

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Vero Beach Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 37th St Vero Beach, FL 32960	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22517</p> <p>Based on observation, interview and clinical and administrative record review, the facility failed to ensure 1 of 8 sampled residents, Resident #5, was assessed by the interdisciplinary team and established a plan of care for self-administration of medication before the resident participated in the practice.</p> <p>The findings included:</p> <p>An observation was conducted on 05/19/25 at 10:50 AM with Resident #5. Upon speaking with the resident, the surveyor noticed that there were approximately 10 bottles of pills and liquid supplements neatly stored on the resident's night stand. The bottles were noted to be open. Photographic Evidence Obtained.</p> <p>The following supplements were stored on the night stand:</p> <ol style="list-style-type: none"> 1. Two (2) bottles of 32 ounces of MCT oil weight management 2. Two (2) bottles of Nugenix Thermo X 3. One (1) bottle of weight loss probiotics 4. One (1) bottle of Veggies capsule 5. One (1) bottle of Testosterone Booster 6. One (1) bottle of Fruit Dietary Supplement 7. One (1) bottle of Nugenix Ultimate Testosterone Booster <p>An interview with the resident at this time revealed the resident has been taking these supplements daily because he says the facility doesn't serve him the right food and he is trying to lose weight.</p> <p>The Licensed Practical Nurse (LPN) came into the room at 11:00 AM and administered the resident his medication. The resident then proceeded to tell the nurse what the surveyor said about his supplements.</p> <p>(continued on next page)</p>

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 05/19/25 at 11:50 AM with the Director of Nursing, who confirmed that the resident had not been assessed for self-administration of medication and was aware that the resident was not to have medications stored at his bedside.</p> <p>Review of the clinical record for Resident #5 revealed the resident was originally admitted to the facility on [DATE]. The clinical record did not provide evidence of an assessment by the interdisciplinary team nor was there a plan of care developed for the resident to self-administer medications.</p> <p>Review of the facility's policy, titled, Medication Administration, revised 01/2024, documented, Residents may self-administer their own medications only if the Attending Physician, in conjunction with the interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.</p>

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22517</p> <p>Based on interview, clinical and administrative record review, the facility failed to honor the resident's bath preference and ensure the resident consistently received his bath preference for 1 of 8 sampled resident, Resident #4.</p> <p>The findings included:</p> <p>During the observational tour of the facility on 05/19/25 at 11:30 AM, the surveyor approached Resident #4, who was sitting in his wheelchair in front of his room. The resident voiced his dissatisfaction that they forget about us in room [room number]. The housekeeping aide was observed in the room at this time mopping the floor. The resident stated, I haven't got my medications yet and has gone about 3 weeks without a shower. They don't ever change my linen. I told them my toilet is leaking, and they don't do anything about it. The resident stated that they will wash him in his private area, but he wants a shower. He stated also that he has said he prefers to wear the pull up type of incontinent briefs but some of the aides keep putting the ones with the tabs on.</p> <p>An interview was conducted on 05/19/25 at approximately 11:40 AM with Staff E, the assigned Certified Nursing Assistant (CNA), for Resident #4. The surveyor inquired about the care needs for Resident #4. She stated the resident requires assistance with his activities for daily living (ADLs). She confirmed she hadn't gotten to the resident yet nor had she changed his linen because they were waiting on linen. She stated she has only been on the job two weeks and this was her first day on this hallway. The surveyor inquired about the resident's shower. Staff D, another CNA, joined the interview and stated the resident gets a shower on Tuesday.</p> <p>Another interview was conducted with Resident #4 on 05/19/25 at approximately 1:00 PM, who remained repeated they will bathe his bottom but he had asked for a shower. He acknowledged that he is a big guy and needs help, and confirmed he had been approached today by staff regarding his showers and medications, but he didn't want to get anyone in trouble so he just accepted it.</p> <p>Review of the Minimum Data Set (MDS) assessment dated 02/23/25 revealed the resident's Brief Interview for Mental Status (BIMS) score was 15 on a scale of 0-15, meaning the resident is cognitively intact.