STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455989	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Borger Healthcare Center	1316 S Florida Borger, TX 79007

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on interviews and record reviews the facility failed to ensure each resident was free from abuse, neglect, misappropriation of resident property and exploitation for 1 (Resident #1) of 5 residents reviewed for abuse, neglect, misappropriation of resident property and exploitation. The facility failed to ensure a 15 ml bottle of morphine prescribed to Resident #1 was not misappropriated. This failure could lead to residents not receiving their medication as prescribed and/or experiencing discomfort due to symptoms not being treated as ordered by a physician. Findings Included: Record review of Resident #1's admission record dated [DATE] revealed a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, heart disease (heart muscle fails to pump blood as it should), dementia with anxiety (a group of thinking and social symptoms that interferes with daily functioning), and type 2 diabetes (insufficient production of insulin, causing high blood sugar). Resident #1 expired on [DATE]. Record review of Resident #1's significant change MDS completed on [DATE] revealed no BIMS as Resident #1 was rarely to never understood. The staff assessment for mental status revealed Resident #1's cognitive skills for daily living were severely impaired. Section J revealed Resident #1 received PRN pain medication during the look-back period. The staff assessment for pain revealed staff knew Resident #1 was in pain over the look-back period due to facial expressions which were observed one or two days of the 5-day look-back period. Section N of the MDS revealed resident #1 received opioid medications. Section O revealed Resident #1 was receiving hospice care. Record review of Resident #1's care plan last reviewed/revised on [DATE] revealed Resident #1 had a pressure ulcer. The approach included, Assess pain level before, during and after treatment. Medicate per physician's order and resident's need and Monitor for pain and medicate as needed per physician's order. The care plan had a goal of Death with dignity. This goal included approaches Medications as ordered by physician and Monitor for restlessness, grimacing . Provide comfort measures . medications as indicated. Record review of Resident #1's order report dated [DATE] revealed in part: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order for morphine concentrate schedule II solution; 100 mg/5mL (20 mg/mL) 0.1 every two hours as needed with a start date of [DATE] and an discontinue date of [DATE]. An order for morphine concentrate schedule II solution; 100 mg/5mL (20 mg/mL) 0.20 every four hours with start date of [DATE] and discontinue date of [DATE]. An order for morphine concentrate schedule II solution; 100 mg/5mL (20 mg/mL) 0.25 every four hours with start date of [DATE] and discontinue date of [DATE]. Record review of Resident #1's MAR with a run date of [DATE] revealed Resident #1 did not receive her 8 AM, 12 PM, 4 PM, and 8 PM doses of morphine as ordered due to the medication being unavailable. Record review of the facility's investigation into Resident #1's missing morphine revealed the bottle of morphine was discovered missing at change of shift the morning of [DATE] when night nurse, RN D asked on-coming day nurse, LVN E to help her fax triplicate requests for a refill on Resident #1's morphine. LVN E had visualized the full bottle of morphine the day before. RN D told LVN E the bottle was not there any longer. The two of them looked in the medication cart and found the bottle missing as well as the sheet of paper in the narcotics book which documented the signing in and out of the cart and medication counts at shift changes regarding Resident #1's morphine. RN D then told ADON she was digging in the dumpster behind the facility looking for the bottle of morphine and she was going to go over all of her steps from the night before to be sure she did not leave the bottle anywhere in the facility. RN D told ADM she took the cart from LVN C the evening of [DATE]. ADM interviewed LVN C and she stated the bottle of morphine was in the cart each and every time she counted the cart. The facility investigation indicated the local police department was called and came out to investigate the missing morphine. Record review of Resident #1's progress notes revealed no information regarding the missing bottle of morphine. A progress noted dated [DATE] at 09:13 PM written by LVN F revealed Resident #1's family members inquired about her morphine arriving earlier that day. LVN F told family that the morphine was not in the facility, and she called HRN B who was on-call for hospice that evening and HRN B stated she would pick up the morphine and bring it to the facility. During an interview on [DATE] at 09:20 PM ADON stated the morphine was found to be missing when an agency nurse was counting with a facility nurse and the agency nurse realized it was not there. ADON stated she was 99.99% certain RN D took the morphine, but she had no proof. She stated RN D was one of the possible suspects in another drug diversion-that time it was hydrocodone-a few months ago but they had no proof RN D took the drugs at that time either. She said RN D was currently on suspension from the facility