STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675637	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wooldridge Place Nursing Center	7352 Wooldridge Rd Corpus Christi, TX 78414

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 2 of 4 medication carts reviewed for labeling and storage. The facility failed to ensure the 100 Hall Nurse Medication Cart belonging to LVN-A and the 100 Hall Nurse Medication Cart belonging LVN-B were locked and secured. This failure could place the residents at risk of gaining access to unlocked medications which were not prescribed to them.The findings included:Observation on 12/17/2025 at 8:14 AM revealed an unlocked med-cart belonging to LVN-A parked in the 100 Hall with no nurses or other staff around it. The keys for the medication cart were sitting on top of the medication cart. There were residents noted to be walking and passing by. The med-cart lock was popped out, and all drawers were able to be opened and accessed. The med-cart was full of medications, including narcotics.In an interview on 12/17/2025 at 8:15 AM, LVN-A stated the med-cart observed unlocked was her med-cart, and she had forgotten to lock it and put the keys away before she walked away. She stated the med-cart should always be locked when not in use because if it was left unlocked residents could get into it and get medications out which did not belong to them, which could cause them harm. She stated the keys left in the med-cart contained the regular med-cart key, as well as the key to the narcotic box inside the med-cart. LVN-A stated it was the responsibility of the nurse who was working the med-cart to keep up with the keys for this med-cart and to ensure the med-cart remained locked when not in use.Observation on 12/17/2025 at 4:36 PM revealed an unlocked med-cart belonging to LVN-B parked in the 100 Hall with no nurses or other staff around it. The keys for the medication cart were sitting on top of the medication cart. There were residents noted to be walking and passing by. The med-cart lock was popped out, and all drawers were able to be opened and accessed. The med-cart was full of medications, including narcotics.In an interview on 12/17/2025 at 4:36 PM, LVN-B stated the med-cart observed unlocked at this time was her med-cart, and she got in a hurry to check on a resident, and she had forgotten to lock the cart and put the keys away before she walked away. She stated the med-cart should always be locked when not in use because if it was left unlocked residents could get into it and ingest medications which did not belong to them, and this could cause them harm, or even death. LVN-B stated the keys left on the med-cart contained the regular med-cart key, as well as the key to the narcotic box inside the med-cart. LVN-A stated it was the responsibility of the nurse who was working the med-cart this shift to keep up with the keys for their med-cart and to ensure the med-cart remained locked when not in use.In an interview on 12/17/2025 at 2:02 PM, the ADON stated it was the nurse's responsibility to keep her medication cart locked and keep up with the keys which went to her medication cart. She stated if the medication carts were left unlocked, residents could have gotten into the carts and taken medication which did not belong to them, and it could have harmed them. She stated the nurses knew this because they had been in-serviced over this topic.In an interview on 12/18/2025 at 8:35 AM, the Administrator stated he had been made aware of the medication carts being left unlocked. He stated it was the nurse's responsibility to keep up with the keys for their med-cart they were working with for that shift, as well as be sure the med-cart was locked every time they stepped away from it. The Administrator stated if the med-carts were not kept locked then residents or anyone else could have gained access to the cart and taken medication which did not belong to them, which could harm them, or even cause death. The Administrator stated the nurses had recently been in-serviced regarding this, and he had already started another in-service regarding the issues with locking the med-carts and wearing/protecting the keys to the med-carts. Record review of the facility's Storage and Expiration Dating of Medications and Biologicals Policy, revised August 2022, revealed Medication and Storage Quick Reference Guide: Medication Cart Security and HIPAA: Med-carts were locked when unattended. Med storage keys were retained by designated staff. Controlled medication must be stored separately, double locked, permanently affixed compartments.