

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Twin Falls Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Eastland Drive Twin Falls, ID 83301	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, policy review, and review of the 2022 FDA Food Code, the facility failed to appropriately store, distribute, and label foods. This deficient practice had the potential to affect all residents who received meals prepared in the facility's kitchen. This placed residents at risk for potential contamination and use of spoiled foods, and adverse health outcomes including food-borne illnesses. Findings include: The facility's Food and Storage Policy dated 11/21/17, documented under Labeling and Rotation, Opened or repackaged food must be labeled with use-by date. The FDA Food Code Section 3-501.17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, states marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded. The facility's Meal Service policy dated 9/12/25, documented For in-room delivery: Ensure food is covered during transport and uncovered at bedside. On 7/19/26 at 12:07 PM, during lunch service CNA #6 was observed taking a meal tray with a cup of coffee without a lid or protective covering on it from the hot cart stationed on the 400-hall and delivered it four rooms away from the hot cart. On 7/19/26 at 12:13 PM, during lunch service the SW was observed taking a meal tray with a cup of juice without a lid or protective covering on it from the hot cart stationed on the 400-hall and delivered it 6 rooms away from the hot cart. The SW had also touched Resident #59's brownie after she unwrapped it. On 7/19/26 at 12:15 PM, the SW stated she did not think the juice had to be covered and did not realize she could not touch the resident's food. On 7/20/26 at 4:28 PM, the CM stated the small cups should of had the clear lids on them and the coffee cups should of had the white lids on them when going down the hall. On 7/20/26 at 4:37 PM, CM stated the staff should not have touched Resident #59's food. On 7/19/26 at 9:20 AM, the following was observed during the kitchen tour: In the refrigerator:- plastic container of lime juice with use by date of 7/17/26- thick dust and dirt observed on the cooler fans In the freezer:- opened package of plant-based burgers with received date but no opened date In the pantry:- scalloped potatoes, dry, opened date of 3/11/26, and used by date of 6/11/26- two coffee carafes stored in pantry, both with dark brown and thick white stains and product on the outside of the containers- croutons with open date of 5/13/25, and use by date of 6/13/26- stuffing with open date of 3/25/26, and use by date of 6/25/26 On 7/19/26 at 10:00 AM, the Culinary Manager stated expired foods should be discarded and opened foods should have an opened date and a discard by date and had not.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Twin Falls Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Eastland Drive Twin Falls, ID 83301	
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 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 observation, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: The facility's Inhalant (Nebulizer) Medication Administration policy revision date 9/16/25, documented equipment must be cleaned and maintained according to infection control protocols. The facility's Cleaning and Disinfecting of Reusable Equipment policy dated 9/25/25, documented all reusable non-critical equipment will be cleaned and disinfected between resident use. The facility's Laundry/Linens policy dated 10/8/25, documented personal clothing is laundered separately and returned promptly to the resident. 5. Delivery to resident care areas is conducted in a manner that minimizes cross-contamination. The following was observed for proper cleaning and storage of respiratory equipment: The facility's Oxygen Administration, Safety, Storage & Maintenance policy, revision date 10/10/25, documented Infection Control 3. Store oxygen and respiratory supplies in a plastic bag when not in use. On 7/19/26 at 10:02 AM, observed Resident #67's CPAP mask lying uncovered in her bedside nightstand. On 7/19/26 at 1:52 PM, observed Resident #53's CPAP mask lying uncovered on her bed under her pillow. On 7/19/26 at 9:55 AM, observed Resident #106's nebulizer lying on his bedside table not bagged. His nebulizer machine was observed to be covered with a gray substance. On 7/20/26 at 5:04 PM, the CNO stated resident's respiratory equipment should have been kept clean, and the tubing should have been in a bag. - The following was observed for multiple resident use equipment: On 7/21/26 at 7:57 AM, the vital sign machine on the cross hall observed with a light brown splattering substance to the base. On 7/21/26 at 8:01 AM, RN#1 stated the vital sign machine should have been cleaned after each resident use. - The following was observed for proper handling and transporting of laundry: On 7/21/26 at 11:14 AM, observed provide incontinent care to Resident #20 and placed his wet under pad on the floor. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Twin Falls Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Eastland Drive Twin Falls, ID 83301	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/21/26 at 11:15 AM, observed CNA #5 removed Resident #7's dirty clothes and bed linen and placed them on the floor. On 7/21/26 at 8:10 AM, observed Laundry Aide #1 carrying personal clothes, on hangers from the laundry room to room [ROOM NUMBER], without a protective covering. On 7/21/26 at 8:14 AM, Laundry Aide #1 stated she should have covered the clothes.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Twin Falls Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Eastland Drive Twin Falls, ID 83301	
