STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676352	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonemere Rehabilitation Center	11855 Lebanon Road Frisco, TX 75035

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview and record review the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents for one (Hall 200) of five medications carts reviewed for medication storage. The facility failed to ensure medication supplies were secured or attended by authorized staff when the medication cart on hall 200 was left unlocked by RN A. This failure could place residents at risk of having access to medications and/or lead to possible harm or drug diversions. Findings included: Observation on 04/02/2026 at 9:57 AM revealed a medication cart on Hall 200 unlocked with drawer pulled open. There was no nurse or medication aide observed anywhere near the medication cart. The medication cart was accessible to investigator to walk around the medication cart and access medications. Observations of Housekeeping staff, Hospice Aide, and Wound Care Nurse walking by the unsecured medication cart. At 10:02 AM RN A was observed walking out of a resident room down the hallway. Interview and observation with RN A on 04/02/2026 at 10:03 AM revealed the unsecured, unlocked medication cart belonged to RN A. RN stated the medication cart should be locked at all times and the narcotics were to be under double lock. RN A walked behind the medication cart and confirmed the cart was left unlocked and that drawers were open. RN A was not able to state why he had left the medication cart unlocked while unattended. RN A stated the cart should have been locked but was not. RN A stated there was a risk of residents taking medications from the cart. RN A then locked the cart. Interview with the DON on 04/02/2026 at 12:24 PM revealed medication carts should be locked at all times or within eyesight of the nurse or medication aide. For example, placing the medication cart directly outside of a resident's door to their room and pulling medications, and walking in to administer them. The DON was informed of the observations made during rounds earlier in the day. The DON stated leaving a medication cart unlocked and/or drawers open allowed anyone (including other staff, residents, or confused people) to have the ability to reach in the medication cart and take out medications and ingest. The DON stated it was up to all of the nurses, medication aides and administration to ensure medication carts were locked as rounds were being made throughout each day. Review of the Storage of Medications policy dated December 2025 revealed Policy Statement The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation.2. The nursing staff shall be responsible for maintaining medications storage AND preparation areas in a clean, safe, and sanitary manner.7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubical, drawer, or other holding area to prevent the possibility of mixing medication of several residents.10. Only person authorized to prepare and administer medications shall have access to the medication, including any keys.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of five (Resident #1) observed for infection control. 1. The facility failed to ensure RN A sanitized the glucometer and surfaces with a recommended germicidal wipe by placing the clean, sanitized glucometer on top of an unsantized medication cart, on top of RN A's handwritten notes and then carried the glucometer into Resident #1's room, placed the glucometer on the unsantized overbed table and then back out to the medication cart. 2. The facility failed to ensure RN A prevented cross contamination of the insulin pin when RN A prepared and cleaned the tip of the insulin pin without wearing gloves, and then carried the insulin pin into Resident #1's room, raised his shirt, cleaned the skin, and injected insulin into Resident #1's abdomen without wearing gloves. These failures could place residents at risk for infection and cross contamination.Findings included: Review of Resident #1's face sheet dated 04/02/2026 revealed Resident #1 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 was diagnosed with Dementia (memory loss), Dysphagia (difficulty swallowing), Acute Kidney Failure (sudden, often reversible loss of kidney function occurring within hours or days, causing waste buildup, reduced urine output and fluid retention), and Type 2 Diabetes Mellitus (chronic metabolic condition where the body resists insulin and fails to produce enough to maintain normal blood sugar levels). Review of Order Summary Report for Resident #1 dated 04/02/2026 revealed Resident #1 was ordered Inject 15 unit subcutaneously before meals for DM [Diabetes Mellitus].Insulin Lispro Subcutaneous Solution Cartridge 100 Unit/ML (Insulin Lispro) Inject per sliding scale if 71-130=0; 131-180=3 units; 181-240=6 units, 241-300=9 units; 301-350=12 units; 351-400=15 units higher than 400; notify MD/NP, subcutaneously five times a day for DM prior to meal. During an observation on 04/02/2026 at 12:05 