturbance, and anxiety, mild cognitive impairment, morbid obesity, schizophrenia, essential hypertension, type 2 diabetes, and acute kidney failure. Record review of Resident #102's Annual MDS, dated [DATE], revealed in Section C - Cognitive Patterns-C0500 a BIMS Summary Score 09, which indicated the resident was moderately impaired. Section N-Medications, documented Resident #102 received Insulin. Record review of Resident #102's Comprehensive Care Plan, initiated 09/10/2023 and reviewed/revised 04/22/2025, revealed the following focused areas: Focus: Diabetes Mellitus: insulin dependent Goal: The resident will be free from any s/sx of hyperglycemia (High blood sugars). The resident will have no complications related to diabetes. The resident will be free from any s/sx of hypoglycemia (low blood sugar).Intervention Task: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #102's physician order, with a start date of 04/05/2024 and a revision date of 08/04/2025, revealed: Lantus SoloStar Subcutaneous Solution Pen-injector 100UNIT/ML (Insulin Glargine), Inject 10 unit subcutaneously one time daily for hyperglycemia Hold if <120. Record review of Resident #102's electronic MAR for the months of January 2026, and February 2026 revealed insulins being administered when blood glucose was <120 revealed: 01/01/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 115 recorded by LVN-K.01/02/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 103 recorded by LVN-I.01/04/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 118 recorded by LVN-I. 01/16/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 117 recorded by LVN-I. 01/17/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 107 recorded by LVN-I. 01/19/2026 Lantus soloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 107 recorded by LVN-K.01/20/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with blood glucose of 118 recorded by LVN-K. 01/23/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 102 recorded by LVN-K. 01/24/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 104 recorded by LVN-J. 01/25/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 91 recorded by LVN-J. 01/26/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 84 recorded by LVN-A. 01/30/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 92 recorded by LVN-I. 01/31/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 99 recorded by LVN-I.02/01/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 103 recorded by LVN-I. 02/02/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 118 recorded by LVN-K. 02/03/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 110 recorded by LVN-K. 02/04/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 114 recorded by LVN-I.02/05/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 units one time a day with blood glucose of 114 recorded by LVN-I.02/07/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 one time a day with blood glucose of 109 recorded by LVN-E. 02/08/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 one time a day with blood glucose of 102 recorded by ADON-A 02/09/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 one time a day with blood glucose of 93 recorded by LVN-I.02/11/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 one time a day with blood glucose of 107 recorded by LVN-E.02/13/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 one time a day with blood glucose of 101 recorded by LVN-I.02/14/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 one time a day with blood glucose of 101 recorded by LVN-I.02/15/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 one time a day with blood glucose of 111 recorded by LVN-I.02/16/2026 Lantus SoloStar Subcutaneous Solution 100 UNIT/ML 10 one time a day with blood glucose of 99 recorded by LVN-J. During an interview on 02/18/2026 at 3:10 PM, LVN-E stated if there was a check mark on the MAR with letters, it would have meant the medication had been administered to the resident. She stated if there was blood sugar below the parameter of 120, she would hold the insulin and check it again at a later time. LVN-E stated if she had a resident with a sliding scale, she would give/hold the insulin depending on the doctor's order and what the sliding scale was in place. She stated there would not have been any reason for her to give insulin if the blood sugar were outside the parameters. She stated if insulin was given if below the parameters, the side effects of the residents could bottom out (low blood sugar), then they would have to give something to bring the sugars back up. LVN-E stated it was the nurse's responsibility to document in the MAR whether the medication was given or not. She stated she felt the order for Resident #102 used to have an order with no parameters and did not know when it had changed to having parameters. During an interview on 02/18/2026 at 3:38 PM, the DON stated the medication Lantus for Resident #102's order had a parameter to hold if less than (<) 120. She stated if there was a check mark, it meant the medication was given. The DON stated she felt there was an order of no parameter a couple of months ago. She stated if doctors change orders they were discussed in the twenty-four (24) hour report. She stated if you had a blood sugar below the parameters the insulin should be held and if there was an order change or update, the LVN's and RNs should be aware of the change. She stated the nurses are briefed on changes during IDT meetings. The DON stated if you give insulin outside of those parameters, the side effects could be hypoglycemia (low blood sugar) and could have led to hospitalization and/or death. She stated the failure occurred with the nurses not paying attention to updated order changes and the DON for not monitoring the nurses close enough. During an interview on 02/18/2026 at 4:06 PM, MD-L, during a returned phone call, he stated if Resident #102's sugar was under the parameter, the nurses should not be giving his Lantus SoloStar Subcutaneous (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication. He stated all nurses administering medications should have followed orders and it was his expectations to do so. Record review of the facility policy Physician Orders, dated 2015 revealed: Purpose:To monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident. Written Orders by the Physician or Nurse Practitioner:1. Nurse will review the order and if needed contact the prescriber for any clarifications2. The nurse will enter the order into PCC for the resident and select prescriber written3. If the order requires documentation, it will be directed to the proper electronic administration record once the order is completed. 4. The receiving nurse will contact any other department or external facilities as required, i.e. dietary department, pharmacy, lab provider, x-ray provider, etc.