STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675943	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Hope Manor	1623 W New Hope Dr Cedar Park, TX 78613

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 - Few	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. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to make sure that drugs are stored properly and only authorized persons have access for 1 of 3 medication carts (MC #1) reviewed for drug storage and labeling. The facility failed to ensure MC #1, was locked, medications secured, and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings included: During an observation on 12/10/2025 at 8:24a.m., revealed MC #1, was in on 100-hall and unlocked. RN A was not on the hall while the medication cart was unlocked. MC #1 contained residents' prescription drugs, over the counter medications, and narcotics in a locked box in the medication cart. There was a resident walking past the medication cart while it was unlocked. During an interview with RN A on 12/10/2025 at 10:02a.m., she said she had been trained on medication storage. She said the policy was staff must lock the medication carts any time the medication cart was out of the staff members sight. She said if staff stepped away or turned their back the staff member was supposed to lock the medication cart. She said the person who was assigned to the medication cart at that time was responsible for ensuring it was locked. She said if it was left unlocked and unattended another nurse could get into the medication cart, or a resident and family member could get into the cart and take medications. She said everyone monitored to ensure that the medication cart were locked. She said staff monitored the medication carts through observation. She said she left the medication cart unlocked because a resident's lips were turning blue in the dining room and she ran to get her blood pressure cuff and forgot to lock the medication cart. During an interview with the DON on 12/10/2025 at 1:19p.m., she said she had been trained on medication storage. She said the policy was if the medication cart was out of sight of the staff it should be locked. She said the person who was on the medication cart was responsible for ensuring the medication cart was locked. She said all staff monitored to ensure staff were locking the medication cart. She said staff monitored by doing observations. She said if the medication cart was left unlocked and unattended anyone could get into the medication cart and access the medications. She also said the medication could get into the wrong hands and cause a drug diversion. She said all managers monitor to ensure the medication carts were locked. She said the managers monitored day to day by observations. She said that RN A had a situation in the dining room and forgot to lock the medication cart when she got her blood pressure cuff. During an interview with the ADM on 12/10/2025 at 1:30p.m., revealed that she had been trained on medication storage. She said the policy on the medication cart was that the medication cart should be locked any time staff walk away from the cart. She said the person on the cart was responsible for locking the cart. She said if the medication cart was left unlocked and unattended someone could get into the medication cart and steal medications, or a resident can get into the cart and have an adverse reaction. She said all the managers monitored to ensure staff were locking the carts. She said the managers monitored through observation. She said RN A did not lock the medication cart due to having an emergency and forgot because she was rushing back to the resident. Record review of Medication Labeling and Storage Policy dated 4/2019, revealed The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use.