

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2025
NAME OF PROVIDER OR SUPPLIER Tuscany Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2750 Miller Ranch Rd Pearland, TX 77584	
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. Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 4 (Cart #3) medication carts reviewed for storage of drugs. The facility failed to ensure that staff personal items were not stored in the medication cart per facility policy. This failure could place residents at risk of medications being cross contaminated with unknown substances in the personal items and possible medication diversion. Findings included: Observation on 8/20/2025 at 9:35 a.m. revealed MA A's personal belongings (handbag, make up bag, lunch bag) in the bottom drawer of medication cart #3. During interview on 8/20/2025 at 9:37 a.m., MA A, said she was sorry, that she always went to the locker room to put her personal items, but she completely forgot. When asked, the risk of leaving personal items in the resident's medication cart, she stated, things can spill, causing contamination and drug diversion could happen. During interview on 8/22/2025 at 3:25 p. m, the DON said staff personal items were not supposed to be in the resident's medication cart. All staff personal items were placed in the locker in the breakroom. When asked, the risk of leaving personal items in the resident's medication cart, she stated, that there could be drug diversion. Record review of facility's undated policy titled employee Handbook - Team Member Property revealed All team members personal belongings shall be stored in the employee breakroom.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen in that:- 1 one-Gal Ziploc bag of hot dogs was not labeled, not dated in the walk-in refrigerator- 1 one-Gal Ziploc bag of peas and carrots was not labeled, not dated in the walk-in freezerThese deficient practices could place residents who received meals from the kitchen at risk for food borne illness.Findings included: Observation on 8/19/25 at 8:41 A.M. in the walk-in refrigerator revealed one-gallon sized bag of hot dogs not labeled and not dated.Observation on 8/19/25 at 8:55 A.M. in the walk-in freezer revealed one-gallon sized bag of peas and carrots not labeled and not dated. In an interview on 8/21/25 at 2:20 P.M. with the Food Service Manager, she said there was a new Dietary Aide that was cleaning when the groceries came in and he probably put the items on the shelves without labeling them. The Food Service Manager said all dietary staff knew to label and date items in the refrigerator and freezer. She said the Cooks should go behind staff to make sure all food items were labeled and dated. The Food Service Manager said the risk to the resident when food was not labeled or dated was it could make the residents sick because she would not know how long the food had been in the kitchen. In an interview with [NAME] A on 8/21/25 at 2:25 PM, she said all kitchen staff were responsible for labeling and dating. She said the cooks were the ones that went behind kitchen staff to make sure all items were dated. [NAME] A said the groceries came in on Monday and Wednesday and she would label the food items as soon as they came in. [NAME] A said the hot dogs and peas and carrots were not labeled because it could have been a last-minute order placed by a resident and staff were rushing and forgot to label the items. [NAME] A said the risk to the resident when food items were not labeled was, they could get sick because she would not know how long the food had been in the refrigerator and freezer. In an interview with Dietary Aide A on 8/21/25 at 2:30 PM, she said the kitchen staff should label food items after each meal. She said the risk to the resident when food items were not labeled was, they could get sick because residents already had a compromised system and any food that was even a few days old could make them sick. Record review of the policy titled Food Labels in Dietary dated March 2004 read in part . all foods taken out of the original packaging must be labeled from date opened or use by date. Perishable items stored in refrigerator or freezer must also be labeled with a use by date and date opened if expiration date not stamped on food container .		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 1 of 5 residents (Resident #31) reviewed for clinical records. The facility failed to ensure Resident #31's Hydrocodone-Acetaminophen tablet 10-325 mg was documented on the MAR for Hydrocodone doses that were pulled 8/17/25 at 10:34 p.m. and 8/18/25 at 6:41 a.m. This failure could place the residents at risk of not receiving therapeutic doses of their medication and/or emotional distress. Findings included: Record review of Resident #31's face sheet dated 8/21/2025, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Intrahepatic Bile Duct Carcinoma (cancer that is in the bile ducts in the liver). Record review revealed that Resident #31's admission MDS was currently in progress. Record review of Resident #31's Order Summary Report dated 8/21/25 revealed Hydrocodone-Acetaminophen Tablet 10-325 mg with instructions to give 1 tablet by mouth every 4 hours as needed for pain with order and start date of 8/12/25. Record review of Resident #31's Administered Transaction Log for time period of 8/1-8/21/25 revealed that Hydrocodone/APAP 