STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676188	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millbrook Healthcare and Rehabilitation Center	1850 W Pleasant Run Rd Lancaster, TX 75146

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observation, interview, and record review, the facility failed to ensure the residents had secure and confidential personal and medical records.for one (Residents #1) of 7 residents reviewed for confidentiality of records. The facility failed to ensure LVN A did not leave Residents #1's medication blister cards on top of an unattended Medication cart on the 100 hall, while she was in Resident #2's room with the door closed. This failure could place all residents at risk of having their medical information disclosed to visitors and other residents, causing embarrassment, frustration, decreased privacy and psycho-social well-being. The findings included: Record review of Resident #1's Admission MDS Assessment completed on 03/20/25 revealed a [AGE] year-old male who admitted [DATE] with a BIMS Score of 13 (No cognitive impairment), one sided upper and lower extremity impairments and he used a wheelchair. He was dependent (Helper did all the help) with ADLs, rolling from left to right and transfers. He was always incontinent to bowel and bladder and had medically complex conditions. He had active diagnoses of atrial fibrillation, hypertension, renal insufficiency, diabetes mellites, aphasia, CVA/TIA, hemiplegia, malnutrition, anxiety, gastronomy, cognitive communication deficit, muscle weakness and dysphagia. He received scheduled pain medications and had recent surgery requiring nursing Skilled Nursing home stay for the GI tract or abdominal contents. He had an application of surgical dressings other than feet, took anti-depressant, anti-psychotic, anti-platelet and anti-convulsant medications. Record review of Resident #1's Physician Order Report printed 05/07/25 revealed 8:00 am was the time these medications were ordered to be given: Buspirone Oral Tablets 5 MG: Give 1 tablet via G-Tube three times a day for ANXIETY AEB AGITATION/RESTLESSNESS related to ANXIETY DISORDER, Pantoprazole Sodium Oral Tablets Delayed Release 40 MG: Give 1 tablet via Gtube two times a day related to DYSPHAGIA, OROPHARYNGEAL PHASE, Gabapentin Capsules 100 MG Give 1 capsule via Gtube three times a day related to MUSCLE WASTING AND ATROPHY, Escitalopram Oxalate Oral Tablets 10 MG: Give 1 tablet via G-Tube one time a day for DEPRESSION AEB: SELF ISOLATION related to ADULT FAILURE TO THRIVE, Metoprolol Tartrate Oral Tablet Give 12.5 mg via G-Tube two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's MARs for May 2025 revealed an 8:00 am time to administer his medications and LVN A initialed on 05/07/25 giving this resident, Buspirone Oral Tablet 5 MG: Give 1 tablet via G-Tube three times a day for ANXIETY AEB: AGITATION/RESTLESSNESS related to ANXIETY DISORDER, UNSPECIFIED. Escitalopram Oxalate Oral Tablet 10 MG: Give 1 tablet via G-Tube one time a day for DEPRESSION AEB: SELF ISOLATION related to ADULT FAILURE TO THRIVE. Metoprolol Tartrate Oral Tablet: Give 12.5 mg via G-Tube two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION. Pantoprazole Sodium Oral Tablet Delayed Release 40 MG: Give 1 tablet via G-Tube two times a day related to DYSPHAGIA, OROPHARYNGEAL. Gabapentin Capsule 100 MG Give 1 capsule via G-Tube three times a day related to MUSCLE WASTING AND ATROPHY. (Dantrolene Sodium Oral Capsule 25 MG: Give 1 capsule via G-Tube every evening shift for Severe Pain was on the unattended medication cart but was not initialed on the MAR as being given). Observation on the 100 hall on 05/07/25 at 10:35 am revealed, six of Resident #1's Medications on top of a Medication cart that was located in front of Resident #1's doorway. The medication cart was unattended for about one minute with Resident #1's name and his medications: Buspirone Oral Tablets 5 MG, Pantoprazole Sodium Oral Tablets Delayed Release 40 MG, Gabapentin Capsules 100 MG, Escitalopram Oxalate Oral Tablets 10 MG, Dantrolene Sodium Oral Capsule 25 MG, Metoprolol Tartrate Oral Tablet 12.5 mg. Observation and interview on 05/07/25 at 10:36 am revealed, LVN A opened the door of Resident #2's room and walked across the hallway to the medication cart in front of Resident #1's room. LVN A grabbed Resident #1's six medication cards and she was about to put them into the med cart. She stated she had just popped Resident #1's medications and gave them to him and heard Resident #2 yelling needing help. She stated she just ran over there to check on Resident #2 to adjust her O2 mask. She stated she should have put Resident #1's medication cards back into the medication cart to secure them before leaving the med cart. She stated she normally did not leave medications unattended on the medication carts but a resident was yelling. She stated leaving medications unattended could cause a HIPAA violation