STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675399	A. Building B. Wing	06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Navasota Nursing & Rehabilitation	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. Based on observation, interview, and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to 1 of 3 medication carts (Medication Cart #1) reviewed for drug storage and labeling.The facility failed to ensure Medication Cart #1, was locked, medications secured, and not accessible to other staff, residents, or visitors and was left unlocked by RN A two times at 6:49 a.m. and 7:30 a.m. on 06/23/2026.This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings include: Observation of Station 3 hall Nurses Station on 06/23/2026 at 6:49 a.m., revealed Medication Cart #1 was facing toward the hall area near the nurses' station. There were not any staff in the hall or near the nurse's station. RN A exited a room approximately 6:55 a.m. on 300 hall and walked toward the nurse's station to the unlocked medication cart. Interview with RN A on 06/23/2026 at 6:51 a.m., stated she was trained on medication storage. She stated the nurse or medication aide who was working on the cart was responsible for locking the medication cart. RN A stated if the staff left the medication cart unlocked and unattended a resident, staff or a visitor could get into the medication cart and take medication that did not belong to them. RN A stated there was a possibility that a resident may have an allergic reaction if ingested medication ordered for another resident. She stated it was a possibility a resident may need to be transferred to emergency room for an evaluation. She stated she had been in-serviced on locking medication carts however; she did not recall the date or time. Observation of Station 3 hall Nurses Station on 06/23/2026 at 7:30 a.m., revealed Medication Cart #1 was facing toward the hall area near the nurses' station. There was not any staff in the hall or near the nurse's station. RN A exited a room approximately 6:55 a.m. on 300 hall and walked toward the nurse's station to the unlocked medication cart #1. Interview on 06/23/2026 at 7:33 a.m., RN A stated she forgot to lock the medication cart. She stated she had been in-service on locking medication cart however; she did not recall the date or time. She stated a staff, a resident or a visitor had opportunity to obtain medications from the med cart. She stated she did not know why she forgot to lock the medication cart for the second time. Interview with the Director of Nurses on 06/23/2026 at 3:00 p.m., she stated all medication carts was expected to be locked when the med-aide or nurse was not standing in front of the medication cart. She stated if the medication cart was left unlocked and unattended, a resident could get into the medication cart and take medications. She stated there was a possibility a resident may become severely ill such a low blood pressure if the resident ingested numerous blood pressure pills. She stated a resident may need to be admitted to hospital for further evaluation. She stated nurse leadership was to monitor by doing observations and in-service training. She stated she did not know why RN A left the medication carts unlocked two times on 06/23/2026. Requested in-service records for locking medication cart and these was not provided prior to exit. Interview with the Administrator on 06/23/2026 at 4:00 p.m., stated the medication cart was to always be locked. She stated no matter what time of day the medication cart should be locked. She stated the nurse or (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication aid who was on the medication cart were responsible for ensuring the medication cart was locked. The Administrator stated if the medication cart was left unlocked and unattended a resident could take medication that was harmful to them and the resident may need medical attention from the hospital. She stated she did not know why RN A left the medication cart unlocked. She stated the staff had received in-services on locking medication cart. Requested the Facility's Locking Medication Cart Policy, dated 2025, reflected Medications and biologicals are stored, safely, 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. Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.