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed food safety. The facility failed to ensure foods were properly labeled in the kitchen. This failure could place residents at risk for food borne illnesses.Findings include: During an observation on 02/16/2026 between 9:02 AM and 9:24 AM, of the kitchen revealed: 2 boxes of bananas in the walk-in refrigerator appeared brown and/or bruised. The box was not labeled with the received date or use by date.1 - 106 oz can labeled Frutas Tropicals was dented along the top rim1 - 112 oz can labeled Banana Pudding was dented along the top rim1 - 116 oz can labeled Blueberry Topping was dented along the top rim1 - 7 lb 8 oz bottle labeled Chocolate Syrup was opened and not labeled with a received date or use by date1 - 15.8 oz bottle labeled Chocolate Syrup was not labeled with a received date or expiration date1 - 5 lb bag labeled white cake mix was not labeled with a received date or expiration date4 - 7.5 oz cans labeled Tomato Soup with no received or use by date1 - 5 lb bag labeled Cornbread Mix was not labeled with a received date or expiration date1 - 128 oz bottle labeled Liquid Smoke, was opened and not labeled with a received date or expiration date1 - 1 gallon bottle labeled Worcestershire Sauce was not labeled with a received date or expiration date2 - 5 lb bags labeled Pecans with 2 handwritten dates - one bag 10/30/25 and 12/30/25 and 2nd bag 10/15/25 and 12/15/254 - 24 oz bags labeled Lemon Gelatin Mix were not labeled with a received date or expiration date4 - 24 oz bags labeled Peach Gelatin Mix were not labeled with a received date or expiration date1 - 24 oz bag labeled Watermelon Gelatin Mix was not labeled with a received date or expiration date3 - 24 oz bags labeled Grape Gelatin Mix were not labeled with a received date or expiration date1 - 24 oz bag labeled Orange Gelatin Mix was not labeled with a received date or expiration date1 - 24 oz bag labeled Berry Blue Gelatin Mix was not labeled with a received date or expiration date1 - 24 oz bag labeled Banana Gelatin Mix was not labeled with a received date or expiration date1/2 bag labeled Lime Gelatin Mix with a handwritten date of 1/18/26 and use by date of 1/24/261 squeeze bottle containing an orange color liquid with no label and was not labeled with a received date or expiration date During an interview on 02/18/2026 at 8:13 AM, DA-F stated all staff were responsible for putting up grocery deliveries. She stated the staff members putting up the deliveries marked all items/boxes with the date delivered and once opened the item was marked with a use by date. During an interview on 02/18/2026 at 8:13 AM, DA-G stated all food items were marked with received date and use by date when opened. She stated the DM was responsible for monitoring for expiration or use by dates and removal of items out of date. During a follow up interview on 02/19/2026 at 9:25 AM, DA-F stated she received training on labeling and storage when she was hired by the staff member assigned to train her. DA-F stated a possible effect on residents for failing to properly label food items could have been spoiled food that could make someone sick. During an interview on 02/19/2026 at 10:27 AM, the DM stated all kitchen staff were responsible for dating food items when delivered. The DM stated she was responsible for monitoring that food items were properly dated. She explained staff training consisted of reviewing policies with the DM, and a tour of food storage areas with an explanation of the process for receiving food deliveries. She stated her expectations were for all staff to follow the policy and label all food items. The DM stated the effect on residents may be a food item may go bad, or staff would not know how old a food item was. She stated she monitored dates and discarded all food items out of date. Record review of the Food Code 2022 https://www.fda.gov/food/retail-food-protection/fda-food-code, accessed 02/19/2026 reflected 3-602.11 Food Labels.(A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers.(B) Label information shall include:(1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement .refrigerated foods must be consumed, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sold or discarded by the expiration date. Record review of facility's, undated, Policy titled Food Storage and Supplies, revealed Procedure 6. If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as to when it is received, and shelf-stable items will be stored in a ?first in, first out' manner, to be used within one year. 7 .products without a dated shipping label should be dated when they are received by the facility so there is a method to keep track of the age of the product. 9. Perishable and non-perishable foods are classified based on their pH and water content. Any food with a pH of less than 4.2 OR a water activity of less than 88% . is automatically classified as perishable or non-perishable based on the tables in the Texas Food Establishment rules (October 2015 edition, page 19). Food manufacturers must determine whether their products meet the perishable criteria when determining whether they are required to declare expiration dates according to the Food and Drug Administration which regulates their manufacturing processes. If a manufacturer is not required to declare an expiration date, then that means that time is not a criteria in determining whether the product is safe to consume. Non-perishable foods meet the criteria in the Texas Food Establishment rules for classifying foods as non-time and temperature controlled for safety foods (NTCS). NTCS foods do not use time or temperature as a criteria for determining food safety. These non-perishable foods are still dated when received if they do not have an expiration date and once opened, but do not need to be discarded within 7 days after opening. Perishable items that are refrigerated are dated once opened and used within 7 days (if they do not have an expiration date or best by/use by date), but non-perishable items that are refrigerated once opened should be dated when opened but do not need to be discarded until their expiration date or until the quality has deteriorated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 1 of 26 residents (Resident #6) reviewed for accurate records.1. The facility failed to have documentation to indicate why Resident #6's long-acting insulin (insulin glargine) was held when chart codes indicated see nurse notes.2. The facility failed to have parameter for Resident #6's long-acting insulin (insulin glargine) documented in physician orders.These failures could place residents of an accurate depiction of care in the facility.Findings include:Record review of Resident #6's electronic physician orders, dated 09/24/2025, reflected Basaglar KwikPen Subcutaneous Solution Pen - Injector 100 