because the resident's names and medication names were on the medication cards. She stated the other residents would know what the resident's medications were or the residents could try to swallow the medications and they could get sick. She stated what each of the six medications were and reason why they were needed and said she mistakenly took out the Dantrolene Sodium medication but did not give to him because he only took that one at night. She stated once she adjusted Resident #2's O2 mask, she was fine. Interview on 05/07/25 at 1:12 pm, LVN B stated she never left the resident's medication cards on the med cart unattended because they had other people that walk around and the medications could end up ingesting the meds. She stated their medications were supposed to be locked up in the med cart, because it was a HIPAA violation. She stated the residents' names and personal information were on their medication cards. She stated they had a training today (05/07/25) about keeping the med carts locked and to not turn their back or step away from the med carts and not to leave the medication out. She stated they needed to prevent others from getting to the resident's medication because something could happen to the medications. She stated if they left medications out, it would fall on the nurses and medication aides. She stated medications left out could cause them to easily get grabbed by anyone. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/07/25 at 2:41 pm, LVN C stated she had not ever left medications on top of the med cart because it could result in a medication error if a resident picked up the medications and took them. She stated a resident might pick the medications up thinking they were candy or an employee or visitor could take the medications. She stated leaving medications out, could lead to suspension, in-service trainings, counseling, or termination. She stated leaving medication unattended could be a HIPAA violation because anyone could see what types of medications the residents took. She stated the last HIPAA and medication administering trainings was earlier this year. Interview on 05/07/25 at 4:41 pm, the DON stated the facility had no issues with HIPAA violations but today they did, involving LVN A leaving a resident's medication on the medication cart unattended. She stated anyone could have passed by her med cart, and the residents or anyone could have taken them off of LVN A's med cart. She stated the nurses were responsible to ensure the medications administered were inside, and locked in the medication cart before they left their medication carts. Interview on 05/07/25 at 5:18 pm, Medical Records D stated they had no issues HIPAA violations of the residents records of which she was aware. She stated for any HIPAA violation issues she would notify the Administrator about it. She stated it was a part of her and the administrator's jobs to ensure the facility was HIPAA compliant. She stated it was a HIPPA violation if a resident's medications were left unattended on the med carts. She stated if she saw that she would stand next to the med cart until that nurse arrived back to it, then report it to the Administrator. She stated today (05/07/25) this morning she saw the medication cart on the 100 hall and saw LVN A coming out of a resident's room and walking to the medication cart. She stated she asked LVN A about getting a wheelchair for a resident and did not realize a resident's medication cards were on the med cart. She stated she saw the HHSC Surveyor standing on the other side of the med cart. She stated leaving medications unattended could cause someone to use the information on the medication card to open up another medication account. She stated the information on the medication cards could be used for personal benefit because the resident's name, date of birth, medication name and dosages were on them. Interview on 05/07/25 at 5:29 pm, the Administrator stated it was brought to her attention today (05/07/25) that LVN A was getting ready to give Resident #1 his medications and Resident #2 located across the hall needed assistance. She stated LVN A went to Resident #2's room and left Resident #1's medications on top of the med cart. She stated LVN A did not follow the facility's protocol because all medications needed to be secured at all times and locked in the med cart or being given to the resident. She stated today (05/07/25) they did an in-service training with all nursing staffing and medication aides. She stated they trained the staff not to leave medications on the medication carts and to put them in the med cart locked. She stated leaving medications out could lead to different things, a resident could get them or result in a drug diversion. She stated for HIPAA violations, she was responsible, nurse administration and nurses were responsible for ensuring they were HIPAA compliant. She stated not leaving medications unattended on medication carts was nursing school 101 and LVN A knew because it could cause a breach in a resident's identity. She stated she and the DON spoke to LVN A by doing a 1 on 1 meeting with her to never leave medications on top of the med carts. She stated LVN A said while administering Resident #1's medications, she went to see about Resident #2 and repositioned her. She stated when she returned back to her med cart the HHSC state lady was standing right next to it. She stated LVN A said she was not all the way down the hall or in the dining room She stated her expectation for HIPAA was for the staff to keep the resident's medications confidential. