

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER Rambling Oaks Courtyard Extensive Care Community		STREET ADDRESS, CITY, STATE, ZIP CODE 112 Barnett Blvd Highland Village, TX 75077	
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 - Some	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

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals that met the needs of each resident for one (Resident #1) of eight residents reviewed for pharmaceutical services. The facility failed to ensure Resident #1 was not self-administering his nasal spray without an assessment and an order for nasal spray on 09/02/2025. This failure could place residents at risk for potential overdose and adverse effects. Findings include: Record review of Resident #1's Face Sheet, dated 09/02/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #1's Comprehensive MDS Assessment, dated 08/13/2025, reflected the resident had a moderate impairment (resident may need additional support and monitoring) in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated the resident had chronic obstructive pulmonary disease. Record review of Resident #1's Comprehensive Care Plan, dated 07/08/2025, reflected the resident had asthma (lung disorder caused by narrowing of the airways) and one of the interventions was to assist the resident in identifying asthma triggers (things, activities, or conditions that could lead to asthma attack). Record review of Resident #1's Physician's Order on 09/02/2025 reflected no order for nasal spray. Record review of Resident #1's Assessment Notes on 09/02/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage their own medications. Observation and interview on 09/02/2025 at 8:28 AM revealed Resident #1 was in his recliner, awake. A container of nasal spray was observed on top of the resident's side table. He said he was the one administering his nasal spray and he had been doing it for some time. He said he was not sure if the staff knew he was doing it and nobody talked to him that the nurse was supposed to administer his nasal spray. He said his nasal spray had been always in his table where he could easily see it. He said he would not call nor tell the nurse everytime he used the nasal spray. He said he would do it every morning and sometimes if his nose were getting itchy. The resident took the nasal spray from the side table and sprayed once on each nostril (opening of the nose). Observation on 09/02/2025 at 8:32 AM revealed LVN A went inside Resident #1's room to administer his medications. She did not notice the nasal spray on the resident's side table was in plain view. Observation and interview on 09/02/2025 at 8:38 AM, LVN A stated she did not notice the nasal spray on top of Resident #1' side table when she administered his morning medications. She said she was not aware the resident was doing it by himself. She said the nasal spray should not be inside the room because they were medications and she was not sure if the resident could self-administer any medication. She said the resident might use them every hour and no one would know until adverse reactions such as nasal irritation and nasal dryness. She went inside the room and talked to the resident that she would get his nasal spray and would place them inside the cart. She also told the resident that she would request an order for his nasal spray. In an interview on 09/02/2025 at 11:08 AM, LVN A stated she already took Resident #1's nasal spray and had placed an order for it. She said the nasal spray should be inside the nurses' cart and should be administered by nurses. She said the resident might be confused and took the medication using a different route. She said other residents, that were allergic to the content of the medication, might access the medication and consume it leading to allergic reactions. She said she also checked the rooms of other residents if there were medications inside the room. She said she would also coordinate with the family members to let the nursing staff know if they were bringing any medication. In an interview on 09/02/2025 at 11:50 AM, the DON stated Resident #1's nasal spray should be administered by nurses and there should be a physician's order for it. She said the expectation was for the staff to check if there were any medications inside the residents' room. She said if a resident was administering medications unsupervised, for this incident a nasal spray, there could be adverse effects if the nasal spray was overused such as nose irritation or allergic reactions. She said if the resident was the one administering the nasal spray, there should be an assessment that the resident was able to do so. She said if the resident was deemed able to administer his nasal spray, the nasal spray should still not be on top of the side table were other confused residents could assess it and consume it. The DON said that since the resident was using it, she would check if a physician order was already in place. The DON said she would do an in-service about not leaving any medication</p>		

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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. (continued on next page)		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the medications were stored properly in locked compartments or provided a safe and secured storage with limited access for three (Residents #1, #2, and #3) of eight residents reviewed for medication storage. 1. The facility failed to ensure Resident #1's nasal spray was not left inside the resident's room on 09/02/2025. 2. The facility failed to ensure Resident #2's zinc oxide (medicated cream used to prevent skin irritation) was not left on top of the resident's side table on 09/02/2025. 3. The facility failed to ensure Resident #3's zinc oxide was not left on top of the resident's side table on 09/02/2025. These failures could place residents at risk to have access to medications that could result to accidental ingestion and misuse of medications. Findings include: 1. Record review of Resident #1's Face Sheet, dated 09/02/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease. Record review of Resident #1's Comprehensive MDS Assessment, dated 08/13/2025, reflected the resident had a moderated impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment indicated the resident had chronic obstructive pulmonary disease. Record review of Resident #1's Comprehensive Care Plan, dated 07/08/2025, reflected the resident had asthma and one of the interventions was to assist the resident in identifying asthma triggers. The care plan did not indicate that the resident could administer his nasal spray. Record review of Resident #1's Physician's Order on 09/02/2025 reflected no order for nasal spray. Record review of Resident #1's Assessment Notes on 09/02/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment the resident was competent to manage their own medications. Observation and interview on 09/02/2025 at 8:28 AM revealed Resident #1 was in his recliner, awake. A container of nasal spray was observed on top of the resident's side table. He said the nasal spray had been with him for a while. Observation on 09/02/2025 at 8:32 AM revealed LVN A went inside Resident #1's room to administer his medications. She did not notice the nasal spray on the resident's side table that was on plain view. Observation and interview on 09/02/2025 at 8:38 AM, LVN A stated she did not notice the nasal spray on top of Resident #1' side table when she administered his morning medications. She said the nasal spray should not be inside the room because the nasal spray was considered as a medication. She went inside the room and talked to the resident that she would get his nasal spray and would place them inside the cart. In an interview on 09/02/2025 at 11:08 AM, LVN A stated she already took Resident #1's nasal spray and placed it inside the nurses' cart. She said the resident might be confused and took the medication using a different route. She said other residents, that were allergic to the content of the medication, might access the medication and consume it leading to allergic reactions. 2. Record review of Resident #2's Face Sheet, dated 09/02/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with protein-calorie malnutrition (a form of malnutrition that could impact the skin causing dryness, roughness, and flakiness). Record review of Resident #2's Comprehensive MDS Assessment, dated 08/01/2025, reflected the resident had a severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS score of 04. The Comprehensive MDS Assessment indicated the resident had protein-calorie malnutrition and was incontinent for bladder and bowel. Record review of Resident #2's Comprehensive Care Plan, dated 09/02/2025, reflected the resident had incontinence and one of the interventions was to apply barrier cream after each episode if needed. Record review of Resident #2' Physician Order, dated 08/19/2024, reflected May apply barrier cream as needed. Observation and interview on 09/02/2025 at 8:41 AM revealed Resident #2 in her wheelchair eating breakfast. It was observed that a tube of zinc oxide was on the resident's side table. When asked if the staff left the zinc oxide on her side table after using it, the resident replied with uncomprehensible words. In an interview on 09/02/2025 at 10:26, CNA B stated she was assigned on Resident #2 and did not notice the zinc oxide on the resident's side table. She said the zinc oxide should be inside the nurse's cart and not at bedside because the resident might eat it. She said she would check Resident #2's room if the zinc oxide was still there and would also check the other rooms of the residents on her hall. 3. Record review of Resident #3's Face Sheet, dated 09/02/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with age-related debility (general decline in physical and mental function due to aging). Record review of Resident #3's Quarterly MDS Assessment dated</p>