unit/ml (insulin glargine) Inject 14 unit subcutaneously two times a day related to type 2 diabetes mellitus without complications. There was no evidence MD-M had parameters to hold insulin if FSBS was less than 70.Record review of Resident #6's electronic face sheet, dated 02/19/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #6 had a diagnosis which included type 2 diabetes (a chronic condition where the body cannot effectively use insulin or produce enough of it, causing sugar to build up in the blood.) Further review of her electronic face sheet reflected MD-M was her primary physician.Record review of Resident #6's quarterly MDS, dated [DATE], reflected a BIMS score of 05, which indicated severe cognitive impairment. Resident #6 took high-risk drug classes which included hypoglycemic (including insulin). Record review of Resident #6's comprehensive care plan, dated 11/13/2023, reflected Focus: The resident has Diabetes Mellitus.Intervention Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness.Record review of Resident #6's MAR, dated January 2026, reflected: Insulin glargine held on 1/3/2026 a.m. dose with code 9 (= other / see nurses notes) used. Insulin glargine held on 1/8/2026 a.m. dose with code 11 (= BS within normal limits no admin required) used. Insulin glargine held on 1/12/2026 a.m. dose with code 12 (no chart code found) used. Insulin glargine held on 1/17/2026 p.m. dose with code 11 (= BS within normal limits no admin required) used. Insulin glargine held on 1/21/2026 p.m. dose with code 9 (= other / see nurses notes) used. Insulin glargine held on 1/27/2026 a.m. dose with code 9 (= other / see nurses notes) used. Insulin glargine held on 1/31/2026 a.m. dose with code 11 (= BS within normal limits no admin required) used.Record review of Resident #6's MAR, dated February 2026, reflected: Insulin glargine held on 2/1/2026 a.m. dose with code 11 (= BS within normal limits no admin required) used. Insulin glargine held on 2/3/2026 p.m. dose with code 2 (= drug refused) used. Insulin glargine held on 2/13/2026 a.m. dose with code 5 (= hold / see nurses notes) used. Insulin glargine held on 2/14/2026 a.m. dose with code 9 (= other / see nurses notes) used. Insulin glargine held on 2/18/2026 a.m. dose with code 9 (= other / see nurses notes) used.Record review of Resident #6's progress notes reflected no notes about insulin not being administered or the physician being notified of holding insulin glargine on 1/3/2026, 1/8/2026, 1/12/2026, 1/17/2026, 1/21/2026, 1/21/2026, 1/27/2026, 1/31/2026, 2/1/2026, 2/3/2026, 2/13/2026, or 2/14/2026. There was a progress note written by LVN-C, dated 2/18/2026 at 3:42 p.m., which reflected Message sent to [MD-M] informing of holding glargine insulin this a.m. FSBS ran off and placed in his box on next review and asked if we could have a hold order if FSBS under what FSBS. There was another progress note written by LVN-C, dated 2/18/2026 at 5:45 p.m., which reflected [MD-M] replied hold if FSBS under 70. During an interview on 02/18/2026 at 2:59 p.m., LVN-C stated she did not administer insulin glargine that morning. She stated she had put in code 9, which meant other / see nurses notes and thought the system would automatically generate and progress note stating why the medication was held. She stated MD-M usually did not want insulin given if a resident's blood sugar reading was under 70. She stated she usually would reach out to the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician when the medication was held at the end of her shift unless she felt it was an emergency. She stated she also printed out a list of blood sugar readings and placed them in the physician's bin to review when he was in the building next. She stated she would make a note in the progress notes when she notified the physician about insulin levels and would ask for a parameter. She stated she thought she told MD-M about Resident #6's blood sugar readings in the past and MD-M told her to hold the insulin glargine. She stated she could not find documentation in the progress notes about that conversation. She stated it was the responsibility of the nurse who held the medication to notify the physician and they should also make a note in the electronic medical record about the physician notification. She stated it was important to notify the physician about holding medications so the physician would know what was going on with their patient. She stated not documenting communication could lead to her being accused of neglect due to no proof that communication had occurred and the resident could receive the wrong care.During an interview on 02/18/2026 at 3:24 p.m., the DON stated she expected the nurses to follow physician's orders. She stated if a medication was held, she expected the nurse to notify the physician right away. She stated she did not know if the nurse notified the physician since the communication between the nurse and physician should be documented in the electronic medical record if the nurse notified the physician. She stated she did monitor the nurses' documentation but she could not monitor all of the MARs of every resident. She stated moving forward, she believed medication education and documentation education needed to occur due to multiple nurses holding the medication and no progress notes were written. She stated the effect of not giving the medication could be hyperglycemia, heart failure, and death. She stated Resident #6 made improvement since she had been a resident at the facility and did not feel any negative impact occurred. She stated not documenting physician communications and updating orders could lead to other staff not knowing parameters of the medication or if the physician had been notified. During a telephone interview on 02/18/2026 at 4:30 p.m., MD-M stated he expected for nursing staff to hold insulin glargine if the resident had a FSBS less than 70. He stated he did remember being notified of Resident #6's blood sugars in the past and holding of the insulin glargine but could not remember exactly when and how many times because he had a lot of patients. He stated he had no concerns about not being notified by the facility's nurses. He stated he would expect the order in Resident #6's electronic medical record to have the parameter to hold insulin glargine if her FSBS was less than 70 and stated different staff putting in his orders may not have carried over the parameter. He stated he was in the building several times a week and the facility nurses always asked him questions about his patients. He stated if those conversations were not documented, it was probably just a slip up in documentation and not a communication issue.Record review of the facility's, undated, policy titled Physician's Orders, reflected Nurse will review the order and if needed contact the prescriber for any clarifications.Clarify