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of LVN A's Counseling Disciplinary Notice dated unsigned by LVN A or nurse management revealed, LVN A's Date of hire: 05/29/24, date of notice: 05/07/25. Type of action being taken: Final written/warning*. 2. Reason (s) why counseling/disciplinary action is necessary, including a complete explanation of the conduct constituting the violation. If additional space is required please see attach a separate sheet. Employee is expected to keep medications secured in nurses cart at all times. No exceptions. Record review of the Facility's Training dated 05/07/25 with nine signatures including LVN A's signature revealed, Medication must be locked in cart when cart is left unattended. Only licensed nurses and Certified Medication Aides may have access to medication cart. Cart should be clean and organized. If nurses are to step away from cart for any reason, med must be stored and cart must be locked. Record review of the Facility's Resident Right policy amended 07/13/17 revealed, Privacy and confidentiality: Secure and confidential personal and medical records. Record review of the Facility's Resident/Patient confidentiality policy undated revealed, Policy: All resident health information is confidential and protected by HIPAA law. HIPPA definition - The Health Insurance Portability and Accountability Act. HIPAA is a federal law that is designed to protect the privacy and security of patient health information. Privacy rule: The HIPAA privacy Rule establishes national standards to protect individuals' medical records and other personal health information .All staff, volunteers, and vendors must not disclose any medical information about a resident, either verbally, written or electronically.

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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	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, administering, and securing of medications for one resident (Resident #1) of 9 residents reviewed for pharmacy services. The facility failed to ensure Resident #1 received 5 of his routine doctor ordered medications between 7:00 am and 9:00 am on 05/07/25; subsequently they were not given to him until around 10:35 am. This failure placed residents at risk of not receiving the physician ordered medications on time, which could cause the residents to have a change of condition, resulting in a decreased quality of life and psychosocial well-being. Findings Included: Record review of Resident #1's Admission MDS Assessment completed on 03/20/25 revealed a [AGE] year-old male who admitted [DATE] with a BIMS Score of 13 (No cognitive impairment), one sided upper and lower extremity impairments and he used a wheelchair. He was dependent (Helper did all the help) with ADLs, rolling from left to right and transfers. He was always incontinent to bowel and bladder and had medically complex conditions. He had active diagnoses of atrial fibrillation, hypertension, renal insufficiency, diabetes mellites, aphasia, CVA/TIA, hemiplegia, malnutrition, anxiety, gastronomy, cognitive communication deficit, muscle weakness and dysphagia. He received scheduled pain medications and had recent surgery requiring nursing Skilled Nursing home stay for the GI tract or abdominal contents. He had an application of surgical dressings other than feet, took anti-depressant, anti-psychotic, anti-platelet and anti-convulsant medications. Record review of Resident #1's Care Plan date initiated 11/24/25 revealed, He had a Cerebral vascular accident (stroke) related to embolism, hemiplegia/hemiparesis of left side related to stroke, hypertension related to CVA, nutritional problem related to acute kidney injury, type 2 diabetes mellitus and new peg tube, had an actual fall with no injury related to poor balance from right hemiplegia, acute/chronic pain, cardiovascular status related to arrhythmia, diabetes mellitus, ADL self-care deficit related to new admission and limited mobility, anti-anxiety related to anxiety disorder, at risk for a communication problem related to expressive aphasia, weak or absent voice. On 03/13/25 at risk for falls related to mobility deficits and impaired cognitive function or thought processes related to history of CVA. Record review of Resident #1's Physician Order Report printed 