STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675329	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEVELLAND NURSING & REHABILITATION CENTER	**210 WEST AVE LEVELLAND, TX 79336**

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, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys, in that: a)Medication storage areas were not secured. Doors to medication storage rooms were left open and the rooms were unattended. A treatment cart with prescription medications was left unlocked and unattended in a public corridor, and b) Medications, dispensed in portion cups, were left on top of a treatment cart, unattended, in a public corridor. These problems could result in the diversion of medications and result in residents ingesting medications not prescribed to them. The findings include: On 3/11/20 at 4:49 AM a treatment cart was unlocked and unattended in the corridor near the central nurse's station in the entrance hall area. There were medications in uncovered portion cups on top of the treatment cart that were labeled #16, 25, 28, 18 and 17. LVN #1 was observed coming out of the medication room at the center nurse station. On 3/11/20 at 4:50 AM the over-the-counter medication storage closet was unlocked and unattended with the door ajar. This room was full of over-the-counter medications. On 3/11/20 at 4:51 AM the medication room at the [LOC] nurse's station had the door ajar, and the room was unattended. There was no staff at the nurse's station. The shelves were filled with resident prescription medications. On 3/11/20 at 5:10 AM the treatment cart was unattended in the corridor near the center nurses' station along the entrance hallway. It was also noted that the over-the-counter medication room was still open (across the hall). The door was a jar and there were medications on the shelves. Also, it was noted that the [LOC] medication room door was ajar, and the medication room and nurse station were unattended. On 3/11/20 at 5:11 AM LVN #1 was observed in the central corridor near the center nurses' station next to the unlocked treatment cart. She then left the cart area and went to [LOC] without locking the treatment cart. On 3/11/20 at 5:16 PM an interview was conducted with LVN #1 regarding what staff were told regarding securing medications on carts. She stated, They say to lock it. It's a wound treatment cart. We don't have a key, but the wound nurse does; I don't. She then looked in the top drawer of the cart and stated, Oh yeah, it does have meds in it. She was then told about the medication room at the [LOC] nurse's station being open and unlocked and the over-the-counter-medication room being open and unlocked. She stated, I have a key for the over-the-counter closet though. Independently ambulatory residents were also observed in the corridors in the early morning hours in the central nurse station and [LOC] areas. On 3/11/20 at 4:45 AM Resident #1 was observed walking the center and back corridors of the facility and had some confusion. Record review of the current resident roster revealed Resident #1 resided on the central hall. Record review of the current face sheet for the resident revealed that he had [DIAGNOSES REDACTED]. On 3/11/20 at 4:59 AM Resident #2 was observed in her wheelchair outside on the dark interior courtyard patio and smoking. Record review of the current resident roster revealed Resident #2 resided on [LOC]. Record review of the current face sheet for the resident revealed that she had [DIAGNOSES REDACTED]. On 3/11/20 at 5:00 AM LVN #1 stated regarding Resident #2, She's outside at this time smoking every morning. On 3/11/20 at 5:03 AM Resident #2 was up and ambulating in the corridors in her wheelchair. The resident also had an electronic monitoring device on her wrist. Resident #1 was observed walking the corridors at this time also. There were also staff on duty during this time that were not licensed or certified to have access to medications such as CNAs and NAs. On 3/11/20 at 4:30, the staff members that were present in the facility were CNA #1, CNA #2, NA #1, LVN #1 and RN #1. Policy: Record review of the facility policy labeled Pharmacy Services - Policy and Procedures for Nursing Facilities, Revised November 2011, Medication Storage In The Facility, Storage of Medications, Section 4.1, 05/12, revealed the following documentation, 4.1: Storage of Medications. Policy. Medications and biological are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures . B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.