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	12/02/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 (Resident #1) of 6 residents, reviewed for care plans. 1. The facility failed to follow the care plan and assess Resident #1 for pain at the start of each shift since 09/17/25. These failures could place the residents at risk of not receiving the care and services to maintain their highest practicable physical, mental, and psychosocial well-being.Findings Included:Record review of Resident #1's face sheet, dated 09/25/25, reflected an [AGE] year-old female, who admitted to the facility on [DATE]. Resident #1 had diagnoses of Dementia (decline in memory, thinking, problem-solving, and reasoning), Cognitive Communication Deficit (difficulty with communication), Type 2 Diabetes (body cannot use insulin properly or produce it), Essential Hypertension (high blood pressure), Heart Failure, Muscle Weakness, Peripheral Vascular Disease (blood vessels typically in the legs become narrowed or blocked), and a history of falling.Record review of Resident #1's Initial MDS Assessment, dated 09/09/5, reflected Resident #1 had a BIMS score of 07, which indicated Resident #1 had severe cognitive impairment. The MDS Assessment noted a pain assessment was completed upon admission, and no pain was noted.Record review of Resident #1's Care Plan reflected the following: Has acute/chronic pain r/t PVDDate initiated 09/08/2025Monitor/document for probable cause of each pain episode. Remove/limit causeswhere possible. Pain assessment every shift.In an interview on 09/25/25 at 2:40 PN, the DON Trainee stated if the care plan stated Resident #1 was to be assessed for pain every shift, then staff should have assessed for pain every shift, and those assessments would have been documented. She stated the nursing staff would be responsible for checking and documenting the pain level of residents. The DON Trainee stated the risk of not completing pain assessments as noted on the care plan was the resident could be in pain and staff would not be aware. The DON Trainee stated she would provide verification of the documented pain levels. Record review of a document titled, Weights and Vitals Summary dated 09/25/25, reflected the following dates and times for pain level checks:09/08/25 16:03 (4:03 PM) Pain Level noted as 009/09/25 16:19 (4:19 PM) Pain Level noted as 009/10/25 16:12 (4:12 PM) Pain Level noted as 009/11/25 16:12 (4:12 PM) Pain Level noted as 009/12/25 15:34 (3:34 PM) Pain Level noted as 009/13/25 6:06 (6:06 AM) Pain Level noted as 009/14/25 7:11 (7:11 AM) Pain Level noted as 009/15/25 15:23 (3:23 PM) Pain Level noted as 009/16/25 15:44 (3:44 PM) Pain Level noted as 009/17/25 15:23 (3:23 PM) Pain Level noted as 009/18/25 15:40 (3:40 PM) Pain Level noted as 009/19/25 15:36 (3:36 PM) Pain Level noted as 109/20/25 10:20 (10:20 AM) Pain Level noted as 009/23/25 11:52 (11:52 AM) Pain Level noted as 609/23/25 15:00 (3:00 PM) Pain Level noted as 0In an interview on 09/25/25 at 4:02 PM, the Administrator stated that care planning was on the nursing side, but everything on the care plan should be followed to ensure the best care for the resident.Record review of the facility's policy titled, Care Planning, dated 07/2020, reflected the following: Policy:It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident.The resident's plan of care focus, goals, and interventions are communicated and implemented by the members of the health care continuum accordingly.

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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. Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 3 Medication Carts (Medication Cart #1) reviewed for pharmacy services. 1. The facility failed to ensure Medication Cart #1 did not include discontinued medication, Lorazepam (Ativan) for Resident #1 after it was discontinued on 09/19/25. This failure could place residents at risk of receiving discontinued medication and possible adverse reactions.Findings Include:Record review of Resident #1's order summery on the electronic record, dated 09/25/25, reflected Lorazepam Oral Tablet 0.5 MG was discontinued.Record review of Resident #1's September 2025 Medication Administration Record reflected the Lorazepam was discontinued on 09/19/25.Record review of a progress note completed by the ADON on Resident #1's electronic record, dated 09/19/25, reflected the following: [Family Member does not [Resident #1] to take Ativan in fear of her becoming drowsy. This nurse states to her that I will reach out to [NP]. This nurse notifies NP with concerns from the [Family Member], and new order to discontinue Ativan 0.5mgIn an observation and interview on 09/25/25 at 1:55 PM, the Lorazepam was observed still on the cart for Resident #1. LVN A stated the Lorazepam was discontinued and she guessed it should be removed from the medication cart. She stated she understood the risk of discontinued mediation on the cart and would remove it. LVN A stated the risk was possible drug diversion. In an interview on 09/25/25 at 3:53 PM, the DON Trainee stated she started working at this facility some days ago and was not sure about their policy on discontinued medications, but from her training discontinued drugs should be quickly removed from the cart and destroyed to avoid issues like giving a discontinued medication to a resident. The DON Trainee stated the ADON would know the facility policy on discontinued medication.In an interview on 09/25/25 at 3:56 PM, the ADON stated the discontinued medications were given to the DON, but the DON was on leave. She stated the nurses who were responsible for the medication cart would continue to count the medication until the DON returned. The ADON stated the DON was the only one who had the key to the narcotic closet. The ADON stated she felt there was no risk of the discontinued medication that remained on the medication cart, because the nurses continued to count the medication to ensure there was no drug diversion.In an interview on 09/25/25 at 4:02 PM, the Administrator Trainee stated she would follow-up with the DON regarding discontinued medication when she returned. She stated she did not know much about medications like the DON would know and was not sure of the specific risks.Record review of the facility's policy, titled, Medication Access and Storage / Drug Destruction, dated 7/2023, reflected the following: Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order exists. Medication destruction is to be handled in accordance with CMS and Texas Administrative codes on Pharmacy and Drug Destruction. Narcotics are given to the Director of Nursing for destruction. They are inventoried and counted and kept under a double lock system until medication destruction can be completed with the Consultant Pharmacist.