05/07/25 revealed 8:00 am was the time these medications were ordered to be given: Buspirone Oral Tablets 5 MG: Give 1 tablet via G-Tube three times a day for ANXIETY AEB AGITATION/RESTLESSNESS related to ANXIETY DISORDER, Pantoprazole Sodium Oral Tablets Delayed Release 40 MG: Give 1 tablet via Gtube two times a day related to DYSPHAGIA, OROPHARYNGEAL PHASE, Gabapentin Capsules 100 MG Give 1 capsule via Gtube three times a day related to MUSCLE WASTING AND ATROPHY, Escitalopram Oxalate Oral Tablets 10 MG: Give 1 tablet via G-Tube one time a day for DEPRESSION AEB: SELF ISOLATION related to ADULT FAILURE TO THRIVE, Metoprolol Tartrate Oral Tablet Give 12.5 mg via G-Tube two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION. (continued on next page)

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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	Record review of Resident #1's MARs for May 2025 revealed an 8:00 am time to administer his medications and LVN A initialed on 05/07/25 giving this resident, Buspirone Oral Tablet 5 MG: Give 1 tablet via G-Tube three times a day for ANXIETY AEB: AGITATION/RESTLESSNESS related to ANXIETY DISORDER, UNSPECIFIED. Escitalopram Oxalate Oral Tablet 10 MG: Give 1 tablet via G-Tube one time a day for DEPRESSION AEB: SELF ISOLATION related to ADULT FAILURE TO THRIVE. Metoprolol Tartrate Oral Tablet: Give 12.5 mg via G-Tube two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION. Pantoprazole Sodium Oral Tablet Delayed Release 40 MG: Give 1 tablet via G-Tube two times a day related to DYSPHAGIA, OROPHARYNGEAL. Gabapentin Capsule 100 MG Give 1 capsule via G-Tube three times a day related to MUSCLE WASTING AND ATROPHY. (Dantrolene Sodium Oral Capsule 25 MG: Give 1 capsule via G-Tube every evening shift for Severe Pain was on the unattended medication cart but was not initialed on the MAR as being given). Observation and interview on the 100 hall on 05/07/25 at 10:36 am revealed, LVN A opened the door of Resident #2's room and walked across the hallway to the medication cart in front of Resident #1's room. LVN A grabbed Resident #1's six medication cards and she was about to put them into the med cart. She stated she had just popped Resident #1's medications and gave them to him. Interview on 05/07/25 at 1:12 pm, LVN B stated the timeframes for giving the residents' 8:00 am medications was an hour before or after the time they were Doctor ordered. She stated she was not sure what to do if medications were given outside of that timeframe because she had not had that issue and would have to ask the DON. Interview on 05/07/25 at 2:10 pm, LVN A stated Resident#1 had right sided weakness and needed assistance with all of his ADL's. She stated Resident #1 was verbally able to make his needs known but was not able to really move right now. She stated he was a resident who had a G-tube and the nurses had to monitor his fluid intake. She stated she gave Resident #1 his first dose of medications around 8:20 am this morning (05/07/25) then he received his second round of medications around 11:00 am). She stated the nurses had an hour before and 1 hour after to give the residents their medications. She stated Resident #1's medications were ordered to be given at 8:00 am and should have been given by 9:00 am. She stated she had 32 residents on her hall and she started administering medications at the far end of the hall and worked toward the nurses station. She stated she had four residents with G-tubes and sometimes the hospice nurses had to talk to her about the residents which was time consuming. She stated she had three oxygen dependent residents and the reason the medications were given late was just a timing issue. She stated the nurses had a training today (05/07/25) about administering the resident's medications within the 1 hour before or after it was ordered. She stated she was not sure of the exact time, but last year, the nurses had a medication administering training about the 5 Rights: right patient and right time. She stated she was not sure what to do if the resident's medications were given late and was not sure how that could affect the residents. She stated their pain may not be controlled effectively or the resident could have a change in condition. She stated she had a lot to do and her hall had 32 residents and one medication aide. She stated a lot of her residents took blood thinners and took medications for seizures, diabetes, and pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/07/25 at 2:41 pm, LVN C stated the timeframes for giving the resident's their medications was an hour before and after it was ordered. She stated the resident's medications was prescribed based on their medical diagnoses. She stated if a resident was not given their medications on time depended on the situation. She stated she had not had a problem giving medications their medications outside of the parameters. She stated the Residents could have adverse