

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	

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. (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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the right to be free from misappropriation of resident property for two of five residents (Resident #1 & Resident #2) reviewed for misappropriation. The facility failed to prevent a diversion (misappropriation) of Resident #1's Amphetamine-Dextroamphetamine Oral Tablet 20 MG, about 25 pills reported missing on 09/20/2025. Amphetamine-Dextroamphetamine is used to treat ADHD. The facility failed to prevent a diversion (misappropriation) of Resident #2's Norco Oral Tablet 5-325 MG (Hydrocodone- Acetaminophen) Give 1 tablet by mouth three times a day for pain Active 10/24/2024, 87 tablets (a hydrocodone is pain reliever) delivered by pharmacy and 57 tablets reported missing on 09/25/2025. These failures could place residents at risk for decreased quality of life, unrelieved pain, misappropriation of property, and dignity. Findings included: Review of Resident #1's face sheet printed 09/29/2025 reflected a [AGE] year-old male admitted to the facility 2/17/2025. His diagnoses included multiple sclerosis, attention deficit hyperactivity disorder ADHD-(is a developmental disorder characterized by an ongoing pattern of one or more of the following types of symptoms-inattention, impulsivity, difficulty with organization, emotional dysregulation, hyperactivity) , unspecified, post traumatic disorder (is a mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it) , and anxiety disorder (involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks). Review of Resident #1's quarterly MDS assessment dated [DATE], Section C (Cognitive Patterns) reflected a BIMS score of 07 indicating severely impaired cognition. Section I (Active Diagnoses reflected Anxiety disorder, Post Traumatic Stress Disorder, Section GG (Functional Abilities) reflected he required maximal assistance with hygiene and bathing and only setup with eating. Review of Resident #1's comprehensive care plan, initiated 02/17/2025, the resident had an ADL self-care deficit related to MS, Resident is at risk for emotional and/or physical symptoms associated with distressing events and an increased inability to cope related to a diagnosis of Post Traumatic Stress Disorder. Pt reports triggers are being startled from behind and loud noises. Review of Resident #1's physician order reflected an order dated 09/23/2025 for Amphetamine-Dextroamphetamine Oral Tablet 20 MG (Amphetamine-Dextroamphetamine) Give 1 tablet by mouth one time a day for ADHD - attempt GDR. Review of Resident #1's medication administration record for April 2025, reflected Amphetamine-Dextroamphetamine Oral Tablet 20 MG (Amphetamine-Dextroamphetamine) Give 1 tablet by mouth two times a day for ADHD -Start Date- 08/25/2025 5:00 PM -D/C Date- 09/23/2025 5:11 PM Review of the Provider Investigation Report dated 09/26/2025 reflected, On the morning of 9-20-2025, the Medication Aide, [MA], was distributing medications to [Resident #1], when she noticed she could not find some of the medication of Amphetamine-Dextroamphetamine. She [MA A] recalled seeing them on her cart the day before. The narcotic count completed at the beginning of the shift appeared to match the narcotics available. However, she approached the charge nurse to ask what happened to the other blister packs asking if the medications had been removed and placed on the nurse cart or possibly in the medication room. They could not be immediately found in another cart of med room. Upon review of the count sheet record and narcotic sheet by this staff, they appeared to have recently been tampered with. Specifically, you could see that the narcotic count sheet and the Narcotic Substance Record had been scratched through in a suspicious manner. At this time, they notified the Director of Nurses, who in turn notified the Administrator. Upon arrival, the Director of Nurse expanded the investigation. The facility investigation included record reviews, observations and interviews. Interviews and record reviews reflected on September 19, 2025, following the 2p-1 Op shift, there were no discrepancies identified in the narcotic sheets and blister packs. At 2pm on September 19, 2025, there was noted a total of 31 narcotic sheets reflected on the count sheets. This included 3 blister packs of Amphetamine Dextroamphetamine (one a partial, one with a count of 20 tablets and one with a count of 30 tablets. After the following 10p-6a shift, worked by [LVN B] from September 19th through 20th, 2025, it appeared the narcotic count sheet and related blister pack had been altered by pen. It appeared the blister pack and count sheets were deliberately altered to hide the missing medications. This was apparent because one can see through the scratched over numbers. In total, it appears there is one card of 20 tablets and another card of approximately 6 tables that are missing. 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</p>		