STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065092	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Manor Care Center	7950 W Mississippi Ave Lakewood, CO 80226

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop and implement policies and procedures related to immunizations for five (#4, #6, #12, #38 and #58) of five residents reviewed for immunizations out of 37 sample residents.Specifically, the facility failed to:-Ensure the residents medical records indicated the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and,-Ensure the residents medical records documented if the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. Findings include:I. Professional referenceAccording to the Centers for Disease Control's (CDC) Staying Up to Date with COVID-19 Vaccines, updated 11/19/25, retrieved on3/30/26 from https://www.cdc.gov/covid/vaccines/stay-up-to-date.html, read in pertinent part, Getting the 2025-2026 COVID-19 vaccine is important because:-Protection from the COVID-19 vaccine decreases with time;-Immunity after COVID-19 infection decreases with time; and,-COVID-19 vaccines are updated to give you the best protection from the currently circulating strains. Getting the 2025-2026 COVID-19 vaccine is especially important if you:-Never received a COVID-19 vaccine;-Are ages 65 years and older;-Are at high risk for severe COVID-19; and,-Are living in a long-term care facility.II. Resident #4 A. Resident statusResident #4, age greater than 65, was admitted on [DATE]. According to the 1/7/26 minimum data set (MDS) assessment diagnoses included stroke, CAD (coronary artery disease), hypertension, hyponatremia, hyperlipidemia, dementia, hemiplegia or hemiparesis (weakness and paralysis) and malnutrition. The assessment documented the resident was cognitively impaired with a brief interview for mental status (BIMS) score of five out of 15.The assessment documented the resident's COVID-19 vaccination was not up to date and did not include if the vaccine was offered or the reason why the vaccine was not received.B. Record reviewA review of Resident #4's immunization record in the electronic medical record (EMR) failed to reveal documentation requesting or offering the SARS-COV-2 (COVID 19) vaccination. III. Resident #6 A. Resident statusResident #6, age greater than 65, was admitted on [DATE]. According to the 12/31/25 MDS assessment diagnoses included stroke, anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, and hemiplegia or hemiparesis. The assessment documented the resident was cognitively impaired with a BIMS score of five out of 15.The assessment documented the resident's COVID-19 vaccination was not up to date and did not include if the vaccine was offered or the reason why the vaccine was not receivedB. Record reviewA review of Resident #6's immunization record in the EMR failed to reveal documentation requesting or offering the SARS-COV-2 (COVID 19) vaccination. IV. Resident #12A. Resident statusResident #12, age greater than 65, was admitted on [DATE]. According to the 3/9/26 MDS assessment diagnoses included anemia, hypertension, hyponatremia, hyperlipidemia, aphasia, and hemiplegia or hemiparesis. The assessment documented the resident was cognitively intact with a BIMS score of 14 out of 15.The assessment documented the resident's COVID-19 vaccination was not up to date and did not include if the vaccine was offered or the reason why the vaccine was not received.B. Record reviewA review of Resident #12's (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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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	immunization record in the EMR failed to reveal documentation requesting or offering the SARS-COV-2 (COVID 19) vaccination. The assessment documented the resident's COVID-19 vaccination was not up to date and did not include if the vaccine was offered or the reason why the vaccine was not receivedV. Resident #38 A. Resident statusResident #38, age greater than 65, was admitted on [DATE]. According to the 2/10/26 MDS assessment, diagnoses included CAD, heart failure, hypertension, PVD (peripheral vascular disease), GERD (gastroesophageal reflux disease, renal failure, arthritis and respiratory failure. The assessment documented the resident was cognitively intact with a BIMS score of 15 out of 15.The assessment documented the resident's COVID-19 vaccination was not up to date and did not include if the vaccine was offered or the reason why the vaccine was not receivedB. Record reviewA review of Resident #38's immunization record in the EMR failed to reveal documentation requesting or offering the SARS-COV-2 (COVID 19) vaccination. C. Resident interviewResident #38 was interviewed on 3/25/26 at approximately 4:00 p.m. Resident #38 said she remembered receiving the flu shot at the facility. She said she received a vaccination sheet from the facility on 3/18/26 that documented she was due for a COVID-19 vaccine on 3/18/26. She said she did not remember being offered the COVID-19 vaccine in October 2025, but she said she never refused a shot.VI. Resident #58A. Resident statusResident #58, age greater than 65, was admitted on [DATE]. According to the 3/24/26 MDS assessment diagnoses included CAD, hypertension, heart failure, hyperlipidemia, dementia, fracture, anxiety and depression. The assessment documented the resident was severely cognitively impaired with a BIMS score of three out of 15.The assessment documented the resident's COVID-19 vaccination was not up to date and did not include if the vaccine was offered or the reason why the vaccine was not receivedB. Record reviewA review of Resident #12's immunization record in the EMR failed to reveal documentation requesting or offering the SARS-COV-2 (COVID 19) vaccination. VII. Record reviewA COVID-19 2025 document was provided by the director of nursing (DON) on 3/25/26 at approximately 4:00 p.m. The document listed columns titled resident room, resident name, [NAME] (manufacturer), brand and yes or no.