STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676245	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pflugerville Nursing and Rehabilitation Center	104 Rex Kerwin Court Pflugerville, TX 78660

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. Based on observation, interview, and record review, the facility failed to make sure that drugs are stored in locked compartments and only authorized persons have access for 1 of 8 medication carts reviewed for pharmacy services. The facility failed to ensure one nursing medication cart was locked. This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings included: Observation of hall 400 on 05/26/2026 at 6:01 a.m. revealed a nursing medication cart was along the wall unattended and unlocked. The nursing medication cart contained residents' prescription drugs, over the counter medications, narcotics in a locked box, and syringes and other supplies. There were no residents, visitors, or staff in the hallway or near the nurse's cart. All the residents in the 400 hallway had their doors closed. RN A was sitting at the nurse's station on the telephone. During an interview on 05/26/2026 at 6:10 a.m., RN A stated she had been trained in medication storage. RN A stated the policy for medication carts was that any time staff walked away from the cart, it should be locked. RN A stated the nurse was responsible for locking the medication cart. RN A stated if the medication cart was left unlocked and unattended, a resident could access the medication and ingest the wrong medications, which could cause the residents to get sick. RN A stated she was a charge nurse, and it was her responsibility to ensure medication carts were locked. RN A stated she left the medication cart unlocked because she was responding to doorbell to let the State surveyors in the building and calling leadership to inform them State had entered the building. RN A apologized to the State surveyor several times for leaving the cart unlocked and unattended. During an interview on 05/27/2026 at 1:15 p.m., the DON stated she had been trained in medication storage. The DON stated the policy for medication carts was that the carts should always be locked anytime the nurse or medication aides walked away. The DON stated whoever was in possession of the keys to the medication cards, was responsible for locking the medication carts. She said if the medication cart was left unlocked and unattended, a resident could get into the cart and take medications which could cause an allergic reaction, or overdose, or poke themselves with needles. The DON stated she and charge nurses monitored to ensure the carts were locked by doing observations during their rounds and had done in-service training. The DON stated that RN A told her she left the nurse medication cart unlocked and unattended when she answered the doorbell to let the State surveyors in the building. During an interview on 05/27/2026 at 1:23 p.m., the ADM stated he had been trained in medication storage. The ADM stated the policy for the medication carts was that the cart was to be locked when the nurses were not working on the carts. The ADM stated the nurse was primarily responsible for ensuring the medication cart was locked. The ADM stated if the medication cart was left unlocked and unattended it could cause residents to get medications that were not meant for them. The ADM stated the ADON and DON monitored to ensure the medication carts were locked during rounds. The ADM stated the RN A told him she left the nurse medication cart unlocked and unattended when she answered the doorbell to let the State surveyors in the building. Record review of facility's policy titled, Medication Carts and Supplies for Administering Meds dated 10/01/2019 reflected: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	ProcedureMed Carts.2. The medication cart is locked at all times when not in use. 3. Do not leave the medication cart unlocked or unattended in the resident care areas.