</p> <p>Review of the facility's Resident Council minutes and Grievance log for January 2025 to present, revealed in the March 2025 Resident Council meeting, Resident #4 expressed he would like to have a shower 2-3 times a week. The Activity Director reported it for grievance. The Director of Nursing (DON) noted the shower schedule was updated to Monday, Wednesday and Friday 7AM-3PM shift. The grievance was noted as resolved on 03/26/25.</p> <p>Review of Resident # 4's Kardex documented the resident requirements for bathing, as: The resident needs assist of 1-2 based on fatigue, weight-bearing, weakness. Shower / Bathing Schedule Monday, Wednesday, Friday 7-3.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reivew of Resident #4's plan of care identified a concern initiated 04/11/24 that the resident needs assist with ADL care related to multiple factors including weakness / decreased mobility s/p (status post) recent hospitalization /illness. Both resident and staff believe resident is capable of increased independence in at least one ADL prior to returning to the community. ADL needs and participation vary.</p> <p>Interventions identified:</p> <p>ADL Care: the resident may need assistance of 1 -2 for ADL care. This may fluctuate with weakness, fatigue, and weight bearing status.</p> <p>BATHING: The resident needs assist of 1-2 based on fatigue, weight bearing, weakness.</p> <p>BED MOBILITY: the resident needs extensive help to move and reposition the bed. Will need one- or two-person assistance to change position or scoot up in the bed. This may involve some lifting of the legs or boosts.</p> <p>TOILETING: the resident can transfer on and off of the toilet bedpan without physical help, but will need limited with wiping, clothing, and washing up.</p> <p>TRANSFER: the resident is limited to extensive and may need assistance x 1 or x 2 for transfers in and out of chair or bed. This may fluctuate with weakness, fatigue, and weight bearing status.</p> <p>Review of the task (Documentation Survey Report of the resident's ADL implementation) for May 2025 revealed the following for the resident regarding bathing 7-3 shift:</p> <p>1st - NA (not applicable)</p> <p>2nd (Friday) - NA</p> <p>3rd - nothing documented</p> <p>4th - NA</p> <p>5th (Monday) - sb (sponge bath), physical help</p> <p>6th - fb (full bath) physical help</p> <p>7th (Wednesday) - NA</p> <p>8th - sb</p> <p>9th (Friday) NA</p> <p>10th - NA</p> <p>11th - NA</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12th (Monday) NA</p> <p>13th NA</p> <p>14th (Wednesday) fb (total dependence)</p> <p>15th - fb physical help</p> <p>16th (Friday) NA</p> <p>17th nothing documented</p> <p>18th - sb</p> <p>19th - nothing documented.</p> <p>Further review of the task sheet documentation for April 2025 for 7 - 3 shift revealed the resident received one shower on April 26th on the 7-3 shift. During this month, the resident was provided 9 sponge baths or full baths on the 3rd, 4th, 8th, 11th, 13th, 18th 20th, 21st and the 27th. The remainder of the month the staff documentation for 7-3, revealed NA or the date was left blank.</p> <p>Review of the facility's recorded individual sheets for showers revealed the staff are to document when the resident receives a bath or shower: All residents must be offered and provided a shower unless they request a bed bath. Wash hair, clean under fingernails, shave. [NAME] any abnormal skin conditions. The form provides for the staff to select one: whether the resident was provided a:</p> <p>Shower, Device used (circle one): standard shower chair, reclining shower chair, shower bed, other:</p> <p>Bed bath</p> <p>Resident refused ** Nurse must verify refusal, notify responsible party and document in PCC [Point Care Click system].</p> <p>Review of the PCC documentation (Progress Notes) for Resident #4 did not provide documentation confirming the resident's refusal of showers during April and May 2025. The documentation revealed 2 completed shower sheets for April and May which were dated 04/01/25 and 05/02/25.</p> <p>Review of the facility's policy regarding ADL care and services, revised 01/2024 documented, The resident has the right to refuse any and all ADL care. The refusal of care will be documented in the resident's medical record with appropriate notification including physician and resident representative.</p>

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22517</p> <p>Based on observation, clinical and administrative record review and interview, the facility failed to ensure the residents received the necessary care and services for skin assessments and timely medication administration, as evidenced by the facility's consistent failure to respond in a timely manner fo residents who developed new skin issues and failed to ensure that residents received their prescribed medications in a timely manner, for 3 of 8 sampled residents, Residents # 1, # 4 and # 6.</p> <p>The findings included:</p> <p>1. Record review revealed Resident #1 was readmitted to the facility on [DATE] with pertinent diagnosis which includes, Diabetes Mellitus, Cerebrovascular disease, Chronic Kidney disease, Stage 3, Essential Hypertension, and Blind Left eye.