

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/12/2026
NAME OF PROVIDER OR SUPPLIER Winnie L Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2104 N Karnes Cameron, TX 76520	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure residents had the right to be free from exploitation and misappropriation of property for one of four residents (Resident #1) reviewed for misappropriation of resident property. The facility failed to prevent a diversion (misappropriation) of Resident #1's Hydrocodone Oral Tablet 10-300 mg, 38 pills reported missing on 05/07/2026. Hydrocodone was used to treat pain. This failure could place residents at risk for decreased quality of life, unrelieved pain, and dignity. Findings included: Review of Resident #1's face sheet printed 05/12/2026 reflected a [AGE] year-old male admitted to the facility 02/02/2026. His diagnoses included unspecified subluxation of right patella subsequent encounter partial kneecap dislocation- considered serious, debilitating injury that requires medical evaluation-causes severe pain) and anxiety disorder (a group of treatable mental health conditions characterized by excessive, persistent, and uncontrollable fear, dread, worry that interferes with daily life. Review of Resident #1's first assessment since the most recent admission /entry MDS, dated [DATE], reflected Resident #1 Section C was not required to be filled out on this type of MDS assessment. Resident #1 had short term memory recall. He had some difficulty making decisions in new situations. He received PRN pain medications. Review of Resident #1's comprehensive care plan, dated 03/26/2026, Resident #1 was on pain medication therapy related to unspecified subluxation of right patella subsequent encounter. Interventions: Administer medication as ordered. Observe for adverse reactions with ever interaction with the resident. Monitor for increased for falls. Review of Resident #1's physician order reflected a supply last order date was on 4/24/2026 and was revised on 05/07/2026 of Hydrocodone- Acetaminophen oral tablet 5-325 mg give 2 tablets by mouth every 6 hours as needed for pain. This was discontinued. Review of Resident #1's physician order reflected supply last order date was on 05/07/2026 and revision date was 05/07/2026 of Hydrocodone- Acetaminophen 10-325 MG give 1 tablet by mouth every 4 hours as needed for pain. Review of Resident #1's physician order reflected supply last order was on 04/25/2026 and revision date 5/7/2026 Hydrocodone- Acetaminophen Tablet 10-300 MG. Give one tablet by mouth every 6 hours as needed for pain. This was discontinued (does not indicate the discontinue date) Review of the Provider Investigation Report dated 05/11/2026 reflected, it was discovered on 05/08/2026 that 38 hydrocodone's were unaccounted for, along with the count sheet that goes with the narcotics. The Facility immediately followed drug diversion protocol: Self-report completed 05/08/2026 Staff that could have potentially been involved have been interviewed and all have been drug tested. Residents were interviewed regarding if they have received doses as documented on the narcotic medication log. Card count sheet has been initiated Counts have been verified for every controlled drug in the facility. Narcotic shift change sheets have been audited Medical Director, pharmacy consultant, and policy have all be notified. Police report #2605-02809. Nursing staff have been in-service related to controlled medication counting procedures; counting with oncoming nurse, logging individual controlled dose at the time of medication administration, abuse and neglect. Narcotics were delivered on 04/24/2026, resident (Resident #1) was administered two doses before going to the hospital on [DATE]. Resident (Resident #1) returned from the hospital on [DATE]. Interviews with staff reveal that the count sheet was verified and (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: 676089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/12/2026
NAME OF PROVIDER OR SUPPLIER Winnie L Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2104 N Karnes Cameron, TX 76520	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accounted for prior to the time it went missing. Residents interviewed verified that they have been receiving doses as documented on the narcotic medication log. Drug test results reveal that no nurse had tested positive for the narcotic that was missing. Other parties notified: physician, pharmacy and police. The facility was unable to locate the missing narcotics. Staff interviews did not identify an eyewitness to the medications being taken. The facility could not identify anyone with access to the carts besides those designated to be on their designated shifts. The pharmacy confirmed delivery of 40 tablets on 04/26/2026. Record review in conjunction with the questioning of [Resident #1] reflected on 05/07/2026 LVN C noticed Resident #1 did not have Hydrocodone in the medication cart. She contacted the physician and received an order for Acetaminophen with codeine 300-60 mg ordered 5/6/2026 d/c 5/7/2026 related to Resident #1 was in pain. Review of Resident #1's medication administration record for May 2026, reflected Resident #1 did not miss a dose of Hydrocodone- Acetaminophen 10-300 mg except for 5/6/2026 and he received another medication for pain. Review of Resident #1's clinical records reflected pain assessment for 05/06/2026 through 05/12/2025 was conducted on Resident #1 and his pain level was from 6-8 on the scale, 10 being the worst pain. Observation on 05/12/2026 of the 500-hall nurse's narcotics book and cart, 100, 200 and 400-halls medication aide narcotics book and cart revealed all medications and blister packets were correct per the narcotic count by the staff. During an interview on 05/12/2026 10:00 am, Resident #1 stated he did not have concerns of not getting his pain medications. Resident #1 stated all was well with his medications. Resident #1 stated the pain medications the nurses give him helps him with his pain. Resident #1 stated when he returned from hospital he did receive a different pain medication the doctor ordered for one or two times, and he stated it did help with his pain. He stated the staff ensured whenever he asks for pain medication and it was time for him to have a pill they always give it to him and he appreciated them being fast in getting his pain under control with the pills. Review of facility's Pharmacy record on 05/12/2026, reflected the facility did receive 40 tablets of Hydrocodone tablets 10- 300 mg on 04/24/2026 Interview on 05/12/2026 about 11:25 am, the DON stated Resident #1's had pills of hydrocodone that was delivered on 04/24/2026 and 38 of those pills were missing night of 05/07/2026. The DON stated there was no evidence of the count sheet. The DON stated she called the pharmacy for refill of Resident #1's hydrocodone and the medication was refilled and delivered to the facility on [DATE]. She stated Resident #1 was in the hospital from [DATE] and returned on 5/6/2026. She stated when he returned from hospital was when LVN C noticed the hydrocodone was missing in the medication cart and she called the physician to obtain pain medication from the emergency kit. The DON stated this order was only for 1 or 2 days. She stated on 5/7/2026 during change of shift was when LVN D and LVN E was notified from LVN C of Resident #1's hydrocodone was missing from the medication cart. She stated LVN D and LVN E began searching the medication carts and looked at everyone's medication to determine if the medication was misplaced with another residents medication. The medication was not found. She stated LVN D did text her on 05/07/2026 and stated he needed to talk to her as soon as she came to the facility. DON stated when she entered the facility on 05/07/2026 she went to a meeting and during the meeting LVN D came to the door and asked her to leave the meeting. She stated this was when the facility investigation began on the missing hydrocodone. DON stated all medication carts was searched again and they began drug testing on all the nurses who had access to the medication cart. She stated the results of the drug testing was negative of any staff having hydrocodone. She stated they immediately began services and interviews with staff. The DON stated with the investigation LVN C and LVN D stated last time they saw the hydrocodone in medication cart was on Sunday 05/05/2026. She stated when the nurses counted narcotics they reviewed the count on the form but did not actually look at the medication blister card. She stated they have changed the system of counting narcotics. DON stated all nurses was to actually look at the blister card with the medication in the card and count the pills in the card and sign that the medication was in the medication cart. She stated LVN F stated last time she saw Resident #1's hydrocodone was the last time she worked on (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/12/2026
NAME OF PROVIDER OR SUPPLIER Winnie L Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2104 N Karnes Cameron, TX 76520	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/06/2026 and the count was correct on 05/06/2026. The DON and surveyor reviewed the facility policy on Medication Administration. The policy reflected Medication errors and adverse drug reactions are immediately reported to the resident's Physician. In addition, the Director of Nurses and or designee should be notified of any medication errors. Any medication error will require a medication error report that includes the errors and actions to prevent the occurrence. The DON stated LVN C did not follow the facility policy. She stated LVN C was expected to contact DON, Administrator and Physician immediately when she found the hydrocodone was missing. The DON stated the former way of counting the controlled drugs form was not following the facility policy. She stated the nurses was not capturing everything we do on the form. She stated on the old form it is not documented of the actual narcotics being counted. The nurses was not looking at the blister card to count the narcotics. She stated without looking at the actual medication it is