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 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 observation and interview, the facility failed to ensure dignity of residents when staff enter their rooms without knocking and waiting for acknowledgement to enter and administered oral medication to residents in the dining room. This was true for 1 of 1 resident room observed during the survey process and 1 of 1 resident (Resident #16) observed in the dining room. This deficient practice placed residents at risk of embarrassment and diminished sense of self-worth. Findings include: Resident #16 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia (a mental disorder characterized by disturbances of thinking, mood, and behavior), anxiety, and paraplegia (paralysis of lower portion of the body). On 7/19/26 at 12:07 PM, observed in the dining room with other residents present, LPN #3 approach Resident #16 with a cup containing oral medications and administered the medications to him while he waited for lunch. On 7/19/26 at 1:17 PM, Resident #16's medical record had not documented his preference to have medications administered in the dining room. On 7/21/26 at 3:35 PM, the CNO stated Resident #16 should not have received medications in the dining room as his medical record had not documented that medications could be administered to him in the dining room. On 7/19/26 at 10:50 AM, observed CNA #1 open and then entered room [ROOM NUMBER] without knocking. On 7/19/26 at 11:20 AM, Resident #60, who resides in room [ROOM NUMBER], stated that sometimes staff don't knock but they just enter her room, and they should knock first. On 7/21/26 at 10:25 AM, the CNO stated staff should be knocking and waiting for a response from residents before entering their room.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Twin Falls Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Eastland Drive Twin Falls, ID 83301	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, staff interview, and policy review it was determined the facility failed to ensure the facility provided call light access within the resident's reach in 2 facility shower stalls. This deficient practice had the potential to cause harm if the resident could not call for assistance when needed or experienced an adverse medical event that required attention. Findings include: The facility's Call Light Response Time policy, revision date 10/15/22, documented 1. Resident Access a. Call light systems are expected to be available, within reach, at the bedside and in toileting and bathing areas. On 7/20/26 at 11:17 AM, observed 100 Hallway shower stall with the call light box mounted on the upper area of the shower stall without a call light string and not within reach of a resident using the shower stall. On 7/20/26 at 11:24 AM, observed 400 Hallway shower stall with the call light box mounted on the upper area of the shower stall without a call light string and not within reach of a resident using the shower stall. On 7/21/26 at 11:57 AM, the CRN stated the showers should have a call light box with strings that are accessible by residents and staff assisting the resident when in the shower stall and did not.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Twin Falls Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Eastland Drive Twin Falls, ID 83301	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a clean, safe, homelike environment. This was true for all residents who resided in the facility whose environment were observed. This deficient practice created the potential for harm if residents were embarrassed by and/or felt the disrepair in the facility was unacceptable, disrespectful, undignified or residents were injured due to unsafe areas in the facility. Findings include: The facility's Homelike Environment policy, revision date 9/17/25, documented under Facility Standards 1.a Maintain a sanitary, orderly, and comfortable interior. The following areas were observed for a clean, homelike environment: On 7/19/26 at 12:25 PM, the vents on the dining room ceiling and the area around the vents were observed with a gray, fuzzy substance. On 7/21/26 at 8:21 AM, observed the vent in the TV room with a gray, fuzzy substance. On 7/21/26 at 8:32 AM, observed the vent in the middle of the 300-hall hallway with a gray, fuzzy substance. On 7/21/26 at 8:57 AM, observed in the medication room cobwebs on the wall above the refrigerators, a gray, fuzzy substance on the vents on the ceiling, and a dry gray substance on the floor. On 7/21/26 at 11:04 AM, the CEO stated the facility did not have a weekly cleaning schedule. The CEO also stated the vents and area around the vents should have been cleaned. Review of the 100-hall and 400-hall Responsibilities form did not include cleaning of the vents on the ceiling. Review of the Environmental Services Checklist: Terminal Cleaning of Patient Rooms form did not document cleaning of the vents. Review of the Housekeeping Checklist: Daily Cleaning of Resident Rooms form did document that the vents were to be dusted. On 7/21/26 at 12:11 PM, the Maintenance Manager stated on Fridays he had an employee that should have cleaned the vents, and he just started working on putting together a cleaning schedule.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Twin Falls Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Eastland Drive Twin Falls, ID 83301	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure resident's care plans were revised to reflect current needs and interventions. This was true for 1 of 21 residents (Resident #52) whose care plans were reviewed. This placed resident at risk of adverse outcomes if care and services were not provided due to care plans not being revised as residents' needs changed. Findings include: The facility's Comprehensive Care Plans and Conference policy, revision date 9/3/25, documented the plan will be created, reviewed, and revised by an interdisciplinary team familiar with the resident's status and care needs, with active involvement from the resident and their representative, when applicable. Updates to the care plan will occur as needed based on the resident's response to interventions or change or change in condition when a resident sustains a fall. Resident #52 was admitted to the facility on [DATE], with multiple diagnoses which include sick sinus syndrome (a heart rhythm disorder) and wedge compression fracture of the fourth lumbar vertebra. On 7/19/26 at 4:16 PM, observed Resident #52 lying in his bed with his oxygen on via nasal cannula. Elbow pads observed on both elbows. Resident #52's Physician's order dated 7/6/26, documented oxygen: 2L/min via Nasal Cannula continuous PRN. Observe resident for signs/symptoms of respiratory distress (e.g., tachypnea, dyspnea, accessory muscle use, cyanosis, unexplained anxiety/agitation) PRN. If concerns noted, alert provider and document in medical record. Resident 52's Physician's order dated 7/14/26, documented wound care to elbows: elbow protectors to be worn at all times, check placement Q shift. Review of Resident #52's medical record documented a CSCD- Skin inspection assessment dated [DATE], documented: Bruising to BUE, Scabs to Bilateral elbows. Elbow protectors to be worn at all times and nurses to check placement Q shift. On 7/19/26 at 4:44 PM, a review of Resident #52's care plan did not have his oxygen use or his elbow pads to elbows documented. On 7/20/26 at 5:00 PM, the CRN stated Resident #52's care plan was updated today but the oxygen and elbow pads should have been on his care plan. On 7/20/26 at 5:11 PM, the CNO stated Resident #52's oxygen and elbow pads were not on his care plan until today and should have been care planned when ordered.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Twin Falls Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Eastland Drive Twin Falls, ID 83301	
