STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055070	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seacrest Post-Acute Care Center	1416 West 6th Street San Pedro, CA 90732

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician when Resident 2 presented a new wandering behavior for one of three sampled residents. This failure resulted in Resident 2's wandering behaviors not being addressed and a physical altercation between Resident 1 and Resident 2. Findings: During a review of Resident 2's admission record, the admission record indicated Resident 2 was initially admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior)- bipolar (sometimes called manic-depressive disorder- mood swings that range from the lows of depression to elevated periods of emotional highs) type, and depression (persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities). During a review of Resident 2's History and Physical (H&P), dated 7/21/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 8/15/2025, the MDS indicated Resident 2 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating, required supervision for toileting and bathing, and required moderate assistance (helper does less than half the effort) for dressing and oral hygiene. During a review of Resident 2's Nursing Progress Note dated 8/25/2025 at 8:27 p.m., the Note indicated Resident 2 touched and removed Resident 1's belongings (a carton of milk and miscellaneous items) without permission resulting in Resident 2's aggressive behavior against Resident 1. During an interview on 9/9/2025 at 2:08 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 2 was a wanderer and would walk around and take food and hot chocolate off the snack carts. CNA 1 stated Resident 2 gets aggressive if he was not given the hot chocolate. During an interview on 9/9/2025 at 4:33 p.m. with CNA 3, CNA 3 stated Resident 2 had a history of wandering. CNA 3 stated Resident 2 was sneaky and would try to get hot cocoa and coffee off the carts. During an interview on 9/10/2025 at 2:51 p.m., with Resident 1, Resident 1 stated Resident 2 was known to walk around and grab waters, juices, and other items off of Residents (general) trays and carts. Resident 1 stated the staff knew about Resident 2's behavior. Resident 1 stated on 8/25/2025, Resident 2 grabbed his belongings from his table. Resident 1 stated he was so upset, he clenched his fist, waited for Resident 2 to walk back towards him, and attempted to punch Resident 2. During a concurrent interview and record review on 9/10/2025 at 11:47 a.m., with the Assistant Director of Nursing (ADON), Resident 2's medical record was reviewed. Resident 2's Nursing note dated 8/17/2025 at 6:43 p.m., indicated a nurse unknown) observed Resident 2 standing outside the facility. The ADON stated a Change of Condition where the physician is notified of a new behavior of attempting to leave the facility was not completed. The ADON stated the physician should have been notified when Resident 2 was found outside the facility on 8/17/2025. The ADON stated if the physician is not notified for a change of condition, the physician will not know to address it and there could be a delay of care. During a concurrent interview and record review on 9/10/2025 at 1:47 p.m. with the ADON, the facility's policy and procedure (P&P), titled Change in a Resident's Condition or Status, revised February 2021, was reviewed. The P&P indicated the nurse will notify the resident's attending physician or physician on call when there has been a(an) accident or incident involving the resident. The ADON stated the resident being found outside the facility is considered an incident that should have been communicated to the physician.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Resident 1 and Resident 2 were free from abuse when Resident 1 and Resident 2 got into a physical altercation on 8/25/2025. The facility failed to ensure: A. Resident 1 received Trazadone (medication for depression [persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities] and insomnia) for three days (8/23/2025, 8/24/2025, and 8/25/2025).B. Resident 2's episodes of wandering (walking around without a specific goal or purpose) and behaviors of taking items from snack carts were communicated to the provider or addressed in a care plan.3.Implement the facility's policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021 which indicated residents have the right to be free from abuse. These deficient practices resulted in a physical altercation between Resident 1 and Resident 2 on 8/25/2025 at approximately 8:30 p.m. when:1. Resident 2 took milk and miscellaneous belongings from Resident 12. Resident 1 made a fist and swung at Resident 23. Resident 2 punched Resident 1 in the face4. Leaving Resident 1 with a bruise to the left nose bridgeFindings: A. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), Heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and major depressive disorder (persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities). The admission Record indicated Resident 1's brother was the responsible party (RP-decision maker). