STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675757	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Pointe	14655 Preston Rd Dallas, TX 75254

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 - Some	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. 35152 Based on observation, interview and record review, the facility failed to store all drugs and biologicals in locked compartments and to permit only authorized personnel to have access for 1 (3rd Floor Treatment Cart) of 2 Treatment Carts, 2 (340 Hall Nurses Medication Cart and 200 Hall Nurse Medication Cart) of 8 Nurses Medication Carts reviewed for medication storage. The facility failed to ensure the 3rd floor Treatment Cart was locked when not in use. RN A and MA B, who shared the 340 Hall Nurses Medication Cart, on the 3rd Floor, failed to ensure it was locked. LVN C failed to ensure the 200 Hall Nurse Medication Cart, on the 2nd Floor - Secured Unit, was locked. These failures could affect residents by placing them at risk of ingestion/exposure to medications not intended for them and drug diversion. Findings include: An observation on 05/29/2024 at 10:49 AM, on the 3rd floor, revealed the Treatment Cart was unlocked and parked across from the nurse's station and against the wall outside the therapy gym. Staff and residents were observed passing the cart. The top drawer of the cart revealed Mupirocin ointment (topical cream used to treat secondarily infected traumatic skin lesions due to specific bacteria and is available only with your doctor's prescription), Bacitracin ointment (used to prevent minor skin infections caused by small cuts, scrapes, or burns), and skin, and wound gel. There was no one at the nurse's station. An observation on 05/29/2024 at 11:37 AM, on the 340 halls revealed a Medication Cart parked against the wall facing outward to the hall. The lock was open and in the unlocked position. There were no staff in the hall, but two residents were observed, in wheelchairs, self-ambulating toward the dining room area. (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 - Some	In an interview on 05/29/2024 at 11:40 AM, RN A stated the 340 Hall Nurse Medication Cart belonged to MA B and should be locked. She said she did not know where MA B was at the time. She said Medication Carts should always be locked to ensure residents do not get into them and take medications that were not prescribed to them. She stated all staff on the 3rd floor have access to the treatment cart, so she did not know who left it unlocked but it should also be secured because it contained treatment ointments that could be harmful if consumed. In an interview on 05/29/2024 at 11:57 AM, MA B stated she had used the 340 Hall Medication cart but passed it back to RN A about 10:00 AM. She denied leaving it unlocked and said RN A last used the Medication Cart. She stated all Medication Carts should be locked when not in use to ensure resident safety. She said anyone could get into the carts and take medications that were not prescribed to them. In an interview on 05/29/2024 at 12:05 PM, the ADON stated the medication and treatment carts should always be locked when not in use to prevent residents from having access to medication that may be harmful to them. She stated the 340 Hall Medication Cart was the responsibility of RN A, however, MA B was helping on the floor today and also had access to the cart. She said all nurses had access to the Treatment Cart on the floor. She stated she expected both Treatment Carts and Medication Carts to be locked and secured when not in use. An observation on 05/29/2024 at 12:25 PM, revealed the 200 Hall Treatment Cart, in the secured unit, parked against the wall facing outward in the dining room. The lock was open in the unlocked position. Residents were observed in the dining room eating and wandering from table to table near the unlocked cart. An unidentified staff member sat at the other end of the dining room assisting a resident to eat. No other staff were observed near the cart. In an interview on 05/29/2024 at 12:30 PM, LVN C stated he was at the nurse's station and got distracted, forgetting to lock the 200 Hall Nurse Medication Cart when he left it in the Dining Room. He stated the Medication Cart should always be locked, especially in the secured unit where residents often wandered around. He stated they could get into the cart and consume medications not prescribed to them. In an interview on 05/29/2024 at 12:16 PM, the DON stated staff know the carts should be locked when not in use. She said they had multiple in-services on the topic. In an interview on 05/29/2024, the Administrator stated she expected the staff to ensure Medication Carts and Treatment Carts were locked to ensure resident could not have access to unprescribed medications. She said it was the DON's responsibility to ensure nursing staff followed this policy. Record review of the facility's policy titled, Security of Medication Cart, revised April 2007, reflected, Policy Statement: 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.