STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065418	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Ridge Health and Rehab LLC	16006 W US Highway 24 Woodland Park, CO 80863

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review and interviews, the facility failed to ensure residents consistently received food prepared by methods that conserved nutritive value and was palatable in taste, texture and temperature.Specifically, the facility failed to ensure the residents' food was palatable in taste, texture and temperature.Findings include:I. Facility policy and procedureThe Standardized Menus policy, dated 10/1/25, was provided by the nursing home administrator (NHA) on 2/25/26 at 1:17 p.m. It revealed in pertinent part, It is the policy of this facility to provide nourishing, palatable meals to meet the nutritional needs of residents based on the Recommended Daily Allowances of the Food and Nutrition Board and that standardized cycle menus are planned in advance and utilized. The facility will make reasonable efforts to provide food that is appetizing and culturally appropriate for residents. Menus will be planned to meet basic nutritional needs by providing meals based on individual nutritional assessment and the individualized plan of care.-However, the policy did not include specific procedures or quality control measures to ensure food was served in an acceptable taste, texture and temperature, including prevention of overcooking, undercooking, dryness or burned food items to assess meal palatability prior to service.II. Resident representative interviewsResident #8's representative was interviewed on 2/23/26 at 11:38 a.m. The representative said food at the facility had been an ongoing issue. The representative said they discussed these concerns during resident group meetings and had tried to advocate for correction of the problem. The representative said the issue had improved recently, however the eggs continued to be served runny at times and the concerns had not been fully resolved. She said she would like the facility to fix the issues.Resident #33's representative was interviewed by phone on 2/23/26 at 3:45 p.m. The representative said the facility's food continued to be a major concern. The resident representative said the food was often cold and the ice cream was soupy. The resident representative said during the past few days, Resident #33 was not awakened for breakfast and when awakened at approximately 10:15 a.m. she was provided cereal with milk, which disrupted her normal meal pattern.Resident #33's representative was interviewed again in-person on 2/24/26 at 10:10 a.m. The representative said on several occasions, she observed potato soup that was too watery, broccoli that was mushy and a baked potato that was not cooked enough and was hard. The representative said the last time she observed these concerns was during the week of 1/17/26 at lunch. The representative said Resident #33 ate some of the baked potato but could not finish it. The representative said the french fries were cold and meats, such as beef, were tough to chew. The representative said Resident #33 preferred to eat at her daughter's home twice each week. The representative said she felt guilty for leaving Resident #33 in the facility and Resident #33 deserved to feel good about living at the facility.III. Resident group interviewA group interview was conducted on 2/24/26 at 1:00 p.m. with seven alert and oriented residents (#15, #19, #33, #46, #59, #62 and #71) who were deemed interviewable per the facility and assessment.The residents said the food was served cold. The residents said the pork was impossible to chew and other meats were tough. The residents said meal delivery took hours, even though they had reported their concerns to the leadership of the facility. IV. Additional resident interviewsResident #8 was interviewed on 2/23/26 at 11:35 a.m. Resident #8 said her eggs were served with excess moisture and were runny. She said (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Specifically, the facility failed to:-Ensure housekeepers followed chemical dwell times and appropriately disinfected residents' rooms; and,-Ensure housekeepers performed appropriate hand hygiene when cleaning residents' rooms.Findings include:I. Professional reference According to the 730 Hydrogen peroxide (HP) Disinfectant Cleaner product specification sheet, retrieved on 3/4/26 from chromeextension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.waxie.com/pdf/spec-sheets/170059-WAXIE 730 HP disinfectant cleaner is a one-step hospital-use germicidal disinfectant cleaner and deodorant designed for general cleaning, disinfecting, and controlling mold and mildew odors on hard, non-porous surfaces when used according to disinfection directions. The contact time ranges from one minute to 10 minutes, depending on the