STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455957	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Health & Rehabilitation Center	1205 Santa Fe Dr Weatherford, TX 76086

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. (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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(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	**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 acquiring, receiving, dispensing, and administering of all drugs) to meet the needs for 1 of 5 residents (Resident #5) reviewed for pharmaceutical services, in that: RN A failed to reorder medication for Resident #5 before his supply was depleted. These failures could place residents who receive medications at risk for a decline in health and of not receiving the intended therapeutic benefit of the medications. The findings included: Record review of Resident #5's face sheet dated 08/07/2025, revealed a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE] with the following diagnosis: diabetes mellitus with high blood sugar (a condition in which the is improper metabolism of carbohydrates resulting in too much sugar in the blood). Record review of Resident #5's admission MDS dated [DATE] revealed Section-C Cognitive Patterns Resident #5 had a BIMS score of 13, meaning mild cognitive impairment. Section N revealed he received insulin injections one time in the last 7 days. Record review of Resident #5's physician orders revealed start date 07/27/25, Monjarno Subcutaneous solution, Auto-injector 5 mg/ml (Tirzepatide) every Monday inject one application subcutaneously (refers to the deepest layer of the skin. containing a layer of fat cells and collagen) in the morning. Daily Blood sugar monitoring was ordered at 8:00 Am daily. Record review of the medication administration record on 08/06/2025 at 3:30 PM for July 2025 and, August 2025 revealed Resident #5 had not been administer his Monjarno since 07/28/25 . It had not been administered for the entire month of August as of 08/06/2025. One dose of Monjarno was ordered weekly. Review of the Care Plan revised 06/25/25 for Resident #5 revealed, Resident #5 has a diagnosis of diabetes and is at risk for hypo/hyperglycemia. Interventions: Administer diabetic meds per MD order. Monitor blood sugars as ordered. During an Interview on 08.06.2025 at 1:00 PM Resident #5 stated that he had not received His Monjarno injection weekly on Monday as ordered by his physician. He stated A nurse told him that they were out of the Medication on 08/04/2025 and it needed to be ordered. He stated he did not know her name, but she told him that she would order it and she was here now and he still had received the medication. He stated he just wanted his medication because he needs it. He stated his blood sugars was 136 this morning. During an Interview with RN A at 4:00 Pm on 08/06/2025, she stated she gave the Monjarno to the resident on 07/27/2025. She stated there must have been one syringe left in the box or she would have reordered the medication at that time. She stated on Monday 08/04/2025 she went to administer the Monjarno, and the box was empty. She stated she ordered the medication at that time. She stated she should have notified the physician that the Monjarno was not available, but she was busy, and she just let it slip her mind. She stated she worked on 08/05/2025 and on 08/06/2025 and the medication still had not come in. She stated she threw the box away when she ordered the medication on 08/04/2025, which she should not have done until the new medication came in. She stated that by failing to administer the medication when the medication was ordered and not notifying the physician that it was not available could have caused an adverse effect for the resident. The resident could have had an increase in his blood sugar and not received the appropriate treatment that he needed. During an interview with the NP 4:30 PM on 08/06/2025 the NP stated she was not aware until today that Resident #5 had missed a dose of his Monjarno. She stated he told her when she saw him today (08/06/2025) that he hadn't received the medication since last week. She stated that Resident #5's blood sugars were normal for him today at 147 and that the delay in him receiving his Monjarno was not detrimental to his health or likely to cause serious illness. She stated she would address the matter, contact the pharmacy, and make necessary treatment changes if indicated. She stated she did expect the nurses to notify her if a resident was not taking their medication or that medication was not available from the pharmacy. During an Interview at 4:40 PM with RN B she stated resident #5 was not administered Monjarno on Monday, Tues, or Wednesday. Resident had just completed a treatment for Mr. [NAME] at the time just prior to the interview. There was no documentation In an interview and observation of the medication cart with the DON and ADON on 08/06/2025 at 3:30 PM, the DON reported she expected the Monjarno to be ordered when the last dose is used, and her expectation was that resident's should not run out of their medications. She stated that there were medications in the emergency kit that could be administered, but due to the price of the Monjarno, it was not a medication that was available in the emergency kit. She stated failure to receive medication as ordered could be detrimental to a resident's health. She confirmed the medication could not be found and stated it had been re-ordered

