

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Coryell Health Rehablving at the Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Chicktown Rd Gatesville, TX 76528	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure in accordance with state and federal laws, all drugs and biologicals were stored in locked compartments for 1 (medication cart #1) of 2 medication carts reviewed for pharmacy services. The facility failed to ensure that MC #1 was locked when staff were not present. This failure could place residents at risk of overdose, hospitalization, and pain. Findings included: An observation conducted on 02/04/2026 at 11:30 AM revealed MC #1 unattended and unlocked in the main lobby area. During the observation a resident was observed in the area the MC was located. An observation conducted on 02/04/2026 at 11:40AM revealed staff members walking by the unlocked MC. An interview conducted on 02/04/2026 at 12:58 PM with RN A revealed she had worked at the facility for 5 years. RN A stated she also received training on medication carts which included the 5 rights to medication administration, as well as the protocol for locking the medication carts. RN A stated that if staff walk away from the MC, they should lock it, and keep it locked at all times when not in use. RN A stated that residents could get medications inside of the MC if it was left unlocked. RN A stated it could negatively affect a resident by the potential for harm if ingested. RN A stated she had left the MC unlocked due to an oversight. An interview conducted on 02/04/2026 at 1:20 PM with LVN B revealed she had worked at the facility for almost 1 year. LVN B stated she also received training on MCs which included the process of signing narcotics and keeping the MC locked. LVN B stated if staff turned their back to the MC, not using the MC, then the MC should be locked. LVN B stated if the MC was left unlocked, then residents or other people could have access to the medications in the cart. LVN B stated that residents could potentially poison themselves if they had access to an unlocked MC. LVN B stated the nurses assigned to the MC were responsible for locking the MC. An interview conducted on 02/04/2026 at 1:45 PM with CNA C revealed she had worked at the facility for 1 year. CNA C stated that anyone assigned to the MC was responsible for ensuring the MC was locked. CNA C stated that residents could get medications and potentially get harmed if they had access to an unlocked MC. An interview conducted on 02/04/2026 at 2:38 PM with CNA D revealed she had worked at the facility for 2 years. CNA D stated that MAs and RN/LVN were responsible for ensuring the MC are locked. CNA D stated that staff should lock the MC if they saw it unlocked. CNA D stated if residents had access to the unlocked MC, the residents could potentially take the medication and it could lead to death. An interview conducted on 02/04/2026 at 2:45 PM with the DON revealed she had worked at the facility for 2.5 years. The DON stated she had received training on RR which included the residents have the right to be free from abuse, neglect, right to privacy, and right to refuse or receive medications. The DON also received training on MC which included to keep the MC locked. The DON stated her expectation for staff was to keep the MC locked, keep the drawers facing the bedrooms, and cart should be locked if not in use. The DON stated residents could enter an unlocked MC and result in</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>them to have access to the medications. An interview conducted on 02/04/2026 at 3:25 PM with the ADM who had worked at the facility for 2.5 years. The ADM stated her policy regarding the MC was that the MC should remain secured when someone was not pulling items in and out of it. The ADM stated her expectation would be for the MC to be locked and secured. The ADM stated that the MA or LVN/RN would be responsible for ensuring the MC was locked. The ADM also stated it could negatively affect the residents if they had access to the unlocked MC, because there would be the potential for residents to retrieve items from the cart that did not belong to them. Record Review of the facility's policy titled Security of Medication Cart dated April 2007 provided the following information: The medication cart should be secured during medication passes. The nurse must secure the medication chart during the medication pass to prevent unauthorized entry. Medication carts must be securely locked at all times when out of nurse's view. When the medication cart is not being used, it must be locked and parked at the nurses st</p>		