

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676305	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER The Stayton at Museum Way		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Museum Way Fort Worth, TX 76107	
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. 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 medication cart (Hall B cart) and 1 medication room (Hall A) reviewed for pharmacy services. The facility failed to ensure expired multivitamin with zinc, with a date of 08/2025 in the Hall B nurse cart, and 2 bottles of expired multivitamin with an expiration date of 05/2025, 1 bottle of multivitamin with an expiration date of 08/2025, 3 bottles of niacin with an expiration date of 09/2025, and a box of bisacodyl suppositories with an expiration date of 06/2025 in the Hall A medication room were removed and destroyed. This failure could place residents at risk of receiving expired medications that were ineffective. Findings included: Observation on 10/02/2025 at 9:47 AM of the Hall B nurse cart with LVN A revealed one bottle of multivitamin with zinc with an expiration date of August 2025. Interview on 10/02/2025 at 10:04 AM with LVN A revealed it was his responsibility to ensure there were no expired medications on the cart. LVN A stated he should check the cart daily, but he did not check that morning. He stated that by failing to remove the expired medication, the medication could be administered, and the dose may not be therapeutic, or it could cause harm to the residents. He stated he had done training on checking carts for expired medications. Observation on 10/02/2025 at 10:15 AM of the Hall A medication room with LVN A revealed the following- Two bottles of multivitamins with an expiration date of May 2025;- One bottle of multivitamins had an expiration date of August 2025;- Three bottles of Niacin with an expiration date of September 2025; and - One box of Bisacodyl suppositories with an expiration date of June 2025. Interview on 10/02/2025 at 10:21 AM with LVN A revealed that it was all the nurses' and Central Supply's staff responsibility to check and remove expired medications from the medication room. LVN A stated that Central Supply should check and remove expired medications when restocking the over-the-counter medications in the medication room. LVN A revealed after Central Supply restocked the medication room, it was up to the nurses to ensure no medications were expired. LVN A stated by failing to remove the expired medications from the medication room, it put residents at risk of being administered the medication, and the medication might not be therapeutic. LVN A stated he had done in-services on checking the medication room and removing expired medications. Interview on 10/03/2025 at 10:53 AM with the ADON revealed that Medication Aides and Nurses should be checking the medication carts daily for any expired medications. The ADON also revealed that Central Supply stocked the cabinets in the medication rooms, and she should be checking and removing any expired medications. The ADON stated after Central Supply stocked the medication room, it was the nurses' responsibility to check the expiration date on medications. The ADON stated she has not gone behind the staff to double-check any medications. The ADON stated she was unsure if any in-services or training had been completed on checking the medication cart/room for expired medication. The ADON revealed that expired medications in the cart and medication room could be given to residents and be ineffective or cause nausea and vomiting. Interview on 10/03/2025 at 1:12 PM with Central Supply B revealed she restocked medications in the medication rooms when the supply was low. Central Supply B stated (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she did check the expiration dates when restocking, but she was unsure the last time the expiration dates were reviewed. She stated the expired medications must have been missed. She stated expired medications in the medication rooms could be given to the residents and make them sick. Central Supply B stated she had not done any in-services training on checking for expired medications. Interview on 10/03/2025 at 2:29 PM with the DON revealed that all the nurses and medication aides should know what medications were on their cart and what the expiration dates were. The DON stated the nurses should be checking their medications on the cart daily. The DON also revealed that Central Supply stocked the medication room and should be checking the expiration date. The DON stated the nurses should also be checking the expiration dates in the medication room when they were pulling medications. The DON stated if staff were not checking the medication room and carts for expired medications, the medications were at risk of being administered to residents and may have been ineffective. The DON revealed there has been training and in-services completed on the rights of medication administration. Review of the facility's Storage of Medications policy, revised 07/29/25, reflected the following: .2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3. Drug containers with missing, incomplete, or incorrect labels are returned to the pharmacy for proper labeling before storing. 