reactions if medications were not given timely. She stated she had not had any trainings on what to do if the nurses got behind schedule. Interview on 05/07/25 at 4:41 pm, the DON stated the parameters for medication administering was an hour before or an hour after it was Doctor ordered. She stated they had no issues with the nurses not giving the residents their medications on time until today (05/07/25). She stated she was not sure if Resident #1 received his medications on time today. She stated it depended on the orders on how it could affect the residents if medications were given late. She stated if LVN A was busy, she should have reached out for the Doctor to see if it was okay to give the residents medications late. She stated not getting medications on time could cause anxiousness increase chances of the resident falling. She stated the resident could become anxious and fidget by moving around and have increased pain and undo stress. She stated the resident's blood pressure could get too high and they could have a heart attack resulting in a change of condition. She stated the nurses were responsible for ensuring the resident's medications were given on time but ultimately she was responsible. She stated she would expect the nurses and medication aides informed her if they were running behind with medication pass. Interview on 05/07/25 at 5:29 pm, the Administrator stated she was not aware LVN A gave Resident #1 his medications late. She stated she would have to talk to the DON and ADON about that, and that it was the nurses responsibility to give the residents their medications within the med pass parameters. She stated giving the residents their medications late depended on what the medication was taken for. She stated in Resident #1's case if his medications were given late, it could cause him to be more anxious. She stated each medication had different risks if they were not taken as Doctor ordered. She stated the expectation for medication administering was for the nursing staff to administer the resident's medications on time, and if they could not, they needed to let the DON ADON know. Record review of the facility's undated Med Pass times for 100 hall and 200 hall revealed, Daily 8 am. Record review of the facility's undated Med Pass times for G-Tube Meds Time Codes undated revealed, QD 8 am. Record review of the facility's Medication Administration policy revised 07/2020 revealed, Policy: It is the policy of this facility that medications shall be administered as prescribed by the attending physician. Procedures: 2. Medications must be administered in accordance with the written orders of the attending physician .5. Scheduled medications must be administered within the facility time frame .7. If a medication is withheld, refused, or given other than the scheduled time, the documentation will be reflected in the clinical record .The seven rights of medication administering are as follows in order to ensure safety and accuracy of administration .1. Right resident, 2. Right time, 3. Right medication, 4. Right dose, 5. Right route, 6. Right documentation, 7. Right diagnosis. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Pharmacy Services/ Nursing Services: Physician Orders revised 07/2022 revealed, Policy: It is the policy of this facility that drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs. It is the policy of this facility to accurately implement orders in addition to medication orders (treatment procedures) only upon the written order of licensed and authorized to do in accordance with the resident's plan of care. Procedures: 2. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. The signing of orders shall be by signature or a personal computer key.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were in locked compartments for 1 (Residents #1) of 7 residents reviewed for medication storage. The facility failed to ensure LVN A did not leave Residents #1's medication blister cards on top of an unattended Medication cart on the 100 hall, while she was in Resident #2's room with the door closed. This failure could place all residents at risk of having their medications taken or consumed by other residents, which could cause a shortage of their medications or cause a change in their medical condition resulting in a decline in their health and psycho-social well-being. The findings included: Record review of Resident #1's Admission MDS Assessment completed on 03/20/25 revealed a [AGE] year-old male who admitted [DATE] with a BIMS Score of 13 (No cognitive impairment), one sided upper and lower extremity impairments and he used a wheelchair. He was dependent (Helper did all the help) with ADLs, rolling from left to right and transfers. He was always incontinent to bowel and bladder and had medically complex conditions. He had active diagnoses of atrial fibrillation, hypertension, renal insufficiency, diabetes mellites, aphasia, CVA/TIA, hemiplegia, malnutrition, anxiety, gastronomy, cognitive