

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: 676499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Springtown Park Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Williams Ward Rd. Springtown, TX 76082	
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 - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys, for the medication cart located on 1 of 4 halls. 1. The medication cart was observed unlocked and unattended by LVN C on Hall 100 on 12/16/2025 at 9:31 AM. 2. Resident #52 was observed walking in Hall 100 to the unlocked medication cart and leaned her arms and head on top of the cart on 12/16/2025 at 9:32 AM. This failure placed residents at risk for adverse reactions from accessing and ingesting medications that were not prescribed for them. The findings included: Review of Resident #52's admission Record, dated 12/18/2025, indicated a [AGE] year-old female initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including chronic congestive heart failure (impairment in the ability of the heart to fill with and pump blood), type 2 diabetes mellitus (characterized by high blood sugar, insulin resistance, and relative lack of insulin), chronic kidney disease (occurs when the kidneys are damaged and cannot filter blood effectively), hypertension (high blood pressure), gastro-esophageal reflux disease (stomach acid flows back into the esophagus), hypothyroidism (thyroid disorder), and anxiety. Review of Resident #52's admission MDS Assessment, dated 11/12/25, indicated the resident had a BIMS score of 13 out of 15 (cognitively intact) and was ambulatory with no mobility devices. Observation on 12/16/2025 at 9:31 AM revealed the medication cart in Hall 100 was found unlocked and the nurse was not observed anywhere in the hallway. The medication cart was located against the wall to the left of the doorway to room [ROOM NUMBER]. During an observation and interview on 12/16/2025 at 9:32 AM, Resident #52 was observed ambulating in the hallway of Hall 100. Resident #52 stopped at the medication cart and leaned her arms on top of the medication cart and lowered her head onto her arms. Resident #52 stated her first name and said her room was not on that hall. Resident #52 was holding a cell phone in her hand. During an observation and interview on 12/16/2025 at 9:35 AM, LVN C came out of room [ROOM NUMBER], where the door to the hallway had been closed, located across the hall from the unlocked medication cart. LVN C looked at the surveyor standing by the medication cart when she came out of room [ROOM NUMBER] and her mouth opened and her eyes opened wide. When the surveyor inquired if she knew her medication cart had been unlocked, LVN C held out her wrists toward the surveyor and stated, Cuff me. I know better than that. During an observation and interview on 12/16/2025 at 9:47 AM, Resident #52 was observed standing near the doorway to room [ROOM NUMBER] and was talking with the resident in that room. Resident #52 stated her full name and said her room was located on Hall 200 and she raised two fingers. Resident #52 said she was just talking with the residents on Hall 100. In an interview on 12/18/2025 at 12:30 PM, the DON said the staff were expected to keep their carts locked when they were not in view of them. She stated not following this expectation may result in adverse outcomes for the residents. In an interview on 12/18/2025 at 1:55 PM, ADON B stated she was the ADON for Halls 100 and 400. During discussion regarding the medication cart on Hall 100 being left unlocked and unattended by LVN C on the morning of (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/16/2025, ADON B stated there were residents with dementia here [in the facility] and they could have accessed the medications. She stated the expectation was that the medication cart be locked if it was not in the nurse's line of vision. ADON B stated potential outcomes of the medication cart being unlocked and unattended was that anyone could have access to the medications in the cart. ADON B stated other residents could have access to medications that were not prescribed to them, and the residents could have adverse reactions such as allergic reactions, over medication, or drug interactions. Review of the facility's policy for Storage of Medications, dated as revised April 2019, specified the following [in part]: Policy StatementThe facility stores all drugs and biologicals in a safe, secure, and orderly manner.Policy Interpretation and Implementation1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls.3. The nursing staff are responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.8. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use.9. Unlocked medication carts are not left unattended.12. Only persons authorized to prepare and administer medications have access to locked medications.14. Access to controlled medications is limited to authorized personnel. Personnel access to controlled medications is recorded. Review of the facility's policy for Administering Medications, dated as revised April 2019, indicated the following [in part]: Policy StatementMedications are administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions.15. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.		