4. The facility may not use medication that has been discontinued, outdated, or has deteriorated. In these cases, medication is returned to the dispensing pharmacy or destroyed by a pharmacist and licensed nursing staff.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure any drug regimen irregularities reported by the Pharmacist Consultant were acted upon, for 1 of 5 residents (Resident #5) whose drug regimens were reviewed. The facility failed to act upon the Pharmacy Consultant's recommendations issued on 07/21/25, 08/19/25, and 09/22/25 to add a 14-day stop date for Resident #5's use of PRN Lorazepam, which is a psychotropic medication used for the treatment of anxiety disorders and severe agitation. This failure could place residents receiving medications at risk for adverse consequences and could cause a decline in their physical, mental, and psychosocial condition. Findings included: Review of Resident #5's admission MDS Assessment, dated 07/26/25, reflected she was admitted to the facility on [DATE]. The MDS reflected she did not have a BIMS score calculated, had short and long-term memory problems, and had severely impaired cognitive skills for daily decision making. Resident #5 did not have any indications of behaviors towards others. Resident #5's active diagnoses included non-alzheimer's dementia (encompasses a variety of conditions that cause cognitive decline and memory loss beyond what is considered a normal part of aging) and anxiety disorder (a group of mental health conditions that cause fear, dread, and other symptoms that are out of proportion to the situation). Review of Resident #5's Medication Profile, dated 10/03/25, reflected the following: Start Date: 07/19/25. Medication/Dose: Lorazepam 0.5 mg tablet. Frequency: As Needed Four Times Daily Starting 07/19/25. Class: Antianxiety Agent- Benzodiazepines. Review of Resident #5's Care Plan, effective 07/21/5, reflected the following: Problems: [Resident #5] has a diagnosis of Anxiety Disorders manifested by Verbal Distress. Interventions: Assess and record behaviors. [Resident #5] requires indefinite PRN anxiety medication for intermittent needs per hospice. Review of Resident #5's Consultation Report, dated 07/21/25 reflected the following: [Resident #5] is receiving hospice, comfort, or palliative care services. Active order for Lorazepam PRN. Recommendation: Even with hospice status, this order would require 14 day stop date. Review of Resident #5's October 2025 and September 2025 MARs reflected she did not receive any tablets of her ordered PRN Lorazepam medication. Review of Resident #5's Consultation Report, dated 08/19/25 reflected the following: [Resident #5] is receiving hospice, comfort, or palliative care services. Active order for Lorazepam PRN. Recommendation: Even with hospice status, this order would require 14 day stop date. Review of Resident #5's Consultation Report, dated 09/22/25 reflected the following: [Resident #5] is receiving hospice, comfort, or palliative care services. Active order for Lorazepam PRN. Recommendation: Even with hospice status, this order would require 14 day stop date. Observation on 10/01/25 at 12:10 PM revealed Resident #5 was in her room in her bed asleep. Resident #5 did not wake up to the HHSC surveyor asking questions or knocking on the door. Interview on 10/03/25 at 9:33 AM with LVN A revealed he was Resident #5's nurse. He stated Resident #5 was on hospice services. LVN A said Resident #5 needed the PRN Lorazepam order because she could get very anxious and agitated at times. LVN A said the order should have a 14-day stop date on it. LVN A said usually when he received an order for a PRN psychotropic he would request a stop date from the provider before adding it to the resident's chart. Interview on 10/03/25 at 10:37 AM with the ADON revealed Resident #5 did have an order for PRN Lorazepam that came from her hospice company provider. The ADON said Resident #5 had intermittent episodes of anxiety and she was not sure why there was not a stop date for the order. The ADON said usually PRN psychotropic orders had a 14 day stop date associated with them that was scheduled to stop in the system. The ADON said once the order was given to the nurse adding the order to the resident's chart, they would ask the provider for the stop date at that point. Interview on 10/03/25 at 2:16 PM with the DON revealed since anti-anxiety medications worked on the spot and the facility had a doctor's indication for use she thought that meant Resident #5's PRN Lorazepam order did not require a 14 day (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stop date. The DON said she thought if the doctor's indication for use was indefinite, as in Resident #5's case, the 14 day stop date was not required. The DON said she had been responsible for completing the pharmacy recommendations made since June 2025. The DON said she saw Resident #5's recommendations and misunderstood the regulation so she never changed her PRN Lorazepam order. The DON said the purpose of the pharmacy recommendations was another layer of review to ensure that medications were appropriate for the resident and were written correctly. The DON said if the pharmacy recommendations were not acted upon, appropriate changes may not be made based on what the recommendation was. Review of the facility's policy revised 07/29/25 and titled Monthly Medication Regimen Review reflected the following: 4. Recommendations are acted upon by the facility staff and/or the prescriber.