

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/26/2025
NAME OF PROVIDER OR SUPPLIER  Ralls Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  1111 Avenue P Ralls, TX 79357	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on Observations, interviews and record review the facility failed to ensure that residents were free of significant medication errors for 1 of 1 resident (Resident #1), reviewed for pharmacy services. The facility failed to ensure Resident #1 was free of significant medication errors when MA B administered Tegretol 200mg (prescribed for seizures, bipolar disorder, and nerve pain), Lipitor 40mg (prescribed to lower cholesterol), Baclofen 10mg (muscle relaxer), Metoprolol 25mg (prescribed to lower blood pressure), Neurontin 300mg (prescribed for seizures and nerve pain), Quetiapine Fumarate 200mg (medication prescribed for bipolar disorder and schizophrenia) to Resident #1 on 10/13/25, when these medications were prescribed to another resident. This failure could place residents at risk of adverse reaction related to taking medications not ordered by the physician. Findings Included: Record review of Resident #1's undated face sheet revealed a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included: Alzheimer's disease with early onset (loss of cognitive functioning), essential hypertension (high blood pressure), cognitive communication deficit (inability to communicate clearly), Intermittent Explosive Disorder (mental health condition characterized by sudden, intense episodes of anger or aggression), psychotic disorder with hallucinations due to known physiological condition (mental health disorder), dry eye syndrome of bilateral lacrimal glands (dry eyes), acute atopic conjunctivitis, right eye (infection in the eye), and muscle weakness. Record review of Resident #1's annual MDS, dated [DATE] revealed a BIMS score of 99, which indicated the resident's cognitive status could not be determined using the BIMS assessment. Record review of Resident #1's physician orders dated 10/16/25, did not reveal orders for Tegretol 200mg, Lipitor 40mg, Baclofen 10mg, Metoprolol 25mg, Neurontin 300mg, Quetiapine Fumarate 200mg. Record review of physician orders did not reveal any new orders regarding the medication error. Record review of Resident #1's Medication Administration Record, dated 10/01/25-10/31/25, did not reveal physician ordered medications for Tegretol 200mg, Lipitor 40mg, Baclofen 10mg, Metoprolol 25mg, Neurontin 300mg, Quetiapine Fumarate 200mg. Record review of Resident #1's Medication Error Report, dated 10/13/25, revealed Resident #1 was given the wrong medication on 10/13/25 at 15:20 (3:30 PM). Record review of Progress notes dated 10/13/25, revealed in part, on 10/13/25 the ADON noted she was advised by MA B that he had given Resident #1 the wrong medications at 15:20 (3:30PM). Record review of Progress notes dated 10/13/25, revealed in part, on 10/13/25 the LVN A noted she was instructed to contact emergency medical services to have Resident #1 transferred to the local hospital at 21:45 (9:45PM). Record review of hospital records, dated 10/14/25, revealed Resident #1 was admitted into the hospital for close monitoring. During an interview on 10/16/25 at 09:30 AM, the ADM said MA B gave Resident #1 the wrong medications. The ADM said the MD was notified and instructed staff to monitor the resident but later instructed staff to send Resident #1 to the hospital. The ADM said Resident #1's vitals were stable when EMS arrived, however Resident #1 was transferred to the hospital as per physician orders. The ADM said Resident #1 returned to the facility on [DATE] with no additional orders. During an observation and interview on 10/16/25 at 11:40 AM, Resident #1 was observed rolling up and down the facility hallways holding a shirt. She said she was doing good. She said she needed a shirt for work and then she rolled away. Resident #1 was active and alert. During an observation and interview on 10/16/25 at 2:48 PM, Resident #1 was observed at the nurse station talking with staff. During an interview on 10/16/25 at 3:45 PM, MA B said Resident #1 was having behaviors and hollering in the dining room when he was passing out medications. He said he was parked with the medication cart in front in the nurses station when the ADON brought Resident #1 by the nurse station. MA B said he became irritated as he had verbalized before that he did not like when they set the residents around him when he prepared medications because it caused him to become distracted. He said he mistakenly gave Resident #1 the wrong medications. He immediately realized the mistake and reported it to the ADON and the DON. During an interview on 10/16/25 at 4:26 PM, the ADON said she was in the medication room when she heard Resident #1 hollering. She said Resident #1 indicated she wanted to be moved to the area by where the medication cart was by pointing her finger in that direction when she parked her there, then she went back to the office to continue working. She said MA B was at the medication cart passing out medications. She said MA B told her he gave Resident #1 the wrong medication. She said the MD instructed staff to monitor Resident #1. She said she had received training on and in-services on medications pass. She said staff were provided in-services and completed competency</p>		