-However, the document failed to include education that was provided to the resident regarding the risks and benefits of the COVID-19 vaccine.VIII. Staff interviewsThe infection preventionist (IP) and director of nursing (DON) were interviewed together on 3/25/26 at 3:23 p.m. The IP said the COVID-19 vaccine was offered to residents at the same time as the flu vaccine in the fall (2025). The IP said the residents that wanted the COVID-19 vaccine signed up and the ones who declined did not sign anything. The IP said all the education provided to the residents about the COVID-19 vaccine was verbal.The DON said the facility completed verbal education with the residents when the facility offered the flu and COVID-19 vaccines. The DON said the facility obtained consent for the vaccine for residents who received the vaccine. The DON said the residents were offered the COVID-19 vaccine at the same time as the flu vaccine, and those residents that requested the COVID-19 vaccine received it. The IP said she saved the documentation of the resident refusals of the COVID-19 vaccine (see record review above).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record review and interviews, the facility failed to ensure infection prevention and control programs (IPCP) were maintained and followed to provide a safe, sanitary and comfortable environment for residents and to help prevent the development and transmission of communicable diseases and infections for two of three units. Specifically, the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) while providing care to residents who were on enhanced barrier precautions (EBP). Findings include: I. Professional reference According to the Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 3/30/26 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, It read in pertinent parts, Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. II. Facility policy and procedure The Infection Control policy, revised 6/13/26, was received from the nursing home administrator (NHA) on 3/23/26 at 5:36 p.m. The policy read in pertinent part, The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Standard and transmission-based precautions to be followed to prevent spread of infections; When and how isolation should be used for a resident; including but not limited to the type and duration of the isolation, depending upon the infectious agent or organism involved, and a requirement that the isolation should be the least restrictive possible for the resident under the circumstances III. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/24/26 at 11:17 a.m. there was a sign on Resident #6's door indicating the resident was on EBP. An unidentified nursing staff member entered the room. The unidentified staff member assisted the resident with dressing and transferring from their bed to chair transfer without donning (putting on) a gown. -The unidentified staff member failed to put on a gown prior to providing Resident #6 with direct care. On 3/24/26 at 3:01 p.m. two unidentified nursing staff members transferred Resident #70 into the shower chair via mechanical lift with gloves on. The resident had a foley catheter and a colostomy bag. -The two unidentified staff members failed to put on gowns prior to providing Resident #70 with direct care. On 3/25/26 at 7:42 a.m. two unidentified staff members were transferring Resident #70 into his mechanical wheelchair from his bed via mechanical lift. -The two unidentified staff members failed to put on gowns prior to providing Resident #70 with direct care. IV. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 3/26/26 at 2:19 p.m. She said if a resident was on EBP she would wear gloves and a gown. She said Resident #6 was on EBP because he had a colostomy bag. She said she did not need to wear gloves and a gown when changing linen, dressing the resident or transferring the resident from bed to chair. She said she was provided training from the facility on EBP three weeks ago, but did not remember all the details. She said she was advised that every precaution signage was different and to read all the details and instructions on the sign on a resident's door. Registered nurse (RN) #3 was interviewed on 3/26/26 at 2:47 p.m. RN #3 said Resident #70 had a physician's order for EBPShe said gloves and a gown should be worn by the facility staff when transferring, dressing, providing toileting and shower hygiene. She said the resident was on EBP because he had a suprapubic foley catheter. She said EBP was utilized to protect the resident from infection because they were at a high risk for acquiring an infection. She said she received training on EBP a month ago at a facility skills fair. She said Resident #6 was also on EBP related to a superficial wound on abdominal area. She said the same EBP considerations would apply to Resident #6. The director of nursing (DON), infection preventionist (IP) and the regional clinical resource nurs were interviewed together on 3/26/26 at 3:26 p.m. The IP said she started working at the facility as the infection preventionist in August of 2023. She said her goals were to help prevent the spread of infection to the facility residents. The IP said gloves and a gown should be worn during high-contact resident care activities if a resident had a wound, foley catheter, Intravenous device, feeding tube or tracheostomy. The DON said high-contact resident care activities included dressing, bathing and showering, transferring, changing linens, providing hygiene and assisting with toileting care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The regional clinical resource nurse said she would start education immediately for facility staff regarding the procedures and requirements when a resident was on EBP. V. Additional observations On 3/24/26 at 3:08 p.m. RN #4 entered Resident #76. RN #4 assisted Resident #76 transfer from her chair to go to the bathroom. RN #4 adjusted her legs off of the chair footrest, placed arms around her waist, then assisted Resident #76 to her wheelchair. There was an EBP sign posted on Resident #76`s door. The sign read Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high-contact resident care activities - dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, trachetomy. Wound care: any skin opening requiring a dressing. -RN #4 failed to wear a gown and gloves when providing direct care to Resident #76. On 3/24/26 at 3:16 p.m. RN #4 entered Resident #76`s room to assist help Resident #76 transfer back to her chair. She adjusted Resident #76's legs to the floor. She placed her arms around Resident #76`s waist and assisted her to pivot back to her chair. -RN #4 failed to wear a gown and gloves when providing direct care to Resident #76. On 3/25/26 at 7:18 a.m. CNA #5 entered Resident #76`s room. He wore gloves. He measured Resident #76`s blood pressure. Then CNA #5 assisted Resident #76 to the bathroom. -CNA #5 failed to don a gown. On 3/25/26 at 11:41 a.m an unidentified CNA entered Resident #76`s room. She placed Resident #76`s heel protector boots. Resident #76 had a wound. -The unidentified CNA failed to put on a gown and gloves when providing direct care to Resident #76. VI. Staff interviews CNA #5 was interviewed on 3/26/26 at 10:52 a.m. He said residents with open wounds, catheter, intravenous therapy, pneumonia or other contagious disease should be on EBP. He said Resident #8 should be on EBP, because he had a PICC. He said staff should wear gown, mask, eyewear or faceshield, and gloves when providing direct care to Resident #8. LPN #3 was interviewed on 3/26/26 at 6:29 p.m. She said residents with catheters, ostomy bags, PICC lines, or open wounds should be on EBP. She said Resident #8 and Resident #76 should be on EBP. The IP was interviewed on 3/26/26 at 3:27 p.m. She said residents with a PICC line should be on EBP. She said residents with open wounds should be on EBP.