related to an altercation between two residents that RN D failed to report. ADON stated nurses were responsible for medications in the facility. ADON stated this was why nurses sign in and out on the medication carts with each other there to ensure nothing is missed. She stated the facility called the police department when they learned of the missing morphine and the police came to the facility and took a report. During an interview on [DATE] at 10:03 AM Resident #1's family member stated Resident #1's morphine was taken from the facility and she was ,d+[DATE] hours without a dose. He stated two other family members of Resident #1 were in the facility when the morphine was found to be missing and they were told about the missing morphine. He stated they did not notice Resident #1 showing signs of being in pain. He stated they were with her 24 hours a day 7 days a week at that point. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 02:11 PM LVN E stated she worked on [DATE] and during that shift she took the medication cart containing Resident #1's morphine from LVN C during LVN C's lunch break. She stated she and LVN C counted the cart together before she took it and again when LVN C came back from her lunch break. LVN E stated during the time she had the cart HRN A came to the facility and the two of them took the bottle of morphine out of the cart to visualize it and ensure Resident #1 had enough of the prescription. LVN E stated she worked the morning of [DATE] and when she came to work, she saw RN D attempting to fill out triplicate orders for Resident #1 for morphine. LVN E said she expressed surprise because there was a whole bottle yesterday. At that time RN D told LVN E there was no bottle in the cart. LVN E stated, The bottle and the paper were missing so there was no way to track who had it last. During an interview on [DATE] at 03:02 PM LVN C stated Resident #1's bottle of morphine was on her medication cart on [DATE] when she left the cart with RN D around 9:30 or 10 PM. During an interview on [DATE] at 12:51 PM HRN A stated she called the hospice doctor on [DATE] at 12:44 PM and explained the bottle of morphine was missing and asked him to sign a new order. She said she tried sending an order through, but the DEA would not let it go through because it was being refilled too soon. HRN A stated she and the doctor then changed the dose of morphine from .2 to .25 and at that point the Pharm P told her they would deliver the medication. She stated she was not sure when the medication was delivered. She stated her notes indicated the facility called hospice on-call on [DATE] at 08:42 PM and the message was read by on-call nurse HRN B at 08:47 PM and HRN B ordered the medication on [DATE] at 09:16 PM. HRN A stated she did not think Resident #1 was affected by missing doses of her morphine. She said she had instructed facility staff that if Resident #1 was sleeping or was not responsive they could hold the dose and document. She stated she was surprised Resident #1 did not pass away sooner as she was in the active stage of dying. During an interview on [DATE] at 02:30 PM HRN B stated she dropped off the new bottle of morphine for Resident #1 to the facility between 12 and 12:30 AM on [DATE]. During an interview on [DATE] at 03:02 PM LVN G stated nurses and medication aides were responsible for maintaining secure storage of medication. During an interview on [DATE] at 03:05 PM ADON stated it was the responsibility of nurses to maintain secure storage of resident's medication. During an interview on [DATE] at 03:10 PM ADM stated it was the responsibility of nurses to maintain secure storage of medications. She stated the facility's investigation into the missing morphine revealed the sign in and out sheet used by the nurses when turning the cart and narcotics over to one another was missing as well making it impossible to determine which nurse had the morphine last. During an interview on [DATE] at 03:50 PM LVN F stated HRN B delivered the new bottle of morphine to the facility at about 12:30 AM on [DATE]. During an interview on [DATE] at 04:19 PM LVN G stated a possible negative outcome of morphine being misappropriated was someone could drink the whole bottle thinking it was something else. During an interview on [DATE] at 04:23 PM CNA L stated a possible negative outcome of morphine being misappropriated was it could cause behaviors and the patient suffers and can be in pain. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 04:24 PM ADON stated a resident's morphine being misappropriated was abuse and inappropriate all around. During an interview on [DATE] at 04:25 PM ADM stated a resident whose morphine was misappropriated could have increased pain and medical concerns. During an interview on [DATE] at 11:03 AM RN D stated regarding Resident #1's bottle of morphine that was missing from her cart, I don't even remember the bottle being there, I will be honest. I know they said it came a few days before and I don't have a clue what happened to it. I don't remember even counting it. I did not take it and I will lay my life on that. I know another nurse told me we counted it together one of the days before it went missing but I do not remember that to be honest. During an interview on [DATE] at 04:01 PM DON stated a possible negative outcome of a resident's morphine being misappropriated was, It could go to the wrong person; a resident would have to go without medication. He stated it was the responsibility of nurses to ensure medications are securely stored. Record review of facility policy titled Abuse, Neglect, and Exploitation and dated ,d+[DATE] revealed the following: . The facility will provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. (This policy was missing a page between point IV and point VII. This page was requested from ADM on [DATE] via email at 11:18 AM) Record review of undated facility policy titled, Abuse and Neglect Policy and Procedure revealed the following: . 