communication deficit, muscle weakness and dysphagia. He received scheduled pain medications and had recent surgery requiring nursing Skilled Nursing home stay for the GI tract or abdominal contents. He had an application of surgical dressings other than feet, took anti-depressant, anti-psychotic, anti-platelet and anti-convulsant medications. Record review of Resident #1's Physician Order Report printed 05/07/25 revealed 8:00 am was the time these medications were ordered to be given: Buspirone Oral Tablets 5 MG: Give 1 tablet via G-Tube three times a day for ANXIETY AEB AGITATION/RESTLESSNESS related to ANXIETY DISORDER, Pantoprazole Sodium Oral Tablets Delayed Release 40 MG: Give 1 tablet via Gtube two times a day related to DYSPHAGIA, OROPHARYNGEAL PHASE, Gabapentin Capsules 100 MG Give 1 capsule via Gtube three times a day related to MUSCLE WASTING AND ATROPHY, Escitalopram Oxalate Oral Tablets 10 MG: Give 1 tablet via G-Tube one time a day for DEPRESSION AEB: SELF ISOLATION related to ADULT FAILURE TO THRIVE, Metoprolol Tartrate Oral Tablet Give 12.5 mg via G-Tube two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676188	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millbrook Healthcare and Rehabilitation Center	1850 W Pleasant Run Rd Lancaster, TX 75146

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's MARs for May 2025 revealed an 8:00 am time to administer his medications and LVN A initialed on 05/07/25 giving this resident, Buspirone Oral Tablet 5 MG: Give 1 tablet via G-Tube three times a day for ANXIETY AEB: AGITATION/RESTLESSNESS related to ANXIETY DISORDER, UNSPECIFIED. Escitalopram Oxalate Oral Tablet 10 MG: Give 1 tablet via G-Tube one time a day for DEPRESSION AEB: SELF ISOLATION related to ADULT FAILURE TO THRIVE. Metoprolol Tartrate Oral Tablet: Give 12.5 mg via G-Tube two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION. Pantoprazole Sodium Oral Tablet Delayed Release 40 MG: Give 1 tablet via G-Tube two times a day related to DYSPHAGIA, OROPHARYNGEAL. Gabapentin Capsule 100 MG Give 1 capsule via G-Tube three times a day related to MUSCLE WASTING AND ATROPHY. (Dantrolene Sodium Oral Capsule 25 MG: Give 1 capsule via G-Tube every evening shift for Severe Pain was on the unattended medication cart but was not initialed on the MAR as being given). Observation on the 100 hall on 05/07/25 at 10:35 am revealed, six of Resident #1's Medications on top of a Medication cart that was located in front of Resident #1's doorway. The medication cart was unattended for about one minute with Resident #1's name and his medications: Buspirone Oral Tablets 5 MG, Pantoprazole Sodium Oral Tablets Delayed Release 40 MG, Gabapentin Capsules 100 MG, Escitalopram Oxalate Oral Tablets 10 MG, Dantrolene Sodium Oral Capsule 25 MG, Metoprolol Tartrate Oral Tablet 12.5 mg. Observation and interview on 05/07/25 at 10:36 am revealed, LVN A opened the door of Resident #2's room and walked across the hallway to the medication cart in front of Resident #1's room. LVN A grabbed Resident #1's six medication cards and she was about to put them into the med cart. She stated she had just popped Resident #1's medications and gave them to him and heard Resident #2 yelling needing help. She stated she just ran over there to check on Resident #2 to adjust her O2 mask. She stated she should have put Resident #1's medication cards back into the medication cart to secure them before leaving the med cart. She stated she normally did not leave medications unattended on the medication carts but a resident was yelling. She stated leaving medications unattended could cause other residents to know what the resident's medications were or the residents could try to swallow the medications and they could get sick. She stated what each of the six medications were and reason why they were needed and said she mistakenly took out the Dantrolene Sodium medication but did not give to him because he only took that one at night. She stated once she adjusted Resident #2's O2 mask, she was fine. Interview on 05/07/25 at 1:12 pm, LVN B stated she never left the resident's medication cards on the med cart unattended because they had other people that walk around and the medications could end up ingesting the meds. She stated their medications were supposed to be locked up in the med cart. She stated they had a training today (05/07/25) about keeping the med carts locked and to not turn their back or step away from the med carts and not to leave the medication out. She stated they needed to prevent others from getting to the resident's medication because something could happen to the medications. She stated if they left medications out, it would fall on the nurses and medication aides. She stated medications left out could cause them to easily get grabbed by anyone. Interview on 05/07/25 at 2:41 pm, LVN C stated she had not ever left medications on top of the med cart because it could result in a medication error if a resident picked up the medications and took them. She stated a resident might pick the medications up thinking they were candy or an employee or visitor could take the medications. She stated leaving medications out, could lead to suspension, in-service trainings, counseling, or termination. