STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675703	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cross Timbers Rehabilitation and Healthcare Center	3315 Cross Timbers Rd Flower Mound, TX 75028

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the interdisciplinary team determined if a resident was able to self-administer medications d for 1 of 5 residents (Resident #1) reviewed for resident rights. The facility's interdisciplinary team failed to ensure Resident #1 was clinically appropriate to self-administer Systane ophthalmic eyedrops that were at the resident's bedside. The failure had the potential to place residents at risk for unsafe drug administration. Findings included:Record review of Resident #1's admission MDS, dated [DATE], reflected Resident #1 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's BIMS score of 14, which indicated his cognition was intact. Resident #1's MDS was pending completion. Record review of Resident #1's Baseline Care Plan, admission date 10/04/25, reflected Section D. Medications revealed Resident #1 was not able to self-administer any medications. Record review of Resident #1's clinical records reflected no assessment was completed to indicate if Resident #1 was able to self-administer medication. Record review of Resident #1's order summary report reflected the following: Systane Ophthalmic Solution 0.4-0.3 % (Polyethylene Glycol-Propylene Glycol (Ophth)) Instill 2 drop in both eyes at bedtime for dry eyes Start date 10/04/25. Record review of Resident #1's order summary reflected Resident #1 had a new order for Systane Ophthalmic Solution 0.4-0.3 % (Polyethylene Glycol-Propylene Glycol [Ophth]) Instill 2 drop in both eyes at bedtime for dry eyes able to keep at bed side for self-administer and Artificial Tears Ophthalmic Solution (Artificial Tear Solution) Instill 2 drop in both eyes every 6 hours as needed for dry eyes able to keep at bed side and self administer Start Date: 10/08/25. Observation and interview on 10/08/25 at 10:21 AM, revealed Resident #1 had a bottle of Systane Ophthalmic Solution (eye drops) at his bedside table and an unopen bag with a box inside which contained Artificial Tears Ophthalmic Solution (eyedrops). Resident #1 stated she had the bottles since being admitted on [DATE], she stated staff had not mentioned anything about her eyedrops. Resident #1 stated she administered the eye drops at bedtime. She stated staff did not come by to ensure if she put them in. She stated she was not sure if staff knew she had them, but they never took them away from her bedside table, she stated I think they trust me. Interview on 10/08/25 at 10:40 AM, RN A revealed he was the nurse assigned to Resident #1. He stated he was not sure if he had residents who could self-administer eyedrops. RN A observed eyes drops at Resident #1's bedside table, he stated he did not observe the eye drops when he completed his rounds. RN A reviewed Resident #1's orders and stated the resident only had one order for eye drops to be administered at bedtime. He stated he was not aware Resident #1 had another bottle of artificial tear ophthalmic solution. RN A stated someone from the night shift might have left the eyedrop solution in the resident's room. Interview on 10/08/25 at 2:24 PM, ADON B revealed residents were able to self-administer eye-drop medications only if they were assessed and obtained a physician's order to self-administer and to keep medications at the bedside. She stated she was not aware of any residents who could self-administer eye drop medication. She stated expectations were for nurses to assess the residents to ensure residents were able to self-administer and obtain an order. ADON B stated there was no potential risk for the resident to self-administer and to keep eye drops at the bedside; however, the eye drops would need to be removed until the assessment was completed on the resident. Interview on 10/08/25 at 2:39 PM, LVN C revealed she was the 2:00 PM-10:00 PM nurse assigned to Resident #1 on 10/07/25. She stated she was not sure if she had any residents who could self-administer eye drops and keep them at the bedside. She stated the Medication Aides administered eye drops to residents, but she could not recall which Medication Aide was assigned to Resident #1. LVN C stated they had to first determine if a resident could self-administer eye drops. She stated she did not observe any eye drops at the resident's bedside during her shift for Resident #1. Interview on 10/08/25 at 2:45 PM, MA D revealed she was the 2:00 PM-10:00PM Medication Aide assigned to Resident #1 on 10/07/25. She stated Resident #1 kept her eye drops at her bedside and kept them at her bedside since admission. MA D stated Resident #1 had an order for the eyedrops, and the resident self-administered her own eye drops. She stated by the time she followed-up with Resident #1 at bedtime to ensure she administered the eyedrops the resident confirmed she had administered them. MA D stated no one had mentioned anything to her regarding whether Resident #1 could keep the eyedrops at her bedside or if she could self-administer them. She stated she assumed Resident #1 had an order to self-administer the eyedrops and to keep the eyedrops at her bedside. MA D stated she should had checked to ensure resident had orders to self-administer. She