STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675004	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McKinney Healthcare and Rehabilitation Center	253 Enterprise Dr McKinney, TX 75069

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. (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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(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	**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 under proper temperature controls and permitted only authorized personnel to have access to the keys for four of fifteen residents (Resident #1, #2, #3, and #4) reviewed for medication storage. 1. The facility failed to ensure a wound cleanser, an antiseptic (substance that stops the growth of microorganisms) skin cleanser, tubes of barrier creams (used to prevent skin irritation), a bottle of nystatin powder (antifungal medication), and sachets of povidone-iodine (solution used to prevent wound infection) were not left within reach inside Resident #1's room on 11/25/2025. 2. The facility failed to ensure there was no squeeze eye drop bottle, a tube of hemorrhoid (swollen veins in the anus) ointment, a tube of hydrocortisone (used to treat inflammation) ointment, and a tube of triple antibiotics (antibiotics used to kill bacteria in the skin) were not left inside Resident #2's room on 11/25/2025. 3. The facility failed to ensure sachets of barrier cream were not left inside Resident #3's room on 11/25/2025. 4. The facility failed to ensure containers of wound cleanser were not left inside Resident #4's room on 11/25/2025. These failures could place residents at risk of misuse of medications that could lead to adverse reactions.Findings include: 1. Record review of Resident #1's Face Sheet, dated 11/25/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with multiple sclerosis (a disease that causes breakdown of the protective covering of the nerves) and reduced mobility. Record review of Resident #1's Comprehensive MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 09/01/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS (screening tool used to assess cognitive status) score of 15. The Comprehensive MDS Assessment indicated the resident had a surgical wound. Record review of Resident #1' Physician Order, dated 07/31/2025, reflected Sacral surgical dehisced wound: Cleansed with N/S, pat dry, apply Gent, collagen, cover with dry dressing. every day shift every Mon, Wed, Fri for surgical graft wound. Record review of Resident #1's Assessment Notes on 11/25/2025, reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment the resident was competent to manage their own medications. During an observation and interview on 11/25/2025 at 8:13 AM revealed several items for wound care were observed on top of Resident #1's dresser and were in plain sight. On top of the dresser was a wound cleanser, an antiseptic skin cleanser, tubes of barrier creams, a bottle of nystatin powder, and sachets of povidone-iodine. Resident #1 stated she had a wound on her bottom and the nurse would clean her wound every other day. The resident said no one talked to her regarding the risks of having the wound care items inside the room. 2. Record review of Resident #2's Face Sheet, dated 11/25/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with dementia and assistance of personal care. The resident did not have any diagnosis for dry eyes, hemorrhoids, or any skin condition. Record review of Resident #2's Comprehensive MDS Assessment, dated 11/05/2025, reflected the resident had moderate impairment (resident may need additional support and monitoring) with a BIMS score of 09. The Comprehensive MDS Assessment indicated the resident had dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #2's Comprehensive Care Plan, dated 11/13/2025, reflected the resident had impaired cognitive function/dementia one of the interventions was to give step by step instructions. Record review of Resident #2' Physician Order, on 11/25/2025, reflected no order for eye drops, hemorrhoid ointment, hydrocortisone ointment. Ther resident did not have an order for wound care that would require a triple antibiotics. Record review of Resident #2's Assessment Notes, on 11/25/2025, reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment the resident was competent to manage their own medications. An observation on 11/25/2025 at 8:21 AM revealed Resident #2 was not inside her room. A plastic rectangular basket was observed on top of her overbed table with a container of eye drops on it. The container of eye drops was in plain view. During an observation and interview on 11/25/2025 at 1:12 PM revealed Resident #2 was in her bed, awake. When asked about the medications found inside her room, the resident did not reply. 3. Record review of Resident #4's Face Sheet, dated 11/25/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with multiple sclerosis and major depressive disorder (persistent feeling of sadness or loss of interest). Record review of Resident #4's Comprehensive MDS