STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675885	A. Building B. Wing	08/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Manor	1022 Presidential Corridor Hwy 21 E Caldwell, TX 77836

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. 40884 Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals, were in locked compartments and inaccessible to unauthorized staff, visitors , and residents for 1 of 2 medication carts (Medication Cart #1) reviewed for medication storage. The facility failed to prevent Medication Cart #1 from 8:30 AM to 8:40 AM being unattended and unlocked on the 400 hall on 08/24/2024. This failure could allow residents unsupervised access to prescription and over-the-counter medications. Findings included: Observation on 08/24/2024 at 8:30 AM of Medication Cart #1, it was in front of Resident # 1's room. The medication cart was unlocked. Med-Aide A was in Resident #1's room with her back toward the door entering into Resident #1's room. Surveyor B opened and closed the top drawer of Medication Cart #1. Med-Aide A did not turn around to check on Medication Cart #1. Surveyor B opened the second drawer of Medication Cart #1 and Med-Aide A turned around and walked toward Medication Cart #1. Did not observe any residents in the hall. In an interview on 08/24/2024 at 8:45 AM Med-Aide A stated no one was to be opening the medication cart except nurses and med-aides. Med-Aide A stated she was under the assumption as long as the drawers were facing the resident room it was ok for the medication cart to be left unlocked. She stated she did not hear the top drawer opening and closing when she turned around and saw Surveyor B closing the second drawer in Medication Cart #1. Med-Aide A stated she had been in-serviced to lock the cart when not giving medications but she thought it was ok for the cart to be unlocked as long as the drawers were not facing the hall. She stated it would have been very easy for someone to open Medication Cart #1 and get the medications out of the cart before she knew it when standing in Resident #1's room. She stated she did have her back turned to the medication cart while talking to Resident #1. Med - Aide A stated Medication Cart #1 was not in her view when she was in Resident #1's room. She stated if a resident had ingested any medications a resident had a potential of dying from interaction of medications. Med-Aide A stated she had been in-serviced on medication administration and medication carts in July 2024, however, she did not recall all the information given during the in-service. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675885	A. Building B. Wing	08/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burleson Manor	1022 Presidential Corridor Hwy 21 E Caldwell, TX 77836

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(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	In an interview on 08/24/2024 at 9:00 AM LVN C stated all medication carts were expected to be locked anytime a med-aide or a nurse was not standing at the cart administering medications. She stated if the med-aide was in a resident's room and the medication cart was in the hall, the medication cart was expected to be locked. LVN C stated there was a possibility a resident or anyone could take medications from the cart. She stated if a resident took any medication by mouth and the resident was allergic to that medication it was a potential for the resident to become severely ill or die. LVN C stated she had been in-serviced in the past month or two months on administering medications and locking the medication carts. In an interview on 08/24/2024 at 2:30 PM the Director of Nurses stated the medication carts were expected to be locked unless the nurse was standing at the cart administering medications. She stated if the medication carts were near a resident's room and the nurse or med-aide was not standing at the medication cart it was expected to be locked, there were no exceptions. The Director of Nurses stated if the med-aide was in a resident's room and had her back to the medication cart there was a possibility another staff, a resident, or visitor could open the medication cart and take medications without the med-aide knowing. She stated a resident may become severely ill if they ingested medications, and they were allergic to or had an interaction with the current medications the resident was already taking on a regular basis. The Director of Nurses stated there was a possibility a resident may die if they were severely allergic to a medication they took from the medication cart. She stated other people who were not residents may take the medications and become severely ill and possibly die if allergic to the medication. The Director of Nurses stated there were numerous things that could happen to a resident, visitor, or a staff. She stated she had been working at this facility a few weeks and she would need to check for any in-services given on medication carts. In an interview on 08/24/2024 at 3:00 PM the Administrator stated the medication carts were expected to be locked when the nurses were not administering medications from the carts. She stated if the med-aide was in a resident's room and the medication cart was in the hallway, she expected the medication cart to be locked. The Administrator stated the only time a medication cart was to be un-locked was when a nurse or med-aide was administering medications from the medication cart. She stated there were no exceptions. The Administrator stated there was a possibility a resident may take medicines from the medication cart. She stated the resident may give medications to another resident or ingest the medications themselves in their room. The Administrator stated the resident may become severely ill and had the potential of dying if the resident was allergic to the medication. She stated she would need to check with nursing administration concerning any in-services on medication carts. Record Review on 08/24/2024 of nursing in-service, dated 07/12/2024, on medication carts reflected Med-Aide A was in attendance of the in-service. The nursing staff was in-serviced on medication carts such as: do not leave med (medication) cart unlocked when unattended. Record review of the Facility's Policy on Medication Use Administration , last reviewed on 05/31/2023, reflected medication cart must be locked when not in use or nurse/medication aide was not utilizing cart or within sight of licensed