all communications.Ensure all elements of the order are included.Immediately transcribe verbal / telephone orders into the patient's medical record or onto a prescription pad as they are being communicated. Read the order back to the prescriber for verification.Record review of the facility's policy titled Medication Administration Procedures, dated 10/25/2017, reflected If a dose of regularly scheduled medication is withheld or refused, the nurse is to initial and circle the front of the medication administration record in the space provided for that dosage administration and an explanatory note is to be entered in the nursing notes or in the PRN nurses notes section of the medication administration record. In the presence of individual facility policies concerning refused and held documentation, the facility policy supersedes this policy.Record review of the facility's, undated, policy titled Documentation, reflected The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.Document in the clinical record regarding notification of the physician of abnormal diagnostic test or laboratory results and any new orders or follow-up from the physician.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure regular inspections were conducted of all bed frames, mattresses, and bed rails, as part of a regular maintenance program to identify areas of possible entrapment for 3 of 4 residents (Resident #7, Resident #22 and Resident #48) reviewed for physical environment.The facility failed to conduct regular inspections of resident side rails, bed frames and mattresses to identify entrapment risks for Resident #7, Resident #22, and Resident #48.This failure could place residents at risk of injury, equipment malfunction, entrapment, or falls.Findings include: Record review of Resident #7's electronic face sheet, dated 02/19/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #7 had diagnoses which included paraplegia (the impairment or total loss of motor and sensory function in the lower half of the body, usually affecting the legs, feet, and sometimes the torso), history of falling, and muscle spasm (a sudden, involuntary, and often painful tightening of a muscle that cannot relax).Record review of Resident #7's quarterly MDS, dated 12/4082025, reflected a BIMS score of 11, which indicated she had moderate cognitive impairment. Resident #7 needed substantial to maximal assistance with bed mobility.Record review of Resident #7's comprehensive care plan, dated 01/07/2025, reflected she was able to hold the rail while getting peri care.Record review of Resident #7's electronic physician orders, dated 04/20/2023, reflected Resident #7 may have bilateral assist rails to the bedside to promote safety with turning, repositioning, transferring and bed mobility.Record review of the facility document Bed Rail Assessment, dated 09/20/2025, for Resident #7 reflected no evidence that regular inspections and maintenance of resident bed frames, mattresses, and bed rails, to identify areas of potential entrapment hazards for Resident #7.During an observation and interview on 02/17/2026 at 9:44 a.m., revealed Resident #7 was lying in bed with bed rails to both sides of the bed and in the up position. Resident #7 stated she used the bed rails when in the bed to help staff turn her.Record review of Resident #22's electronic face sheet, dated 02/19/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #22 had diagnoses which included dementia (a general term for a range of conditions affecting memory, thinking, and social abilities) and Alzheimer's disease (the most common cause of dementia, affecting memory, thinking, and behavior). Record review of Resident #22's quarterly MDS assessment, dated 01/10/2026, reflected a BIMS score of 12, which meant moderate cognitive impairment. Resident #22 used a walker, needed supervision or touching assistance with rolling in bed, going from lying to sitting, going from sitting to standing, and transferring from the bed to the chair. Record review of Resident #22's comprehensive care plan, dated 05/22/2024, reflected the resident had an actual fall on 05/10/2024 and was assessed and provided a hand assist bar for assistance with transfers and maintain independence. Resident #22's care plan noted she needed assistance x 1 for transfers.Record review of Resident #22's electronic physician orders reviewed on 02/19/2026 reflected no order for the use of bed rails.Record review of facility document Bed Rail Assessment, dated 08/21/2025, for Resident #22 reflected no evidence that regular inspections and maintenance of resident bed frames, mattresses, and bed rails, to identify areas of potential entrapment hazards for Resident #22.During an observation and interview on 02/16/2026 at 10:31 a.m., revealed Resident #22's bed had a mobility bar to the right of her bed. Resident #22 was sitting in a chair in her room. The right mobility bar was loose and moved approximately one inch when pushed against. Resident #22 stated she used the bar for getting out of bed. She stated she did not notice that it was loose and did not know if she told anyone about the loose bar. Resident #22 could not provide an explanation to how long the rail had been loose.During an observation and interview on 02/19/2026 at 10:33 a.m., the DON stated she expected all residents who utilized bed rails to have staff member assess the beds to make sure they rails were tight and fit (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455915	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granbury Care Center	301 S Park St Granbury, TX 76048

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the bed properly. The DON stated she was asked by Maint D just before the survey had started for a list of residents who utilized bed rails and she did not have the chance to get that list to him. She stated, prior to Maint D assessing the bed, there were Champion Rounds where leadership staff were assigned to go into resident's rooms and check equipment to make sure it was in working order. She stated she was unsure who was assigned to Resident #22 and verified the bed rail was loose and needed to be tightened. She told Maint D. which room Resident #22 was in so he could tighten the quarter bed rail.3. Record review of Resident #48's electronic face sheet, dated 02/19/2026, reflected a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #48 had diagnoses which included dementia (a general term for a range of conditions affecting memory, thinking, and social abilities), left femur fracture (broken left hip bone), obesity (increased body mass index greater than being overweight) and pain.Record review of Resident #48's quarterly MDS assessment, dated 11/17/2025, reflected a BIMS score of 15, which meant cognitively intact. Resident #48 used a walker and wheelchair, needed setup assistance for bed mobility and