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, in full recognition of his or her individuality for one (#70) of five residents out of 37 sample residents reviewed for respect and dignity.Specifically, the facility failed to ensure Resident #70 was covered appropriately during transport through the facility hallway. Findings include:I. Resident #70A. Resident statusResident #70, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included quadriplegia (paralysis of all four limbs and a torso caused by a spinal cord injury), diabetes type two, muscle weakness, contractures of the upper left and right arm, major depressive disorder and anxiety.The 2/17/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was dependent on staff for showers, toileting hygiene, upper and lower body dressing and oral hygiene. The resident was dependent on facility staff for chair to chair transfers and tub to shower transfers. B. ObservationsOn 3/24/26 at approximately 3:20 p.m. Resident #70 was being transported by facility staff in a white shower chair in the hallway from one shower room to another shower room. Resident #70 was covered with a white bed sheet exposing his back, lower torso, thighs and feet. Four other facility residents were present in the hallway while Resident #70 were transferred.On 3/24/26 at 3:40 p.m. Resident #70 was transported by facility staff to his room. Resident #70 was covered with two towels in a chair, he was naked underneath and did not have any clothes on. The resident was visible from his bare knee up to his mid waist on each side. There were four residents in the common areas of the hallway in the common area between the units that were visible to the resident. The resident was taken to the shower, a towel was wrapped around his hair.C. Record reviewResident #70's activities of daily living (ADL) care plan, dated 7/4/2020, documented Resident #70 had an activity of daily living self-care performance deficit due to muscle weakness, poor trunk control and cognitive impairment. Pertinent interventions included providing the resident assistance from two facility staff for transferring and shower hygiene. D.Staff Interviews Registered nurse (RN) #3 was interviewed on 3/26/26 at 2:47 p.m. She said residents should always be fully covered after a shower. She said the nursing staff could use sheets and towels to provide privacy. She said the staff were to ensure the resident's skin was not exposed when assisting a resident from the shower back to their room. She said it was important that the facility staff respect the residents because they were people too. The director of nursing (DON) was interviewed on 3/26/26 at 3:19 p.m. She said the facility had an expectation for nursing staff regarding providing facility residents showers assistance. The DON said the staff should cover the resident. The DON said residents should be covered and ensure dignity was preserved. The DON said making sure residents covered after bathing could be done in a variety of ways and it could be as simple as a bath sheet. Certified nurse aide (CNA) #4 was interviewed on 3/26/26 at 6:40 p.m. She said she had worked as a CNA for over 30 years. She said she gave the residents showers as a part of her staff responsibility and daily task. She said she put the resident in the shower chair with their clothes on, assisted the resident into the shower room with a new change of clothes, and after the shower was complete, she would change the resident into the new clothes. She said she never brought a resident in the hall with only a sheet draped over them because she would not want someone doing that to her. She said she wanted to preserve their resident respect and dignity. She said she had seen other staff assist residents out of the shower room with only a sheet on. She said she did not think that was the right thing to do.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report alleged violations of potential abuse to the State Survey and Certification Agency in accordance with state law for one (#85) of five residents reviewed for abuse out of 13 sample residents.Specifically, facility staff failed to report an allegation of abuse by Resident #85 towards Resident #79 to the facility's abuse coordinator and the State Agency. Findings include:I. Facility policy and procedureThe Abuse-Inservice Training policy, reviewed 6/17/24, was provided by the nursing home administrator (NHA) on 3/23/26 at 9:42 a.m. It read in pertinent part, The facility will maintain an effective training program for all staff, which included, at a minimum, training on abuse, neglect, exploitation of resident property, and dementia management, that is appropriate and effective, as determined by staff need and the facility assessment. Facilities must also provide training to their staff that at a minimum educates staff on procedures for reporting incidents of abuse, neglect, exploitation or the misappropriation of resident property. Procedure: Staff orientation and training included the prohibition of all forms of abuse, neglect and exploitation prohibition. The training must address forms of abuse, neglect, misappropriation of resident property, exploitation and dementia management; identifying physical or psychosocial indications of abuse (including injuries from an unknown source), neglect, exploitation and misappropriation of resident property from situations which include, but are not limited to verbal, mental, sexual or physical abuse; and identifying physical or psychosocial indicators of abuse; and facility procedures and federal and state requirements for reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, time frames of reporting, and to whom staff and others must report their