STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745022	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ware Memorial Care Center	1510 S Van Buren St. Amarillo, TX 79101

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** 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 (Resident #1) of 6 residents reviewed for medication administration.The facility failed to ensure LVN A stayed with Resident #1 until the medications she gave him were taken on the morning of 04/16/26.This failure could place residents at risk of harm due to not receiving necessary medications or receiving medications at the wrong time as well as taking medication that does not belong to them.Findings Included:Record review of Resident #1's admission record dated 04/16/26 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, persistent atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), essential hypertension (high blood pressure), heart failure (heart muscle fails to pump blood as it should), and edema (swelling).Record review of Resident #1's quarterly MDS assessment completed on 03/10/26 revealed a BIMS of 15 which indicated intact cognition. Section GG Functional Abilities revealed Resident #1 was dependent with all ADLs except eating and oral hygiene where he required only setup or clean-up assistance. Section N Medications revealed Resident #1 was receiving medications from the following high risk drug classes: antidepressant, anticoagulant (blood thinner), diuretic (increases urine production to remove excess water and salt from the body), opioid (pain medication), and anticonvulsant (helps prevent or control seizures).Record review of Resident #1's care plan completed 03/10/26 revealed no mention of Resident #1 self-administering his medication.Record review of Resident #1's MAR for April 2026 dated 04/16/26 revealed the following medications administered by LVN A on the morning of 04/16/26:Lasix Oral Tablet 40 MG (diuretic medication)Multiple Vitamin TabletSenna-Plus Oral Tablet 8.6-50 MG (laxative [medication to help with bowel movement if constipated] and stool softener)Spironolactone Tablet 25 MG (diuretic medication)Zoloft Oral Tablet 100 MG (antidepressant medication)Eliquis Oral Tablet 5 MG (anticoagulant medication)Gabapentin Capsule 100 MG (anticonvulsant medication)Metoprolol Tartrate Oral Tablet 100 MG (blood pressure medication)Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (opioid pain medication)During an observation and interview on 04/16/26 at 07:27 AM Resident #1 was seated with another resident at a table in the dining room. Resident #1 had a small oval orange-pink pill on the table in front of him and a small plastic medication cup on the table in front of him containing approximately eight medications. He had a lidded cup with a straw of what appeared to be coffee on the table in front of him. No staff were in sight. Resident #1 stated staff leave his medications with him for him to take on his own every day.During an observation on 04/16/26 at 07:30 AM Resident #1 was seated at the table in the dining room with medications in the plastic medication cup in front of him on the table and LVN A was standing 4-6 yards away behind her medication cart looking at her computer screen.During an interview on 04/16/26 at 07:32 AM LVN A stated she leaves Resident #1's medications with him for him to take on his own because, He takes (continued on next page)

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	one pill at a time and if you stand there with him, he won't take them. I stay close where I can watch. She stated a possible negative outcome of not watching Resident #1 take his medication was he could not take the medicine and if he did not take the medicine it could affect his health or he could save up the medicine.During an interview on 04/16/26 at 07:36 AM RN B stated it was never okay to leave a resident alone with their medication. She stated, Another resident could swing by, grab it (medication) and swallow.During an interview on 04/16/26 at 07:46 AM LVN C stated it was never okay to leave a resident alone with their medication. She stated residents could store their medication and take too much at once or another resident could come along and grab the medication.During an interview on 04/16/26 at 07:50 AM ADON and DON stated nurses were to stay with residents until all medications administered were taken. DON stated otherwise the nurse could not know if the resident took the medication which could lead to the resident not receiving needed treatment. She stated, I worry about them (residents) choking or residents could hoard medication.Record review of an undated page from the facility's admission packet titled Common Items Not Allowed in Nursing Home Resident's Rooms revealed the following: . MEDICATIONS: (Includes all prescription and over-the-counter drugs) NOTE: if a resident is requesting to administer his/her own medications(s), the Physician must approve the request and the Care Plan Team must evaluate whether the resident is capable of this task, and there must be specific precautions taken to prevent other residents from possible harm by inadvertently eating or drinking it.Record review of facility policy titled Drug Administration Policy and dated 01/26/17 revealed no mention of nurses remaining with residents while medications were taken.Record review of facility policy titled Pharmacy Services and dated 01/26/17 revealed no mention of nurses remaining with residents while medications were taken.Record review of undated facility form titled POC Education-Medication Administration revealed the following: . 2. Unattended Medications Nursing best practice for medication administration is to observe every resident while taking their medications to ensure they have been swallowed. Medications are never to be left unattended with a resident . Leaving medications unattended with residents places them at risk for:-intentional or unintentional medication avoidance-potential abuse of medications (stockpiling medications)-potential decline in condition due to missed medications-chokingIt is also a violation of the Nurse Practice Act which requires a nurse's direct supervision with medication dispensing and administration.I understand the information above and have had the opportunity to ask questions. I understand these responsibilities and agree to administer medications according to best practice guidelines. I understand that if I choose to leave medications unattended with a resident, I will face disciplinary action up to and including termination and jeopardize my nursing license.LVN A signed the form on 03/04/26.