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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676289 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/08/2025 |
| NAME OF PROVIDER OR SUPPLIER The Atrium of Bellmead | | STREET ADDRESS, CITY, STATE, ZIP CODE 2401 Development Blvd. Bellmead, TX 76705 | |

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) |
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| 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 |
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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services that assures the accurate acquiring, receiving, dispensing and administering of medications to meet the needs for one resident (Resident #1) of 5 residents reviewed for pharmacy services, in that: The facility failed to ensure Resident #1's narcotic medications were recorded in the EMR, showing they had been administered on 10/3/2025, 10/5/2025, 10/6/2025, and 10/8/2025. This failure placed residents at risk for medical errors, complications, decreased quality of life and hospitalization. Findings included: Review of Resident #1's face sheet dated 10/14/2025 reflected she was an [AGE] year-old-female admitted on [DATE] with diagnosis that included: acute respiratory failure (condition where the lungs cannot properly exchange gases), Chronic Obstructive Pulmonary Disease (COPD) (a group of lung diseases that cause long term breathing problems), atrial fibrillation (an abnormal heart rhythm), congestive heart failure (condition where the heart is weakened and cannot pump effectively), and hypertension (high blood pressure). Review of Resident #1's admission MDS assessment dated [DATE] reflected she had a BIMS score of 13 suggesting no cognitive impairment. Review of Resident #1's orders reflected an order dated 10/2/2025: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for Pain DNE 3G/24HR. Review of Resident #1's narcotic count sheet for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) reflected that she had been given 1 tablet on the following dates and times: 10/3/2025 at 10:00 am 10/5/2025 at 3:00 pm 10/5/2025 at 8:07 pm 10/6/2025 at 2:15 pm 10/8/2025 at 6:00 pm Review of Resident #1's October MAR reflected no administration entries for the following dates and times: 10/3/2025 at 10:00 am 10/5/2025 at 3:00 pm 10/5/2025 at 8:07 pm 10/6/2025 at 2:15 pm 10/8/2025 at 6:00 pm During an interview on 10/14/2025 at 1:00 pm, the ADM stated her expectation was that staff would do both parts for medication administration - click off the MAR and sign out in the narcotic book. She stated their policy stated staff were supposed to click off in the MAR when medications were administered. She stated if the MAR was not signed off, medication would be given too soon, and the facility would not have an accurate record of when medications are being given. During an interview on 10/14/2025 at 2:10 pm, the DON stated she had worked on the floor on 10/3/2025, and she had administered Resident #1 her narcotic medications at 10:00 am. She confirmed the signature on the narcotic count for 10/3/2025 was her signature. She stated she signed the medication out on the narcotic count sheet, but forgot to sign it off on the MAR. She stated she got pulled into a room where Resident #1 had requested medication before therapy, so she rushed it down to her without taking her medication cart with her. When she got back to her cart, another resident was already asking for something, and she forgot to document the administration on the computer in Resident #1's MAR. She stated her expectation as the DON was that staff - including herself - would document in the MAR and the narcotic count sheet when the medication was given. She stated if staff did not document in the MAR, a medication error could happen, staff could get medication at the wrong time, and it could cause the patient to not have their pain controlled effectively or they could get too much medication. During an interview on 10/14/2025 at 2:22 pm, LVN A stated she had worked on 10/5/2025 and 10/8/2025 and had administered narcotic medication to Resident #1 as it was recorded on the narcotic count sheet. She confirmed the signature on the narcotic count for 10/5/2025 and 10/8/2025 were her signatures. She stated she had signed the medication out on the narcotic count sheet but forgot to sign it off on the MAR. She stated she was supposed to sign off on the MAR and narcotic count sheet as soon as the person took the medication. She stated by not signing off the medication on the MAR, it looked like they may not have gotten it and could lead to a medication error. She stated if staff went by the MAR alone, a resident could get a double dose and it could cause respiratory depression, which could cause them to stop breathing and possible kill them. She stated the reason she forgot to document in the MAR was because she had a load of 42 residents and [SH1] [LP2] got pulled left and right that day and she had to complete a bunch of assessments and just forgot. During an interview on 10/14/2025 at 2:50 pm, LVN B stated she had worked on 10/6/2025, and had administered narcotic medication to Resident #1 at 2:15 pm. She confirmed she had signed the narcotic count sheet. She stated they were supposed to sign off the MAR when they gave the medication and stated the reason she did not sign off the administration on the MAR as I might have had something come up with another resident, and got distracted. She stated if a medication was not signed off in the MAR it could lead to a med error as the next nurse might not recognize the medication had been</p> | | |