knowledge related to any alleged violation without fear of retaliation.II. Resident #85 (assailant) A. Resident statusResident #85, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included hypertensive heart disease with heart failure, chronic obstructive pulmonary disease (COPD), congestive heart failure, vascular dementia and peripheral vascular diseaseThe 3/3/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. He needed substantial/maximum assistance with hygiene and bathing, and lower body dressing, and set up with other activities of daily living (ADL).The MDS assessment documented the resident had verbal behavioral symptoms directed toward others (threatening others, screaming at others, cursing at others). The MDS assessment documented the resident's behavior status, care rejection, or wandering was worse compared to the prior assessment.B. Record reviewResident #85's psychosocial care plan, revised 5/22/23, documented the resident had a psychosocial wellbeing problem/low mood related to labile mood due to his diagnosis of dementia with behaviors. The resident had a history of isolation and decreased socialization. Pertinent interventions, initiated 8/12/19, included that when conflict arose, to remove residents to a calm safe environment and allow the resident to vent and share his feelings. A review of the state reporting portal failed to reveal an allegation of abuse was reported.III. Resident #79 (victim)A. Resident statusResident #79, age greater than 65, was admitted on [DATE]. According to the 2/2/26 MDS assessment diagnoses included cancer, hypertension, peripheral vascular disease and renal failure.The MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She needed supervision with shower transfers and was independent with all other activities of daily living.The MDS assessment documented the resident had verbal behavioral symptoms directed toward others (threatening others, screaming at others, cursing at others) and other behavioral symptoms not directed toward others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	screaming, disruptive sounds) The MDS assessment documented the resident rejected care. B. Resident interviewResident #79 was interviewed on 3/24/26 at 3:51 p.m. Resident #79 said Resident #85 had called her names. She said he called her an explicit word and made an obscene hand gesture toward her. Resident #79 said the incident happened approximately two to three weeks ago. Resident #79 said she told the social worker and a unit manager. She said she quit going to the unit manager because nothing was done, but the NHA did something about it.-However, staff interviews (see below) revealed allegations of abuse were not reported to the NHA and the facility was unable to provide documentation the allegations were reported to the State Agency.IV. Staff interviewsThe NHA was interviewed on 3/24/26 at approximately 4:00 p.m. The NHA said the staff had not reported an incident between Resident #85 and Resident #79 as reported by Resident #79 (see resident interview above).The concierge was interviewed on 3/26/25 at 3:32 p.m. The concierge said she had observed behaviors for Resident #85. She said Resident #85 told her he just did not like Resident #79. The concierge said on 3/25/26 she was approached by the activities director. The concierge said the activities director asked the concierge on 3/25/26 if she saw Resident #85 call Resident #79 an explicit word and make an obscene gesture the previous day (on 3/24/26 - during the survey). The concierge said the activities director told her it happened again during Bingo (during the survey). Registered nurse (RN) #2 was interviewed on 3/26/25 at 3:30 p.m. RN #2 said she had seen Resident #85 make an obscene gesture toward Resident #79 and Resident #79 did see him. RN #2 said the incident happened at the end of February 2026. RN #2 said she did not report the incident to anyone. She said she did not know that she had to report the incident to the NHA at the time of the incident, but learned she should have reported it after she received abuse education (after the incident).The NHA was interviewed again on 3/26/26 at 3:45 p.m. The NHA said staff had not reported to him any allegations of incidents between Resident #85 and Resident #79 that occurred during the survey.The NHA and the director of nursing (DON) were interviewed together on 3/26/26 at approximately 6:30 p.m. The NHA said he was the abuse coordinator for the facility and staff should report allegations of abuse to him. The DON said the abuse coordinator's phone number was posted throughout the facility. The DON said if the staff were unable to reach the NHA they could call her if needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for two (#4 and #58) of three residents reviewed for accidents out of 36 sample residents.Specifically, the facility failed to ensure Resident #4 and Resident #58's fall interventions were consistently implemented. Findings include: I. Resident #4 A. Resident status Resident #4, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included muscle weakness, dementia, respiratory failure, muscle weakness, and a history of falling. The12/23/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of five out of 15. The resident required substantial to maximum assistance with chair-to-chair transfers, toileting hygiene, and lower body dressing. The MDS assessment indicated Resident #4 had a recent fall at the facility. B. Observations On 3/24/26 at 11:30 a.m. Resident #4 was in his bed There was not a fall mat next to his bed. The resident was wearing black socks that were not non-skid socks. During a continuous observation on 3/24/26, beginning at 2:19 p.m. and ending at 4:15 p.m., the following was observed: At 2:19 p.m. Resident #4 was lying in his bed with his room door open. There was not a fall mat next to the resident's bed. There was a fall mat behind the chair in the resident's room. The resident had regular socks on both feet. At 2:22 p.m. Resident #4 turned his call light on above his bedroom door for staff assistance. At 2:23 p.m. an unidentified staff member walked past the Resident #4's room with his call light on above his bedroom door. At 2:30 p.m. the maintenance director answered the resident's call light and asked the resident if he needed anything. The resident replied and said he did not need anything. Staff did not put the fall mat in place. At 2:33 p.m. Resident #4 was sitting on the edge of the bed when the same unidentified CNA entered the resident's room and asked the resident if he needed anything. The resident said he wanted a banana. There was not a fall mat next to the resident's bed. The fall mat was folded behind the resident's chair. The resident was wearing regular socks on both feet. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:58 p.m. Resident #4 put on his call light for assistance. On 3/25/26 at 7:40 a.m Resident #4 was lying in his bed on his left side facing his bedroom wall. The resident was not wearing non-slip socks. The fall mat remained folded behind the resident's chair. C. Record review The fall care plan, initiated 4/8/24 and revised 6/1/25, revealed Resident #4 was at risk for falls related to impaired mobility, cognitive deficit, poor safety awareness, use of high risk medications, history of falling, adjustment to new environment and advanced age. Pertinent interventions included ensuring the resident was wearing non-slip socks (initiated 8/5/24), placing the bed in low position (initiated 4/8/24) and placing fall mat next to the resident's bed (initiated 1/9/26). -However, the fall mat was not consistently in place and the resident was not wearing non-slip socks (see observations above). A nursing progress note, dated 2/22/26 at 12:31 p.m., revealed the resident had an unwitnessed fall. According to the note the resident was heard yelling for help when facility staff entered the room. The resident was found sitting on the floor in front of his bed wearing socks with no shoes and trying to sit on the wheelchair to go to the bathroom. The resident was placed in his bed by facility staff using a mechanical lift. The resident was assessed with no injury, neurological checks were initiated and the resident's call light was placed within reach. The 2/22/26 facility investigation for Resident #4's fall was received from the NHA on 3/26/26 at approximately 1:30 p.m. The investigation documented that on 3/19/26 Resident #4 was found in his room on the floor next to his bed and reported to have an unwitnessed fall by facility staff. The investigation noted the resident's fall care plan was reviewed and updated. A nursing progress note, dated 3/19/26 at 10:00 a.m., revealed the resident had an unwitnessed fall. The staff found the resident on the floor next to his bed and the resident was unable to describe the incident according to staff. The resident was assessed with no injuries. The resident was assisted back to his bed and was provided a floor mat. Neurological checks were initiated. The 3/19/26 facility investigation for Resident #4's fall was received from the NHA on 3/26/26 at approximately 1:30 p.m. The investigation documented that on 3/19/26 Resident #4 was found in his room on the floor next to his bed and reported to have an unwitnessed fall by facility staff. The investigation noted the resident fall care plan was reviewed and updated. A nursing progress note, dated 3/24/26 at 2:09 a.m., revealed the resident had an unwitness fall. The resident was found by facility staff on his knees in front of his bed on the floor. The resident had bruising on his knees with no complaints of pain and no injury to the head was noted. The resident was assessed and found to have no injuries and was assisted back to bed by facility staff. Neurological assessments were initiated and the resident would be monitored per facility protocol A fall assessment, dated 3/24/26, revealed Resident #4 had three or more falls in the past 90 days. The 3/24/26 facility investigation for Resident #4's fall was received from the NHA on 3/26/26 at approximately 1:30 p.m. The investigation documented that on 3/24/26 Resident #4 was reported to have an unwitnessed fall. Nursing staff reported hearing yelling from Resident #4's room. The resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was assessed with no injuries noted. The investigation noted the fall care plan was reviewed and updated. -The investigation report failed to mention if the resident had his fall mat in place at the time he was found by facility staff. D. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 3/26/26 at 2:19 p.m. She said Resident #4 was a fall risk. She said the resident had fallen at the facility in the past. She said she could locate fall interventions in the resident's chart and obtain a verbal report from the nurse. She said some of the interventions for Resident #4 include maintaining a low bed and making sure he had his fall mat next to his bed. She said she checks on the resident often when the resident was in his bed to make sure the resident's fall mat and non-skid socks were in place. Registered nurse (RN) #3 was interviewed on 3/26/26 at 2:47 p.m. She said Resident #1 was a fall risk because he became confused. She said the resident would roll over out of his bed onto the floor. She said because Resident #4 rolled out of his bed, the facility nursing staff used a fall mat and non-skid socks as fall prevention interventions. She said the nursing staff were responsible for ensuring that these fall prevention measures were in place. She said fall prevention interventions should be added to the residents care plan for nursing staff to access. The director of nursing (DON) and the regional clinical resource nurse were interviewed together on 3/26/26 at 4:42 p.m. The DON said Resident #4 had sustained multiple unwitnessed falls at the facility. She said the resident often rolled out of bed while trying to transfer to his wheelchair. The DON said Resident #4 should have his non-skid socks on and his fall mat next to his bed, because it was one of his fall interventions. The DON said it was the responsibility of all facility nursing staff to ensure Resident #4 had his fall intervention in place such as his fall mat and non-skid socks. The regional clinical resource nurse said the fall mat was important because it would lessen the likelihood of a possible injury in the event of the resident having another fall. II. Resident #58 A. Resident status Resident #58, age greater than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included hypertensive heart disease with heart failure, endocarditis (bacterial infection of the heart), chronic obstructive pulmonary disease (COPD), restless leg syndrome, and burst fracture of T11-T12 (middle spine) vertebrae. The 3/15/26 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of four out of 15. The resident needed substantial assistance or was dependent on staff for all activities of daily living (ADLs). B. Observations (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/24/26 at 9:20 a.m. Resident #58 