

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER The Oaks at Radford Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 725 Medical Dr Abilene, TX 79601	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>44728</p> <p>Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in permanently affixed compartments during medication storage inspection for 1 (cart #2) of 2 medication carts reviewed for storage.</p> <p>The facility failed to ensure medication cart #2 was locked and secured while unattended.</p> <p>This failure could result in a drug diversion.</p> <p>Findings included:</p> <p>During an observation on 12/17/2024 at 11:29 am, the medication cart #2 was observed to be unlocked with residents and visitors within 10 feet of the cart and within eyesight.</p> <p>During an interview on 12/17/2024 at 11:29 am, the ADMN asked was this medication cart left unlocked? He stated he had not known who was responsible for the opened medication cart. The ADMN stated it should have been locked at all times while not in use.</p> <p>During an interview on 12/17/2024 at 11:32 am, LVN A stated she was responsible for the medication cart, and it should have been locked. She stated she had left the medication cart to go help a CNA with resident care and had forgotten to lock it. LVN A stated the medication cart should have been locked so residents, along staff and visitors could not have access and take anything out. She stated if residents had done so, they could have taken medications. LVN A stated she felt the narcotic were safe due to them being under one lock. She stated it would not have created a possible drug diversion due to those only pertained to narcotics.</p> <p>(continued on next page)</p>

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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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/17/2024 at 4:48 pm, the DON stated nurses were to keep medication carts that included medications, scissors and syringes locked at all times. She stated it was a matter of safety, as anyone could have gotten into the cart. She stated staff should always take the time to lock the carts at all times. The DON stated it was herself as well as the ADON who monitored the carts. She stated the negative impact to resident could have been someone taking medicine other than their own which could have been detrimental to the resident with having had a reaction. She stated it would be the same for staff or visitors as well. The DON stated she was not sure where the failure occurred, but possibly education or LVN A had been in a hurry. She stated her expectations were to keep medications as well as scissors and syringes always to be locked behind closed doors.</p> <p>During an interview on 12/17/2024 at 5:22 pm, the ADON stated the protocols for medication carts were to be locked when not in used. She stated it was herself as well as the DON who monitored the medication carts with randomly spot-checked staff and carts. The ADON stated the negative impact to resident was that someone could get into the medications causing the possibility of a reaction, poisoning themselves or others. She stated if anyone took medications that would be a drug diversion which would have included all medications, not only the narcotics. The ADON stated the failure occurred, with nervous energy. She stated her expectations were for all medication carts to remain locked and for the nurses to secure them when away from them.</p> <p>Record review of facility policy Security of Medication Cart dated 12/17/2024 revealed:</p> <p>Policy Statement The medication cart shall be secured during medication passes.</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 2. The medication cart should be parked in the doorway of the resident's room during the medication pass. The cart doors and drawers should be facing the resident's room. 3. When it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall with doors and drawers facing the wall. The cart must be locked before the nurse enters the resident's room. 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurses' station or in the medication room. 		