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/07/25 at 4:41 pm, the DON stated today (05/07/25) LVN A left a resident's medication on the medication cart unattended. She stated anyone could have passed by her med cart, and the residents or anyone could have taken them off of LVN A's med cart. She stated the nurses were responsible to ensure the medications administered were inside, and locked in the medication cart before they left their medication carts. Interview on 05/07/25 at 5:18 pm, Medical Records D stated if a resident's medications were left unattended on the med carts. She stated if she saw that she would stand next to the med cart until that nurse arrived back to it, then report it to the Administrator. She stated today (05/07/25) this morning she saw the medication cart on the 100 hall and saw LVN A coming out of a resident's room and walking to the medication cart. She stated she asked LVN A about getting a wheelchair for a resident and did not realize a resident's medication cards were on the med cart. She stated she saw the HHSC Surveyor standing on the other side of the med cart. She stated leaving medications unattended could cause someone to use the information on the medication card to open up another medication account. She stated the information on the medication cards could be used for personal benefit because the resident's name, date of birth, medication name and dosages were on them. Interview on 05/07/25 at 5:29 pm, the Administrator stated it was brought to her attention today (05/07/25) that LVN A was getting ready to give Resident #1 his medications and Resident #2 located across the hall needed assistance. She stated LVN A went to Resident #2's room and left Resident #1's medications on top of the med cart. She stated LVN A did not follow the facility's protocol because all medications needed to be secured at all times and locked in the med cart or being given to the resident. She stated today (05/07/25) they did an in-service training with all nursing staffing and medication aides. She stated they trained the staff not to leave medications on the medication carts and to put them in the med cart locked. She stated leaving medications out could lead to different things, a resident could get them or result in a drug diversion. She stated not leaving medications unattended on medication carts was nursing school 101 and LVN A knew because it could cause a breach in a resident's identity. She stated she and the DON spoke to LVN A by doing a 1 on 1 meeting with her to never leave medications on top of the med carts. She stated LVN A said while administering Resident #1's medications, she went to see about Resident #2 and repositioned her. She stated when she returned back to her med cart the HHSC state lady was standing right next to it. She stated LVN A said she was not all the way down the hall or in the dining room. Record review of LVN A's Counseling Disciplinary Notice dated unsigned by LVN A or nurse management revealed, LVN A's Date of hire: 05/29/24, date of notice: 05/07/25. Type of action being taken: Final written/warning*. 2. Reason (s) why counseling/disciplinary action is necessary, including a complete explanation of the conduct constituting the violation. If additional space is required please see attach a separate sheet. Employee is expected to keep medications secured in nurses cart at all times. No exceptions. Record review of the Facility's Training dated 05/07/25 with nine signatures including LVN A's signature revealed, Medication must be locked in cart when cart is left unattended. Only licensed nurses and Certified Medication Aides may have access to medication cart. Cart should be clean and organized. If nurses are to step away from cart for any reason, med must be stored and cart must be locked. Record review of the Facility's Resident Right policy amended 07/13/17 revealed, Privacy and confidentiality: Secure and confidential personal and medical records. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Recorde of the Facility's Medication Access and Storage/Destruction policy dated 7/2023 revealed, Policy: It is the policy of this facility to store all drugs and biologicals in locked compartments under proper temperature controls. The medication supply is assessible only to licensed nursing personnel, pharmacy personnel, or staff member authorized to administer medications: Procedures Only licensed nurses, consutltant pharmacist and those lawfully authorized to administer medications (e.g. medication aides) are allowed access to medications, medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.