1. Misappropriation of resident property - The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Record review of facility policy titled Controlled Substances and dated [DATE] revealed the following: . The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. 4. Access to controlled medications remains locked at all times and access is recorded 8. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. 12. At the End of Each Shift: a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. Record review of facility policy titled Storage of Medications and dated [DATE] revealed the following: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals used in the facility are stored in locked compartments . Only persons authorized to prepare and administer medications have access to locked medications. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended. 8. Schedule II-V controlled medications are stored in separately locked permanently affixed compartments. Access to controlled medication is separate from access to non-controlled medications.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46534 Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 24 hours if the events that cause the allegation do not involved abuse and do not result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 (Resident #2) of 5 residents reviewed for abuse/neglect. The facility failed to report an injury of unknown origin (bruising to Resident #2's chest) to the administrator and to the state within 24 hours. This failure could place residents at risk of not having incidents of possible abuse and neglect reviewed and investigated in a timely manner by the facility and state survey agency. This could place residents at risk of continued and/or unrecognized abuse or neglect. Findings included: Record review of Resident #2's admission record dated 04/25/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, congestive heart failure (a progressive heart disease that affects the pumping action of the heart muscles resulting in shortness of breath and fatigue), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), dementia (a group of thinking and social symptoms that interferes with daily functioning), chronic obstructive pulmonary disease (inflammation of lung tissue due to non-infectious causes, which results in cough without mucus or phlegm, shortness of breath, and fatigue), and chronic kidney disease (longstanding disease of the kidneys leading to kidney failure). Record review of Resident #2's Admission MDS completed on 03/27/24 revealed a BIMS of 00 which indicated severely impaired cognition. Section GG revealed Resident #2 was independently ambulatory and utilized a walker. Section N indicated Resident #2 was not taking an anticoagulant (blood thinning) medication. Record review of Resident #2's care plan with a last review/revision date of 04/25/24 revealed anticoagulation therapy as one of the approaches which was created on 04/25/24. A problem area with a start date of 04/15/24 stated Resident #2 had potential to bruise easily due to daily use of aspirin. Resident #2 was noted to have impaired cognition due to dementia and to habitually wander throughout the facility. Record review of Resident #2's active orders dated 04/25/24 revealed an order for aspirin delayed release 81 mg once a day in the morning with a start date of 03/13/24. Record review of Resident #2's progress notes dated 04/29/24 revealed the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 04/14/24 at 10:35 AM written by LVN H which stated Resident #2 had bruising to her chest which measured 3 inches wide by 7 inches long. Resident was unable to tell LVN H what happened to her chest. A progress note dated 04/15/24 at 11:28 AM written by DON which stated he was notified of the bruise to Resident #2's chest and called the Nurse Practitioner and family member of Resident #2 to inform them of the bruise. Record review of facility's investigation of Resident #2's bruise revealed it was reported to State authorities on 04/15/24 at 01:32 PM. Staff interviews attached to the facility's investigation revealed two CNAs and one LVN noticed the bruise on the evening of 04/13/24 but did not report it to anyone or document it in the progress notes. Staff interviews also revealed 3 CNAs, 1 LVN, and 1 RN noticed the bruise on Sunday 04/14/24. The LVN was LVN H. She recorded the bruise and its measurements in the progress notes. Record review of facility's in-service for staff on reporting following the failure to report Resident #2's bruise revealed a sign-in sheet attached to facility's Abuse/Neglect policy. This policy did not include any information regarding reporting of abuse or neglect. The policy skipped from point IV to point VII. This page was requested from ADM on 05/02/24 via email at 11:18 AM. ADM failed to provide