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident, in accordance with accepted professional standards and practices, which were complete and accurate for 1 of 5 (Resident #5) residents reviewed for resident records. RN A failed to ensure she documented treatment orders on the MAR or progress notes when not administered for Resident #5. This failure could place residents at risk of having errors with their care and treatment. Findings included: Record review of Resident #5's face sheet dated 08/07/2025, revealed a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE] with the following diagnoses: dermatitis (a condition in which the skin becomes red, swollen and sore, with small blisters forming caused from irritation or allergic reaction), diabetes mellitus with high blood sugar (a condition in which the is improper metabolism of carbohydrates resulting in too much sugar in the blood). Record review of Resident #5's physician orders revealed start date 07/30/2025 Clotrimazole Cream 1 percent apply to face and ears two times a day for fungal involvement of face and ears for 14 days. For 2 weeks. Record review of Resident #5's MAR for August 2025 revealed the Clotrimazole 1 percent Cream was applied at 9:00 AM on 08/01/2025, at 9:00 AM on 08/02/2025, and at 9:00 AM 08/03/2025. There was no documentation on 08/04/2025 of Clomitrazole cream administration, and there was documentation on 08/05/2025 at 9:00 AM only and 08/06/2025 at 9:00 AM only. Record review of Resident #5's physician orders revealed start date 07/30/2025 Triamcinolone Acetonide Cream 0.1 percent, apply to both arms 2 times a day for dermatitis for 2 weeks. Monitor for effectiveness x 1 week and may continue 1 more week if needed not to exceed 2 weeks. Record review of Resident #5's progress notes and the MAR/TAR for August of 2025, revealed no evidence of Triamcinolone Cream administration or monitoring for effectiveness per physician order on 08/01/2025 thru 08/06/2025. Record review of Resident #5's active orders for August 2025 revealed: start date 08/01/25 Lotrisone1-0.05 percent cream apply to penis two times a day for fungal infection. Record review of Resident #5's MAR for August 2025 revealed the Lotrisone1-0.05 percent cream apply to penis two times a day cream was applied 2 times at 9:00 AM and 5 PM on 08/02/2025, and 2 times at 9:00 AM and 5 pm on 08/03/2025, There was no documentation on 08/04/2025 , and there was documentation on 08/05/2025 of one administration at 9:00 AM and one administration on 08/06/2025 at 9:00 AM . During an interview on 08.06.2025 at 1:00 PM Resident #5 stated that he had not received the 3 creams that the physician ordered for his dermatitis since Saturday 08/02/2025). Resident stated he had a rash that was on his face, ears, and his penis. He stated he thought he had not received the medication because his regular treatment nurse was on vacation starting 08/01/25. He stated he hadn't received his cream 2 times a day since then. He stated he told a couple of nurses, but he did not know their names. He stated he didn't want to get anybody in trouble, but he just wanted his medicine like he was supposed to have it. During an interview on 08/06/2025 at 3:15 PM the ADON stated she was educated on how to document when received her education for her license. The ADON stated she expected that the nurses had been trained to document in school, and they were also trained during orientation and provided in-services by the facility on an as needed basis. The ADON stated her expectation would have been that staff document the care when given and that they administer the creams as ordered, She stated an adverse outcome for the resident would be the resident not receive the care he needed to make him better. During an interview on 08/06/2025 at 3:25 PM the DON stated her expectation was that nurses follow physician orders and document their actions in residents electronic chart in the MAR and/or the progress notes. The DON stated if an order stated, apply the medication 2 times a day, the nurse should have applied the medications 2 times a day and monitoring the resident's response to the treatment in the resident's electronic chart. The DON stated resident's response should have been documented on the MAR or in the progress notes. The DON stated the failure could have caused Resident #5 to have a negative outcome of not having the care that he needed . The DON stated the failure occurred because of the nurses' failure to follow the policy on proper documentation of medications. The DON stated herself and the ADONs were ultimately responsible to monitor to ensure residents were receiving their medications as ordered. Record review of facility policy titled, Medication Treatment Administration and Documentation dated January 2014 stated in part: Verify labels accurately reflect the physicians orders on the MAR or TAR prior to administering medication and treatments. Verify and provide medication or treatment focused assessment such as wound status, blood pressure as indicated by physician orders. Administer the medication according to the physicians orders