was in bed. The resident did not have a fall mat on the floor by his bed. The fall mat was folded in the corner of the room against the wall. On 3/24/26 at 4:32 p.m. Resident #58 was in bed. The resident did not have a fall mat on the floor by his bed. The fall mat was folded in the corner of the room against the wall. At 4:36 p.m. an unidentified staff member passed by Resident #58's room and did not move the fall mat to the floor by the resident's bed. On 3/25/26 at 10:26 a.m. Resident #58 was in bed. The resident did not have a fall mat on the floor by his bed. The fall mat was folded in the corner of the room against the wall. C. Record review Resident #58's fall care plan, revised 12/21/25, documented he was at risk for falls due to his advanced age, use of high risk medications, and he required assistance with ADLs. He had a history of falls. Pertinent interventions initiated 12/23/24 included placing a fall mat next to his bed. Resident #58's Kardex (staff directive tool) documented safety interventions that included anticipating the resident's needs and a fall mat in place. D. Staff interviews RN #2 was interviewed on 3/26/26 at 3:30 p.m. RN #2 said fall interventions for the residents were the responsibility of all the staff. RN #2 said she was not aware that Resident #58 needed his fall mat on the floor when he was in bed. The DON was interviewed on 3/26/26 at 3:50 p.m. The DON said the CNAs had information about a resident's fall interventions on the Kardex, and the nurses had access to a resident's fall interventions on the care plan. The DON said the unit managers spot check to ensure the fall interventions were in place and that the resident's representative sometimes moved the resident's fall mat. The DON said Resident #58 had the fall mat intervention in place because of a previous fall and he was admitted with a diagnosis of a fracture. The DON said the fall mat was in place to prevent further injury.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure staff provided respiratory care consistent with professional standards of practice for two (#4 and #1) of four residents reviewed for oxygen services out of 37 sample residents. Specifically, the facility failed to ensure staff administered oxygen to Resident #4 and Resident #1 per physician's order. Findings include: I. Professional reference According to Nursing Skills, Open Resources for Nursing (Open RN); Ernstmeyer K, [NAME] E, editors. Eau [NAME] (WI): [NAME] Valley Technical College; published 2021, accessed on 3/31/26 from https://www.ncbi.nlm.nih.gov/books/NBK593208/, Oxygen is considered a medication and, therefore, requires a prescription and continuous monitoring by the nurse to ensure its safe and effective use. (Chapter 11) Manage oxygen therapy and equipment: If the patient is already on supplemental oxygen, ensure the equipment is turned on, set at the required flow rate, correctly positioned on the patient, and properly connected to an oxygen supply source. If a portable tank is being used, check the oxygen level in the tank. Ensure the connecting oxygen tubing is not kinked, which could obstruct the flow of oxygen. Feel for the flow of oxygen from the exit ports on the oxygen equipment. II. Facility policy and procedure The Oxygen Administration policy, revised date 3/3/26, was received from the nursing home administrator (NHA) 3/25/26 at 6:56 p.m. It read in pertinent part, Oxygen therapy is the administration of oxygen at concentrations with the intent of treating or preventing symptoms and manifestations of hypoxia. To ensure that oxygen was administered and stored safely within the facility or in an outside storage area. Oxygen orders should include a specific leader flow required by the resident. Residents receiving oxygen at 4 liters per minute (LPM) or greater via concentrator should be connected to humidifiers. I. Resident #4 A. Resident status Resident #4, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included muscle weakness, dementia, respiratory failure, congestive heart failure, muscle weakness, and a history of falling. The 12/23/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of five out of 15. The resident required substantial to maximum assistance with chair-to-chair transfers, toileting hygiene, and lower body dressing. The MDS assessment indicated Resident #4 was receiving oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Observations On 3/24/26 at 11:30 a.m. Resident #4 was in his bed, lying on his back. The resident bed was positioned in the lowest position. The resident had an oxygen concentrator next to his bed in the off position. There was a nasal cannula connected to the oxygen concentrator. The resident was not receiving oxygen. During a continuous observation on 3/24/26, beginning at 2:19 p.m. and ending at 4:15 p.m., the following was observed: At 2:19 p.m. Resident #4 was in his room, lying on his bed with his room door open. The oxygen concentrator in the resident's room was turned off. At 2:22 p.m. the resident turned on his call light for staff assistance. At 2:23 p.m. an unidentified staff member walked past the resident's room with his light on. At 2:30 p.m. The maintenance director staff answered the resident's call light and asked the resident if he needed anything. The resident replied and said he did not need anything. The facility staff responding to the residents' call light did not apply oxygen to the resident. At 2:36 p.m. certified nurse aide (CNA) #3 transferred the resident into his wheelchair with a gatebelt. CNA #3 assisted the resident with putting his sneakers on his feet before the resident's transfer. An unidentified CNA took the resident to the bathroom to change his pants that were wet with urine. The facility staff did not apply oxygen to the resident At 2:50 p.m. The unidentified CNA assisted the resident to the kitchen to get him a banana. At 3:05 p.m. Resident #4 sat in his wheelchair in the center common area. The resident did not have his oxygen on. At 3:12 p.m. an unidentified nurse gave the resident medication and took his blood pressure and pulse. The resident sat in his wheelchair without oxygen with a nasal cannula on his nose. At 3:56 p.m. Resident #4 was assisted back to his room by the MTD and left in his room. The resident was not assisted with applying his oxygen. At 3:58 p.m. the resident put on his call light for assistance. At 4:15 p.m. an unidentified facility staff responded to the resident's call bell and assisted the resident out of his room, and took the resident into the dining room