STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675540	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liberty Health Care Center	1206 N Travis St Liberty, TX 77575

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, 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 the keys for one of nine residents (Resident #2) reviewed for pharmacy services. The facility failed to ensure Resident #2 took her morning medications and the medications were not left in her room, unsecured, on her bedside table on 02/10/26. This deficient practice could place residents at risk of not being monitored for their medications, adverse reactions, and drug diversion.Findings included: Record review of Resident #2's face sheet, dated 01/11/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included delusional disorder (a type of serious mental illness characterized by holding one or more firm, false beliefs) and schizophrenia (mental health condition that affects everything from how you think, to how you feel, and how you behave). Record review of Resident #2's quarterly MDS assessment, dated 02/08/26, reflected she had a BIMS score of 14, which indicated her cognition was intact, and she was independent for functional abilities. Record review of Resident #2's Care Plan, on 02/11/26, reflected no evidence that Resident #2 could self-administer her medications or keep medications in her room. Record review of Resident #2's Medication Administration Record, dated printed 02/11/26, reflected four different medications (six tablets) were signed off as given that morning of 02/10/26 (exact times were not listed). During an observation and interview on 02/10/26 at 10:02 AM, a small medication cup was sitting at Resident #2's bedside and Resident #2 stated they (the medications) have not been here long.I need to take them. She immediately sat up, grabbed the medications, and took them herself. She stated she must have been asleep, and they were not able to wake her up. She stated medications were not left on her bedside table often. During an interview with RN A on 02/11/26 at 10:21 AM, she stated the medication administration process was to check the medication administration record to verify the resident, and the medications that were to be administered. She stated she would stay until the resident took the medication. She stated medications should not be left in the room. She stated at times, residents would not want to take them immediately and would be upset, but they had to say no and stay in the room until the resident took the medication. She stated the failure could cause a different resident to pick up the medications, the medications could end up in the wrong hands, or the resident might miss a dose. She stated registered nurses, licensed vocation nurses, and medication aides were responsible for medication administration. During an interview with LVN B on 02/11/26 at 11:06 AM, she stated she would pull up the medication administration record to verify medications and the residents. If she did not know the resident, she would compare the picture in the record to the resident and ask them to state their name. LVN B stated she would never leave medication with (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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(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	the residents; that is a big no. She stated, I tell them I can't leave meds with them. LVN B stated registered nurses, licensed vocational nurses, and medication aides were responsible for medication administration. She stated the failure could be the resident could miss a dose. During an interview with the DON on 02/11/26 at 01:02 p.m., she stated nurses or medication aides passed medications. She stated they looked at the medication administration record to verify medications, and popped them out into a cup. She stated the staff go to the bedside, and verify the correct resident, right medication, and right route. She stated medications were never to be left with a resident and they knew that. She stated that failure could cause the residents to not receive their medications or someone else might get them. She stated all staff have been in-serviced on medication administration. Related trainings were requested by email from the Administrator on 02/11/26 at 02:11 p.m.; none were received upon exit. Record review of the facility's policy Medication Administration, dated February 2023, reflected Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice.16. Observe resident consumption of medication. Record review of the facility's policy Medication Storage, dated February 2023, reflected It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.