STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035196	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandridge Post Acute	255 West Brown Road Mesa, AZ 85201

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that resident-identifiable information and records were kept confidential and not visible to the public. The deficient practice could result in the violation of residents' rights to privacy.Findings include:An observation conducted on December 16, 2025, at 11:27 a.m., revealed that an unattended medication cart on the Beta 1 unit had a laptop on top of it with resident records open on the screen. The nurse was observed in a resident room.An interview was conducted on December 16, 2025, at 11:28 a.m. with a Licensed Practical Nurse (LPN/Staff#202) who stated that it was not her process, or the facility's process, to leave her laptop open with resident records visible and unattended. The LPN stated that the risk of leaving the records open on her laptop was that it was a Health Insurance Portability and Accountability Act (HIPAA) violation. An observation conducted on December 17, 2025, at 8:02 a.m., revealed that a medication cart on the Beta 2 unit was unattended and had a laptop on top of it with resident records open on the screen. The nurse was observed in a resident room. An interview was conducted on December 17, 2025, at 8:08 a.m. with a Licensed Practical Nurse (LPN/Staff#41) who stated that she left her medication cart unattended, and it was not her process to leave resident records open on her laptop when she walked away from it. The LPN further stated that the risk of leaving her laptop open and unattended was the exposure of patient information, and it was a violation of their rights. An interview was conducted on December 18, 2025, at 8:24 a.m. with the fill-in Director of Nursing and Licensed Practical Nurse Manager (LPN Manager/Staff#13), who stated that nursing staff leaving their medication cart would be expected to ensure their computer screen was not open because it would violate HIPAA. The LPN manager stated that if a nurse were to leave resident records open on the medication cart and unattended, it would violate their right to privacy because their personal information, date of birth , and medications could be visible. A Review of a policy titled, Resident Rights, revised in February 2021, revealed that the unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing the privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPAA compliance officer.

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, staff interviews, facility documentation, policies and procedures, and the State Agency (SA) database, the facility failed to implement its policy requiring a thorough investigation of abuse and neglect allegations for four residents (#29, #33, #37 and #38). This deficient practice could place residents at risk for ongoing abuse and neglect.Findings include: Regarding Resident #38 Resident #38 was admitted on [DATE], with diagnoses that included senile degeneration of the brain, hypertension, and a personal history of COVID-19. Resident #38 expired at the facility on [DATE]. Review of the SA database revealed that the facility submitted a self-report on [DATE]. The report indicated that Resident #38 experienced an unwitnessed fall in the resident's room on [DATE]. According to the report, a hematoma was noted on the resident's head during a skin assessment, and no other injuries were identified. The report further stated that the resident was unable to explain how or why the fall occurred and that Hospice and the resident's family representative were notified. Additionally, a request for a 5-day investigation report was made to the facility on [DATE], at 2:07 p.m.; however, the facility stated that the 5-day report was not available in its records. Further review of the resident's clinical record dated [DATE], at 3:30 p.m., revealed a change-of-condition note related to the fall. A physician assessment completed on the same date indicated that no neurological changes were observed following the incident. A nursing note documented that facility nursing staff notified the Hospice nurse to report the fall to the resident's wife on [DATE], at 5:47 p.m. Attempts to contact the nurses who were working at the time of the incident were unsuccessful. An interview with the resident's wife was conducted by telephone on [DATE], at 8:58 a.m. The wife stated that although she was not present at the facility at the time of the incident, the facility did not contact her on the date of the fall. She further stated that when she visited the resident on [DATE], she observed that he appeared to be in significant pain and went to the front office to voice her concerns. Regarding Resident #37 Resident #37 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, vascular dementia, seizures, major depressive disorder, mood disorder, nicotine dependence, adjustment disorder with mixed disturbance, and dependence on a wheelchair, among other conditions. The resident was discharged on February 28, 2023. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #37 had a care plan initiated on [DATE], which identified the need for extensive assistance with ADLs, including bed mobility, transfers, locomotion, and toileting, due to her medical conditions. The care plan also documented that the resident exhibited, or had the potential to exhibit, verbal behaviors related to cognitive loss and dementia, including verbal outbursts directed toward others, use of abusive language, a pattern of challenging or confrontational verbal behaviors, and a history of physical abusiveness toward staff. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, with reported symptoms of depression, including tiredness, trouble sleeping, feeling down, and little interest in activities for seven to eleven days. The same MDS indicated that the resident required one-person assistance with bed mobility and two-person assistance for transfers between surfaces, as well as assistance with other activities of daily living (ADLs). Review of nursing progress notes dated [DATE], revealed no documentation of a staff-to-resident altercation. Review of the SA database revealed that the facility submitted a self-report on [DATE]. The report indicated that on [DATE], Resident #37 reported to a nurse that a certified nurse aide (CNA), staff #45, was very rough during care on [DATE], resulting in a 1.5 cm bruise on the resident's left arm. The report stated that staff #45 was temporarily suspended while the investigation was conducted. It further indicated that three additional staff members and eight residents were interviewed as part of the investigation. However, the 5-day report provided by the facility was incomplete and did not include staff or resident interview accounts. A request was made on [DATE] and the facility was unable to provide documentation of any disciplinary action taken against staff #45. Attempts to contact nursing staff who worked on [DATE], were unsuccessful. An interview was conducted with staff #13, who was present at the facility at the time of the incident and is currently the Acting Director of Nursing, on [DATE], at 11:43 a.m. Staff #13 stated that she did not recall the incident involving Resident #37. She further stated that current practice is for the facility to complete internal investigations separately unless there is an injury, skin tear, or bleeding, in which case documentation is included in the nursing progress notes for clinical monitoring. An interview with CNA staff #22 was conducted on [DATE], at 9:50 a.m. Staff #22 stated that during an incident investigation, staff are required to follow facility protocol, which includes reporting the incident to management and completing questionnaires detailing staff accounts related to the incident. Staff #22 further stated that random residents are interviewed to determine whether they feel safe residing at the facility. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the facility Administrator, who also serves as the Abuse Coordinator (staff #20), was conducted on [DATE], at 12:30 p.m. Staff #20 stated that the 5-day report should include resident demographic information; the date and time of the incident; a description of the incident; interviews with witnessing staff; and interviews with residents or others present at the scene. Staff #20 reiterated that random resident interviews are included in the 5-day report and stated that the facility is required to notify the resident's family representative immediately following the incident. Staff #20 also stated that former staff records should be retained at the facility for at least five years. -Regarding resident #29: The resident was admitted [DATE], and discharged [DATE], with diagnoses that include chronic obstructive pulmonary disease; schizophrenia; bipolar disorder, unspecified; anxiety disorder, unspecified; major depressive disorder, recurrent, unspecified; and personal history of transient ischemic attack, and cerebral infarction, without residual deficits. Review of the care plan initiated on [DATE] revealed a focus area for mood, resident is at risk for fluctuating mood symptoms related to sadness, depression, anxiety, fear caused by functional changes. Interventions include observe signs and symptoms for worsening sadness, depression, anxiety, fear, anger, and agitation. Review of a social service progress note dated [DATE] at 10:00AM revealed social services assisted the resident with a call to Veteran Affairs (VA) for his share of costs. It was later identified that the resident stated he wanted to close his account at the bank due to some misappropriation of funds and that the resident would need a valid identification card in order to close his account. Further review of the complaint tracking system revealed no facility reported incidents for misappropriation of funds. Review of the facility reportable event record and report with a discovery date of [DATE] at 3:00PM revealed that resident #29 reported that he was missing a wallet. The resident reported to facility staff that his wallet went missing sometime around his last hospital stay in July. The resident did not recall reporting the missing wallet to any staff member. The resident stated he did not believe his wallet was stolen, and he did not want police involvement. The resident stated that his VA card and social security card were missing. Further review of the facility reportable event record and report revealed that the facility was unable to determine what happened with resident #29's wallet. The interventions included interview of two nurses and three certified nursing assistants, and that facility social work will assist resident in recovering a new VA card and social security card. Additional review of the reportable event record and report revealed no documented interviews with staff, residents, and resident #29. On [DATE] at 2:07PM, a written request was made for the five day investigation for resident #29. The written request was returned on [DATE] at 2:20PM stating we do not have this information. An email was received [DATE] at 2:38PM from the administrator (staff #23) stating This email is confirmation that we do not have the following information that you requested: 5 day investigation for resident #29, 5 day investigation for resident #38, and Grievance log for [DATE]. