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	05/12/2026

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 - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 pharmacy services. LVN C failed to document on the EMAR when she administered hydrocodone (pain medication) to Resident #1 on 05/11/26 at 4:00 AM. This failure could place residents at risk for loss of prescribed medications, potential for not receiving their prescribed medications, and risk of drug diversion. Findings included: Review of Resident #1's None of the Above MDS Assessment, dated 05/06/26, reflected she was an [AGE] year-old female who was admitted to the facility on [DATE]. Her MDS did not included any active diagnoses, information regarding her cognition nor medications. Review of Resident #1's admission Record, dated 05/12/26, reflected the following diagnoses: non-displaced intertrochanteric fracture of left femur (a hip fracture where the bone cracks below the hip joint but remains properly aligned). Review of Resident #1's Order Summary Report, dated 05/12/26, reflected the following:Hydrocodone-Acetaminophen Tablet 5-325 MG, Give 1 tablet by mouth every 6 hours as needed for Pain with an active order date of 05/07/26. Review of Resident #1's Licensed Medication Administration Record for May 2026 reflected the following: Hydrocodone- Acetaminophen Tablet 5-325 MG, Give 1 tablet by mouth every 6 hours as needed for Pain and showed she received only 2 doses on 05/11/26, one dose at 10:47 AM by LVN A and one dose at 6:30 PM by LVN B. There was no documentation of a dose given by LVN C at 4:00 AM. Review of Resident #1's Controlled Drug Receipt/Record/Disposition Form, dated 05/01/26, reflected the following: 05/11/26 at 4:00 AM LVN C signed that she administered Resident #1 her hydrocodone medication. Review of Resident #1's Progress Notes for May 2026 did not reflect any note about her receiving hydrocodone on 05/11/26 at 4 AM. Review of Resident #1's Care Plan, revised 05/11/26, reflected the following: Focus: [Resident #1] is on pain medication therapy.Hydrocodone 5-325mg [sic] PRN r/t hip pain.Interventions: Administer ANALGESIC [sic] medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT [sic]. Observation and interview on 05/12/26 at 1:00 PM, Resident #1 was in her room watching television and appeared comfortable. Resident #1 said she was not in any pain, and the staff brought her pain medications to her timely. Resident #1 said she had no concerns about her pain medications. Resident #1 said she could not recall the exact times she got her pain medications but each time she requested one, they brought one to her. Interview on 05/12/26 at 1:31 PM, the ADON said all staff knew to document both on the narcotic count sheet and the resident's EMAR when they administered a narcotic medication. The ADON said the purpose of making sure staff documented on both the narcotic count sheet and the EMAR was to make sure that they can follow-up and see if the medication was effective or not and can also look to see what medications the resident received. The ADON said this information also helps the next nurse know when the last time the resident received the medication. The ADON looked at Resident #1's narcotic count sheet and saw that LVN C failed to document in Resident #1's EMAR that a medication was administered to her at 4 AM on 05/11/26. The ADON said LVN C would have (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been responsible for making sure the nurse documented the administration on the resident's EMAR. Interview on 05/12/26 at 2:07 PM, LVN C said she did give Resident #1 a hydrocodone on 05/11/26 at 4:00 AM because the resident was complaining of pain. LVN C said she recalled documenting on the narcotic count sheet that she administered the medication, but she was not certain whether she documented it in the resident's EMAR. LVN C said she knew she was supposed to document in the resident's EMAR when she administered a medication. LVN C said she knew since she was the person who administered that medication at that time that she was responsible for documenting the administration in the resident's EMAR. Interview on 05/12/26 at 2:10 PM, the DON said she had been auditing all the medication carts recently to make sure the narcotic count sheets were matching the information documented in each resident's EMARs. The DON said staff knew that when they administered a narcotic medication they were supposed to sign off on the narcotic count sheet and document in the resident's EMAR that the medication was administered. The DON said the purpose was to show that the medication was given at that time by that nurse. The DON said the nurse who administered the medication would be responsible for this documentation in the resident's EMAR. The DON said if the nurse did not document a medication administration in the resident's EMAR then it might not be true that it was administered. The DON said staff were recently trained on 05/01/26 and 05/08/26 regarding medication administration and should have been aware of the expectations to document in their EMAR when a narcotic was administered to them. Review of the facility's In-Service Training Report, dated 05/01/26, and titled Narcotic Count.When administering narcotics, you must sign the narcotic book and the EMAR; you must also go back and do follow up documentation reflected staff were trained, but LVN C was not listed. Review of the facility's In-Service Training Report, dated 05/08/26, and titled Medication Cart.You must sign the narcotic out on the EMAR and on the narcotic sheet at the same time reflected staff were trained but LVN C was not listed. Review of the facility's policy, revised 12/01/25, and titled Medication Administration reflected: .19. Sign MAR after administered.20. If medication is controlled substance, sign narcotic book.