difficult to determine how long the hydrocodone was missing due to Resident #1 was in the hospital and his medications was not being administered. Attempted to call the Physician on 05/12/2026 at 12:46 pm and the physician stated she was not in the position to talk. She did not return surveyors phone call. Interview on 05/12/2026 approximately 12:45 pm LVN D stated when he entered the facility on 05/07/2026 and he received report from LVN C, and he did count medications with her. He stated every medication was accounted for according to the sheets that was in the narcotic book . He stated LVN E was with him when the medications was counted with LVN C. He stated LVN C mentioned when she began to give Resident #1 his hydrocodone she noticed the medications was not in the medication cart. LVN D stated she had called the Physician to get a order for a pain medication from the emergency kit. He stated he had worked on the weekend, and he did see Resident #1's hydrocodone on the medication cart on Sunday 05/05/2026. He stated Resident #1 was in the hospital. He stated he text the DON ad stated he needed to talk to her and it was urgent. (he did not have his phone with him to show the text). LVN D stated I suspected the hydrocodone was missing and the narcotic sheet for the hydrocodone was also missing. He stated when the DON entered the facility on 05/07/2026 she went to a meeting, and he asked her to leave the meeting he needed to speak to her as soon as possible. He stated the DON and the former Administrator began the investigation of the missing Hydrocodone. LVN D stated Resident #1 did not complain about being in pain and he was satisfied with the pain medication ordered on 05/06/2026. He stated the pharmacy system was not working and it did take until early Friday 05/08/2026, before Resident #1 did receive his hydrocodone. LVN D stated he was administered another pain medication until the hydrocodone arrived on 05/08/2026 to the facility. He stated he did take a drug test and was inserviced on drug diversion. LVN D stated a new system was put in place immediately when counting narcotics during change of shift. He stated the new system was more effective than the old system. He stated the nurses was required to actually look at the medications and do the count and the old system of counting narcotics was not required to actually look at the medication. Interview on 05/12/2026 at 1:30 pm LVN C stated she counted medications with LVN G on Monday (05/04/2026) and Resident #1's hydrocodone was in the medication cart. She stated Resident #1 was in the hospital and he did return from the hospital on [DATE]. She stated when Resident #1 returned from the hospital and the night of 05/06/2026 approximately 9:00 pm Resident #1 began to complain about being in pain. She stated at this time is when I noticed his (Resident #1) hydrocodone was missing. She stated she did not believe any one had stole the hydrocodone and believed the DON had taken the hydrocodone out of the medication cart related to Resident #1 being in the hospital. She stated she did not think about calling the DON or anyone about the missing hydrocodone. LVN C stated she did contact the Physician and ordered pain medication in the emergency kit. She stated Resident #1 pain subsided after he was administered pain medication. LVN C stated he did not complain about being in pain the rest of the night. She stated she looked at another Resident in the hospital to determine if her narcotic medication was taken off the cart and her narcotic medication was still on the medication cart. She stated she did not know what to think about Resident #1's missing hydrocodone. She stated she continued working and did not think anything about the missing (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/12/2026
NAME OF PROVIDER OR SUPPLIER Winnie L Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2104 N Karnes Cameron, TX 76520	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications. She stated now she realized she was expected to call the DON Administrator immediately, but she did not want to wake anyone up about the situation. LVN C stated she did take a drug test, and she was in-service on reporting missing medications and medication errors. LVN C stated she was suspended from the facility until the facility completed investigation. She stated she continued to be suspended. Interview on 05/12/2026 approximately 1:50 pm LVN E stated the last time he saw Resident #1's hydrocodone was on Sunday (05/03/2026). He stated when he entered the facility for duty on 05/07/2026 is when LVN C stated Resident #1's hydrocodone was missing. LVN E stated they (LVN D) began looking in every medication cart attempting to locate the hydrocodone. He stated the narcotic sheet was also missing. LVN E stated LVN D sent a text to the DON he needed to talk to her as soon as possible. LVN E stated the hydrocodone was not in any of the medication carts. He stated when the DON came to the facility an investigation began and all nursing staff was interviewed , in serviced on drug diversion and received a drug test. LVN E