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on [DATE] at 2:26PM with the administrator (staff #23). Staff #23 stated that he is also the abuse coordinator and that misappropriation is a reportable incident. Staff #23 stated that he coordinates investigating reported incidents, which would include interviewing the staff, social services, witness, and the alleged victim. Staff #23 stated he keeps written record of interviews, but is unsure what previous management did. Regarding Resident #33: Resident #33 was initially admitted to the facility on [DATE], with a readmission date of [DATE], and a diagnosis of dementia. Review of the Care Plan dated [DATE], with a revision on [DATE], revealed resident #33 was at a risk for falls related to cognitive loss, lack of safety awareness, and impaired mobility. Interventions included having the resident's bed in the lowest position, assistance with getting in and out of bed, reminders to use the call light when attempting to ambulate or transfer, maintaining a clutter-free environment, and placing all personal items within reach when the resident is in bed. Review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicates the resident was cognitively intact. The facility reported to the State Agency (SA) that resident #33 was walking by the nurse's station and had a witnessed fall in an incident dated [DATE]. Review of the records and documentation requests revealed that the facility did not conduct a through investigation as resident clinical records had not been updated, staff and resident interviews had not been completed, and facility policies and procedures were not followed. Review of the clinical record revealed the facility had completed a change of condition on [DATE], at 8:39 PM, documenting the resident had grimacing pain from the left hip. Review of the progress note dated [DATE], at 7:10 AM stated the resident's power of attorney (POA) wanted the resident sent to the hospital for an evaluation of the injury. A physician's general note dated [DATE], at 8:19 AM stated, resident #33 got into an altercation with a resident, and that led to a fall and a left hip fracture. Further review of the clinical record did not reveal any indication of a resident-to-resident altercation. The facility incident report addressed the resident's fall but failed to include the resident to resident altercation as probable cause for fall. An interview was conducted on [DATE], at 11:03 AM with Licensed Practical Nurse (LPN, staff #13), Unit Manager. She confirmed the clinical record did not indicate how the resident fell; however, because the general note from the physician stated the resident fell due to a resident-to-resident altercation that resulted in a hip fracture is what should be believed. Attempts were made for to conduct interviews but either no one remembered the incident, or staff were no longer employed and could not be contacted. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Accidents and Incidents – Investigating and Reporting (revised [DATE]) indicated that an incident report must include:(1) the date and time of the incident; (2) the nature of the injury or illness; (3) the circumstances surrounding the incident; (4) the location of the incident; (5) names and accounts of witnesses; (6) the injured person's account; (7) the date and time the attending physician was notified and the physician's response; (8) the date and time the family was notified and by whom; (9) the condition of the injured person, including vital signs; (10) the disposition of the injured person; (11) corrective actions taken; (12) follow-up information; (13) other pertinent data as required; and (14) the signature and title of the person completing the report. The policy further states that the nurse supervisor, charge nurse, the department director or supervisor is responsible for completing the incident report and submitting the original to the Director of Nursing Services within 24 hours of the incident. However, according to staff #20 there was no 5-day investigation report on record for the incident involving Resident #38. Review of the facility policy titled Retention of Medical Records indicated that medical records of discharged residents are to be retained for a period of six years. Review of the policy titled Charting and Documentation (revised [DATE]) stated that all services provided to the resident, progress toward care plan goals, and any changes in the resident's medical, physical, functional, or psychosocial condition must be documented in the medical record. The policy further stated that the medical record must facilitate communication among the interdisciplinary team and include documentation of changes in condition, events, incidents, or accidents involving residents. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised [DATE], states that The resident abuse, neglect and exploitation prevention program consists of a facility -wide commitment and resource allocation to support the following objectives: . Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Review of the facility policy titled Abuse, Negect, Exploitation or Misappropriation – Reporting and Investigating, revised [DATE], states that The individual conducting the investigation as a minimum . interviews any witnesses to the incident, . interviews the resident, . interviews staff members. This policy also states The follow up investigation report will provide as much information as possible at the time of submission.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, review of facility policies and review of SA database, the facility failed to ensure a through investigation was conducted for abuse and misappropriation of property for two residents (#29 and #33). The deficient practice could result in ongoing abuse of residents.Findings include: -Regarding resident #29Resident #29 was admitted [DATE], and discharged [DATE], with diagnoses that include chronic obstructive pulmonary disease; schizophrenia; bipolar disorder, unspecified; anxiety disorder, unspecified; major depressive disorder, recurrent, unspecified; and personal history of transient ischemic attack, and cerebral infarction, without residual deficits. Review of the care plan initiated on March 2, 2022 revealed a focus area for mood, resident is at risk for fluctuating mood symptoms related to sadness, depression, anxiety, fear caused by functional changes. Interventions include observe signs and symptoms for worsening sadness, depression, anxiety, fear, anger, and agitation. Review of a social service progress note dated August 19, 2022 at 10:00AM revealed social services assisted the resident with a call to Veteran Affairs (VA) for his share of costs. It was later identified that the resident stated he wanted to close his account at the bank due to some misappropriation of funds and that the resident would need a valid identification card in order to close his account. Further review of the complaint tracking system revealed no facility reported incidents for misappropriation of funds. Review