PM revealed RN A was headed to Resident #1's room. The glucometer was noted on the top of the medication cart, sitting on a stack of handwritten papers. RN A removed a test strip, some alcohol pads, a lancet and pulled out some tissues. RN A performed hand hygiene, put on gloves, and entered Resident #1's room. RN A placed a tissue on the overbed table for Resident #1 and placed the glucometer on top of the tissue. RN A pricked Resident #1's finger, obtained a blood sample with a reading of 141. RN A returned to the medications, disposed of the lancet and test strip and placed the used glucometer on the top of the medication cart on top of the stack of handwritten papers. RN A then sanitized his hands. RN A pulled out the insulin pin, cleaned the top of the insulin pin with alcohol, without wearing gloves. RN A walked back into Resident #1's room, assisted Resident #1 with pulling up his hospital gown, RN A primed the insulin pin, then cleaned Resident #1's skin on the right side of his abdomen with an alcohol swab with his bare hands. RN A then administered it into Resident #1's abdomen with no gloves. RN A then went back to the medication cart, placed the soiled insulin pin on top of the medication cart, and went back into the bathroom and washed his hands. Interview with RN A on 04/02/2026 at 12:18 PM revealed RN A originally sanitized the glucometer prior to investigator walking up. RN A stated he sanitized the glucometer before use and then again after using it. RN A stated he did not clean the top of the medication cart. RN A stated there was a kill time of three minutes. RN A stated he should have worn gloves while prepping the insulin pin and administering the insulin to Resident #1. RN A stated this was to reduce the spread of possible infections. Interview with the DON on 04/02/2026 at 12:24 PM revealed glucometers were to be cleaned prior to use and after use. The DON stated the nurse should take the supplies needed in the room and obtain the blood sample, get the blood sugar reading and then come back out of the room and put the glucometer in a dirty spot on the medications cart which was usually a wash basin or on a piece of wax paper to prevent touching the medication cart. The DON stated then the nurse would draw up the insulin depending on the blood sugar reading and orders (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from physician. The nurse would then prepare the skin, inject the insulin, wipe the skin and discard the sharps. The DON stated the process should be completed while wearing gloves. The DON stated wearing gloves and completing hand hygiene in between tasks was to prevent spreading infections to the next person. The DON stated the nurse could pass anything onto the glucometer on to the next patient. The DON stated that tissue was not considered an effective barrier and should be using wax paper on a clean surface. The DON stated RN A was a new employee to the facility and would need to receive additional education regarding infection control practices. Review of Infection Control Guidelines for All Nursing Procedures dated revised December 2025 revealed Purpose To provide guidelines for general infection control while caring for residents.1. Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease. Stand Precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes.4. Employees must wash their hands for twenty (20) seconds or longer using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents:.d. After removing gloves;.e. After handling items potentially contaminated with blood, body fluids, or secretions;5. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are no visibly soiled, use an alcohol based hand rub containing 60-95% ethanol or isopropanol for all the following situations:a. Before and after direct contact with residents:b. Before donning sterile gloves;.d. Before preparing or handling medications;.g. After contact with a resident's intact skin;h. After handling used dressings, contaminated equipment, etc.;i. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident: andj. After removing gloves. Review of Obtaining Accucheck/Fingerstick Glucose Level dated December 2025 revealed Purpose The purpose of this procedure is to obtain a blood sample to determined the resident blood glucose level.Steps in the Procedurel . Place the equipment on the bedside stand or overbed table. Arrange the supplies so that they ran be easily reached.2. If using the blood glucose monitoring system (blood glucose meter with test strips), use test strips before their expiration date. Do not use test strips that have been wet, bent or otherwise damaged.3. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Single-resident use fingerstick devices (pen-like devices) should never be used by more than one resident.4. Wear clean gloves.gauze to seal the puncture site.17. Clean and disinfect reusable equipment between uses according- to the manufacturer's instructions and current infection control standards of practice.18. Remove gloves and discard into designated container.19. Wash hands.