type of bacteria, virus or fungus. II. Facility policy and procedureThe Hand Hygiene policy and procedure, revised 10/1/25, was received from the clinical resource nurse on 2/25/26 at 3:21 p.m. It documented in pertinent part, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.The Routine Cleaning and Disinfection policy and procedure, revised 10/1/25, was received from the clinical resource nurse on 2/25/26 at 3:21 p.m. It documented in pertinent part, It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to: toilet flush handles, bed rails, tray tables, call buttons, TV (television) remotes, telephones, toilet seats, monitor control panels, touch screens and cables, resident chairs, IV (intravenous) poles, sinks and faucets, light switches and door knobs and levers. Follow manufacturer recommendations regarding appropriate contact time to ensure adequate disinfection.III. ObservationsDuring a continuous observation on 2/24/26, beginning at 12:00 p.m. and ending at 12:30 p.m., the following was observed:Housekeeper (HK) #2 was observed cleaning resident room [ROOM NUMBER]. -HK #2 donned (put on) clean gloves without performing hand hygiene. HK #2 rinsed the shower. HK #2 changed her gloves and donned a new pair of clean gloves.-HK #2 failed to perform hand hygiene after removing her gloves and putting on a new pair of gloves. HK #2 wiped the shower with a rag soaked in Waxie 730 HP disinfectant chemical. HK #2 immediately rinsed the shower with the shower head. HK #2 changed her gloves and donned a new pair of clean gloves.-HK #2 failed to allow the disinfectant to remain on the shower surface for the appropriate dwell time before rinsing the shower.-HK #2 failed to perform hand hygiene after removing her gloves and putting on a new pair of gloves. HK #2 mopped the bedroom. HK #2 changed her gloves and donned a new pair of clean gloves.-HK #2 failed to perform hand hygiene after removing her gloves and putting on a new pair of gloves. HK #2 mopped the bathroom and removed her gloves prior to exiting room [ROOM NUMBER].-HK #2 failed to perform hand hygiene after removing her gloves and exiting room [ROOM NUMBER]. HK #2 moved the cleaning cart to resident room [ROOM NUMBER]. -HK #2 donned clean gloves without performing hand hygiene. HK #2 dusted the bedroom furniture. HK #2 changed her gloves and donned a new pair of clean gloves.-HK #2 failed to perform hand hygiene after removing her gloves and putting on a new pair of gloves. HK #2 swept the bedroom floor. HK #2 changed her gloves and donned a new pair of clean gloves.-HK #2 failed to perform hand hygiene after removing her gloves and putting on a new (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pair of gloves. HK #2 sprayed Waxie 730 HP disinfectant chemical into the sink, around the toilet and the grab bar in the bathroom and immediately wiped it down. HK #2 changed her gloves and donned a new pair of clean gloves.-HK #2 failed to allow the disinfectant to remain on the sink, toilet and grab bar for the appropriate dwell time before rinsing the shower.-HK #2 failed to perform hand hygiene after removing her gloves and putting on a new pair of gloves. HK #2 cleaned the bathroom mirror. HK #2 changed her gloves and donned a new pair of clean gloves.-HK #2 failed to perform hand hygiene after removing her gloves and putting on a new pair of gloves. HK #2 wiped down the sink and counter with a rag soaked in Waxie 730 HP disinfectant chemical. HK #2 immediately dried the sink with paper towels.-HK #2 failed to allow the disinfectant cleaner to remain on the sink and counter for the appropriate dwell time before rinsing the shower. -HK #2 changed her gloves and failed to perform hand hygiene prior to donning clean gloves. HK #2 wiped down the wall next to the toilet with a rag soaked in Waxie 730 HP disinfectant chemical. HK #2 changed her gloves and donned a new pair of clean gloves.-HK #2 failed to perform hand hygiene after removing her gloves and putting on a new pair of gloves. HK #2 wiped down the toilet. HK #2 changed her gloves and donned a new pair of clean gloves.-HK #2 failed to perform hand hygiene after removing her gloves and putting on a new pair of gloves. HK #2 scrubbed the inside of the toilet. HK #2 changed her gloves and donned a new pair of clean gloves.-HK #2 failed to perform hand hygiene after removing her gloves and putting on a new pair of gloves. HK #2 mopped the bedroom and the bathroom. HK #2 removed her gloves prior to exiting room [ROOM NUMBER].-HK #2 failed to perform hand hygiene after removing her gloves and exiting room [ROOM NUMBER].-Additionally, HK #2 failed to disinfect the high touch surfaces in room [ROOM NUMBER] and room [ROOM NUMBER]. During a continuous observations on 2/25/26 beginning at 11:24 a.m. and ending at 11:50 a.m., the following was observed: HK #1 was observed cleaning resident room [ROOM NUMBER]. HK #1 swept the bedroom floor and then mopped the bedroom and bathroom floors. HK #1 removed his gloves prior to exiting room [ROOM NUMBER].