STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675330	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Radford Hills Healthcare Center	725 Medical Dr Abilene, TX 79601

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments and permit only authorized personnel to have access to the keys during medication storage inspection for 3 (cart #1, cart #2, and cart #3) of 4 medication carts reviewed for storage. The facility failed to ensure medication carts #1, #2 and #3 were locked and secured while unattended. This failure could result in drug diversion. Findings included: During an observation on 09/24/2025 at 05:30 AM, medication carts #1 and #2 were observed to be unlocked with residents and staff within 10 feet of the cart or within eyesight with the medication drawers facing outward. These carts were observed to have the following medication:* heart medications (amiodarone, amlodipine, metoprolol), *depression medications (trazodone), * diuretics (metolazone), * antinausea (meclizine, ondansetron), * diabetes medications (glucagon, insulin), * inhalation medications (albuterol, ipratropium bromide, budesonide), * anti-yeast medications (nystatin powder and cream), *OTC pain medication (aspirin, Tylenol), and *OTC constipation medication (MiraLAX). During an interview on 09/24/2025 at 05:38 AM, RN C stated she was the charge nurse for the night shift, and it was her responsibility to make sure all carts remained locked when not being used. She stated she had left medication carts #1 and #2 unlocked intentionally because the day shift would be coming onto their shift soon. During an observation on 09/24/2025 at 12:12 PM, Medication Cart #3 was observed to be unlocked with residents and staff within 10 feet of the cart out of eyesight with unlocked drawers facing outward. Cart #3 was observed to have the following medications:* heart medications (amiodarone, amlodipine, metoprolol), * depression medications (trazodone), * diuretics (metolazone), * antinausea (meclizine, ondansetron), *diabetes medications (glucagon, insulin), * inhalation medications (albuterol, ipratropium bromide, budesonide), *anti-yeast medications (nystatin powder and cream), *OTC pain medication (aspirin, Tylenol), and*OTC constipation medication (MiraLAX). During an interview on 09/24/2025 at 12:12 PM, RN D stated cart #3 was her responsibility. She stated she felt she had her eyes on the cart, but when the cart had been found unlocked, her back was toward the cart. She stated she did not know what medications were in her cart, or which residents they were for. RN D stated she had driven to the facility early and was tired. She stated she was also in the process of attaining her master's degree and felt she did not need to be written a citation for not following protocols of having an unlocked medication cart. During an interview on 09/24/2025 at 11:58 PM, the ADMN stated all medication carts should have been locked when not in use. She stated the nurses on shift should have monitored their own carts, as well as all staff being aware of the possibility of unlocked carts. The ADMN stated, the potential harm to residents was the residents and/or staff could have taken medications out of the carts causing a medication diversion or misappropriation of property as well as a possible overdose or allergic reaction. The ADMN stated the failure was the staff being too busy to take the time to lock the medication cart when done, with her expectations to have kept all medication carts always locked. During an interview on 09/24/2025 at 12:05 PM, the ADON stated the medication carts should have always been locked. She stated the potential harm for residents was that they could have taken medications that were not theirs. The ADON stated she believed the potential failure was that the nurses were in a hurry and busy with staff not paying attention to their surroundings. She stated her expectations were for all carts to be always locked when not in use. Record review of facility policy Medication Storage in the Facility dated 06/09/2025 revealed: Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The 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 aids) permitted to access medications. Medication room, carts, and medication supplies are locked when not attended by persons with authorized access.