stated a new system was in place when counting narcotics and it was a better system. He stated the staff was required to actually look at the medication. He stated he did not have anything else to add to the situation of the missing narcotic. Interview on 05/12/2026 at 5:00 PM LVN G stated she was off on 05/05/2026 and returned to work on 05/07/2026. She stated when she returned to work on 05/08/2026 was when she was notified of the missing hydrocodone. She stated she did work on 05/04/2026 and received report from LVN C. LVN G stated I did a narcotic count with LVN C, however, I do not recall if the hydrocodone was missing on 05/04/2026. She stated she did not remember. LVN G stated she was given a drug test and in-service on the new form to use when counting narcotics and drug diversion. She stated she needed to take care of her children and did not have anything to add about the situation of the missing hydrocodone. Review of the facility's AD Hoc QAPI meeting was held on 05/08/2026 related to the diversion of medications. The former Administrator, DON, Adon, Medical Director , Social Worker and Activity Director was in attendance. Review of the facilities in-service dated 05/08/2026 given by the Director of Nurses reflected an in-service titled :Controlled medication counting procedures Counting with oncoming nurse Logging individual controlled dose at the time of medication administration. Review of interviews with interview able (not dated when the interviews was conducted with the residents) Residents reflected all residents stated they did receive the correct medications. Signed by the DON. Reviewed LVN C personnel record on 05/12/2026 reflected LVN C was suspended until facility completed investigation. Record review of the facility's policy of Controlled Medications, revised on 04/06/2026 reflected Medications included in the Drug Enforcement Administration classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. Procedure: At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and or one nurse and a CMS, QMAP, Med Tech or equivalent as allowed by your State regulatory agency and is documented on the audit record. Alternatively, the shift change audit may be recorded on the accountability record if there is a designated column for the audit. Current controlled medication accountability records and audits records are kept on the medication cart, either in the MAR or in a separate folder. When completed, audit and accountability records are submitted to the Director of Nursing and kept on file for three years at the facility. Any discrepancy in controlled substance medication counts is reported to the Director of Nursing immediately. The Director of Nursing or designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The Director of Nursing documents irreconcilable discrepancies in a report to the Administrator. If a major discrepancy of a pattern of discrepancies occurs or if there is apparent criminal activity , The Director of Nursing notified the Administrator and the Consultant Pharmacy immediately. A determination will be made by the Administrator, the Consultant Pharmacist, and the Director of Nursing concerning possible notification of police or other enforcement agencies and any other actions to be taken. Controlled medications are not surrendered to anyone, including the resident's physician; other than releasing controlled medications for a (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/12/2026
NAME OF PROVIDER OR SUPPLIER Winnie L Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2104 N Karnes Cameron, TX 76520	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident on pass or therapeutic leave. However, controlled medications may be surrendered to DEA or other law enforcement officials functioning in a professional capacity in exchange for a receipt documenting the transaction. Controlled medications remaining in the facility after the order has been discontinued are retained in the facility, in a securely locked area with restricted access, until destroyed by the facility Director of Nursing, Administrator, and Consultant Pharmacist; or as otherwise directed by state and federal law. Safety of the facility personnel and residents is to be assured in the event of an intruder entering into the facility for the purpose of stealing controlled medications. This may necessitate surrendering medications if bodily harmed is threatened. The local public safety agency, the Administrator, and the Director of Nursing are notified immediately in that order once the intruder has gone.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/12/2026