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident was not given a psychotropic drug unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 5 residents (Resident #5) reviewed for unnecessary medications, in that: The facility failed to ensure Resident #5 was prescribed a psychotropic drug for anxiety no longer than 14 days PRN. Resident #5 was ordered PRN Lorazepam (a benzodiazepine medication used primarily to treat anxiety disorders and severe agitation) on 07/19/25 without a stop date. This failure could place residents at risk of receiving unnecessary psychotropic medications. Findings included: Review of Resident #5's admission MDS Assessment, dated 07/26/25, reflected she was admitted to the facility on [DATE]. The MDS reflected she did not have a BIMS score calculated, had short and long-term memory problems, and had severely impaired cognitive skills for daily decision making. Resident #5 did not have any indications of behaviors towards others. Resident #5's active diagnoses included non-alzheimer's dementia (encompasses a variety of conditions that cause cognitive decline and memory loss beyond what is considered a normal part of aging) and anxiety disorder (a group of mental health conditions that cause fear, dread, and other symptoms that are out of proportion to the situation). Review of Resident #5's Medication Profile, dated 10/03/25, reflected the following: Start Date: 07/19/25. Medication/Dose: Lorazepam 0.5 mg tablet. Frequency: As Needed Four Times Daily Starting 07/19/25. Class: Antianxiety Agent- Benzodiazepines. Review of Resident #5's Care Plan, effective 07/21/25, reflected the following: Problems: [Resident #5] has a diagnosis of Anxiety Disorders manifested by Verbal Distress. Interventions: Assess and record behaviors. [Resident #5] requires indefinite PRN anxiety medication for intermittent needs per hospice. Review of Resident #5's Consultation Report, dated 07/21/25 reflected the following: [Resident #5] is receiving hospice, comfort, or palliative care services. Active order for Lorazepam PRN. Recommendation: Even with hospice status, this order would require 14 day stop date. Review of Resident #5's October 2025 and September 2025 MARs reflected she did not receive any tablets of her ordered PRN Lorazepam medication. Review of Resident #5's Consultation Report, dated 08/19/25 reflected the following: [Resident #5] is receiving hospice, comfort, or palliative care services. Active order for Lorazepam PRN. Recommendation: Even with hospice status, this order would require 14 day stop date. Review of Resident #5's Consultation Report, dated 09/22/25 reflected the following: [Resident #5] is receiving hospice, comfort, or palliative care services. Active order for Lorazepam PRN. Recommendation: Even with hospice status, this order would require 14 day stop date. Observation on 10/01/25 at 12:10 PM revealed Resident #5 was in her room in her bed and was asleep. Resident #5 did not wake up to the HHSC surveyor asking questions or knocking on the door. Interview on 10/03/25 at 9:33 AM with LVN A revealed he was Resident #5's nurse and she was on hospice services. LVN A said Resident #5 needed the PRN Lorazepam order because she can get very anxious and agitated at times. LVN A said the order should have a 14 day stop date on it. LVN A said usually when he received an order for a PRN psychotropic he would request a stop date from the provider before adding it to the resident's chart. Interview on 10/03/25 at 10:37 AM with the ADON revealed Resident #5 did have an order for PRN Lorazepam that came from her hospice company provider. The ADON said Resident #5 had intermittent episodes of anxiety and she was not sure why there was not a stop date for the order. The ADON said usually PRN psychotropic orders had a 14 day stop date associated with them that was scheduled to stop in the system. The ADON said once the order was given to the nurse adding the order to the resident's chart, they would ask the provider for the stop date at that point. Interview on 10/03/25 at 2:16 PM with the DON revealed since anti-anxiety medications worked on the spot and the facility had a doctor's indication for use she thought that meant Resident #5's PRN Lorazepam order did not require a 14 day stop date. The DON said she thought if the doctor's indication for use was indefinite, as in Resident #5's case, the 14 day (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stop date was not required. The DON said she misunderstood what the regulation required as far as a clinical indication past the 14 days. The DON said the purpose for the stop date was to meet the regulation in this instance regarding Resident #5. The DON said whoever audited Resident #5's chart or the nurse who entered the order should have asked the doctor for the stop date and included it. The DON said normally she also reviewed physician's orders in resident's charts as well. The DON said if the resident's order did not have a stop date they would continue to have the medication available to administer past 14 days. Review of the facility's policy, revised 07/29/25, and titled Psychotropic Medications reflected the following: .PRN orders for psychotropic medications are limited to 14 days.		