missing information from the policy. During an interview on 04/24/24 at 08:51 PM CNA I stated she received an in-service over the phone regarding who to report injuries of unknown source to when she noticed any on a resident. She stated she was trained to tell the charge nurse about the injury and if the charge nurse did not handle it correctly by reporting it to the ADM, she was to go over the head of the charge nurse and tell ADON, DON, or ADM. During an interview on 04/24/24 at 08:56 PM CNA J stated she received an in-service over the phone regarding reporting resident injuries to her charge nurse and up the chain of command from there if need be. During an interview on 04/24/24 at 09:20 PM MDS LVN stated the facility was unsure how Resident #2 got the bruise to her chest. She stated she noticed Resident #2 scratching her chest in the dining room a few days before the bruise was discovered. During an interview on 04/24/24 at 09:20 PM ADON stated when staff notice an injury of unknown source like Resident #2's bruise, They should report it to abuse coordinator as soon as they see it. She said ADM was the abuse coordinator. She stated the facility in-serviced all staff following the failure to report Resident #2's bruise. She stated the in-service included who to tell about injuries of unknown source and how to properly document the injury by creating an event in the EHR. During an observation on 04/25/24 at 08:33 AM Resident #2 was lying on her back on her bed which was in lowest position with HOB slightly raised. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/25/24 at 11:33 AM Resident #2's family member stated she had no concerns with the care the facility provided. She stated Resident #2's bruise seemed to be from lying on her side to sleep as it was a line down her sternum. Resident #2's family member stated Resident #2 bruised very easily and mentioned a bruise on Resident #2's hand from a recent stay in the hospital and an IV she had while there. During an interview on 04/25/24 at 12:02 PM CNA K stated she recently received an in-service on reporting injuries of unknown origin. During an interview on 04/25/24 at 01:25 PM CNA M stated she recently received an in-service on reporting injuries of unknown origin to the nurse. During an interview on 04/25/24 at 02:02 PM CNA N stated he noticed the bruise to Resident #2's chest on 04/15/24 when Resident #2 approached the nurses' station wearing a low-cut nightgown. He stated he received an in-service regarding reporting injuries of unknown source to the nurse on duty. During an interview on 04/29/24 at 12:46 PM LVN H stated Resident #2 was at the nurses' station in a nightgown with a V-shaped collar on 04/15/24. She stated one of the CNAs told her about the bruise, so she looked at it and documented it in the progress notes. She stated the bruise was long and narrow. LVN H stated she received an in-service over the phone the next day about how to document and report injuries of unknown source. During an interview on 04/29/24 at 03:00 PM CNA Q stated she had worked for the facility for 5 days. She stated she was trained to report injuries of unknown source to her charge nurse but if her charge nurse did respond she was to report to the other nurse on duty, ADON, DON, or ADM. During an interview on 04/29/24 at 03:02 PM LVN G stated she would access an injury of unknown source and then report it to ADON, DON, or ADM. She stated not reporting or documenting an injury of unknown source correctly could cause it to get worse as staff would not know to keep an eye on it. During an interview on 04/29/24 at 03:05 PM ADON stated a possible negative outcome of staff not reporting and documenting injuries of unknown source correctly was resident's family members might think they are being abused. During an interview on 04/29/24 at 03:06 PM CNA L stated a possible negative outcome of not reporting injuries of unknown source was, A patient could be hurt, and the state could get called. She stated she would report an injury of unknown source to her charge nurse, ADON, DON, or ADM. During an interview on 04/29/24 at 03:10 PM ADM stated she expected her staff to report injuries of unknown origin to their supervisors and the supervisors would report to her as she was the Abuse Prevention Coordinator. She stated since Resident #2's bruise she, ADON, and DON had in-serviced all staff on how to document and report injuries of unknown origin and changes of condition. She stated a possible negative outcome of staff not reporting injuries of unknown origin was further injury to the resident. She said her investigation into Resident #2's bruise revealed the resident bruises easily and was rubbing on her chest a few days prior to the bruise appearing. She stated she spoke to staff about documenting any changes in skin condition including reddening as one staff member mentioned noticing a redness to Resident #2's chest the day before the bruise was noted. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/24 at 04:01 PM DON stated a possible negative outcome of an injury of unknown source not being reported and documented correctly in the EHR was the injury could get worse if not treated. Record review of facility policy titled Abuse, Neglect, and Exploitation and dated 10-2023 revealed the following: . B. Possible indicators of abuse include, but are not limited to: . 3. Physical injury of a resident, of unknown source . (This policy was missing a page between point IV and point VII. This page was requested from ADM on 05/02/24 via email at 11:18 AM) Record review of facility policy titled, Change in a Resident's Condition or Status revealed the following . Our facility promptly notifies the resident, his or her attending physician, health care provider and the resident representative of changes in the resident's medical/mental condition and/or status . 1. The nurse will notify the resident's attending physician, health care provider or physician on call when there has been a . b. discovery of injuries of an unknown source . 4. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. Record review of undated facility policy titled, Abuse and Neglect Policy and Procedure revealed the following: . An investigation will be performed on all suspected and reported allegations of abuse or any occurrences of bruising or other injuries of unknown cause. 1. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source or abuse is reported the facility Administrator, or his/her designee, will notify the Department of Aging and Disabilities Services (Immediately upon learning of the incient and a written investigation no later than the fifth working day safter the oral report. CMS believes immediately means as soon as possible, but ought not to exceed 24 hours after discovery of the incident.) The following persons or agencies will be notified of such incident when appropriate: . State Licensing and Certification Agency . h. Injuries of unknown source - An injury should be classified as an 'injury of unknown source' when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident The injury is suspicious because of the extent of the injury or the location of the injury .

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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. 46534 Based on observation, interview, and record review the facility failed to store all drugs and biologicals in accordance with State and Federal laws in locked compartments for 1 (200 hall cart) of 3 medication carts reviewed for medication storage. The facility failed to lock the medication cart in hall 200. This failure could place residents at risk for obtaining medications not prescribed to them and experiencing adverse reactions. Findings Included: During an observation on 04/24/24 at 08:49 PM the medication cart in hall 200 was unlocked. All three drawers were easily opened and full of medications. The double locked drawers to the right of the medication cart were unlocked on the first lock but the second lock of each drawer was still locked. A resident was awake and seated in his recliner in his room in line of sight of the medication cart. No staff members were in sight. During an observation on 04/24/24 at 08:54 PM the unlocked medication cart in hall 200 was unattended and no staff members were in sight. During an interview and observation on 04/29/24 at 03:02 PM LVN G stated an unlocked medication cart could lead to residents taking medication that was not prescribed to them. She stated it was the nurse's responsibility to keep the medication cart lock and medications secured. During an interview on 04/29/24 at 03:05 PM ADON stated if a medication cart was left unlocked residents could get hold of medication. She stated it was the responsibility of nurses to keep the medication carts locked when not in use. During an interview on 04/29/24 at 03:06 PM CNA L stated if a medication cart was left unlocked patients have access to meds and staff freely have access to meds. She stated, Someone can get poisoned. During an interview on 04/29/24 at 03:10 PM ADM stated if a medication cart was left unlocked medications could be taken and residents might not be able to receive the medications they have been prescribed. She stated the facility was responsible for the overall security of medication we have been entrusted with. During an interview on 04/29/24 at 03:50 PM LVN F stated it was the responsibility of the nurse to keep the medication cart locked. She said if a medication cart was left unlocked medications could be taken. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455989	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Borger Healthcare Center	1316 S Florida Borger, TX 79007

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	During an interview on 04/30/24 at 11:03 AM LVN D stated it was the nurse's responsibility to keep medication carts locked to keep residents out of the medication. During an interview on 05/01/24 at 04:01 PM DON stated he did not remember leaving the medication cart unlocked during the evening of 04/24/24. He stated nurses were responsible for ensuring medication carts were locked. DON stated a possible negative outcome of an unlocked medication cart was anyone could get in the medication cart. Record review of facility policy titled Controlled Substances and dated April 2019 revealed the following: . The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Record review of facility policy titled Storage of Medications and dated November 2020 revealed the following: . The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals used in the facility are stored in locked compartments . Only persons authorized to prepare and administer medications have access to locked medications. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.