STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675892	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulf Pointe Plaza	1008 Enterprise Blvd Rockport, TX 78382

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 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 accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 5 residents (Resident #1) reviewed for pharmacy services. The facility failed to ensure LVN A's medication cart on hall 400 and MAR contained an accurate count and record for Resident #1's liquid Morphine (a narcotic used to treat pain). This failure could place residents at risk for drug diversion and/or a delay in medication administration, as well as risk of not having allegations investigated or timely. Findings included:Record review of Resident #1's face sheet dated 04/19/25 revealed a [AGE] year-old female with an admission date of 04/19/25. Diagnoses included Warnicke's Encephalopathy (a brain disorder caused by a severe deficiency of thiamine (vitamin B1), Alzheimer's, Chronic Respiratory Failure (advanced lung disease which makes it progressively harder to breathe over time and can lead to sudden flare-ups), Cirrhosis (advanced liver disease characterized by the formation of scar tissue over time that can lead to liver failure), Depression, and Malignant Neoplasm of the Vulva (Cancer of the groin/vagina). Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 04, indicating severe cognitive impairment. She was dependent on staff for toileting, showering, footwear, and positioning. She required substantial assistance with dressing and personal hygiene. She required supervision with eating and oral hygiene. She was always incontinent of bladder and bowel. Her pain scale averaged 4 out of 10. Record review of Resident #1's physician orders start date 06/18/25 revealed Morphine Sulfate (Concentrate) Oral Solution 20mg/ml. Give 1 ml by mouth every 2 hours as needed for severe pain rated 7-10. Record review of Resident #1's Individual Drug Administration Record revealed the Morphine count signed by LVN A on 09/13/25 at 9:30 am was 2ml. The next column had the sequence of 1ml remaining, and it was crossed through with LVN A's signature and written, Bottle is empty left in drawer. Record review of Resident #1's Individual Drug Administration Record revealed the Morphine count signed by LVN C on 10/02/25 at 11:25 pm was 49ml. The next column had a sequence of 39 ml remaining and was signed by LVN D. Record review of the PIR dated 10/20/25 revealed an incorrect narcotic count of Resident #1's Morphine 100mg/5ml on 10/19/25 at 10:00 pm. The controlled medication count revealed 5 ml were missing. The incorrect count was identified when the on-coming LVN B counted with the off-going LVN A. According to the PIR, both LVN A and LVN B stated the count was correct the previous night when on-coming LVN B counted with off-going LVN A. Both nurses were suspended pending investigation, with LVN A ultimately being terminated. During an observation on 10/30/25 at 8:25 AM revealed that off-going LVN E and on-coming LVN D were counting controlled medications whereas LVN D would actually count the medications, but LVN E just looked to verify the count on the controlled medication sheet was correct. LVN E was not actually watching LVN D count the medications, and LVN E was not actually looking at the sheet to verify it was correct. In an interview with LVN E on 10/30/25 at 8:35 am, she said she was just doing what everyone else was when it came to counting the narcotics. She said she did not think it was the right way to do it. She said the accuracy of narcotic counts was important because it was something that could go missing, and the residents might not get their pain controlled. She said she did not know why she never brought it up (the way the narcotics were counted) to anyone.Observation and interview with Resident #1 on 10/30/25 at 8:45 am revealed a well-kept female on oxygen. She was awake and oriented. She was on a pressure-reducing air mattress. She said the doctor changed her pain medications last week, and she was no longer taking the liquid morphine every 2 hours, but now an extended-release morphine pill every 12 hours, and was due at 9:00 am. She said those were not working very well. She said she also got oxycodone scheduled every 6 hours and had a fentanyl patch. (100mcg). She said her pain scale right now was a 7 or 8 (up from her usual 5). She said she was on hospice, and they came in three times a week for showers. She said she tolerated her showers without her oxygen. She said she was on hospice and took strong pain medication because she had a groin wound from cancer. She said her pain was not out of control, but she wished she could have the liquid morphine again because it worked well for her. In an interview with the DON and DR on 10/30/25 at 8:55 am regarding the resident's pain level. The DR said to the DON to get her on whatever works best for her without knocking her out. He said the fentanyl was not really working for her. He said he did not know how she was still alive with that horrible wound she has. The DON said they were getting the liquid morphine in 120ml vials, and the missing 5 ml's was so random and everyone freaked out over it, meaning it was difficult to think about a nurse stealing morphine from a