STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676249	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carlyle at Stonebridge Park	170 Stonebridge Lane Southlake, TX 76092

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. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 5 residents (Resident #1) reviewed for medication administration.The facility failed to acquire and administer Resident #1's physician ordered medications timely when she admitted to the facility on [DATE], which resulted in the resident missing one dose of the antibiotic, Daptomycin-Sodium Chloride Intravenous Solution 700-0.9 mg/100 ml, six doses of the central nervous system stimulant, Adderall 20 mg, and seven doses of Juven, a physician-ordered therapeutic nutrition powder for wound healing, after she admitted to the facility on [DATE] following knee revision surgery.This failure could place residents at risk of not receiving medications as prescribed, decreased therapeutic effects of the medications, risk for drug diversion, delay in medication administration and worsening of their medical conditions.Findings included:Record review of Resident #1's admission MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included infection reaction to internal right knee prosthesis. Resident #1 had a BIMS of 15 which indicated her cognition was intact. Record review of Resident #1's Face Sheet printed on 10/16/25 reflected she had additional diagnoses of depressive episodes and attention-deficit hyperactivity disorder (ADHD), predominantly inattentive type.Record review of Resident #1's care plan initiated on 09/06/25 reflected she was on antibiotic therapy and the care plan interventions included administering antibiotic medications as ordered by the physician. The care plan further reflected the resident had an intravenous access device with care plan interventions which included administering intravenous fluids as prescribed. Record review of Resident #1's hospital discharge records dated 09/05/25 reflected the resident had an infected knee revision following a knee replacement with polymicrobial infection (infection caused by two or more different microorganisms) and a chronic open wound for about six months. The hospital discharge records reflected the resident had orders for the following medications: - 0.9% sodium chloride with daptomycin 700 mg into the vein daily;- Adderall oral tablet 20 mg, give 1 tablet by mouth two times a day for ADHD; and- Juven one packet by mouth two times a day.Record review of Resident #1's September 2025 MAR reflected the following:- the antibiotic daptomycin-sodium chloride was not administered on 09/06/25 and first dose was on 09/07/25;- the first dose of Adderall was administered on 09/09/25, which meant the resident missed six doses since she admitted to the facility on [DATE]; and- two administrations of the Juven packet missed on 09/06/25; two administrations of the Juven packet missed on 09/07/25; one administration of the Juven packet missed on 09/08/25; and two administrations of the Juven packet missed on 09/09/25. In total, Resident #1 was not administered a total of seven Juven packets between 09/06/25 and 09/09/25.Interview on 10/15/25 at 5:29 PM, Resident #1 revealed she was admitted to the facility on [DATE] from the hospital. She stated there appeared to be some confusion with her medications at the facility. The resident said she did not know why, but she did not get some of her medications for a few days. She stated she did not recall how many, but it included her antibiotic, wound healing powder, and medications for her ADHD. Resident #1 said all she was told was that they were trying to get the medications from the pharmacy. She recalled she got the first doses on Monday or Tuesday (09/08/25-09/09/25). Resident #1 further stated she did not recall having any unwanted side effects as a result. Interview on 10/16/25 at 1:21 PM, MA A revealed she worked with Resident #1 on 09/06/25 and 09/07/25 from 6:00 AM to 10:00 PM. MA A said it appeared the pharmacy did not deliver all Resident #1's medications. She stated some of those medications included the resident's Adderall and Juven. She stated she did not know why the medications did not get delivered. MA A stated she thought the previous DON and LVN B had attempted to contact the pharmacy during that time. Interview on 10/16/25 at 3:56 PM, LVN C, who was the nurse who admitted Resident #1, revealed he did not recall who Resident #1 was. He stated many residents come and go on the skilled hall. LVN C stated that if a resident was missing some medications from the pharmacy, they would contact the physician to see if they could substitute it for something else. LVN C further stated it was important for the residents to have all their medications to continue their care. Interview on 10/16/25 was attempted via telephone with LVN B; however, the attempts were unsuccessful.Interview on 10/16/25 at 5:05 PM, the ADON revealed she was not aware Resident #1 had gone without some of her medications when she was admitted . The ADON said she only recalled Resident #1's name but no other details surrounding her stay. She stated the charge nurses were