

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2025
NAME OF PROVIDER OR SUPPLIER Morada Temple		STREET ADDRESS, CITY, STATE, ZIP CODE 4312 S 31st St Temple, TX 76502	

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. (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 - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide routine and emergency drugs and biologicals to its residents or obtain them for 1 (Resident #1) of 6 residents reviewed for pharmacy services. The facility failed to ensure Resident #1 received her routine Midodrine medication for low blood pressure on 06/27/25 at 7:00 p.m. and 06/28/25 at 7:00 a.m. Resident #1's blood pressure was low, which made her feel dizzy and lightheaded. This failure could place residents at risk of hypotension, accidents, injuries, and diminished quality of life. Findings included: Review of Resident #1's admission Record, dated 06/30/25, reflected she was a [AGE] year old female who was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident #1 had medical diagnoses including Campylobacter enteritis (a common intestinal infection, often referred to as a type of food poisoning, caused by bacteria), acute (suddenly) and chronic (over a longer period) respiratory failure with hypoxia (the body's inability to adequately oxygenate the blood), and syncope and collapse (a temporary loss of consciousness and postural tone due to reduced blood flow to the brain). Review of Resident #1's admission MDS, dated [DATE], reflected she had a 15/15 BIMS, which indicated she was cognitively intact. Review of Resident #1's Care Plan, dated 06/30/25, reflected she was at moderate risk for falls related to her syncope and collapse diagnosis. One of the interventions reflected Resident #1 was required to be evaluated and treated as ordered or PRN. Review of Resident #1's admission Assessment, dated 06/27/25 at 3:14 p.m., reflected she was admitted to the facility on [DATE] at 3:16 p.m. with a BP of 108/53. Review of Resident #1's Order Summary Report, dated 07/02/25, reflected she was required to have vital signs checked for skilled vital assessments and documented in POC every shift that was ordered and started on 06/27/25. Resident #1 was also required to take one tablet of 10 mg Midodrine HCl Oral tablet by mouth three times a day related to syncope and collapse that was ordered and started on 06/27/25. Review of Resident #1's Order Entry Details, dated 07/02/25, reflected Resident #1's PCP communicated a written order on 06/27/25 at 1:42 p.m. for 10mg Midodrine HCl oral tablet to be administered to Resident #1 by mouth three times a day for syncope and collapse. The order was to start being administered on 06/27/25 at 7:00 p.m. and routinely at 7:00 a.m., 1:00 p.m. and 7:00 p.m. Review of Resident #1's Order Audit Report, dated 07/02/25, reflected LVN A created and entered Resident #1's Midodrine order from her PCP on 06/27/25 at 1:43 p.m. LVN B confirmed and submitted Resident #1's Midodrine order on 06/27/25 at 9:22 p.m. Review of Resident #1's Blood Pressure Summary for the last 90 days, dated 07/02/25, reflected her blood pressure was taken on the following dates:-06/27/25 at 3:16 p.m. 108/53 mmHg -06/28/25 at 4:59 a.m. 107/51 mmHg-06/28/25 at 7:41 a.m. 102/66 mmHgThere were no other levels documented between 06/27/25 at 3:16 p.m. through 06/28/25 at 11:15 a.m. Review of a Handwritten Vital Check Sheet, undated, reflected Resident #1's blood pressure was taken on the following dates:-06/28/25 at 7:41 a.m. 102/66 mmHg-06/28/25 at 8:13 a.m. 86/60 mmHg-06/28/25 at 9:15 a.m. 88/64 mmHg-06/28/25 at 10:15 a.m. 92/58 mmHg-06/28/25 at 11:15 a.m. 97/68 mmHgThere were no other levels documented between 06/27/25 at 3:16 p.m. through 06/28/25 at 11:15 a. m. Review of MT E's Statement, dated 06/28/25, reflected. On 06/27/25, my shift started at 2:00 p.m.-10:00 p.m [Resident #1] had been admitted on day shift. At the end of my shift, [Resident #1's] medications had not been delivered. My Nurse [LVN B] said to leave her medications open and she would give [Resident #1's] medications. The only medication from form the emergency medication kit was Gabapentin on my shift. Review of LVN B's Statement, dated 06/28/25, reflected, [Resident #1] was new admission on [DATE]. Medications were ordered from Pharmacy by 6:00 a.m.-2:00 p.m. nurse. Medications had not yet arrived from Pharmacy by the end of my shift at 10:00 p.m. Informed 10:00 p.m.-6:00 a.m. nurse of this, she said she would give medication when they arrived. Review of LVN D's Statement, dated 06/27/25, reflected, Shift 10 p.m.-6:00 a.m.: At this time, [Pharmacy] delivers medication for new patient admission, but does not deliver 2 medication that were on patient's medication list. Those medication were Midodrine. Nurse from previous shift informed to be on lookout for new patient's mediation. Once medication arrived, I asked delivery driver from pharmacy if he was missing a bag due to medication not being in stock with others. Driver states that was what she had and all they sent. This was communicated to morning nurse to be on the lookout for these medication from morning run. Issue was not pressed on my shift due to patient's VS WNL and denial of patient. Review of Resident #1's Progress Notes reflected:-LVN A's note on 06/28/25 at 10:02 a.m. This nurse was made aware at 8:10 a.m. of missing medication by medication aide. Medication is</p>		