

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Rayburn Health Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 144 Bulldog Avenue Jasper, TX 75951	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 2 of 2 medication carts (Medication Cart L and Medication Cart R) reviewed for labeling and storage. The facility failed to ensure Medication Aide A's (the only assigned staff for medication administration on the secure unit.) assigned medication cart's (Medication cart L, and Medication cart R) were kept locked and under direct observation where 13 residents and unauthorized staff could not access it when left on the hall of the secure unit for four minutes. This failure could place residents at risk of gaining access to and swallowing medications not prescribed for them. Findings included: During an observation on 02/11/2026 from 4:00 p.m. to 4:04 p.m., Medication Aide A's Medication Carts R and L were noted to be unsecured and unsupervised on the secure unit. The Medication Cart R was front facing against the wall with the drawers facing the hallway with the lock mechanism out with the keys inside (indicating it was unlocked). Medication Cart L was front facing against the wall with the second drawer open. Medication Cart L was observed with one white pill in a medication cup on top of the unattended and unsupervised medication cart. Observation of Medication Cart L indicated it had a medication cup with white crushed specks with a brown substance and a wooden spoon inside left unattended and unsupervised. The secure unit housed 13 residents. There was one visitor and 4 residents (sitting in chairs talking to each other.) in the hallway approximately 15 feet from medication cart R and L. the medication cart. Further observation indicated at 4:04 p.m. Medication Aide A was observed exiting the employee break room approximately 75 feet away from the unlocked medication carts (R and L). Further observation of Medication Carts R and L, with Medication Aide A, indicated inside the Medication Cart L and R Drawer #1 were OTC (over the counter) aspirin, vitamins, minerals and eye drops and drawer #2 contained multiple resident's individual bubble-blister packets that contained medications. During an interview on 02/11/2026 at 4:05 p.m., Certified Medication Aide A said she was in charge of the carts. She said she administered medication on the secure unit. Certified Medication Aide A said she was sorry for leaving the cart open, I shouldn't have left the keys there either. Certified Medication Aide A said she went to the employee break room to get a drink of water. Certified Medication Aide said she forgot to lock both carts (R and L) and take the keys out of the lock on Medication Cart R before she stepped away from it. Certified Medication Aide A said the cart should not be unlocked and unattended because anyone walking on the secure unit could get into the medications and risk medication theft or diversion. She said she was setting up medications and went to get a drink of water and that was the reason she left the medications on top of Medication Cart L. She said the reason Medication Cart R was left with the keys inside the lock was due to her getting trash bags out for the trash cans. Certified Medication Aide A said she was in-serviced on keeping the medication cart locked at all times when not in use. During an interview on 02/11/2026 at</p> <p>(continued on next page)</p>

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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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4:20 p.m., the DON said she expected the certified medication aides to follow the facility policy and procedure for medication pass and drug safety. She said the medication carts should be locked if staff walked away from it or turned their back to it. The DON said the certified staff member that was in charge of the medication cart (nurse or certified medication aide) was responsible for making sure the medication carts were locked at all times when not in use. She said she had in-serviced nursing staff to keep the medication cart locked at all times. She said medication aides were trained during orientation, annually and as needed, on medication administration and securing medications. During an interview on 02/11/2026 at 4:30 p.m., the Administrator said her expectation was that staff would follow medication safety policy and procedures related to locking and securing the medication cart when not in use. She said all nursing staff, including medication aides, were responsible for securing medications when not in use. She said the potential risk of unsecured medication cart was residents or visitors getting into the cart. Record review of the facility's Security of Medication Cart policy and procedure, dated April 2007, Policy Statement: The medication cart shall be secured during medication passes.</p>		