</p> <p>Review of the resident's plan of care identified a concern initiated on 02/24/25, The resident has a Skin Impairment: eczema. Interventions included:</p> <p>Encourage and assist resident to Off Load Heels as ordered</p> <p>Monitor the Resident's changes in skin condition, and pain levels. Report changes to the physician (MD)</p> <p>Monitor/observe skin while providing routine care. Notify nurse for any area of concern as indicated.</p> <p>Skin checks weekly and as indicated. Report any s/s (signs and symptoms) of skin breakdown to MD/wound team as indicated. Treatments as ordered/indicated.</p> <p>An observation and interview was conducted on 05/19/25 at approximately 2:50 PM with Resident #1. Interview with Resident #1 revealed the resident asked the surveyor to look at her thighs because she had some spots on her thighs that itch and hurt. The resident confirmed she couldn't see what it was, but stated it felt like she was allergic to something because it feels like a rash but it hurts. Upon closer assessment, the surveyor observed the resident had dark colored rash like areas on her right and left thighs which are slightly raised and had pimples like bumps on the area, of approximately 2-3 inches in diameter. The resident stated there was an another area under her left arm near her elbow that itched and hurt. Upon observations, the area was dark colored and of about 1 inch in diameter. The resident then lifted her duster dress and pointed to an area on her stomach that was itchy</p> <p>The surveyor asked Staff B, Licensed Practical Nurse/LPN, to assess the resident to address the resident's concern. After assessing the resident, Staff B stated she would get a dermatology consult.</p> <p>Review of the clinical record on 05/20/25 at 11:15 AM did not provide evidence that Staff B had documented the new identified skin issues; and there was no evidence that the nurse contacted the physician or that new orders to treat the resident's new symptoms or skin issues were ordered.</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 05/20/25 at approximately 11:25 AM with the Director of Nursing (DON). The surveyor explained to the DON that the review of the electronic record for Resident #1 did not document identification of the skin issues identified yesterday, 05/19/25.</p> <p>An interview was conducted on 05/20/25 at 11:45 AM with the DON and Unit Manager, who reported the resident's skin issues are similar areas which reoccur periodically and they previously had an order to treat this reoccurrence but the order must have fallen off. She stated she has just contacted the physician and obtained an order for cortisone. She confirmed when new skin issues arise, the area(s) are to be documented in the clinical record.</p> <p>2. During the observational tour of the facility on 05/19/25 at 11:30 AM, the surveyor observed Resident #4, who was sitting in his wheelchair in front of his room. The resident was voicing his dissatisfaction that they forget about us in this room. The resident stated, I haven't got my medications yet, and have gone about 3 weeks without a shower. They [staff] don't ever change my linen. I told them my toilet is leaking and they don't do anything about it. The resident stated they will wash him in his private area, but he wants a shower. He stated he has told them he 'prefers to wear the pull up type of incontinent briefs but some of the aides keep putting the ones with the tabs on'.</p> <p>The surveyor asked the Director of Nursing at approximately 12:00 PM to check to see if Resident #4 had received his medications because the resident has stated he had not received his medications. She reviewed the electronic record and the medications were signed off as given. She stated she would follow-up with the nurse, who had gone to lunch and was off the unit. The DON later reported to the surveyor that she spoke with the nurse and the nurse had given the resident his medications.</p> <p>At approximately 12:35 PM, the surveyor observed Staff B down the hall giving medications. The surveyor inquired and noted the nurse was preparing to give medications to Resident #4. The surveyor then conducted a medication administration observation with Staff B for Resident #4. The nurse prepared the following medications:</p> <ol style="list-style-type: none"> 1. FeSo4 325 mg one tablet 2. ASA 81 mg one tablet 3. Sodium Bicarbonate 650 mg one tablet 4. Drizaline Cap 20 mg DR one cap Twice daily for depression 5. Furosemide tablet 40 mg one tablet every day Shortness of breath 6. Metoprolol suc tab 50 mg one tablet Hypertension 7. Potassium Chloride 10 meq one tablet every day <p>All 7 pills were verified.