-HK #1 failed to perform hand hygiene after removing his gloves and exiting room [ROOM NUMBER]. HK #1 moved the cleaning cart to resident room [ROOM NUMBER]. -HK #1 donned clean gloves without performing hand hygiene. HK #1 wiped down the high touch surfaces in the bedroom and then proceeded to wipe down the high touch surfaces in the bathroom. HK #1 scrubbed the toilet and then swept the bedroom and mopped the bedroom and bathroom without changing gloves. -HK #1 failed to remove his gloves and perform hand hygiene after cleaning the toilet and prior to sweeping and mopping the floors.HK #1 removed his soiled gloves, exited room [ROOM NUMBER] and moved the cleaning cart to resident room [ROOM NUMBER].-HK #1 failed to perform hand hygiene after removing his gloves and exiting room [ROOM NUMBER]. -HK #1 donned clean gloves without performing hand hygiene, prior to entering room [ROOM NUMBER]. HK #1 wiped down the high touch surfaces in the bedroom and then proceeded to wipe down the high touch surfaces in the bathroom. HK #1 scrubbed the toilet and then swept and mopped the bedroom and the bathroom without changing gloves. -HK #1 failed to remove his gloves and perform hand hygiene after cleaning the toilet and prior to sweeping and mopping the floors.HK #1 removed his soiled gloves and exited room [ROOM NUMBER].-HK #1 failed to perform hand hygiene after removing his gloves and exiting room [ROOM NUMBER].IV. Staff interviews The environmental services supervisor was interviewed on 2/25/26 at 3:35 p.m. The environmental services supervisor said the Waxie 730 HP disinfectant dwell time was three to four minutes. She said the importance of following the dwell times was so the surfaces were appropriately disinfected to help control the transmission of infection. She said high touch surfaces, such as door knobs, light switches, dresser knobs and bedside tables should be cleaned every day to prevent the transmission of infection. She said hand hygiene should be completed after removal of gloves. She said gloves should be changed with every new task, such as moving from the bedroom into the bathroom. The infection prevention (IP) and the assistant director of nursing (ADON) were interviewed together on 2/26/26 at 9:37 a.m. The IP said she conducted monthly audits of hand washing and did not have concerns with staff not performing hand hygiene. The IP said hand hygiene should be (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed before going into residents' rooms, after coming out of rooms, before and after perineal care, when moving from dirty to clean tasks, after gloves removal and before and after medication pass. The IP said it was important to follow the dwell times for cleaning products so the chemical had time to appropriately disinfect the surface. The director of nursing (DON) was interviewed on 2/26/26 at 11:00 a.m. The DON said hand hygiene should be performed when going in and out of residents' rooms, when hands were visibly soiled, between resident cares, when moving from a dirty area to a clean area and after removal of gloves. She said hand hygiene was important for infection control. The DON said the importance of following chemical dwell times was so the product had time to kill germs on surfaces. She said the high touch surfaces, including door knobs, TV remotes, bed controls, bedside tables, toilet handles and other remotes should be cleaned daily.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were free from sexual abuse for one (#54) of three residents reviewed for abuse out of 37 sample residents.Specifically, the facility failed to protect Resident #54 from sexual abuse by Resident #57.Findings include:I. Facility policy and procedureThe Abuse, Neglect and Exploitation policy, undated, as provided by the director of nursing (DON) on 2/23/26 at 3:15 p.m. It read in pertinent part, It is the policy of the facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploiAbuse means the willful infliction, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which include staff to resident abuse and certain resident to resident altercations. It includes verbal abuse, sexual abuse, physical abuse and mental abuse.Sexual abuse is non-consensual sexual contact of any type with a resident.II. Sexual abuse allegation involving Resident #54 and Resident #57 on 12/25/25A. Facility investigationThe 12/26/25 facility investigation revealed that staff witnessed Resident #54 and Resident #57 walking toward each other in the hall when Resident #54 gave a hug to Resident #57. As Resident #54 was walking away, Resident #57 grabbed Resident`s #54 buttocks and slid his hand down to her crotch. After the incident, Resident #57 was placed with a one-to-one staff member. The facility substantiated the allegation of sexual abuse.B. Resident #54 (victim)1. Resident statusResident #54, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included Pick`s disease (causes the atrophy of the brain's frontal and temporal lobes) dementia, and Alzheimer`s disease. The 2/10/26 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment and a brief interview for mental status (BIMS) assessment was not conducted. She exhibited physical behavior problems toward others. The resident required maximal assistance with toileting and showering. She required set up assistance with eating, supervision, oral hygiene and moderate assistance with dressing. 