10-325 mg tablet was pulled on 8/17/25 at 10:34 p.m. and 8/18/25 at 6:40 a.m. by RN A. Record review of Resident #31's August 2025 MAR revealed documented administration of Hydrocodone-Acetaminophen Tablet 10-325 mg on 8/17/25 at 6:15 p.m. with the next dose documented on 8/18/25 at 1:33 p.m. During interview on 8/19/25 at 10:39 a.m., Resident #31's family member expressed concern that they could not get a clear answer regarding when Resident #31's last Hydrocodone was administered when they returned on 8/18/25. Resident #31's family member said when they returned on 8/18/25 the board in Resident #31's room had 6:45 a.m. for the last Hydrocodone administration but was told by staff that it was 6 p.m. the night before on their records. Resident #31's family member said they were aware that Resident #31 had received pain medication around 11 p.m. to midnight prior on 8/17/25. Resident #31's family member said they were not present but that other family members who were present believed Resident #31 had received pain medication that morning of 8/18/25. Resident #31's family member said she never received a for sure answer if Resident #31 had gotten pain medication from staff. During interview on 8/21/25 at 1:46 p.m., the state surveyor explained to the DON according to the Administration Transaction Log for Resident #31 there was Hydrocodone pulled on 8/17/25 at 10:34 p.m. and 8/18/25 at 6:41 a.m. which was not documented on the MAR but Resident #31's family member had reported that pain medication was administered to Resident #31 around those times. During interview on 8/21/25 at 3:15 p.m., the DON said it looked like RN G had pulled the Hydrocodone for Resident #31 during the night of 8/17-8/18/25 per the Administration Transaction Log. During interview on 8/21/25 at 3:17 p.m., RN G said she remembered LVN R had pulled medications for Resident #31 during the night shift of 8/17-8/18/25 and she was the witness. During interview on 8/21/25 at 3:17 p.m. the DON said the automated medication dispensing system required two witnesses to pull any narcotic medications. The DON said she had not had any issues with LVN R not documenting medications. The DON said pain medication should be documented on the MAR right after being administered. The DON said the automated medication dispensing system had its own limit so it would not let staff pull the next dose before it was due for narcotics. The DON said audits were done on MARs and TARs for holes or missing documentation by the managers who were assigned different halls that they monitored. The DON said the managers audited daily and this task was worked into their daily work week. The DON said she did not have any knowledge regarding the medications being administered to Resident #31 as she was not present. During interview on 8/21/25 at 3:40 p.m., LVN R said she remembered pulling and administering medications for Resident #31 during the night of 8/17/25 around 10:30 p.m. and then (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before 7 a.m. the following day. LVN R said they must have two staff to pull narcotics from the automated medication dispensing system. LVN R said she pulled the medications from the automated medication dispensing system and took them straight to the room. LVN R said she had an admission that night and it was hectic. LVN R said she was not sure if she documented the Hydrocodone administration on the MAR. LVN R said she normally documented immediately on the laptop and documented the time the medication was given after going to the automated medication dispensing system. LVN R said training she received from the facility included that when they got medication they had to document, get the pain level and go back and check and see if the medication worked. LVN R said this was what she always did. LVN R said she received in-services weekly from the facility but they were not limited to medications. LVN R said an effect the resident could receive if pain medication was not documented on the MAR was that it could affect follow up with the progress of the medication. During interview on 8/21/25 at 3:50 p.m. the DON said an effect the resident could have if a pain medication was not documented on the MAR was that someone could assume that the pain medication was not administered but the automated medication dispensing system would not let them pull medication if it was not time for the next dose. The DON said that there were three managers, Unit Manager A, Unit Manager B who was off right now and Unit Manager C who worked evenings. During interview on 8/21/25 at 3:53 p.m., Unit Manager A said she tried to do MAR and TAR audits daily or every two days. Unit Manager A said the audit included making sure medications were administered and if not administered then what the reason was. Unit Manager A said she checked to see if as needed medications were given. Unit Manager A said she oversaw the #300 and #600 hallways. Unit Manager A said if she found an issue she reached out to the nurse or medication aide and let them know what happened or to fix it. Record review of the facility's policy Documentation of Medication Administration with revision date of November 2022 revealed A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication administration record (MAR) and Administration of medication is documented immediately after it is given.		