supervision for transfers.Record review of Resident #48's comprehensive care plan, dated 02/02/2026, reflected 1/8 rail to be used on left and right side of the bed. Further review of the care plan reflected staff to perform a bed rail assessment at least every quarter.Record review of Resident #48's electronic physician orders, dated 1/28/2026, reflected Resident #48 may use bed rail/grab assist bar on the bed for bed mobility.Record review of the facility document Bed Rail Assessment, dated 02/13/2026, reflected no evidence that regular inspections and maintenance of resident bed frames, mattresses, and bed rails, to identify areas of potential entrapment hazards for Resident #48.During an observation and interview on 02/17/2026 at 1:19 p.m., revealed Resident #48 was sitting in a wheelchair in his room. There were bed rails on his bed on both sides. Resident #48 stated they helped him move around in his bed.During an interview on 02/19/2026 at 10:35 a.m., Maint D stated he did not have a system in place for assessing the bed rails. He stated he asked for a list of residents who used bed rails but had not performed any assessments on the bed rails. He stated the direct care staff would notify him if the bed rails were loose and he would go and tighten them. He did not have anything in the computer system the facility used to report maintenance issues for Resident #22. He stated he would be notified of items that needed to be maintained during the morning stand-up meetings but he had not been notified of Resident #22's bed rail being loose.During an interview on 02/19/2026 at 10:39 a.m., the ADMN stated she expected the Champion Round representative, SW-B, to notice Resident #22's bed rail was loose and report to the Maint D during morning meeting. Or, for SW-B to enter the loose bed rail in the maintenance tracking computer system. She stated she would monitor the issue that had been corrected by watching the maintenance tracking log system. The ADMN stated the facility did not have a process in making sure the Champion Round representative was checking bed rails when they checked on the residents they were assigned to. She stated she had not been informed of the loose bed rail for Resident #22 and that was why she had not been tracking that the work had been completed. She stated not performing the regular maintenance checks on bed rails could cause harm by the resident falling when using the loose bed rail or entrapment from the rail not being tight.During an interview on 02/19/2026 at 10:50 a.m., SW-B stated she performed Champion Rounds for Resident #22. She stated the Champion Round would be done by her entering the residents' rooms twice a day and making sure items were in working order. She stated she was told to look at the bed to make sure it was in working order but she had not been instructed on how to assess the bed rails. She stated she assumed the therapist or direct care staff were checking the bed rails for tightness during their assessments. She stated she would ask the residents if everything was in working order but did not physically check the bed to see if the bed rails were tight. She stated Resident #22 had not told her there was anything wrong with her bed and that was why she had not reported it to Maint D.Record review of facility's policy titled Bed Rails, dated November, 8 2016, reflected The facility will conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	possible entrapment and ensure rails are installed according to manufacturer recommendations. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident had the right to be informed of, and participate in, his or her treatment including the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he/ she preferred for 1 of 6 residents (Resident #8) reviewed for antipsychotic consents.The facility failed to ensure Resident #8 or their representative signed consent for antipsychotic medication aripiprazole (an antipsychotic medication used to treat mental health disorders, such as schizophrenia) prior to administering medication after dosage increased and prior to administering new dosage ordered by physician. This failure could affect residents by placing them at risk of not being informed of their health status which would allow them to make informed decisions regarding their care.Findings include: Record review of Resident #8's electronic face sheet, dated 02/19/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #8 had a diagnosis which included bipolar disorder (a chronic mental health condition characterized by intense, extreme shifts in mood, energy, and activity levels).Record review of Resident #8's significant change MDS, dated [DATE], reflected a BIMS score of 15, which meant cognitively intact. Resident #8 was taking high risk antipsychotic medication.Record review of Resident #8's comprehensive care plan, dated 03/13/2024, reflected Resident #8 required anti-psychotic medication with interventions which included educate the resident / family / caregivers about risks, benefits and side effects.Record review of Resident #8's electronic physician orders reflected Resident #8 started taking risperidone 1mg in the AM and 2mg in the PM starting on 01/28/2026. Resident #8's risperidone was changed to 2mg in the AM and PM starting on 2/18/2026. Record review of Resident #8's MAR, dated January 2026, reflected Resident #8 received risperidone 1mg in the AM and 2mg in the PM starting the night of 01/28/2026 - 01/31/2026.Record review of Resident #8's MAR, dated February 2026, reflected Resident #8 received risperidone 1mg in the AM and 2mg in the PM from 02/01/2026 - 02/18/2026 AM. Resident #8 received risperidone 2mg twice a day starting the night of 02/18/2026 - 02/19/2026.Record review of Resident #8's electronic medical chart, accessed on 02/18/2026, reflected no evidence she or her representative consented to risperidone prior to receiving the medication starting on January 28, 2026, using HHSC Form 3713. There was no evidence she or her representative agreed to a dosage increase on February 18, 2026, using HHSC Form 3713.During a telephone interview on 02/19/2026 at 1:09 p.m., Resident #8's representative stated she had been informed about the risperidone changes. She stated Resident #8 had been on the medication in the past and was happy the medication had been ordered. She stated she was informed about the increase in dosage. She stated she had not signed a form stating she was informed about the risks from the medication. She stated she was not able to come up to the facility frequently and stated she would sign the next time she went to the facility. During an interview on 02/19/2026 at 1:07 p.m., ADON-A stated she was responsible for getting the HHSC state form 3713 signed by residents or their representatives prior to the medication being administered. She had a form from 2024 with