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 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 policy review, observation, record review, and interviews, it was determined the facility failed to provide respiratory services as ordered by the physician. This was true for 1 of 1 resident (Resident #60) whose record was reviewed for respiratory services. This failure created the potential for the resident to experience increased fatigue and low oxygen levels. Findings include: The facility's Oxygen Administration, Safety, Storage and Maintenance policy dated 10/10/25, documented the following:- verify provider order prior to initiating/changes oxygen therapy.- supplemental oxygen use is reflected in the Resident's care plan.- monitor oxygen parameters as needed and/or as ordered. Resident #60 was initially admitted to the facility on [DATE], and readmitted to the facility on [DATE], with multiple diagnoses including stroke and chronic respiratory failure with hypoxia (a long-term, progressive inability of the lungs to oxygenate the blood sufficiently). Resident #60's physician oxygen order dated 3/14/26, documented oxygen 3 L/min via Nasal Cannula continuous. Observe resident for signs/symptoms of respiratory distress (e.g., tachypnea, dyspnea, accessory muscle use, cyanosis, unexplained anxiety/agitation) PRN. If concerns noted, alert provider and document in medical record. Resident #60's care plan documented give oxygen as ordered by the physician. On 7/19/26 at 10:50 AM, observed Resident #60 did not have her oxygen cannula on during Hoyer lift transfer and while ADL cares were performed at the sink. When the surveyor questioned CNA #3 about Resident #60's oxygen CNA #3 applied the oxygen cannula to her. On 7/21/26 at 10:30 AM, the CNO stated the CNAs should have had Resident #60 on her oxygen during the Hoyer lift transfer and during ADLs as prescribed by the physician and had not.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Twin Falls Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Eastland Drive Twin Falls, ID 83301	
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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, staff interviews, and the State Operations Manual, Appendix PP it was determined the facility failed to ensure nurse staffing information was accurate and included scheduled and actual hours. This failed practice had the potential to affect all residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include: State Operations Manual, Appendix PP -.the facility posts the following information on a daily basis: facility name, current date, total number and actual hours worked by licensed and unlicensed nursing staff, and resident census. On 7/20/26 at 1:40 PM, the daily posted staffing sheets were reviewed for the months of January 2026 - July 2026, the following was observed: No actual licensed and unlicensed staff hours documented on the sheets for the 7 months reviewed. On 7/21/26 at 11:55 AM, the CRN stated the facility had not documented the actual licensed and unlicensed staff hours on the daily posted staffing sheets and should have.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Twin Falls Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Eastland Drive Twin Falls, ID 83301	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medications available for residents were stored appropriately; this was true for 1 of 21 resident's rooms inspected (Resident #101) and 1 of 1 treatment carts audited. This failure created the potential for adverse effects if residents self-administered medications inappropriately or did not take their medications and created the potential for harm to a resident if they were to obtain medications which were left unattended and unsecured by staff. Findings include: The facility's Self-Administration of Medication policy revision date 9/16/25, documented Residents may self-administer medications when it is determined to be safe and appropriate. The facility will assess each request using a team-based approach that includes input from nursing staff, the resident's physician, and other relevant disciplines. The assessment will consider the resident's ability to manage medication independently and safely, including whether bedside storage is appropriate. Resident #101 was admitted to the facility on [DATE], with multiple diagnoses including urinary tract infection and bacteremia (bacteria in the blood stream). Resident # 101's admission MDS start dated 7/17/26, documented he had a BIMS of 9, meaning he had moderate cognitive impairment. On 7/21/26 at 1:31 PM, observed on Resident #101's bedside table a bottle of Systane (artificial tears) eye drops. On 7/21/26 at 1:37 PM, LPN #2 stated the eye drops should not have been in the room. On 7/21/26 at 2:35 PM, a review of Resident #101's medical record did not document an order for Systane eye drops. On 7/21/26 at 2:38 PM, a review of Resident #101's medical record did not document a self-administration of medication assessment. On 7/19/26 at 9:25 AM, observed an unlocked and unattended treatment cart on the 400 Hall. On 7/19/26 at 10:00 AM, RN # 1 opened the resident's closed room door and came out of a resident's room and stated she forgot to lock the treatment cart door and should have. On 7/21/26 at 10:30 AM, the CNO stated the wound care treatment cart should have been locked when unattended by a licensed nurse and was not.		