without his oxygen. On 3/25/26 at 7:40 a.m. Resident #4 was in his room lying on his bed. The oxygen concentrator next to his bed was turned off. C. Record review A review of Resident #4's March 2026 CPO revealed the following physician's orders: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Oxygen at 4 LPM continuously per nasal cannula related to congestive heart failure and hypoxia (low oxygen in the tissues). Every shift for hypoxia. Ordered 3/23/26 -Monitor the resident for signs and symptoms of shortness of breath when lying flat or avoid lying flat due to signs and symptoms of shortness of breath (increased respiratory rate, pursed lip breathing, a prolonged expiratory phase, audible respirations, gasping for air, interrupted speech pattern, use of accessory muscles, anxiety, restlessness etc.) Monitor every shift. Ordered 3/21/26 -However, observations revealed Resident #4's oxygen was not not administered per physician orders (see observations above). Resident #16's oxygen care plan, initiated 10/10/25, indicated the resident had oxygen therapy related to ineffective gas exchange secondary to hypoxia and respiratory failure. Pertinent interventions included providing residents with extension tubing or portable oxygen apparatus, oxygen via nasal cannula per physician orders, monitoring for signs/symptoms of respiratory distress and report to physician as needed (PRN): respirations, pulse oximetry (measures oxygen saturation, increased heart rate (tachycardia), restlessness, diaphoresis (sweating), lethargy, confusion, atelectasis (lung collapse), hemoptysis (coughing up blood), cough, pleuritic (inflammation of lung lining) pain, accessory muscle usage, and skin color. Review of the March 2026 medication administration record (MAR) revealed nursing staff were documenting and signing off that Resident #4 was receiving oxygen at 4 LPM. -However, on 3/24/26 and 3/26/26, the resident's oxygen flow rate was not applied to the resident. (see observations above). D. Staff interviews Registered nurse (RN) #1 was interviewed on 3/24/26 at 4:32 p.m. RN #1 said she worked full-time in the facility and was very familiar with facility procedures. She said the nursing staff were responsible for checking the physician's orders every day for each resident on her assignment. She said she was unsure if Resident #4 needed to wear oxygen. She said Resident #4 had an order for oxygen at 4 LPM via nasal cannula. She said if a resident had an order for oxygen, then the resident should have the oxygen on to ensure the resident did not have difficulty breathing. She said she would put the oxygen on the resident and call the doctor for a clarification to check if the resident should still have the oxygen order. She said the oxygen order for Resident #4 may have been a temporary order. RN #2 was interviewed on 3/25/26 at 4:00 p.m. She said Resident #4 did not usually wear oxygen. She said she would check and verify the resident had an order for oxygen. She said the resident had an order for oxygen to be worn a 4 LPM via nasal cannula. She said she would place the oxygen on the resident. She said it was the nurses responsibility to make sure oxygen orders were carried out. The director of nursing (DON) was interviewed on 3/25/26 at 4:11p.m. The DON said the nurses would obtain a physician's order with oxygen setting if a resident required oxygen therapy. The DON said the nursing staff were responsible for monitoring the resident's oxygen saturation with a pulse oximeter and assessing the resident's physical response to oxygen therapy. She said the nurse and the therapy staff were both responsible for monitoring the residents while on oxygen therapy. The DON said the CNA collected vital signs including oxygen level every shift and as needed and reported to the nurses (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if the oxygen level were below 90%. The DON said oxygen therapy settings with interventions should be included in the residents care plan for the nurses to reference and the Kardex (staff directive tool) for the CNAs to reference. She said the therapy department could also access the care plan. She said the nursing staff and the therapy staff were responsible for checking the residents at the beginning of the shift to ensure the correct settings were enabled on oxygen devices. The DON said it was important to follow oxygen orders for the safety of the residents. She said hypoxia (low oxygen in the tissues) could cause inability to breathe, increased heart rate and confusion. She said she was notified of the oxygen concern of the residents and started re-education for the facility staff on the importance of monitoring residents who require oxygen therapy on 3/23/36. III. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included emphysema, acute respiratory failure with hypoxia, pneumonia, hypertensive heart disease with heart failure, pulmonary hypertension, and dependence on supplemental oxygen. The 3/3/26 MDS assessment revealed Resident #1 had no cognitive impairments with a BIMS score of 14out of 15. She required setup assistance with eating and required substantial assistance with toileting, moderate to maximal assistance with dressing and moderate assistance with personal hygiene. The MDS assessment revealed that the resident required continuous oxygen at 4 LPM with a nasal cannula. B. Observations On 3/23/26 at 10:10 a.m. Resident #1 was sitting in her room. The resident's oxygen concentrator was set to 1 LPM. -However, Resident #1`s oxygen flow rate was supposed to be 4 LPM, per physician's orders (see record review below). At approximately 3:45 p.m. Resident #1 was sitting in her room. The resident's oxygen concentrator remained set at 1 LPM. At approximately 4:30 p.m Resident #1 was sitting in her room. The resident oxygen concentrator remained set at 1 LPM. At 4:43 Resident #1 oxygen concentration was set to 1 LPM. RN #5 said that the oxygen level was set to 1.5 LPM. C. Record review The respiratory care plan, dated 3/4/26, documented that the resident had oxygen therapy. The interventions included the use of supplemental oxygen at 4 LPM continuously via nasal cannula. Review of Resident #1's March 2026 CPO revealed the following physician's order: Oxygen at 4 LPM (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continuously via nasal cannula, ordered 3/5/26. A nurse progress note, dated 3/21/26 at 4:18 p.m., documented Resident #1 was on 2 liters of oxygen via nasal cannula. She maintained oxygen saturation at 96% on that morning. She did not show shortness of breath or signs of respiratory distress. A nurse progress note, dated 3/22/26 at 6:21 p.m., documented Resident #1 was alert and oriented times two to three. She cooperated with the plan of care. She showed no sign or symptoms of shortness of breath. III. Staff interviews RN #4 was interviewed on 3/23/26 at 4:52 p.m. She said that Resident #1 was prescribed 4 LPM of oxygen. She said occupational therapy might have titrated the oxygen level to 1 LPM. She said there was no documentation of current titration in the progress notes. She said staff were supposed to follow the physician`s order until it was determined that the oxygen level could be adjusted to a lower setting. She said the oxygen level should be set to 4 LPM as the physician`s order said. She said she was not informed about any changes in the physician`s order.  