consent for risperidone and the dosage was 1mg. She stated a new consent should be obtained when there was a dosage change and not getting the consent could cause the representative to not be able to make an informed decision about the medication. She stated she had not been told by the psychiatric physician he was changing Resident #8's medications and that was why she had not gotten the form signed.During an interview on 02/19/2026 at 1:15 p.m., the DON stated consents for antipsychotic medications should have been obtained prior to the medication being administered. She stated ADON-A was responsible for obtaining those consents and she monitored those consents were obtained. She stated the psychiatric physician placed the order in the electronic system without notifying her or the ADON-A of the medication change which led to the failure of obtaining the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consent. She stated not obtaining the consent could cause Resident #8's representative to not make an informed decision. She stated she was unaware who notified Resident #8's representative of the medication change.During an interview on 02/19/2025 at 4:20 p.m., LVN A stated nurses were responsible for obtaining medication consent for psychoactive medications. She stated nurses got the consent prior to giving the medication. She stated sometimes the DON would assist with getting psychoactive medications. LVN A stated there was a form that would be filled in on the electronic medical system under the observations section. She stated after the form was filled out then the process would be to print the form and get a physical signature on the form. She stated it was okay to get a verbal consent if person not available in person to sign the form and when a verbal was obtained the DON would be notified. She stated as far as she knew, there was not another process for medications like Seroquel that were antipsychotics.Record review of facility's policy titled Psychoactive Medications, dated 10/25/2017, reflected A psychotropic consent form explains the risks and benefits of psychotropic medication. The resident or their representative must provide documented consent prior to administration of a newly ordered psychotropic medication.Consent for antipsychotics must be in a written form. Phone or verbal consent is not allowed. Permission given by or a request made by the resident and/or representative does not serve as a sole justification for the medication itself.Record review of drugs.com accessed on 02/19/2026 at https://www.drugs.com/risperidone.html, revealed risperidone .Drug class: Atypical antipsychotics .Warnings Risperidone carries a Boxed Warning for increased risk of death in elderly patients with dementia-related psychosis. It is not approved for use in older adults with dementia-related psychosis.Most Common Side Effects Headache; Blurred vision, rash; Dizziness, drowsiness, tired feeling; Tremors, twitching or uncontrollable muscle movements, numbness; Depressed mood, agitation, anxiety, feeling restless; Back pain, muscle or joint pain, pain in your arms or legs; Upset stomach, constipation, dry mouth; Upper stomach pain, nausea, vomiting, diarrhea; Increased salivation; Cold symptoms such as a stuffy nose, sneezing, sore throat; Increased appetite, weight gain. High doses or long-term use of risperidone can cause a serious movement disorder that may not be reversible. The longer you use risperidone, the more likely you are to develop this disorder, especially if you are a woman or an older adult.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days, except if the attending physician or prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the residents medical record and indicate the duration for the PRN order for 2 of 7 residents reviewed for unnecessary medications. The facility failed to ensure Resident #40's PRN Lorazepam (medicine used to treat the symptoms of anxiety) was discontinued after 14 days or document a rationale for the continued provision of the medication.The facility failed to ensure Resident #117's PRN Diazepam (medicine used to treat the symptoms of anxiety) was discontinued after 14 days or document a rationale for the continued provision of the medication. These failures could place residents at risk for adverse reactions and negative side effects from the administration of medication and dependence on unnecessary medications.Findings include: 1. Record review of Resident #40's electronic face sheet, dated 02/18/2026, revealed an [AGE] year-old female initially admitted to the facility on [DATE] with a recent admission date of 05/05/2025. Resident #40 was admitted with medical diagnoses which included dementia (a decline in mental ability), anxiety (a feeling or worry or nervousness), and abnormal weight loss. Record review of Resident #40's Quarterly MDS assessment, dated 01/11/2026, revealed in Section C - Cognitive Patterns, subsection C0100 Should Brief Interview for Mental Status (C0200-C0500) be Conducted? 0 was entered, which indicated No (resident is rarely/never understood). Section review of Section N - Medications, subsection N0415. High-Risk Drug Classes: Use and Indication, B. Antianxiety 1. Is taking and 2. Indication noted were checked. Record review of Resident #40's Comprehensive Care Plan, last revised 02/02/2026, revealed: Problem: The resident uses anti-anxiety medications, Interventions/Tasks Give anti-anxiety medications ordered by physician. Monitor/document side effect and effectiveness. Record review of Resident #40's electronic Physicians Orders revealed: LORazepam Oral Tablet 0.5 mg (Lorazepam) Give 1 tablet by mouth every 6 hours as needed for Combative/anxiety One 0.5mg tablet by mouth every 6 hours as needed. Order date 10/17/1015, Start Date 10/17/2025. A stop date was not included in the physician's order. Record review of Resident #40's November 2025 MAR revealed no doses of Lorazepam were administered. Record review of Resident #40's December 2025 MAR revealed no doses of Lorazepam were administered. Record review of Resident #40's January 2026 MAR revealed no doses of Lorazepam were administered. Record review of Resident #40's February 2026 MAR until 02/18/2026, revealed no doses of Lorazepam were administered. Record review of Resident #40's physician progress notes revealed no evidence of documented rationale to order PRN Lorazepam for more than 14 days. 2. Record review of Resident #117's electronic face sheet, dated 02/18/2026, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #117 had medical diagnoses which included dementia and chronic obstructive pulmonary disease (difficulty breathing). Record review of Resident #117's Annual MDS, dated [DATE], revealed in Section C-Cognitive Patterns, subsection C0500. BIMS Summary Score, the resident scored 7 out of 15, which indicated moderate cognitive