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/7/2025, the MDS indicated Resident 3 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating, required moderate assistance (helper does more than half the effort) for oral hygiene and upper body dressing, and was dependent for toileting hygiene, bathing, and lower body dressing. During a review of Resident 3's Physician Order Summary dated 9/19/2025, the Physican Order Summary indicated an order for Trazodone Hydrochloride (HCL), 50 Milligrams (MG - a unit of measurement) give 1 tablet by mouth at bedtime for depression manifested by (m/b) inability to sleep, start date 1/19/2025. During a concurrent interview and record review on 9/9/2025 at 3:26 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 1's Medication Administration Record (MAR) for August 2025 was reviewed. The MDSC stated the MAR indicated Resident 3 had an order for Trazodone HCL Oral Tablet 50 MG to be given at bedtime for depression manifested by inability to sleep started on 1/9/2025. The MDSC stated there is no documentation indicating Resident 1 received the scheduled Trazodone 50 MG on 8/23/2025, 8/24/2025, and 8/25/2025. The MDSC stated the MAR did not indicate that adverse effects or side effects of Trazodone were being monitored for Resident 1. During a concurrent interview and record review on 9/9/2025 at 3:43 p.m., with licensed vocational nurse (LVN) 3, Resident 1's MAR for August 2025 was reviewed. LVN 3 stated the MAR did not indicate Resident 1 received the evening dose of Trazadone 50 mg on 8/23/2025, 8/24/2025, and 8/25/2025 for the evening shift, the documentation was blank. LVN 3 stated if the resident refused or the medication was held (not administered due to clinical judgment), the documentation would have indicated it. LVN 3 stated if a resident missed Trazadone for three days, it would affect a resident's ability to get enough sleep and could result in the resident becoming restless, agitated, or lead to falls or other safety concerns. During an interview on 9/9/2025 at 4:52 p.m., with Resident 1, Resident 1 stated about two weeks ago (unknown date), a nurse tried to give him his night time medications including the sleeping pill (Trazadone) in the afternoon around 4:30 p.m. Resident 1 stated he told the nurse it was too early, and was unsure if he received the medication. During an interview on 9/10/2025 at 11:47 a.m., with the Assistant Director of Nursing (ADON), the ADON stated it was important that the nurse documented medication administration after the medication was given. The ADON stated documentation is proof that the medication was administered to the resident, and the resident received it. The ADON stated it is important to monitor indicated behaviors such as hours of sleep and monitor adverse effects or side effects every shift to ensure that medications are effective for the resident. The ADON stated if the resident misses 3 consecutive doses of Trazadone for 3 days, the Resident 1 can become irritable and emotional due to lack of sleep. During a concurrent interview and record review on 9/10/2025 at 1:47 p.m. with the ADON, the facility's policy and procedure (P&P) titled Administering Medications, revised April 2019, was reviewed. The P&P indicated

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a psychotropic (any medication capable of affecting the mind, emotions, and behavior) medication was not used unnecessarily for one of three sampled residents (Resident 1) by: 1. Failing to monitor manifested behaviors for which Trazadone (medication used to treat depression or insomnia) was prescribed for three consecutive days2. Failing to monitor adverse effects of Trazadone 3. Failing to obtain an active psychotropic informed consent (a process to ensure a resident or the resident's representative receives and understands information about a treatment or medication including its risks, benefits) for Trazadone administration for one of three sampled residents. This failure had the potential to result in lack of identification of adverse effects and the potential to violate the resident's right to be informed or refuse care.Findings: During a review of Resident 1's admission record, the admission record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), Heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and major depressive disorder (persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities). The admission record indicated Resident 1's brother was the responsible party (RP-decision maker). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/7/2025, the MDS indicated Resident 3 had moderate cognition (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating, required moderate assistance (helper does more than half the effort) for oral hygiene and upper body dressing, and was dependent for toileting hygiene, bathing, and lower body dressing. During a concurrent interview and record review on 9/9/2025 at 3:26 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 1's Medication Administration Record (MAR) for August 2025 was reviewed. The MDSC stated the MAR indicated Resident 3 had an order for:a. Trazodone HCL Oral Tablet 50 Milligrams (MG- a unit of measurement) to be given at bedtime for depression manifested by inability to sleep started on 1/9/2025b. Monitor hours of sleep during 11-7 and 3-11 shift every evening and shift for Trazodone started on 1/9/2025The MDSC stated there was no documentation for the evening shift (3 p.m. to 11 p.m.) on 8/23/2025, 8/24/2025, and 8/25/2025 indicating Resident 1's hours of sleep were monitored to see if the Trazadone was effective or not. The MAR did not indicate that adverse effects or side effects were being monitored for Resident 1. During a concurrent interview and record review