2. Record reviewThe capacity to consent care plan, initiated 12/31/25 (after the incident with Resident #57), identified Resident #54 lacked the capacity to consent to sexual intimacy related to severe cognitive impairment, placing the resident at risk for misunderstanding interpersonal boundaries, exploitation, or emotional and physical harm. The goal was to allow Resident #54 to maintain psychosocial well-being and dignity while engaging in safe, appropriate, non-sexual, affectionate interactions. The interventions included not allowing sexual activity at that time due to lack of resident capacity to consent.-However, the care plan failed to include interventions to keep the resident safe from another recurrence due to her lack of capacity to consent.C. Resident #57 (assailant)1. Resident statusResident #57, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included severe vascular dementia (restricted blood flow to the brain), personal history of transient ischemic attack (mild stroke) and cerebral infarction without residual deficit, disorientation, and post-traumatic stress disorder. The 12/23/25 MDS assessment revealed the resident had severe cognitive impairment, and a BIMS assessment was not conducted. He required set up assistance with eating, supervision with oral hygiene and dressing, and moderate assistance with showering. The MDS assessment identified the resident did not have physical and verbal behavioral symptoms directed at others.2. Record reviewThe behavior care plan, revised 12/18/25, identified Resident #57 had a history of exhibiting affectionate behavior with female residents related to cognitive impairment. The goal was to prevent Resident #57 from engaging in inappropriate touching of others. Pertinent interventions included having two staff members to provide gentle redirection to the resident if consent could not be clearly established and if the resident's behavior escalated beyond kissing or one resident appeared uncomfortable (initiated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/18/25) and providing one-to-one supervision with emphasis on ensuring the resident had no opportunity for physical contact with any other resident and not to seat him near female residents (initiated 12/26/25).A progress note, dated 12/11/25, revealed Resident #57 exhibited increased interest in female residents starting on 12/11/25. The staff documented approximately ten separate progress notes between 12/11/25 and 12/25/25 when he exhibited these behaviors. A progress note, dated 12/26/25 at 6:37 a.m., documented Resident #57 had been having issues with touching certain female residents. Resident #57 was in the hallway with a female resident (Resident #54) who he was not supposed to be touching. Both residents were hugging each other and rubbing each others' arms. Resident #57 was asked to please stop and continue to his room. When Resident #57 started to walk away from Resident #54, he smacked her on the bottom and then slid his hand from her bottom to her crouch. After sliding his hand on her crouch, went to his room. Resident #54 was not upset or agitated by the actions of Resident #57.D. Staff interviewsCertified nurse aide (CNA) #5 was interviewed on 2/25/26 at 1:06 p.m. CNA #5 said Resident #57 often exhibited flirtatious behaviors toward females in the memory care unit. He said Resident #57 seemed to pay more attention to female residents than male residents. CNA #5 said Resident #57 frequently initiated physical contact with females, including holding hands and kissing them on the cheek. He said it was difficult to determine whether the contact was consensual due to the female residents' cognitive impairment He said Resident #54 did not exhibit any behaviors that would suggest her dislike of Resident #57's attention. CNA #5 said he reported all incidents to the nurse. CNA #5 said that the staff agreed to increase monitoring for Resident #57 due to his behaviors. Registered nurse (RN) #3 was interviewed on 2/25/26 at 12:55 p.m. RN #3 said Resident #57's behavior slowly escalated over the weeks on the unit. She said Resident #57`s behavior started innocently, such as sitting by female residents and holding hands with