

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2025
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1405 E Washington Navasota, TX 77868	

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. (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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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications and biologicals were stored in locked compartments for one of three ([NAME] Hall) medication carts reviewed for medication storage. The facility failed to ensure [NAME] Hall medication cart was locked and medications were secure and not accessible to other staff, resident, or visitors. This failure could place residents at risk of having unauthorized access to prescription, biologicals, and over-the-counter medications. Findings included: Observation on 07/01/2025 at 8:35 AM revealed an unlocked medication cart 1 across from station one nurses station and near the entrance to [NAME] hallway. The back of the cart was against the wall with the drawers facing the nurse's station. The locking mechanism was protruding outward on the medication cart. The state surveyor opened the drawers and captured photos. The nursing staff or any staff was not near the nurse's station or the unlocked medication cart. Observation on 07/01/2025 at 8:43 AM revealed RN A walking from the Mc [NAME] Hall toward the unlocked medication cart 1. Interview on 07/01/2025 at 8:44 AM RN A stated he did leave the medication cart unlocked. He stated he was in a resident room assisting with a transfer. He stated the medication cart was not in view where he was in a resident room. Interview on 07/01/2025 at 9:10 AM RN A stated the medication cart was to always be locked except when he was dispensing medications from the medication cart. He stated it was his responsibility to ensure the medication cart was locked and secure. RN A stated the key to the medication cart was in his pocket. He stated if residents had accessed the medication cart they could have overdosed, taken wrong medication, had an allergic reaction, and could require admission to the hospital. He stated he had previously been in-serviced on locking the medication carts and could not recall the specific date. He stated he was aware the medication cart should have been locked. RN A stated the narcotics was locked in the medication cart 1. He stated there was PRN medications, glucose monitor, and blood pressure cuff. Interview on 07/01/2025 at 4:45 PM the Director of Nurses stated her expectation was for all medication carts to be locked when the nurse was not administering medications. She stated the staff had been in-serviced on securing the medication carts when not in use. The Director of Nurses stated she did not the exact date of the in-service. She stated residents, other staff, and visitors would have access to the medications in the unlocked medication cart. She stated if a resident ingested medications not prescribed to them, there was a potential the resident may have an allergic reaction or may need to be admitted to the hospital. She stated it was the nurse responsibility to ensure the medication cart was locked when not dispensing a resident's medication. The Director of Nurses stated she was responsible for monitoring the nurse supervisor. Interview on 07/01/2025 at 5:05 PM the Administrator stated her expectations was for the medication carts to be locked when the nurses were not administering medications from the carts. She stated there was a possibility a resident may get medications out of the medication cart. The Administrator stated if a resident did take the medications by mouth there was a possibility a resident may have an allergic reaction. She stated it depended on the medication the resident ingested. She stated the nurse assigned to the medication cart was responsible for locking the medication cart after administering medications to a resident. The Administrator stated the Director of Nurses was responsible to monitor the nurse supervisor. Review of the facility's Policy on 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. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access.</p>		