on 9/9/2025 at 3:43 p.m., with licensed vocational nurse (LVN) 3, Resident 1's MAR was reviewed. LVN 3 stated on 8/23/2025, 8/24/2025, and 8/25/2025 for the evening shift, the documentation was blank. LVN 3 stated if the resident refused or the medication was held, the documentation would have indicated it. During a concurrent interview and record review on 9/10/2025 at 11:47 a.m., with the Assistant Director of Nursing (ADON), Resident 1's medical record was reviewed. The ADON stated Resident 1 had an informed consent for Trazodone dated 1/9/2025 and an informed consent for Trazodone dated 8/31/2025 which should have been renewed on 7/9/2025 instead of 8/31/2025. The ADON stated Resident 3 received Trazadone from 8/1/2025 to 8/22/2025 without an active informed consent. The ADON stated it was important to have an active informed consent to ensure that the resident or responsible party is informed of the risks and benefits, and have the right to refuse. The ADON stated it is important to monitor indicated behaviors such as hours of sleep and monitor adverse effects or side effects every shift to ensure that medications are effective for the resident. The ADON stated not receiving Trazadone for 3 days can make the resident irritated or affect their emotions due to lack of sleep. During a review of the facility's policy and procedure (P&P), Verification of Informed Consent for Psychotherapeutic Medications, revised May 2024, the P&P indicated the facility will obtain a written informed consent for treatment using psychotherapeutic drugs and consent renewal every six months. During a review of the facility's P&P, titled Psychotropic Medication Use, revised July 2022. the P&P indicated psychotropic medication management includes indications for use, adequate monitoring for efficacy and adverse consequences, and preventing, identifying, and responding to adverse consequences. The P&P indicated consideration of the use of any psychotropic medication is based on comprehensive review of the resident which includes evaluation or the resident's signs and symptoms in order to identify underlying causes. The P&P indicated residents receiving psychotropic medications are monitored for adverse consequences

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Seacrest Post-Acute Care Center	1416 West 6th Street San Pedro, CA 90732

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update a care plan for a new wandering behavior for one of three sampled residents, when Resident 2 was found with new wandering behaviors. This failure resulted in Resident 2's wandering behaviors not being addressed and a physical altercation between Resident 1 and Resident 2. Findings: During a review of Resident 2's admission record, the admission record indicated Resident 2 was initially admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior)- bipolar (sometimes called manic-depressive disorder- mood swings that range from the lows of depression to elevated periods of emotional highs) type, and depression (persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities). During a review of Resident 2's History and Physical (H&P), dated 7/21/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 8/15/2025, the MDS indicated Resident 2 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating, required supervision for toileting and bathing, and required moderate assistance (helper does less than half the effort) for dressing and oral hygiene. During a review of Resident 2's Nursing Progress Note dated 8/25/2025 at 8:27 p.m., the Nursing Progress Note indicated Resident 2 touched and removed Resident 1's belongings without Resident 2's permission resulting in Resident 2's aggressive behavior against Resident 1. During a concurrent interview and record review on 9/9/2025 at 3:05 p.m., with the MDS Coordinator (MDSC), Resident 2's medical record was reviewed. The MDSC stated Resident 2 was known to walk around a lot and tried to leave the facility on 8/17/2025. The MDSC stated Resident 2's wandering care plan was not updated when he was found (wandering) outside the facility on 8/17/2025. During an interview on 9/9/2025 at 2:08 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 2 was a wanderer and would walk around and take food and hot chocolate off snack carts. CNA 1 stated Resident 2 would get aggressive if he was not given the hot chocolate. During an interview on 9/9/2025 at 4:33 p.m., with CNA 3, CNA 3 stated Resident 2 had a history of wandering. CNA 3 stated Resident 2 was sneaky and would try to get hot cocoa and coffee off the carts. During an interview on 9/10/2025 at 2:51 p.m., with Resident 1, Resident 1 stated Resident 2 was known to walk around and grab waters, juices, and other items off of trays and carts. Resident 1 stated the staff knew about Resident 2's behavior. Resident 1 stated on 8/25/2025, Resident 2 wandered into his room and grabbed his belongings from his (Resident 1's) table. Resident 1 stated he was so upset, he clenched his fist, waited for Resident 2 to walk back towards him, and attempted to punch Resident 2. During a concurrent interview and record review on 9/10/2025 at 11:47 a.m., with the Assistant Director of Nursing (ADON), Resident 2's medical record was reviewed. Resident 2's Nursing note dated 8/17/2025 at 6:43 p.m., indicated a nurse observed Resident 2 standing outside the facility. There was no care plan addressing this behavior after the 8/17/2025 incident. The ADON stated the nurse should have revised the care plan to address Resident 2 wandering outside of the facility. The ADON stated care plans should be reviewed and revised when there is a change of condition (behavior) to ensure the interventions are appropriate for the resident. During a review of the facility's policy and procedure (P&P), titled Care Plans, Comprehensive Person-Centered, revised March 2022. The P&P indicated care plans are revised as information about the residents and the resident's conditions change. The P&P indicated the interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition. During a review of the facility's policy and procedure (P&P), titled Safety and Supervision of Residents, revised July 2017, the P&P indicated the interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The P&P indicated the facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. The P&P indicated risk factors and environmental hazards include unsafe wandering.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled employees, Licensed Vocational Nurse (LVN) 1, was competent in medication administration upon hire. This failure resulted in Resident 1 not receiving trazadone for three days on 8/23/2025, 8/24/2025 and 8/25/2025.Findings: During a review of Resident 1's admission record, the admission record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), Heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and major depressive disorder (persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities). The admission record indicated Resident 1's brother was the responsible party (RP-decision maker). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/7/2025, the MDS indicated Resident 3 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating, required moderate assistance (helper does more than half the effort) for oral hygiene and upper body dressing, and was dependent for toileting hygiene, bathing, and lower body dressing. During a concurrent interview and record review on 9/9/2025 at 3:26 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 1's Medication Administration Record (MAR) for August 2025 was reviewed. The MDSC stated the MAR indicated Resident 3 had an order for Trazodone Oral Tablet 50 Milligrams (MG- a unit of measurement) to be given at bedtime for depression manifested by inability to sleep started on 1/9/2025. The MDSC stated there was no documentation on 8/23/2025, 8/24/2025, and 8/25/2025 indicating Resident 1 received Trazadone as scheduled. During a concurrent interview and record review on 9/9/2025 at 3:43 p. m., with licensed vocational nurse (LVN) 3, Resident 1's MAR was reviewed. LVN 3 stated on 8/23/2025, 8/24/2025, and 8/25/2025 for the evening shift, the documentation was blank. LVN 3 stated if the resident refused or the medication was held, the documentation would have indicated it. LVN 3 stated if a resident missed Trazadone for three days, it would affect a resident's ability to sleep and could result in the resident becoming restless, agitated, or lead to falls or other safety concerns. During an interview on 9/9/2025 at 3:56 p.m., with the Director of Staff Development (DSD), the DSD stated Licensed Vocational Nurse (LVN) 1 was assigned to Resident 1 on 8/23/2025. 8/24/2025, and 8/25/2025 for the evening shift. During an interview on 9/10/2025 at 11:47 a.m. with the Assistant Director of Nursing (ADON), the ADON stated it is important that the nurse documents medication administration after the medication is given. The ADON stated there is a possibility that a nurse could have dropped the medication. The ADON stated documentation is proof that the medication was administered to the resident, and the resident received it. The ADON stated if you do not document it, it cannot be proved that it happened. The ADON stated not receiving Trazadone for 3 days can make the resident irritated or affect their emotions due to lack of sleep. During a concurrent interview and record review on 9/10/2025 at 1:50 p.m. with the ADON, the facility's policy and procedure (P&P), Competency of Nursing Staff, dated March 2025, was reviewed. The ADON stated it is important for a medication competency to be completed upon hire to get a baseline of what a nurse can or cannot do. The ADON stated if a nurse is deficient of a skill, it can be addressed at the time of hire. The ADON stated if a nurse is not competent, the nurse can make mistakes such as not giving medications or not administering medications safely. The P&P indicated competency in skills and techniques necessary to care for residents' needs includes medication management. The P&P indicated facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment. During a concurrent interview and record review on 9/10/2025 at 4:02 p.m., LVN 1's employee file was reviewed. The DSD stated LVN 1's date of hire was 5/14/2025. The DSD stated LVN 1 has one competency checklist dated 9/2/2025. The DSD stated there are no other competency skill checklists in LVN 1's employee file. The DSD stated the medication competency checklist is completed by the Director of Nursing (DON) and completed upon hire and yearly after.During a review of the facility's P&P titled Administering Medications, revised April 2019, was reviewed. The P&P indicated medications are administered in accordance with prescriber orders. The P&P indicated medication administration times are determined by resident need and benefit, not staff convenience.