STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676208	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Crest Rapid Recovery	9602 Huffmeister Rd Houston, TX 77095

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 - 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** 27846 Based on observation, interview, and record review the facility failed to ensure that drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles for 1 of 7 Residents (Resident #12) reviewed for medication storage. LVN A left Resident #12's insulin unattended at her bedside. The failure could place residents at risk for possible drug diversions or accidental ingestion. Findings included: Resident #12 Record review of Resident #12's admission face sheet dated 06/20/2024 revealed the resident was admitted on [DATE]. Resident #12 was an [AGE] year-old female. The resident's admitting diagnosis included Type 2 diabetes mellitus (elevated blood sugar). Record review of Resident #12's annual Minimum Data Set (MDS) dated [DATE] revealed Cognitive Patterns Brief Interview for Mental Status (BIMS) Summary Score of 13 out of 15 indicating the resident's cognition was intact. Resident 12's Functional Abilities and Goals revealed the resident required supervision or touch assistance to move from bed to chair. Resident 12's active diagnosis revealed diabetes mellitus. Record review of Resident #12's care plan focus onset dated 06/21/2022 revealed: Focus: Resident #12 had an alteration in blood glucose related to diabetes mellitus; Goal: The resident had no complications related to diabetes; Approach: Diabetes medications as ordered by doctor. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #12's Physician Order Summary Report dated 06/20/2024 revealed Basaglar (long acting insulin) Kwikpen (disposable insulin pen with dial up dosage and push button extension to dispense insulin) 28 units subcutaneous (insertion of medication under the skin by injection) one time a day. Record review of Resident #12's Medication Administration Record dated 06/01/2024-06/30/2024 revealed LVN A administered 28 units of insulin to Resident #12 on 06/19/2024. During an observation on 06/19/2024 at 7:25 AM revealed LVN A removed Resident #12's Basaglar insulin Kwikpen from the medication cart. LVN A dialed the flex pen to administer 28 units of insulin. As the observation continued at 7:25 AM LVN A carried the Basaglar insulin Kwikpen to Resident #12's bedside. LVN A placed the medication on the table approximately 5 feet from the resident's bed. Resident #12 was sitting up in bed awake and alert. LVN A walked into the bathroom to wash her hands. The medication was left unattended at the resident's bedside. At 7:26 AM LVN A returned to the resident's bedside. During an observation and interview on 06/19/2024 at 1:00 PM revealed Resident #12 was sitting up in a wheelchair in her room next to her bed. Resident #12 stated she did not see the medicine on her table. During an interview on 06/20/2024 at 10:05 AM the covering DON stated her expectations for medication security was to follow the facility policy and procedure. She stated all medications were to be secured. Medications were not to be left out in the open where a resident or someone could take it. The covering DON continued and stated the medications were to be out of sight to keep the residents safe. She stated all medications were to be locked. The covering DON stated there were multiple risks to the medications not being secured. Residents or staff could take the medications. The covering DON stated the policy was all medications were secured. The nurses, charge nurses, ADON and DON were responsible for ensuring medications were secured and not left unattended by rounding multiple times during their shift. The covering DON stated the nurse did not follow the facility policy and procedure for medication storage. The resident was at risk of getting the medication. During an interview on 06/20/2024 at 10:19 AM the Administrator stated the policy was all medications were to always be locked where residents and family cannot have access to the medication. The Administrator stated the nurses and managers were responsible for monitoring the medications were secured by rounding every shift. She stated the risk was the resident could get the medication and be harmed. During a phone interview on 06/20/2024 at 10:49 AM LVN A stated she did leave the insulin at the resident's bedside while she went to the bathroom and washed her hands. LVN A stated she should not have done that. Medications were to be kept with you . The LVN stated the risk was the resident would get the medication and stick herself. To prevent this in the future she would be more careful. She should keep the medication with her so the resident could not get the medication. The nurse was responsible for locking the cart before leaving it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Storage of Medications revision dated November 2020 reflected in part, Policy heading The facility stores all drugs and biologicals in a safe, secure, and orderly manner .1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperatures, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications . 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner .