STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676234	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village at Gleannloch Farms	9505 North Pointe Blvd Spring, TX 77379

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** Number of residents sampled: Number of residents cited: Based on observations, interviews, and record reviews, the facility failed to ensure all drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for 1 of 2 medication carts (Cart B) and 1 of 1 medication storage rooms, reviewed for medication storage.- The facility failed to ensure 2 albuterol inhalers without an open date for Resident #24 and a Fluticasone-Salmeterol inhaler without an open date for Resident #24, were removed from Medication Cart B.- The facility failed to ensure a box of Juven packets with 19 packets in it, expired 9/1/25, and a glucose test trip bottle without an open date on it, were removed from Medication Cart B.- The facility failed to ensure a box of Align with 7 capsules in it, expired 8/31/25, was removed from the medication storage room. These failures could place residents at risk of not receiving therapeutic benefits of the medication, adverse reactions, inaccurate test results, and hospitalization.Findings included:Record review of Resident #24's undated face sheet revealed she was a [AGE] year-old female, readmitted [DATE], and originally with an original admitted admission date of 5/22/25. Her diagnoses included COPD (progressive lung disease causing airflow limitation and breathing problems), Afib (irregular heartbeat), dysphagia (trouble swallowing), dementia (progressive or persistent loss of intellectual functioning), major depression, HTN (high blood pressure), anemia (low iron), and polyneuropathy (nerve pain).Record review of Resident #24's admission MDS assessment, dated 8/7/25, revealed a BIMS score of 15 out of 15, which indicated normal cognition. The MDS revealed the resident had asthma (COPD) or chronic lung disease and had shortness of breath or trouble breathing when lying flat.Record review of Resident #24's Care Plan, dated 8/2/25, revealed a Focus: Resident has COPD, with a goal of optimal breathing pattern daily through the review date. The interventions were to give aerosols or bronchodilators (medications that open the lungs) as ordered, monitor for breathing difficulty, elevate the head of the bed, monitor for s/sx of acute respiratory insufficiency (not enough oxygen in the blood), and monitor/document/report to MD any s/sx of respiratory infection.Record review of Resident #24's H&P, dated 8/28/25, at 9:15am from CNS P, revealed the resident was taking Advair Diskus (fluticasone propion-salmeterol) 100-50 mcg/dose, 1 puff inhale orally BID for COPD/asthma.Record review of Resident #24's Physician Orders as of 9/10/25, revealed the following orders from MD N:- Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) mcg/act (Albuterol Sulfate), 2 puff inhale orally BID for asthma. Ordered on 8/1/25, discontinued 8/4/25.- Advair Diskus Aerosol Powder Breath Activated 100-50 mcg/dose (Fluticasone-Salmeterol), 1 puff inhale oral every 12hrs for COPD/asthma. Ordered on 8/4/25.In an observation on 9/10/25 at 11:45am, medication Cart B had 2 Albuterol Sulfate inhalers of Resident 24's that did not have an open date on them and 1 Fluticasone-Salmeterol inhaler of Resident #24's (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 - Some	that had an open date of 8/3/25, which was past the 30 days of being opened. There was also a box of Juven Nutrition Powder in the cart with 19 packets in it that had expired 9/1/25, and a bottle of glucose test strips that did not have an open date on it and were only good for 30 days after opening. In an observation and interview on 9/10/25 at 11:55am, the medication storage room had a box of Align (probiotic) with 7 pills left in the box that had expired on 8/31/25. RN L said there was no one assigned to monitor the medications for those expired. She said all the nurses looked at the expiration dates as they were giving medications. She said all the nurses were responsible for checking the dates on the medications in the medication carts as well. RN L said if a resident took an expired medication, it would not be as effective.In an interview on 9/10/25 at 3:25pm, the DON said she expected the staff to be mindful before administering medications and to look at the expiration date before giving them. She said the facility had someone who looked in the medication storage closet for expired medications and she would get with them about being more thorough. The DON said the medication carts were checked by the staff who were using the cart, and they should be checking them as they gave the medications. She said inhalers should be dated as soon as they were first opened and then they were only good for 30 days because they could get bacteria