STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675222	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seabreeze Nursing and Rehabilitation	6602 Memorial Dr Texas City, TX 77590

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44241 Based on interview, and record review the facility failed to ensure the residents were being properly supervised to prevent accidents and hazards. The facility staff failed to ensure resident's environment was safe and free from any potential harm. LVN-B did in fact bring in a weapon namely a pellet gun into the facility. The facility failed to ensure that facility staff were trained on how to properly ensure the resident environment remains as free of accident hazards as possible. Findings include: Record review of Resident #1's care plan dated 12/05/2024 revealed Resident#1 was care planned for falls and that his medication should be administered to him as prescribed by his physician. In an interview with CNA-A on 02/06/25 at 11:50am CNA-A said that on 02/05/25 on the overnight shift she asked LVN B if she had the keys to the CMA medication cart. CNA-A said that LVN-B told her no and that when CNA-A said that she saw LVN-B sticking something in her pocket. CNA-A said she asked LVN-B what you put in your pocket. CNA-A said that's when LVN-B put a gun on the counter and said this is what I have. In an interview with DON on 02/06/25 at 1:20pm she said that LVN-B told her that she went to her car to get her bag and that when she returned to the nurse's station, she realized that the gun was in her bag. The DON said that LVN-B told her that it was a pellet gun. The DON said that she does not consider the gun to be lethal because it is a pellet gun. In an interview with Administrator on 02/06/25 at 2:15pm he said that he wasn't made aware by his DON that there was an accusation of a gun being in the facility until 02/05/25. And that he was investigating to see if the accusation was true. He said that any kind of weapon should not be at the facility. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN-B on 02/06/25 at 2:52pm she said I went to my car to get my bag that I carry my computer in and when I got back to the nurse's station and looked in my bag I realized that the gun was in my bag. LVN-B said she removed the gun from the bag and put it in her pocket to take it back to her car when LVN-A and CNA-A accused her of having keys. She said that she told them that she did not have the keys and that she slowly stood up and showed them the gun. LVN-B said she put the gun in her bag and took it to her car. Record review on 02/06/25 of the facilities' policy Professional Behavior dated 12/2019 reflected that staff should not be in Possession of a firearm or other weapons and dangerous devices on facility property.

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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 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** 44241 Based on interview, and record review the facility failed to ensure that Resident#1 medications were properly stored. The facility staff failed to ensure that resident's medication was stored and secured in a secure manner. LVN-A did not secure her keys, nor did she ensure that the med room was secure. As a result, Norco drugs were unaccounted for. This failure could place residents at risk of not having their prescribed medications given to them as directed according to physician orders. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included major depressive disorder, bipolar disorder, dementia, shortness of breath, and congestive heart failure. Review of Resident #1's Quarterly MDS (Minimum Data Set) dated 01/11/25, section C revealed a BIMS (Brief Interview for Mental Status) score of 14. Record review of Resident #1's care plan dated 12/05/2024 revealed Resident#1 was care planned for falls and that his medication should be administered to him as prescribed by his physician. Record review of Narcotic sheet for the CMA cart on 02/06/25 at 1:30pm reflected that on 02/05/25 that six pills were missing from Resident#1 Narcotic blister pack. Record review of physician orders dated 12/26/24 on 02/24/25 for Resident#1 narcotic medication Hydrocodone 325mg tablet reflected that medication should be given by mouth 1 tablet every eight hours as needed. - In an Interview with staffing coordinator on 02/06/25 at 12:18pm,. the staffing coordinator said that she received a call on 02/05/25 from LVN-B and LVN-B told her that LVN-A and CNA-A accused her of taking keys to the CMA medication cart. The staffing coordinator said that when she got to the facility, she got LVN-B's keys so that a count of LVN-B medication cart could be conducted. The staffing coordinator said that she and the DON counted LVN-B medication cart and the count was good. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with DON on 02/06/25 at 3:05pm the DON said that she received a call the morning of 02/05/25 at about 4:47am from LVN-A informing her that Norco medication was missing. The DON said that she immediately called the facility and told no one to leave until she arrives. The DON said that when she arrived, she had her staffing coordinator to get all nurses keys. The DON said at that point she and the staffing coordinator began to count meds and that all meds cleared except for LVN-A's. The DON said that a total of six hydrocodone pills were missing. The DON said she drug tested all staff and everyone passed. The DON said she called the local police and when they arrived, she informed them of the missing pills. In an interview with LVN-A on 02/06/25 at 4:42pm LVN-A said that when she came on duty the day of 02/04/25 that her nursing cart medication count cleared. And that at 9:00pm her CMA medication count cleared. LVN-A said that at 12:00am she gave meds to Resident#1 out of the CMA medication cart. LVN-A said that she then put the keys to the CMA cart in the med room on top of the CMA cart in a binder. LVN-A said that the CMA box is locked but the med room where the cart was kept was not locked. LVN-A said that at 4:50am she went back to the med room to get meds out of the CMA cart and when she opened the cart, LVN-A noticed six pills missing. LVN-A said that she immediately called the DON, and the DON told her to tell all staff not to leave. LVN-A said that she along with other staff were given a drug test. LVN-A said the DON informed her that everyone had tested negative, and the DON asked for statements from staff. In an interview with CMA-A on 02/06/25 at 5:32pm CMA-A said that at the end of her shift, that she and LVN-A counted the CMA medication cart at 9:15pm the night 0f 02/04/25 and that there were no missing medications. Record review of the facilities' medication policy on 02/06/25 at 5:00pm dated 06/01/22 reflected that All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/aide.