STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676318	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windmill Village Rehabilitation & Care Center	507 Martin Luther King Blvd Lubbock, TX 79403

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** 36954 Based on interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of property and exploitation for 1 of 3 residents (Resident #1) reviewed for misappropriation of property. The facility failed to prevent the misappropriation of Resident #1's Morphine Medication. This failure could place residents at risk for not receiving prescribed medication. Findings include: Record review of Resident #1's, undated, face sheet revealed the resident was an [AGE] year-old female admitted to the facility on [DATE]. Resident #1 had diagnoses which included: dementia (loss of remembering), anxiety (feeling of uneasiness), dysphagia (swallowing difficulties), Cognitive communication deficit (difficulty communication) and chronic pain (long lasting pain). Record review of a Resident #1's quarterly MDS, dated [DATE], revealed a BIMS of 11, which indicated cognitively intact. Record review of Resident #1's physician orders, dated 02/25/25, revealed an active order for Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) Give 0.25 ml by mouth every 4 hours as needed for pain. Ordered on 09/28/2024. Record review of Resident #1's Individual Control Drug Record Narcotic Count sheet for the Morphine Sulfate Oral Solution revealed the facility received the medication from the pharmacy on 09/20/24 and quantity received 30ml. The record revealed one dose of medication administered on 01/26/25. During an interview on 02/25/25 at 10:15 AM, the ADM stated she worked with the DON on the investigation of the 29.50 ML missing morphine. She stated the best she could tell was the morphine had to have gone missing on the weekend of 02/08-09/25. She stated RN B completed the medication cart and narcotic count and LVN A did not call out the morphine for Resident #1, and since there was not a bottle of morphine in the medication cart, RN B didn't realize something was missing. (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 - Few	During an interview on 02/25/25 at 12:50 PM, LVN A stated she worked a double shift on 02/08/25 and 2/09/25 and the morphine was discovered missing on 02/10/25. She stated she couldn't recall which nurses she worked with the weekend of 02/08-09/25 but was able to recall she counted the medication cart not the papers in the narcotic book when she started her shift. She stated she did not recall morphine being counted for Resident #1 that weekend. She stated when she went on shift, she counted the medications in the cart not the papers in the narcotic book, the off going nurse counted the medications in the book. She stated when she finished her shift on 02/09/25 she counted the paper in the narcotic book and RN B counted the medications in the cart. She stated she did not see a paper for the morphine for Resident #1. She stated she did not know the morphine was missing until Monday 02/10/25 when she received a call and was asked about the morphine. During an interview on 02/25/2025 at 1:10 PM, the DON stated she interviewed staff who worked before, during and after the weekend of 02/08-09/25 and RN B stated when doing the medication cart and narcotic book, LVN A did not call out the morphine from the narcotic book, and RN B did not know the morphine was missing until change of shift on the morning of 02/10/25 when counting with LVN C. She stated she spoke with LVN A and stated, something like that happened at another facility I worked at and it was an agency nurse that took it. She stated LVN A told her she was only calling out the medication from the book she knew were in the cart. The DON stated Resident #1 did not have any increased pain or negative outcome as the morphine was ordered as needed, and Resident #1 did not take the morphine. During an interview on 02/25/25 at 2:06 PM, Resident #1 could not answer questions about her medication and stated, leave me alone and get out. During an interview on 02/25/25 at 2:30 PM, LVN D stated she worked the day shift on 02/08/25 and the morphine for Resident #1 was in the cart and counted on 02/08/25. She stated at the end of her shift on 02/08/25 she counted the medication cart and narcotic book with LVN A and everything was in the medication cart and narcotic book. She stated she did not work on Sunday, 02/09/25. During an interview on 02/25/25 at 3:09 PM, RN B stated she worked 10PM -6AM on 02/09/25. She stated when she started her shift, at 10PM, on 02/09/25, she counted the medication cart and narcotic book with LVN A. She stated LVN A did not call out the morphine from the narcotic book, so she was not aware at that time the morphine was missing. She stated the following morning on 02/10/25, LVN C arrived for work and around 6AM they were counting the cart and narcotic book and LVN C called out the morning for Resident #1 and that was when they started looking for the morphine. She stated they did not locate the morphine, and they notified the DON and ADM the morphine was missing. During an interview on 02/25/25 at 3:20 PM, LVN C stated when she arrived for work on 02/10/25 while counting the medication cart and narcotic book she noticed the morphine was in the narcotic book and there was not any morphine for Resident #1 in the medication cart. She stated she asked RN B where the morphine was, and RN B did not know. She stated she spoke with LVN D, and LVN D remembered she saw the morphine for Resident #1 in the medication cart the weekend of 02/08-09/25. Record review of the facility's in-service: Drug Pass, dated 02/10/24, revealed 9 staff received in-service drug pass, and reviewed the policy titled Reporting Suspicion of a Crime. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy Reporting Suspicion of a Crime, dated 2001, with a revised date of July 2017, revealed the following: Policy Statement The Administrator, Director of Nursing, or any other designated individual will report (within the required time frames) any reasonable suspicion of a crime against a resident to the state Survey Agency and local law enforcement agency. Employees will be protected against retaliation for reporting any reasonable suspicion of a crime against a resident. 3. Each covered individual must report to the state Survey Agency and at least one local law enforcement agency any reasonable suspicion of a crime against a resident of the facility. d. Examples of crimes that would be reportable in any jurisdiction include but are not limited to: (6) Theft/robbery (7) Drug diversion for personal gain or use Record review of the facility's policy Controlled Substances, dated 2001, with a revised date of December 2012, revealed the following: Policy Statement The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Policy Interpretation and Implementation Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.