impairment. Review of Section N - Medications, subsection N0415. High-Risk Drug Classes: Use and Indication revealed Resident #117 was receiving anti-anxiety medication. Record review of Resident #117's Comprehensive Care Plan, last revised 02/02/2026, revealed Focus: The resident requires antidepressant medication for new onset of anxiety with agitation. Goal: The resident will show decreased episodes of s/sx of anxiety and agitation . Interventions/Tasks: Monitor/document/report to MD PRN ongoing s/sx of anxiety, aggression, agitation. Record review of Resident #117's electronic Physicians Orders revealed: Diazepam Gel 10 mg/mL Apply to wrist topically every 4 hours as needed for Anxiety; Agitation. Order date 06/03/2025, start date 06/03/2025. Diazepam (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspension 5 mg/0.5mL. Give 5 mg sublingually (under the tongue) every 4 hours as needed for Anxiety; Agitation. Order date 06/02/2025, start date 06/03/2025. A stop date was not noted in the physician's order. Record review of Resident #117's December 2025 MAR revealed 1 dose of diazepam suspension was administered. Record review of Resident #117's January 2026 MAR revealed 1 dose of diazepam suspension was administered and 2 doses of diazepam gel was administered. Record review of Resident #117's February 2026 MAR up until 02/18/2026, revealed no doses of diazepam suspension or diazepam gel were administered. Record review of Resident #117's physician progress notes revealed no evidence of documented rationale to order PRN diazepam for more than 14 days. During an interview on 02/19/2026 at 10:43 AM, RN-H stated she started working at facility one week ago. She explained the nurse who received orders was responsible for entering a 14-day stop date. She stated the DON was responsible for monitoring stop dates. RN-H stated training on receiving and entering PRN physician orders included her nursing education and a review of policies during new hire orientation. She was unable to state how failing to enter a stop date on psychotropic PRN medications may affect a resident.During an interview on 02/19/2026 at 11:01 AM, the DON stated the nurse who received an order for a PRN psychotropic medication was responsible for ensuring a stop date was entered. She explained monitoring the accuracy of orders entered which included a stop date was done by the nursing staff. The DON stated staff training consisted of reviewing the medication policies during new hire orientation and periodically. She stated her expectations were for a 14-day stop date to be entered when a new PRN medication order was put into the system. The DON stated the effect on residents of failing to enter a stop date for psychotropic PRN medications could have been a long-term medication effect and it could have impacted a resident's gradual dose reduction. During an interview on 02/19/2026 at 12:46 PM, ADON-A stated she thought all the nurses were entering stop dates as per policy. Record review of the facility's policy titled Psychotropic Drugs, revised 10/25/2027, revealed in part: The facility must will ensure that - 4. PRN orders for psychotropic drugs are limited to 14 days. and 5. PRN orders for anti-psychotic drugs are limited to 14 days .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to review the risks and benefits of bed rails with the resident or a resident representative and obtain informed consent prior to installation for 1 of 4 residents (Resident #22) reviewed for bed rail consents. The facility failed to obtain informed consent from Resident #22 or her representative or maintain evidence that Resident #22 or her representative had been provided with sufficient information so that they could make an informed decision prior to installing bed rails.This failure could place residents at risk for not being able to make an informed decision due to not having sufficient information on the risks of bed rail usage.Findings include:Record review of Resident #22's electronic face sheet, dated 02/19/2026, reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #22 had diagnoses which included dementia (a general term for a range of conditions affecting memory, thinking, and social abilities), and Alzheimer's disease (the most common cause of dementia, affecting memory, thinking, and behavior). Record review of Resident #22's quarterly MDS assessment, dated 01/10/2026, reflected a BIMS score of 12, which meant moderate cognitive impairment. Resident #22 used a walker, needed supervision or touching assistance with rolling in bed, going from lying to sitting, going from sitting to standing, and transferring from the bed to the chair. Record review of Resident #22's comprehensive care plan, reviewed on 02/19/2026, reflected the resident had an actual fall on 05/10/2024 and was assessed and provided a hand assist bar for assistance with transfers and maintain independence. Resident #22's care plan noted she needed assistance x 1 for transfers.Record review of Resident #22's electronic physician orders, reviewed on 02/19/2026, reflected no order for the use of bed rails.Record review of Resident #22's electronic records on 02/19/2026 revealed no evidence of an informed consent for the use of bed rails.During an observation and interview on 02/16/2026 at 10:31 a.m., Resident #22's bed had a mobility bar to the right of her bed. Resident #22 was sitting in a chair in her room. The right mobility bar was loose and moved approximately one inch when pushed against. Resident #22 stated she used the bar for getting out of bed. She stated she did not notice it was loose and did not know if she had told anyone about the loose bar. During an observation and interview on 02/19/2026 at 10:33 a.m., the DON stated she expected all residents to have an informed consent for mobility bars / bed rails prior to them being installed on a resident's bed. The DON stated she started working in the facility as the DON in October 2025 and she made sure all residents who utilized mobility bars had a consent along with other items for those bars. She stated she was unsure why she missed Resident #22 not having a consent for the mobility bar at that time. She stated the facility did not have to have a physician's order to install mobility bars because they were to promote independence and not used as a restraint. She stated Resident #22 used the bar to help transfer out of bed. She stated Resident #22 had the bar before she started working in the facility and did not know who was responsible for getting that consent prior to her becoming the DON. She stated she monitored that the consents were obtained. The DON stated consents were to inform residents and their representatives of the risks as well as the benefits of having those mobility bars. Resident #22 was lying in bed and had a mobility bar to the right of her bed during the interview. The mobility bar continued to be loose.During an interview on 02/19/2026 at 1:17 p.m., ADON-A stated she was not responsible for obtaining consents for bed rails or mobility bars. She stated she did not know who was responsible for obtaining those consents.During an interview and record review on 02/19/2026 at 1:24 p.m., the ADMN stated she expected facility policies and regulations to be followed. She stated she had been the ADMN of the facility for about 3 months and did not know why the consent had not been obtained and should have been obtained prior to bed rails being utilized. Record review of the (continued on next page)