them. RN #3 said Resident #57's behavior escalated and he was seen rubbing a female resident's knee and then he started going into female residents' rooms. RN #3 said the staff tried to intervene and redirect the residents involved. She said the staff was encouraged to monitor and redirect Resident #57. She said Resident #57 was placed on alert charting and the management was aware of his behavior. RN #3 said that the occurrence between Resident #57 and Resident #54 was a surprise to her, as she had never seen Resident #57 being interested in Resident #54 before. She said Resident #57 was placed on one-to-one observation after the occurrence with Resident #54 on 12/26/25.The DON was interviewed on 2/25/26 at 2.30 p.m. The DON said Resident #57 was redirected numerous times and the staff educated him on personal boundaries but Resident #57's behavior did not change. She said Resident #57 was placed on one-to-one observation after the incident between him and Resident #54 due to lack of available rooms off of the memory care unit. She said Resident #57's behavior with other female residents prior to the occurrence was not foretelling and the facility did not suspect that his behavior would escalate. She said that the facility had initiated a sexual capacity consent since the occurrence with Resident #54. She said a resident with dementia would consent to physical contact by their body language. She said if they were pulling away, walking away, showing any sign of fear or standing by the nurse, that would show disagreement. RN #1 was interviewed on 2/25/26 at 3:37 p.m. RN #1 said she witnessed Resident #57 initiate contact with several female residents on 12/26/25. She said Resident #57 kept inviting the females to kiss him on the cheek. She said the staff intervened and redirected him several times during that day and reminded him that the other residents did not want to be engaged physically. She said Resident #57 walked away but then initiated contact again later. She said it was hard to tell whether it was consensual contact or not. She said the residents did not verbally refuse or pull away. She said she did not believe that the female residents involved in these occurrences were able to understand the weight of their consent. She said it was possible that the female residents only agreed to the attention to avoid conflict.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065418	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Ridge Health and Rehab LLC	16006 W US Highway 24 Woodland Park, CO 80863

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#9) of five residents were free from chemical restraints out of 37 sample residents.Specifically, the facility failed to monitor behaviors, side effects and effectiveness for Resident #9, who was prescribed a psychotropic medication.Findings include:I. Facility policy and procedureThe Unnecessary Drugs policy, revised 10/1/25, was provided by the regional clinical resource on 2/25/26 at 3:15 p.m. It read in pertinent part, It is the facility's policy that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being free from unnecessary drugs. Each resident's drug regimen will be reviewed on an ongoing basis, taking into consideration the following elements: -Dose; -Duration;-Indications;-Adequate monitoring for efficacy and adverse consequences; and,-Preventing, identifying and responding to adverse consequences.II. Resident #9A. Resident statusResident #9, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included unspecified mood disorder, anxiety disorder, vascular dementia and depression. The 12/15/25 minimum data set (MDS) assessment revealed the brief interview for mental status (BIMS) assessment was not conducted as the resident was rarely understood. According to the staff assessment for mental status, the resident had short and long term memory problems. His cognitive skills for daily decision making were severely impaired. He required maximal assistance with most of his activities of daily living (ADL).B. Record reviewReview of Resident #9's February 2026 CPO revealed the resident had a physician's order for Sertraline (an antidepressant) 25 mg (milligrams) one time a day with a start date of 1/14/26.-Review of Resident #9's electronic medical record (EMR) revealed there was no documentation related to behavior monitoring, monitoring the resident for side effects related to the use of the medication or the effectiveness of the medication.