NAME OF PROVIDER OR SUPPLIER Winnie L Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2104 N Karnes Cameron, TX 76520	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews the facility failed to ensure the facility remained free of accidents and hazards a for one of two housekeepers carts (Housekeeping Cart #1) reviewed for hazards. The facility failed to ensure Housekeeping Cart #1, with chemicals inside the compartments, was locked when unsupervised. The housekeeping cart was located on 400 hall in front of room [ROOM NUMBER]. This failure could place residents at risk for injuries, illness, and hospitalization. Observation on 05/12/2026 at 9:03 am Housekeeping Cart #1 was located in front of 405 room. The compartment where chemicals were stored was not locked. The compartment had micro-kill bleach, disinfectant cleaner, Clorox, and two bottles filled with chemicals without a label on the bottles. Housekeeper G was not standing near the housekeeping cart. She exited room [ROOM NUMBER] at 9:00 a.m. and walked to the housekeeping cart and was standing beside surveyor. There were not any residents or staff in hallway when observation was made of the housekeeping cart #1 was unlocked. During an interview on 05/12/2026 at 9:10 a.m., Housekeeper A stated the housekeeping cart was expected to be locked anytime housekeeper walked away from the cart. Housekeeper A stated she could not see Housekeeping Cart #1 from inside the 405 room and the door was partially closed. She stated there was a possibility that if a resident drank some of the chemicals the resident may become sick with stomach issues or have an allergic reaction. She stated it was possible a resident may need to be evaluated at the hospital. Housekeeper A stated all chemicals were required to have labels on the bottles. She stated she did have a key to the housekeeping cart. Interview on 5/12/2026 at 9:25 am, the Housekeeping Supervisor stated all housekeeping carts were expected to be locked anytime the housekeeper was not standing in front of the cart. The Housekeeping Supervisor stated if a resident ingested some chemicals there was a potential for an allergic reaction, such as burning their throat, stomach and may need to be assessed at the hospital. She stated all housekeeping staff was in-service on locking housekeeping carts. She stated there was a possibility if a resident spilled chemical on their skin it may cause irritation to the skin. Review of the administrative staff on 5/12/2026 schedules reflected the Administrator was no longer an employee at the facility. Her last day was on 5/11/2026. Review of the Facilities Daily Common Area Cleaning, not dated, reflected Housekeeping carts/chemicals must be locked when not within the eyesight of a staff member.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/12/2026
NAME OF PROVIDER OR SUPPLIER Winnie L Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2104 N Karnes Cameron, TX 76520	
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. Based on observations, interviews, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 3 medication carts (Medication Cart #1) reviewed for medication storage. The facility failed to ensure Medication Cart #1 were locked and medications were secured and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to prescriptions, biologicals, and over-the counter medications. Findings included: Observation on 05/12/2026 at 4:40 p.m. revealed the locking mechanism protruding outward (indicated the medication cart was unlocked) on Medication cart #1 at the end of 400 hall. There was no nurses on the hall. In an interview on 05/12/2026 at 5:30 p.m. LVN B stated he forgot to lock medication cart when he exited 400 hall and entered another hall. He stated all medication carts were to be locked except when a nurse was obtaining medications from the cart. LVN B stated if a resident did ingest medications such as inhalers or any type of medications there was a possibility resident was allergic to the medications and may need to be transferred to the hospital for further evaluation. He stated there were needles on the medication cart and a resident could obtain a needle and hurt themselves or another resident. He stated he had been in-serviced on locking medication carts; however, he did not recall the date of this in-service. LVN B stated there were all types of inhalers, insulin and some medications on the cart. In an interview on 05/12/2026 at 4:50 p.m. the Director of Nurses stated her expectation was for all medication carts to be locked when the nurse was not administering medications. She stated the staff had been in-serviced on securing the medication carts when not in use. The Director of Nurses stated she did not know the exact date of the in-service. She stated residents, other staff, and visitors would have access to the medications in the unlocked medication cart. She stated if a resident ingested medications not prescribed to them; there was a potential the resident may have an allergic reaction or may need to be admitted to the hospital. She stated it was the nurse or Medication Aide's responsibility to ensure the medication cart was locked when not dispensing a resident's medication. The Director of Nurses stated she was responsible for monitoring the nurse supervisors. Record review of the facility's Policy on Medication Cart Security and Locking Procedures, not dated, reflected Medication carts must remain locked at all times when not actively in use. This includes during resident care, charting breaks, and any time the nurse or medication aide steps away.		