STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675891	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeport Medical Lodge	2108 15th Street Bridgeport, TX 76426

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide safe and secured storage of drugs and biologicals by not keeping medication in locked compartments, for 2 of 8 carts reviewed for medication storage. The facility also failed to label drugs and biologicals in accordance with currently accepted professional principle by not labeling opened dates on 22 of 25 insulin pens reviewed for medication labeling. _LVN A failed to lock medication cart when the cart was not in use. _Treatment cart was left unlocked when not in use._22 of 25 insulin pens were not labeled with an open date.These failures could result in drug diversion, medication ineffectiveness, adverse reactions to residents, and overdosing to residents. Findings includedAn observation on [DATE] at 5:30AM revealed medication cart for the 200 hall was left unattended and unlocked at the nurses' station. There was also a treatment cart that was left unattended and unlocked, out of view, behind the nurses' station. There were 3 residents sitting by the nurses' station. Inside 200 hall medication cart were 7 insulin pens. They were not labeled with an open date. There were labels on the pen caps instructing to discard after 28 days.An observation on [DATE] at 5:48AM revealed 9 insulin pens in the 500 hall medication cart were not dated with an open date, 4 insulin pens in 600 hall medication cart without an open date. All insulin pens were labeled with instruction to discard after 28 days of opening.An observation on [DATE] at 6:00AM revealed 2 out of 3 insulin pens in the 100 hall medication cart were not dated with an open date. All insulin pens were labeled with instruction to discard after 28 days of opening. In an interview on [DATE] at 5:35AM with LVN A, he stated that he was in charge of 200 hall medication cart. He stated he left briefly to change the trash bag of another cart he had. He stated all carts should remain locked when they were not in use and they were out of sight. He stated the risk of carts being left unlocked included residents getting ahold of medications which could cause adverse reactions or overdosing. LVN A also identified an insulin pen he used to administer insulin to Resident #1 in 200 hall medication cart. He stated he was unsure why the insulin pens were not labeled. He stated once an insulin pen was opened, it could be used for 28 days before it had to be discarded. He stated he forgot to check for opened dates on the insulin pens. He stated the risk of administering insulin without knowing an opened date included ineffectiveness, hyperglycemia (high blood sugar). In an interview with LVN B on [DATE] at 5:48AM, she stated she had 500 and 600 hall medication carts. She stated all carts should be always locked when they were not in use. She stated the treatment cart was shared among night shift nurses and she was unsure who left it unlocked. She stated she was not aware it was left unlocked. She stated residents could get ahold of medications which could result in allergic reactions, overdosing. She stated she used 1 out of 9 pens to administer insulin to Resident #2. She stated she did not check for opened dates on the pens. She stated the risk of giving insulin without an opened date included potentially giving expired insulin to residents which could result in ineffectiveness of medication. She stated all undated insulin should be disposed. In an interview with RN C on [DATE] at 6:00AM, she stated she had the 100 hall medication cart. She stated she did not notice 2 of 3 insulin pens were not labeled. (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 - Some	She stated the risk of giving insulin without knowing the opened date included ineffectiveness of medication. She also stated all medication and treatment carts should always be kept locked when not in use to prevent unauthorized access to medication.In an interview with the DON on [DATE] at 6:44AM, she stated she expected her staff to label insulin pens with an opened date when they were in use. She stated the nurses had a checklist they needed to complete daily which included dating insulin pens. She stated the risk of not dating insulin pens included medication ineffectiveness which could result in hyperglycemia. The last in-service regarding labeling medication was done on [DATE]. The DON also stated all nurses should lock carts when they were not in use. She stated regardless of the shifts, all carts should always be kept locked when they were unattended. She reminded all nurses daily to lock their carts and if she saw an unlocked cart she would lock it and reminded the nurse in charge of the cart.Record review of Daily nursing charting requirements checklist, unknown date, revealed the checklist included ensure all inhalers, insulin, breathing treatment, . are dated when opened and stored appropriately.Record review of Pharmacy in-service, dated [DATE], conducted by the facility's pharmacy provider, Medication Therapy Solution, revealed the in-service included the topic of med cart checklist. It mentioned all insulin vials/pens must be labeled with unrefrigerated/date opened. Record review of Security of Medication cart policy, dated [DATE], revealed the policy stated Medication carts must be securely locked at all times when out of the nurse's view. When medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.