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's policy titled Bed Rails, dated November 8, 2026, reflected Consent - The resident and/or resident representative will provide consent for the use of rails prior to installation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455915	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granbury Care Center	301 S Park St Granbury, TX 76048

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable and, in accordance with State and Federal laws, drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 1 of 26 residents (Resident # 25)reviewed for label and storage of drugs and biologicals. The facility failed to ensure Resident #25's medications were locked and labeled when unattended.This failure could place residents at risk of having access to unauthorized medications, leading to possible harm or drug diversions. Findings include: Record review of Resident #25's electronic face sheet, dated 02/19/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #25 had diagnoses which included multiple sclerosis (a chronic, inflammatory and autoimmune disease of the central nervous system that causes widespread damage to the protective covering of nerve fibers, leading to communication problems between the brain and the rest of the body) and pain in knee.Record review of Resident #25's quarterly MDS assessment, dated 02/06/2026, reflected a BIMS score of 11, which meant moderate cognitive impairment. Resident #25 was on high-risk medication in the class of antidepressant and opioid.Record review of Resident #25's comprehensive care plan, reviewed on 02/19/2026, reflected the following focused areas: Resident #25 required antidepressant medication, date initiated 08/23/2026, with intervention to give antidepressant medications ordered by physician; Resident #25 required anti-anxiety medication, date initiated 08/23/2026, with intervention to give anti-anxiety medications ordered by physician.Record review of Resident #25's MAR, dated 02/16/2026, reflected the following medications were given by MA-D that morning: Atorvastatin Calcium Oral Tablet 40 MG (Atorvastatin Calcium) Give 1 tablet by mouth one time a day; Lexapro Oral Tablet 5 MG (Escitalopram Oxalate) Give 1 tablet by mouth one time a day; Myrbetriq Oral Tablet Extended Release 24 Hour 25 MG (Mirabegron) Give 1 tablet by mouth one time a day; Potassium Chloride ER Oral Tablet Extended Release 10 MEQ (Potassium Chloride) Give 1 tablet by mouth one time a day; Thiamine HCl Oral Tablet 100 MG (Thiamine HCl) Give 1 tablet by mouth one time a day; Vitamin D3 Oral Tablet 25 MCG (1000 UT) (Cholecalciferol) Give 2 tablet by mouth one time a day; ZyrTEC Allergy Oral Tablet 10 MG (Cetirizine HCl) Give 1 tablet by mouth one time a day; Baclofen Oral Tablet 5 MG (Baclofen) Give 1 tablet by mouth two times a day; Carvedilol Oral Tablet 6.25 MG (Carvedilol) Give 1 tablet by mouth two times a day; Diroximel Fumarate Oral Capsule Delayed Release 231 MG (Diroximel Fumarate) Give 2 capsule by mouth two times a day. May take aspirin 325mg 30 minutes prior to Diroximel Fumarate oral capsule DR 231mg administration to reduce side effects; hydrOXYzine Pamoate Oral Capsule 50 MG (Hydroxyzine Pamoate) Give 1 capsule by mouth two times a day; Gabapentin Oral Tablet 600 MG (Gabapentin) Give 1 tablet by mouth three times a day.Record review of Resident #25's electronic medical record, on 02/16/2026, revealed no evidence of a completed assessment for self-administering of medication.During an observation and interview on 02/16/2026 at 09:35 a.m., Resident #25 was found to have 9 medications in a pill cup on her bedside table. Resident #25 was lying in bed during the observation. Resident #25 stated she did not want to get anyone in trouble and the medication aide usually did not leave medications on her table in a cup. She stated the medication aide knew she would take them. She would not give the name of the person who passed medications that morning.During an interview on 02/16/2026 at 10:17 a.m., MA-D stated she had not passed medications to Resident #25 that morning. She stated she placed the medications in a medication cup and handed them to Resident #25. She stated she saw Resident #25 raise the medication cup to her (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mouth but did not watch Resident #25 place the medication cup down. She stated she thought Resident #25 took all her medications. She stated the medication she placed in the pill cup would have been more than 9 and stated Resident #25 must not have swallowed all of them. She stated she knew she should have made sure all of the medications were gone out of the cup before leaving the room and thought that the resident had taken all of the medications. She stated a cup of medications on the bedside table could have led to another resident taking them or Resident #25 taking them at the wrong time leading to medication errors. During an interview on 2/16/2026 at 11:05 AM, the DON stated she expected medications not to be left at the beside. She stated she thought MA-D must have thought Resident #25 took all the medications, and that was why she left the room. The DON stated anyone who passed medications should have made sure all the medications were consumed. She stated medications should not be left unattended because it could cause other residents to take the medications or cause residents to take the medication at the wrong time. She stated she would re-educate nursing staff on proper medication administration. She stated she monitored that nursing staff administered medications appropriately and she had not been concerned about staff leaving medications at the bedside in the past. The DON stated she thought that was a one-time occurrence. Record review of the facility's policy titled Medication Storage in the Facility, dated 2025, reflected Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedure 1. [facility pharmacy] dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers. Transfer of medications from one container to another is done only by a pharmacist. 2. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications (e.g. medication aides) are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access.