STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676194	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mason Creek Transitional Care of Katy	21727 Provincial Blvd Katy, TX 77450

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments for two of eight medication carts observed for medication security. -An unlocked and unattended medication cart was observed in a resident hall (Hall 400). -An unlocked medication cart (Hall 300 Nurse's medication cart) was observed near the nurses' station, with the assigned nurse in another room with her back turned.The failure placed the residents at risk of drug diversion by staff, residents, and visitors, overdose, or residents' medications not being available when needed. Findings included:Observation and interview on 03/12/2026 at 08:19 a.m. revealed an unlocked and unattended medication cart in front of a resident's room. The room was the most distant from the nurses' station, located near the hall exit. The doors of the residents' rooms near the medication cart were observed to be closed. There were no staff within sight of the cart. At 08:21 a.m., LVN A exited room [ROOM NUMBER] into the hallway. She said she had been in the room for between 10 and 15 minutes. She said she should have locked the cart. She said any person could have gotten into the cart. In an interview on 03/12/2026 at 10:42 a.m., the DON said the medication cart should be locked if the Nurse or Medication Aide was in a room. She added that if the cart was left unlocked, anyone could get into the contents.Observation and interview on 03/12/2026 at 12:41 p.m. revealed an unlocked medication cart at the nurses' station, near the 300 Hall. The surveyor stood next to the unlocked cart for approximately 30 seconds. A nurse from the other side of the nurses' station approached the cart and locked it. She said it was not her cart. She then went to the dining room and alerted LVN B, who was sitting at a table with her back to the nurses' station. The DON approached the medication cart as did LVN B. The DON said she had provided an in-service that day about locking medication carts. LVN B then said she had seen the surveyor standing by the medication cart. When the surveyor asked LVN B how long he had been standing by the cart, LVN B replied, Five minutes. A long time. The surveyor informed her he had been next to the cart for approximately 30 seconds. Record review of the in-service dated 03/12/2026 revealed the topic Keeping Medication Carts Locked at All Times revealed LVN A and LVN B both attended.The facility's policy Security of Medication Cart (revised April 2007) read, in part, . The nurse must secure the medication cart during the medication pass to prevent unauthorized entry.4. Medication carts must be securely locked at all times when out of the nurse's view.

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