STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675964	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mrc Creekside	1433 Veterans Memorial Parkway Huntsville, TX 77340

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional principles for 1 of 2 medication carts (medication aide cart for the second floor) reviewed for pharmacy services. The facility failed to ensure a bottle of morphine sulfate in a medication cart on the second floor was labeled properly in accordance with professional principles for Resident #8 on 1/13/2025. The bottle had a label without any writing on it. This failure could place residents at risk for adverse effects and improper administration of medications. Findings include: Record review of an Admission Record for Resident #8 dated 1/14/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of Alzheimer's Disease, hypertensive heart disease (a condition where high blood pressure makes the heart work harder) and spondylosis (arthritis that affects the neck and low back). Record review of active physician orders for Resident #8 dated 1/14/2025 indicated an order for morphine sulfate oral solution 20 mg/ml give 0.25 ml by mouth every 3 hours as needed for pain that started on 8/28/2024. Record review of a Quarterly MDS Assessment for Resident #8 dated 12/31/2024 indicated she had severe impairment in thinking with a BIMS score of 6. She required substantial/maximal assistance with personal hygiene and showering/bathing. She required set up or clean-up assistance with eating. During the 5 day look back period she did not receive any PRN pain medication. Record review of a care plan for Resident #8 dated 10/7/2022 indicated she was on hospice services related to Alzheimer's. Interventions included to administer pain medication as ordered. (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 - Few	During an observation of the medication cart for the second floor on 1/13/2025 at 10:32 AMMA A was present and a narcotic count was conducted with the State Surveyor and MA A. A bottle of morphine sulfate 100 mg/5 ml was in a clear, plastic bag prescribed to Resident #8. The plastic bag was labeled with the resident's name, dosage, date filled, expiration date, pharmacy information, prescribing physician, and quantity of the medication. The medication bottle inside of the plastic bag had a label but the label was blank without any writing on it. During an interview on 1/13/2025 at 10:34 AM, MA A said she had been employed at the facility since September 2024 and worked 6 am - 2 pm. She said medication bottles should have labels on them and the bottle of morphine for Resident #8 did not. She said normally the bottles of morphine were in boxes that were placed inside of a plastic bag and the bag along with the box would be labeled. She said she was not aware the bottle did not have a label. She said during the narcotic counts conducted with other staff, she would ensure the quantity of the medication was correct but never noticed that the label did not have any writing on it. She said she would let LVN B know about the medication. She said she had never given Resident #8 any of the morphine and the only time the medication was administered was during the evening shift. She said if a medication was not labeled properly, the resident could potentially be given the wrong dose or medication. During an interview on 1/13/2025 at 10:38 AM, LVN B said she had been employed at the facility for a year and worked 6 am - 6 pm. She said she was not aware of the morphine for Resident #8 not having a label on the bottle. She said the bottle should have a label that included the prescriber, resident's name, date prescribed, date of birth, route, and directions. She said normally if morphine came from the facility pharmacy, it would be in a box. She said the bottle of morphine for Resident #8 came from the hospice pharmacy. She said the facility would place the box in a zip lock bag as a safety net. She said if the sticker fell off the bottle, staff would not have any idea of what the medication was and could potentially cause a medication error. She said she contacted hospice to notify them as the medication was dispensed through the hospice pharmacy and they would take care of it. During an interview on 1/14/2025 at 12:07 PM, the ADON said the medication aides were responsible for checking the medication carts weekly to ensure medications were properly labeled. She said she was aware of the bottle of morphine for Resident #8 that was found in the medication cart that was not labeled properly. She said Resident #8 received the morphine prn and had not received it since September 2024. She said medications should be labeled with the name of the resident, date it was filled, route to be given, and dosage to confirm how to be given. She said residents could be at risk of a medication error if medications were not labeled properly. During an interview on 1/14/2025 at 12:37 PM, the DON said the medication aides were responsible for checking the medication carts at least weekly. He said medication bottles should have labels that included identifier information for the residents that included date filled, route, dose, and time to be given. He said he was made aware of the bottle of morphine for Resident #8 that was found on yesterday 1/13/2025. He said the facility started an in-service with the nurses and medication aides for proper labeling of medications. He said residents could be at risk for medication errors if medications were not labeled properly. Record review of a facility in-service dated 1/13/2025 titled Medication Aides and Nurses indicated that if medications had missing/incomplete, improper, or incorrect labels they were to immediately contact the pharmacy for instruction. The DON conducted the training. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/14/2025 at 1:36 PM, the Administrator said the medication aides along with the charge nurses were responsible for checking the medication carts at least weekly. He said his expectations were to make sure staff were following the proper policy and procedures. He said if staff were not able to see a label on a prescription, then a resident could be given the wrong medicine. Record review of a facility policy titled Medical Labeling and Storage revised February 2023 indicated, . Medication Labeling, 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 2. The medication label includes, at a minimum: a. medication name (generic and/or brand); b. prescribed dose; c. strength; d. expiration date, when applicable; e. residents' name; f. route of administration; and g. appropriate instructions and precautions. 8. If medications containers have missing, incomplete, improper, or incorrect labels, contact the dispensing pharmacy for instruction regarding returning or destroying these items. 10. Only the dispensing pharmacy may label or alter the label on a medication container or package .