of the facility reportable event record and report with a discovery date of November 18, 2022 at 3:00PM revealed that resident #29 reported on November 17, 2022 that he was missing a wallet. The resident reported to facility staff that his wallet went missing sometime around his last hospital stay in July. The resident did not recall reporting the missing wallet to any staff member. The resident stated he did not believe his wallet was stolen, and he did not want police involvement. The resident stated that his VA card and social security card were missing. Further review of the facility reportable event record and report revealed that the facility was unable to determine what happened with resident #29's wallet. The interventions included interview of two nurses and three certified nursing assistants, and that facility social work will assist resident in recovering a new VA card and social security card. Additional review of the reportable event record and report revealed no documented interviews with staff, residents, and resident #29. On December 17, 2025 at 2:07PM, a written request was made for the five day investigation for resident #29. The written request was returned on December 17, 2025 at 2:20PM stating we do not have this information. An email was received December 17, 2025 at 2:38PM from the administrator (staff #23) stating This email is confirmation that we do not have the following information that you requested: 5 day investigation for resident #29, 5 day investigation for resident #38, and Grievance log for November 2022. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on December 18, 2025 at 2:26PM with the administrator (staff #23). Staff #23 stated that he is also the abuse coordinator and that misappropriation is a reportable incident. Staff #23 stated that he coordinates investigating reported incidents, which would include interviewing the staff, social services, witness, and the alleged victim. Staff #23 stated he keeps written record of interviews, but is unsure what previous management did. -Regarding Resident #33: Resident #33 was initially admitted to the facility on [DATE], with a readmission date of September 9, 2022, and a diagnosis of dementia. Review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicates the resident was cognitively intact. Review of the Care Plan dated July 4, 2019, with a revision on October 24, 2022, revealed resident #33 was at a risk for falls related to cognitive loss, lack of safety awareness, and impaired mobility. Interventions included having the resident's bed in the lowest position, assistance with getting in and out of bed, reminders to use the call light when attempting to ambulate or transfer, maintaining a clutter-free environment, and placing all personal items within reach when the resident is in bed. The facility reported to the State Agency (SA) that resident #33 was walking by the nurse's station and had a witnessed fall in an incident dated September 7, 2022. Review of the clinical record revealed the facility had completed a change of condition on September 6, 2022, at 8:39 PM, documenting the resident had grimacing pain from the left hip. Review of the progress note dated September 7, 2022, at 7:10 AM stated the resident's power of attorney (POA) wanted the resident sent to the hospital for an evaluation of the injury. A physician's general note dated September 10, 2022, at 8:19 AM stated, resident #33 got into an altercation with a resident, and that led to a fall and a left hip fracture. Further review of the clinical record did not reveal any indication of a resident-to-resident altercation. Review of the records and documentation requests revealed that the facility did not conduct a through investigation as resident clinical records had not been updated, staff and resident interviews had not been completed, and facility policies and procedures were not followed. An interview was conducted on December 17, 2025, at 11:03 AM with Licensed Practical Nurse (LPN, staff #13), Unit Manager. She confirmed the clinical record did not indicate how the resident fell; however, because the general note from the physician stated the resident fell due to a resident-to-resident altercation that resulted in a hip fracture is what should be believed. Attempts were made to conduct interviews but either no one remembered the incident, or staff were no longer employed and could not be contacted. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy on Accidents and Incidents-Investigating and Reporting, dated July 2017, states, All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. The following data, as applicable, shall be included on the Report of Incident/Accident Form; a. the date and time the accident or incident took place; b. the nature of the injury/illness (e.g., bruise, fall, nausea, etc.); c. The circumstances surrounding the accident or incident d. where the accident or incident took place; e. the names of witnesses and their accounts of the accident or incident; f. the injured person's account of the accident or incident; g. the time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions; h. the date/time the injured person's family was notified and by whom; i. the condition of the injured person, including his/her vital signs; j. the disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.); k. any corrective action taken; l. follow-up information; m. other pertinent data as necessary or required; n. the signature and title of the person completing the report. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2017, states that The resident abuse, neglect and exploitation prevention program consists of a facility -wide commitment and resource allocation to support the following objectives: . Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation – Reporting and Investigating, revised December 2025, states that The individual conducting the investigation as a minimum . interviews any witnesses to the incident, . interviews the resident, . interviews staff members. This policy also states The follow up investigation report will provide as much information as possible at the time of submission.

