STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455925	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veranda Rehabilitation and Healthcare	4301 S Expressway 83 Harlingen, TX 78550

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. Based on observation, interview, and record review the facility to ensure when not in use, medication carts were stored and secured in a designated area for 1 of 4 carts (1 and 2 hallways) medication carts reviewed for drug security. The facility failed to ensure that the nurses medication cart for 1 and 2 hallways was secured by a lock when it was left unattended by RN A. The failure could place residents at risk of injury to other residents if medication left unsecured were consumed.Findings include: During an observation on 11/5/2025 from 03:20 PM revealed surveyor walking next to the medication cart and the 1 and 2 hallways nurse's medication cart was left unlocked and unattended in front the nurse's station. During the observation RN A was at the nurses' station. RN A was informed of the unlocked medication. RN A secured the cart by locking it. During an interview on 11/5/2025 at 03:25 PM with RN A revealed he was responsible for the nurse's medication cart that was left unlocked. He stated he was expected to lock the nurse's medication cart when he walked away from it. He stated if it was left unlocked then a resident could open a drawer and take anything that was not for them, or medications could get stolen. He stated he unlocked the medication cart for an auditor and that person left it unlocked, and he was not aware. RN A said that he thought the auditor locked it. During an interview on 11/5/2025 at 04:30 PM with the DON revealed numerous staff, including her and the ADON, were responsible for ensuring medications carts were locked. The DON stated her expectation of staff when they walked away from the medication cart was to lock it. The DON stated that the negative outcome for leaving the cart unlocked was that a resident or visitor could grab the medication from the cart, and it could harm them. Record review of facility policy Medication Storage, with a revised date 8/2023 revealed, All medications shall be stored to insure potency, patient safety and security of the product. Only licensed nurses, the consultant/clinical pharmacist, and those lawfully authorized to administer medications are allowed access to medications. Medications rooms, carts, and medication supplies are locked or attended to by persons with authorized access.

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