The unit manager was interviewed on 3/25/26 at 2.50 p.m. She said that Resident #1 definitely needed 4 LPM. She said the staff followed the physician`s order for setting oxygen levels. She said that Resident #1 participated in therapy on the day of the observation. She said staff must have made an error when they connected Resident #1`s oxygen tube to the concentrator. She said it was important to keep an eye on the residents` oxygen levels for safety reasons. She said the CNAs were responsible for connecting the oxygen tube to the concentrator and to fill the tanks. She said the oxygen tube was changed on Sundays. The DON was interviewed on 3/25/26 at 4:18 p.m. The DON said the facility received the oxygen order from the physician. She said the nurses were responsible to follow, monitor, assess, and set oxygen level settings. She said the CNAs were responsible for collecting vital signs at the beginning of every shift. She said the CNAs were responsible to check the oxygen setting and report to the nurse if it was abnormal. She said the CNAs could not change oxygen settings. She said the CNAs could apply cannula, fill portable oxygen tanks, and change oxygen tubing. She said theCNAs should be able to notice signs of shortness of breath. She said the care plan and the Kardex indicated the oxygen setting. She said CNAs were able to access the Kardex. She said nurses were able to access the care plan and the Kardex. She said the therapist was able to access the care plan. She said the oxygen setting was documented in the point of care system. She said following the oxygen order was the most important thing to be able to breathe.

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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 - 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 observations and interviews, the facility failed to remove medications and biologicals that were stored and labeled properly according to professional standards in two of five medication carts.Specifically, the facility failed to ensure expired medications were removed from the medication cart and disposed of. Findings include:I. Facility policy and procedureThe Storage of Medication policy, revised 6/30/25, was received from the nursing home administrator on 3/25/26 at 6:39 p.m. It revealed in pertinent part, The facility should ensure that only authorized facility staff, as defined by the facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with applicable law. The facility should ensure medications and biologicals were stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding. The facility should ensure infusion therapy products and supplies were stored separately from other medications and biologicals, under appropriate temperature and sterility conditions, according to the manufacturer or supplier recommendations.II. ObservationsOn 3/25/26 at 8:24 a.m. the medication cart on 100 Hall was observed with license practical nurse (LPN) #1. The drawer on the medication cart for Resident #82 contained the following: Methocarbamol Oral Tablet 500 milligram (mg). The order read: Give 1 tablet by mouth every six hours as needed for leg pain for five Days. Order on 1/13/26 and discontinued on 1/18/26. -The medication was not disposed of despite the medication being discontinued for two months. On 3/25/26 at 11:09 a.m. the medication cart on 500 Hall was observed with LPN #2. The medication cart contained guaifenesin tablet extended release. The medication expired on 3/16/26. III. Staff interviewsLPN #1 was interviewed on 3/25/26 at 8:35 a.m. She said the discontinued medication for Resident #82 should not be in the medication cart. She said nurses were responsible for removing discontinued medications. LPN #1 said the medication should have been discarded after the completion of the order. She said the medication should have been removed from the medication cart. She said when a medication was discontinued the nursing staff were supposed to put it in the basket for discontinued medications in the medication storage room. She said she would remove the medication from her medication cart and advise the director of nursing (DON) to dispose of the medication. LPN #1 said the resident was not administered the medication after the medication was discontinued. LPN #2 was interviewed on 3/25/26 at 11:09 a.m. LPN #2 said she thinks the medication for Resident #27 was left in the medication cart because the resident would often have an order for this medication. She said this was only a speculation and that she was not completely sure why this medication was left in her medication cart. She said it was a facility standard of practice to discard any medication for facility residents that have been discontinued or expired. She said she was trained by the facility to always check the medication expiration date and the Physicians orders to ensure the safety of facility residents The DON was interviewed on 3/25/26 at 4:35 p.m. She said the unit managers were responsible for ensuring the nursing medication carts were free from storing discontinued and expired medications. The DON said the unit managers made weekly rounds to dispose of the discontinued medications. The DON said medications that were left in the cart were overlooked. She said it was important to remove discontinued medications to decrease the chance of the occurrence of medication errors. The DON said she also did medication audits of the storage rooms and the med carts to further ensure medications were stored as ordered. The DON said she would provide education starting today for the nursing staff and the unit managers on the importance of what to do with expired and discontinued medications.