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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** 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 of 5 residents (Resident #82) reviewed for medication administration on Hall 100. Resident #82's medications were in a paper medication cup on her overbed table on the morning of 12/16/2025 at 9:13 AM. This failure could place the resident at risk for adverse consequences from not taking her prescribed medications at the prescribed time. The findings included: Review of Resident #82's admission Record, dated 12/18/2025, indicated a [AGE] year-old female initially admitted on [DATE] and re-admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (lung disease with shortness of breath), recurrent pneumonia, cerebral infarction (stroke), hypertension (high blood pressure), atherosclerotic heart disease (buildup of plaque in the coronary arteries leading to reduced blood flow and increased risk of heart attacks), gastro-esophageal reflux disease (stomach acid flows back into the esophagus), hyperlipidemia (high cholesterol), depression, and allergic rhinitis (allergic reaction that causes sneezing, congestion, itchy nose and watery eyes). Review of Resident #82's Annual MDS Assessment, dated 12/04/2025, indicated a BIMS score of 15 out of 15 (cognitively intact). Review of Resident #82's MAR, dated 12/01/2025 - 12/31/2025, revealed the following morning medications for 12/16/2025 were initialed as administered by LVN C: Acidophilus 100 mg by mouth one time a day [in the morning] for probiotic. Aspirin 325 mg by mouth one time a day [at 9:00 AM] for atherosclerotic heart disease. Cetirizine HCL 10 mg by mouth one time a day [at 9:00 AM] for allergic rhinitis. Clopidogrel Bisulfate 75 mg by mouth one time a day [at 9:00 AM] for atherosclerotic heart disease. Diltiazem HCL ER 180 mg by mouth one time a day [at 9:00 AM] for hypertension. Mirabegron ER 25 mg by mouth one time a day [at 9:00 AM] for overactive bladder. Sertraline HCL 50 mg by mouth one time a day [at 9:00 AM] for depression. Cefdinir 300 mg by mouth two times a day [morning dose at 8:00 AM] for pneumonia. Guaifenesin ER 600 mg by mouth two times a day [morning dose] for allergies, congestion, wheezing. Prednisone 10 mg by mouth two times a day [morning dose] for URI. Baclofen 5 mg by mouth three times a day [morning dose at 9:00 AM] for pain. During an observation and interview on 12/16/2025 at 9:13 AM, Resident #82 was observed sitting up in bed watching television with the overbed table positioned in front of her over her lap. The resident was using colored pencils to color in a coloring book. A paper medication cup containing approximately 10 pills of different colors, shapes and sizes was on the resident's overbed table. Resident #82 stated the nurse had just left her pills and the nurse knew she would take them. Resident #82 proceeded to take the pills from the medication cup, placed a few of them at a time in her mouth, and drank water from a plastic glass. Resident #82 was using supplemental oxygen via nasal cannula. She stated she had pneumonia and had started antibiotics last Friday [12/12/2025]. Resident #82 stated she was feeling better now. During an observation and interview on 12/16/2025 at 10:53 AM, MA-D was observed standing by the medication cart on Hall 100 and was administering medications. She stated she worked for an agency and was not a facility employee. MA-D stated she had been on Hall 300 earlier that morning and but she had not given medications to Resident #82 that morning. MA-D stated the nurse for Hall 100 [LVN C] had helped her that morning and gave the residents their medications earlier that morning. During an observation and interview on 12/17/2025 at 8:11 AM, Resident #82 was sitting up in bed eating breakfast. Resident #82 stated she had received and taken her medications that morning. An empty medication cup was observed in the waste basket at the resident's bedside. During an interview and observation on 12/17/2025 at 1:51 PM, LVN C stated she had been employed in the facility as a charge nurse for one year and was usually assigned to work on Hall 100. She stated she had been a nurse for a long time, at least 30 years or more. LVN C stated on (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the morning of 12/16/25 the usual Medication Aide for Halls 100 and 300 had called in and MA-D had worked and given medications on Halls 300 and 100. LVN C stated she helped give medications to the Hall 100 residents on the morning of 12/16/2025 and gave as many as she could for the ones who needed their medications between 8:00 AM and 9:00 AM. LVN C stated the procedure for administering medications was to follow the 5 Rights of medication administration and included verifying the medication, verifying the resident, and taking the medications with water to the resident. LVN C stated she checked vital signs and visited with the residents to see how they were doing. LVN C stated she normally did not leave the medication cups with the residents and usually stayed until the medications were swallowed and the empty medication cup and water glass were handed back to her. LVN C stated she threw the empty medication cup in the room waste basket. LVN C stated she took Resident #82's medications to her on the morning of 12/16/2025 and set them on the overbed table. She stated she may have done other things for Resident #82 and did not realize the resident had not taken her medications. LVN C proceeded to review Resident #82's medication administration record and said her initials were on the eMAR and there were 11 medications that would have been in the medication cup. LVN C stated the morning classification of medications can be given during a 4-hour time frame between 6:00 AM and 10:00 AM. LVN C printed the page with the medications that would have been in the medication cup. She stated there were 11 medications she had pulled from the medication cart. LVN C stated a negative outcome could be another person/resident took the pills or the resident could hoard them and take too many at one time and cause self-harm. In an interview on 12/18/2025 at 1:55 PM, ADON B stated she was the ADON for Halls 100 and 400. During discussion of Resident #82's medications being left on her overbed table by LVN C, ADON B stated the expectation was that medications were never left at the resident's bedside. ADON B stated a potential outcome was that the resident did not take her medications. During an interview on 12/18/2025 12:30 PM, the DON said medications should be completed within an hour before or an hour after the time prescribed and document with each medication provided with no exceptions. The DON said that not following this expectation may result in adverse outcomes for the residents. Review of the facility's policy for Administering Medications, dated as revised April 2019, indicated the following [in part]: Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. 2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. 3. Medications are administered in accordance with prescriber orders, including any required time frame. 6. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 9. The individual administering medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 15. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. 18. The individual administering the medication electronically signs or signs with initials on the resident's MAR/EMAR after giving each medication and before administering the next ones. 25. New nursing personnel will orient with a charge nurse on their medication rounds for at least 2-3 days to ensure established procedures are followed and proper resident identification methods are learned.		