</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted at 12:43 AM with Staff B. The surveyor inquired because of what was previously told to her regarding the nurse having already administered the medication and the medication was already signed off as administered. The nurse stated she had poured the resident's medications previously and she clicked on the meds. Then the resident stated he wanted to eat his popcorn first. So she went to lunch. The surveyor asked about her previously poured medications because she prepared them again. Staff B responses they aren't allowed to pre-pour meds. The surveyor asked about the medications being signed as administered, when she had not administered the medications, and Staff BB stated she clicked on them and was going to go back to click them green once she had administered the medication but they were already showing as administered. Staff B stated she went to lunch and told the resident she was going to lunch and would finish after lunch. The morning medication time is 9:00 AM.</p> <p>Another observation was conducted on the next day on 05/20/25 at 11:28 AM with Staff B. The nurse was again observed with her medication cart in the hallway administering medications. The surveyor inquired what medication pass was she completing and Staff B confirmed she was still completing her morning medication administration. Staff B stated, This is a heavy hall with 32 residents. I don't finish medication pass until 11 AM-12 PM, and I have 6 more residents still to give medications to.</p> <p>3. An interview was conducted on 05/20/25 at 11:50 AM with Resident #6, who stated that he resigned today from being the Resident Council President as it's useless. He stated he has been in this position for one year and expressed his dissatisfaction with getting things resolved. He stated that 'we continue to have the same ongoing issues, meds late, showers, food cold and late and food quantity.' He stated he had an issue with his medications on Mother's Day, as the usual nurse was off and he normally would receive his meds by 9:30 AM but on this day at around 11:00 AM he had told the nurse but he still didn't get his morning medications until after 12:30 PM. He stated the nurse did his blood sugar as well. He stated he went to the DON about this because he could speak up for himself, but his concern was about the residents who couldn't. He said he also got his afternoon meds on the evening that day and the evening nurse told him, she was giving him his medications that he didn't get earlier.</p> <p>Observation on 05/20/25 at 12:35 PM revealed the Registered Nurse, Staff C, came into the room and gave Resident #6 his medications. The surveyor asked what medications were being administered and Staff C stated some morning and some afternoon medications were being given.</p> <p>An interview was conducted at 12:45 AM with Staff C who stated that the hall has 29 residents and he typically finishes between 11:00 AM - 12:00 PM.</p> <p>An interview was conducted on 05/20/25 at approximately 1:00 PM with the DON. The DON confirmed the resident had come to her about his medication being late on Mother's Day, and that he was concerned about other residents. It should be noted that there was no grievance initiated for this resident's concern and the facility had not addressed the persistent late medication administration concerns.</p> <p>Review of the facility's policy and procedure regarding Medication Administration, revised 2024, documented, Medication are administered in accordance with prescriber orders, including any required time limit.</p> <p>Medications are administered within one (1) hour before or after their prescribed time, unless otherwise specified (for example, before or after meal orders, at bedtime).</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>22517</p> <p>Based on observation and interview, the facility failed to ensure all medications and/or supplements were not stored at the residents' bedside but were safely secured in locked compartments for 1 of 8 sampled residents, Resident #5.</p> <p>The findings included:</p> <p>An interview was conducted on 05/19/25 at 10:50 AM with Resident #5. Upon speaking with the resident, the surveyor observed there were approximately 10 bottles of pills and liquid supplements neatly stored unsecured on top of the resident's bedside night stand. Photographic Evidence Obtained.</p> <p>The following supplemental pills were stored on the night stand and clearly visible upon entering the resident's side of the room:</p> <ol style="list-style-type: none"> 1. Two (2) bottles of 32 ounces of MCT oil weight management 2. Two (2) bottles of Nugenix Thermo X - 60 capsules bottles 3. One (1) bottle of weight loss probiotics 4. One (1) bottle of Veggies capsule 5. One (1) bottle of Testosterone Booster 6. One (1) bottle of Fruit Dietary Supplement 7. One (1) bottle of Nugenix Ultimate Testosterone Booster. <p>An interview was conducted with the resident at this time revealed the resident has been taking these supplements daily and he has the medication stored on top of his night stand.</p> <p>An interview was conducted on 05/19/25 at 11:50 AM with the Director of Nursing, who confirmed that the resident had not been assessed for self administration of medication and was aware that the resident was not to have medication stored at his bedside.</p>		