in them and not be as effective. She said glucose strips were supposed to be dated as soon as they were opened as well and were only good for 30 days because they lost effectiveness. The DON said if a resident took an expired medication, a number of adverse effects could happen, but also the medication would not work as well.Record review of the facility's policy and procedure on Medication Labeling and Storage, (Revised February 2023), read in part: .If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.Record review of the facility's policy and procedure on Administering Medications, (Revised April 2019), read in part: .The director of nursing services supervises and directs all personnel who administer medications and/or have related functions.The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 10%, based on 3 errors out of 28 opportunities, which involved 1 of 4 residents (Resident #13) reviewed for medication administration.- RN A failed to administer Fluticasone Propionate nasal spray 50mcg/act, Biotin 5000mcg, and Magnesium Oxide 400mg to Resident #13 on 9/9/25, resulting in missed doses.This failure could place residents at risk of incomplete therapeutic outcomes, increased negative side effects, and decline in health.Findings included:Record review of Resident #13's undated face sheet revealed she was a [AGE] year-old female admitted [DATE] and readmitted [DATE]. She had diagnoses of acute sinusitis (sinus infection), afib (irregular heartbeat), major depression, osteoarthritis (protective cartilage wears away, causing pain, stiffness, and swelling), GERD (reflux), HTN (high blood pressure), polyneuropathy (nerve pain), cardiac pacemaker (controls heart rate), and arthrodesis (surgical immobilization of a joint by fusion of the adjacent bones).Record review of Resident #13's admission MDS assessment, dated 8/7/25, revealed a BIMS score of 15 out of 15 which indicated normal cognition.Record review of Resident #13's Care Plan, dated 8/1/25, revealed a Focus: Medication Management with a goal that the resident would be informed of the medication regimen. The interventions included confirming all orders with the MD, the pharmacist's medication review with recommendations, and reviewing the medication list.Record review of Resident #13's H&P, dated 9/8/25, at 9:00am by MD N revealed she was taking Magnesium Oxide Oral Tablet 400mg, 1 tablet PO BID for supplement, Biotin Oral Tablet 5000mcg, 1 PO Qam for supplement and Fluticasone Propionate 50mcg/actuation spray, 1 spray in each nostril Qam for allergen control.Record review of Resident #13's Physician Orders as of 9/9/25, by MD N revealed the following orders:- Fluticasone Propionate Nasal Suspension 50mcg/act, 1 spray in each nostril Qam for allergen control. Ordered on 8/1/25.- Biotin Oral Tablet 5000mcg, Give 1 tablet PO Qam for supplement. Ordered on 8/4/25.- Magnesium Oxide Oral Tablet 400mg, Give 1 tablet PO BID for supplement. Ordered on 9/5/25.In an observation on 9/9/25 at 8:28am, RN A took Resident #13's blood pressure on her L wrist and it was 107/58 with a HR of 65. RN A held Resident #13's metoprolol (blood pressure) 25mg and her hydralazine (blood pressure) 50mg due to the DBP (bottom number in blood pressure) being less than 60. RN A also did not give the MiraLAX (laxative) 17gm or the Tums (heartburn) because the resident refused them. Therefore, 8 pills were confirmed to be in her medicine cup for the medication pass on Resident #13.In an interview on 9/9/25 at 9:45am, RN A said, Oh shoot, I did forget about the Fluticasone when asked about the 3 missed medications. She said she must have checked off the Biotin and the Magnesium but forgot to pull them. She said she did not check off the medication before pulling them, so she was not sure what happened.In an interview on 9/9/25 at 1:58pm, the DON said she expected the staff to check off the medications in the system while they were pulling them, but to not save the screen stating all the medications were given until after the resident took the medication, in case they did not take something. She said if a resident missed a medication, they would not receive what was ordered and were not getting the benefits of the prescribed treatment.Record review of the facility's policy and procedure on Administering Medication, (Revised April 2019), read in part: Medications are administered in a safe and timely manner, and as prescribed.The director of nursing services supervises and directs all personnel who administer medications and/or have related functions.Medications are administered in accordance with prescriber orders.Medication errors are documented, reported, and reviewed by the QAPI committee to (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inform process changes and or the need for additional staff training.The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication.