STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676374	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midlothian Healthcare Center	900 George Hopper Rd Midlothian, TX 76065

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident and failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for 3 (Resident #37, Resident #40 and Resident #55) of 12 residents reviewed for pharmacy services.The facility failed to ensure Every controlled drug administered and documented in the MAR was accurately reflected in the controlled drug log form of Resident #37, Resident #40 and Resident #55.Discarding 20 prefilled syringes that expired on [DATE] and were stored in the medication storage room, containing 0.5ml dose of influenza vaccine. There were no unidentified medications left in the medication cups in the Med cart.No charging cables stored in the Med cart with the medications for the residents.These failures could place residents at risk of medication error, drug diversion and contamination of drugs. Findings included:During an observation on [DATE] at 12:10 p.m., it was observed that the medication refrigerator in the med storage room located at the South Nursing Station contained two expired packets of influenza vaccines. Each packet contained 10 prefilled syringes, each with a 0.5 ml dose of influenza vaccine, with the expiration date [DATE] printed on them.During an observation on [DATE] at 12:50 p.m., it was observed that there were two medication cups containing medications in the 'MA-South Med Cart.' One cup contained seven tablets, and the other contained ten tablets. Neither cup had resident identifiers on them. Further inspection of the med cart revealed a charging cable stored in one of the drawers among the medications.Record review of Resident #37's face sheet dated [DATE] indicated she was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of heart failure, difficulty in walking, muscle weakness, lack of coordination, hypertension, dementia, anxiety disorder and type 2 diabetes.Record review of Resident #37's most recent quarterly MDS assessment dated [DATE] indicated she had a BIMS score of 15 indicating her cognition was intact.Record review of Resident #37's comprehensive care plan dated [DATE] revealed that there was no care plan for pain.Record review of Resident #37's physician orders reflected: Tramadol HCl Oral Tablet 50 MG (Tramadol HCl): Give 1 tablet by mouth three times a day for pain. Start Date-[DATE].Record review of Resident #40's face sheet dated [DATE] indicated he was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of type 2 diabetes, muscle weakness, contracture of muscle, lack of coordination, dementia, depression, anxiety disorder, adjustment disorder and chest pain.Record review of Resident #40's most recent quarterly MDS assessment dated [DATE] indicated he had a BIMS score of 0 indicating his cognition was severely impaired.Record review of Resident #40's comprehensive care plan dated [DATE] indicated he was at risk for adverse consequences related to antianxiety medication use. The relevant intervention was giving anti-anxiety medications ordered by physician and monitoring and documenting side effects and effectiveness.Record review on [DATE] of Resident #40's physician orders reflected: Lorazepam Oral Tablet 1 MG (Lorazepam): Give 1 tablet by mouth three times a day for Anxiety. Start Date-[DATE].Record review of Resident #55's face sheet dated (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	[DATE] indicated he was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of heart failure, encounter for fracture with routine healing, chronic kidney disease, restlessness and agitation, muscle weakness, hypertension, dementia and anxiety disorder.Record review of Resident #55's most recent quarterly MDS assessment dated [DATE] indicated he had a BIMS score of 0 indicating his cognition was severely impaired.Record review of Resident #55's comprehensive care plan dated [DATE] indicated he had potential for acute/chronic pain r/t disease process, wedge compression fracture and the relevant intervention was identifying, recording and treating the pain.Record review of Resident #55's physician orders reflected: Tramadol HCl ER Oral Tablet Extended Release 24 Hour 100 MG (Tramadol HCl): Give 1 tablet by mouth one time a day for pain. Do not crush.-Start Date- [DATE]Record review of the MAR of [DATE] of Resident #40 and Resident #55 on [DATE] started at 12:50pm revealed that MA B had administered all their morning medications, including Lorazepam 1mg of Resident #40 and Tramadol HCl 100mg of Resident #55. Resident #37 received Tramadol HCl 50mg in the morning, administered by MA A.Record review on [DATE] at 1:10 p.m. of the controlled drug logs for Resident #37, Resident #40, and Resident #55 revealed that no entries were recorded on [DATE]. The most recent entries in the logs were on [DATE].An observation on [DATE] at 12:50pm of the reconciliation of the controlled drug logs for Resident #37, Resident #40 and Resident #55 with the medication stock revealed a discrepancy of one tablet for each residents'-controlled drugs. Resident #37's Tramadol 50mg, recorded in the log on [DATE], indicated 59 tablets, whereas the actual stock contained only 58 tablets. For Resident #40, the log showed Lorazepam 1mg on [DATE] with 2 tablets recorded, but the actual stock was only 1 tablet. Resident #55 had Tramadol 100mg in stock, with 19 tablets recorded, but 18 tablets were found in the actual stock.During an interview on [DATE] at 12:55 p.m., MA B stated that in the morning of [DATE], she reconciled the controlled drugs with the night nurse during the shift change and confirmed that Resident #55 had 59 tablets of Tramadol #100mg. She also stated that she administered one tablet of Tramadol 100mg to Resident #55 in the morning, along with other morning medications. She explained that she documented this in the MAR and had planned to record it in the controlled drug log sometime later. MA B further stated that she was aware, according to facility policy, that she was supposed to enter the quantity of the controlled drug in the log immediately after it was removed from stock. She said that this practice was essential to maintain an accurate account of the drugs in stock. She mentioned that she had received in-service training on documenting-controlled drugs dispensed in the logs accurately, but she was unable to recall the exact date of the training.During an interview on [DATE] at 1:20 p.m., MA A stated that she had reconciled the controlled drug log with the night shift nurse against the stock in the morning. She explained that in the morning she accurately documented the administration of controlled drugs to Resident #37 and Resident #40 on the MAR, but she did not record these in the controlled drug logs at the time. She stated she had planned to cross-check the controlled drugs removed in the morning and document them later in the logs after completing the administration of morning medications to all residents. She said this was incorrect practice and stated she would be more mindful in the future to record medications immediately after they were removed for administration. MA A also stated that it was her mistake to dispense medications into medication cups and store them for later use. She explained that since there were no identifiers on the cups, there was a risk of mixing up medications, which could result in residents receiving the wrong medications. MA A said that such errors could lead to serious health issues for residents. She stated she understood the principles of safe medication administration; she could not recall whether she had received any in-service training on this topic. When the investigator asked about the charging cable found in the medication cart drawer with the residents' drugs, she acknowledged that by storing the cable there she compromised infection control protocols, as it increased the risk of cross-contamination.During an interview on [DATE] at 1:30 p.m., the ADON, who was observing discrepancies in the controlled drug logs, stated that it was the responsibility of the MAs and nurses to maintain the controlled drug logbook accurately and properly. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She emphasized that this was essential to track medication usage and prevent drug diversion. The ADON also observed expired vaccines in the refrigerator within the medication storage room and stated that having outdated vaccines in storage was unacceptable. She explained that this could increase the risk of administering ineffective vaccines to residents, thereby preventing them from receiving the full therapeutic benefit. The ADON stated that she and the DON were responsible for overseeing and ensuring that medications in stock were valid and suitable for use. She expressed her concern about the prolonged presence of expired vaccines in storage and stated that she did not know how those vaccines had remained in stock for such an extended period.During an interview on [DATE] at 3:30 p.m., the DON stated that the facility was committed to maintaining accurate records of both in-stock and administered controlled drugs. She explained that all MAs and nurses were instructed to follow facility policy and record the removal of controlled drugs in the log immediately after they were taken for administration. She said the logs were reconciled at the end of each shift with the actual medication stock to identify any missing doses. The DON stated the ADON's audit the controlled drug logs weekly for accuracy. She stated that the medication cart was exclusively for storing residents' medications, and no other items should be kept there. She stated that storing charging cables with residents' medications increases the risk of cross-contamination and should be avoided. She also mentioned that expired, damaged, or unidentified medications should not be present in the medication cart or storage room. Regarding the expired influenza vaccines, she explained that these should have been removed and disposed of as soon as they expired. She expressed her concern, though she also was responsible to oversee the efficacy of the medication in storage, about how the influenza vaccines expired in [DATE] were still in storage, unidentified as expired, and had remained there for such a long time. The DON further stated that staff were expected to follow at least the five rights of medication administration: the right medication, right patient, right route, right time, and right dose. She indicated that storing dispensed medications for two residents in medication cups for future use was unacceptable and against facility policy. She highlighted that the lack of resident identifiers on the cups increased the risk of medication mix-ups, which could lead to administering the wrong medications to the wrong residents and potentially cause serious harm. She noted that there had been multiple in-service trainings on the fundamental principles of medication handling, including proper medication storage and administration.Record review of the policy medication Access and Storage /Drug destruction revised in [DATE] reflected: . Outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy if a current order exists. narcotics are to be inventoried and counted.Record review of the policy Administration of Medications revised in [DATE] reflected: .identification of resident must be made prior to administering medication to the resident.Prior to administering the resident's medication, the nurse or medication technician should compare the drug and dosage or the schedule, the nurse or med tech should check the physician's orders.The nurse or medication technician administering the medication must record such information on the resident's MAR before administering the next resident's medication. Should a drug be withheld, refused or given other than at the scheduled time, the staff administering must indicate the reason on the MAR.