-Review of Resident #9's there was no care plan for behavior monitoring or side effect monitoring related to the use of the antidepressant medication. III. Staff interviewsCertified nurse aide (CNA) #1 was interviewed on 2/25/26 at 2:01 p.m. CNA #1 said Resident #9 would yell out for help, move tables around in the dining room and hit staff. He said he did not know Resident #9 was started on an antidepressant. He said he did not know what behaviors or side effects staff should be monitoring for the effectiveness of the resident's antidepressant medication. Licensed practical nurse (LPN) #1 was interviewed on 2/25/26 at 2:06 p.m. LPN #1 said Resident #9 slept all the time and that was all he did. She said he would get angry when awoken and the facility started the antidepressant to help with his energy and happiness. She said when a resident was started on a psychotropic medication, the resident was added to the alert charting binder. -However, LPN #1 reviewed the alert charting binder and said Resident #9 was not added to the binder when he started the antidepressant medication. LPN #1 said Resident #9 should have had monitoring for side effects and behavior tracking for the effectiveness of the antidepressant medication. She said she was not sure if a care plan was required when a resident was started on a psychotropic medication. The director of nursing (DON) was interviewed on 2/25/26 at 2:40 a.m. The DON said when a resident was started on a new psychotropic medication, the resident should be added to the alert charting binder which alerted staff to the start of a new psychotropic medication. She said the residents' medications were discussed monthly in the psychotropic/pharmacological meeting. She said all psychotropic medications should have a care plan implemented which identified behaviors and what side effects of the medication to monitor for. She said the facility monitored the effectiveness of psychotropic medications through behavior charting.

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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, record review and interviews, the facility failed to ensure proper storage of medications in two of four medication carts and one of four medication storage rooms. Specifically, the facility failed to: -Ensure medications were labeled with the date they were opened; and,-Ensure expired medications were removed and discarded from medication carts and medication storage rooms.Findings include: I. Professional referenceAccording to the Xalatan (latanoprost) package insert, retrieved on 3/2/26 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/020597s044lbl.pdf, Once a bottle is opened for use, it may be stored at room temperature up to 25 degrees Celsius (77 degrees Fahrenheit) for 6 (six) weeks. According to the Symbicort (budesonide formoterol) package insert, retrieved on 3/3/26 from https://www.accessdata.fda.gov/spl/data/1f05ded1-7d31-4cfc-8537-0e75f99ad452/1f05ded1-7d31-4cfc-8537-(The inhaler should be discarded when the labeled number of inhalations have been used or within 3 (three) months after removal from the foil pouch.II. Facility policy and procedure The Medication Storage policy, revised 10/1/25, was received from the clinical resource nurse on 2/25/26 at 3:20 p.m. It documented in pertinent part, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. The medication carts and all medication rooms are routinely inspected by the consultant pharmacist (or designee) for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy.III. Observations and staff interviews On 2/24/26 at 1:20 p.m., the Maple unit medication cart was observed with licensed practical nurse (LPN) #1. The following items were found: -A hospice emergency kit containing five different medications. All five medications in the kit had an expiration date of 12/24/25. -One bottle of Pro-Stat (concentrated liquid protein) had an expiration date of 5/21/25.On 2/24/26 at 1:40 p.m., the Pine medication cart and medication storage room were observed with LPN #2. The following items were found in the medication cart: -Latanoprost ophthalmic solution (eye drops used to treat pressure in the eye) 0.005% was not labeled with an open date. -Budesonide/formoterol (inhaler to treat chronic obstructive pulmonary disease) 160 micrograms (mcg)/4.5 mcg had an open date of 3/1/26, however the medication was already open. -A bottle of vitamin B12 1000 mcg had an expiration date of January 2026.The following item was found in the medication storage room: -A bottle of sunscreen had an expiration date of May 2021. LPN #2 said she would dispose of the expired medications. She said the night shift nurses were responsible for the disposal of expired medications. IV. Additional staff interview The director of nursing (DON) was interviewed on 2/25/26 at 2:35 p.m. The DON said the night shift nurses audited the medication carts on Sunday nights for expired medications. She said it was important to keep the medication storage areas free from expired medications and mislabeled medications so the residents were getting the correct strength of medication. She said it was additionally important so the nurses were aware of the expiration dates for medications with shortened expirations date, such as eye drops.