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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. Based on observations, interviews, and a review of facility policy and procedure, the facility failed to ensure that three medication carts were secured in accordance with professional standards and facility policy when left unattended. The deficient practice could result in residents, visitors, and/or staff members having unrestricted access to medications and medical supplies.Findings include:An observation conducted on December 16, 2025, at 11:13 a.m., revealed that a medication cart on the Beta 2 unit was unattended and unlocked while outside of the direct line of sight of staff. The observation was evidenced by the State Agency (SA) being able to pull open three drawers holding resident medications, over-the-counter (OTC) medications, and diabetic supplies, including lancets.An observation conducted on December 16, 2025, at 11:21 a.m., revealed that the fill-in Director of Nursing and Licensed Practical Nurse Manager (LPN Manager/Staff#13) walked by the unlocked medication cart on the Beta 2 unit and locked it as she walked by. An interview was conducted on December 16, 2025, at 11:21 a.m. with the fill-in Director of Nursing and LPN Manager, Staff#13, who stated that the medication cart did not belong to her and that she did not know the location of the nurse who was responsible for the cart. The Nurse Manager stated that the cart was unlocked, and that was why she locked the cart as she walked by. The Nurse Manager stated that it was not the expectation or process in the building to leave medication carts unattended and unlocked, and she further stated that the risk of leaving the cart unlocked was that anyone could get into the cart and access medications and diabetic supplies, including lancets. An observation conducted on December 16, 2025, at 11:27 a.m. revealed that a medication cart on the Beta 1 unit was unattended and unlocked while the nursing staff was in a resident room. An interview was conducted on December 16, 2025, at 11:28 a.m. with a Licensed Practical Nurse (LPN/Staff#202) who stated that it was not her process, or the facility's process, to leave medication carts unlocked and unattended. The LPN stated that there was an inherent risk to any medication cart being unlocked, and that the risk here was that someone could steal medications from the cart.An observation conducted on December 17, 2025, at 8:02 a.m., revealed that a medication cart on the Beta 2 unit was unattended and unlocked while outside of the direct line of sight of staff. The nurse was observed in a resident room. An interview was conducted on December 17, 2025, at 8:08 a.m. with a Licensed Practical Nurse (LPN/Staff#41) who stated that she left her medication cart unlocked, and it was not her process to leave it unlocked when she walked away from it. The LPN further stated that the risk of leaving her medication cart unlocked was that someone could get into it and take medications from the cart. The LPN also opened the drawers and stated that the cart was holding narcotic medications, diabetic supplies, lancets, medicated patches, and alcohol pads.A follow-up interview was conducted on December 18, 2025, at 8:24 a.m. with the fill-in Director of Nursing and Licensed Practical Nurse Manager (Staff #13), who stated that nursing staff would be expected to lock their medication cart when walking away from it. The LPN manager stated that the risks of leaving medication carts unlocked included the possibility that anyone could access the cart to obtain blood sugar supplies and potentially ingest medications from it. A review of a policy titled, Medication Labeling and Storage, revised in December 2025, revealed that nursing staff were responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The policy also revealed that compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals should have been locked when not in use, and trays or carts used to transport such items should not be left unattended if open or otherwise potentially available to others.