STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Covington, The	1600 E Liberty St Covington, IN 47932

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. A. Based on observation, record review, and interview, the facility failed to ensure the kitchen dish machine temperature and sanitation logs, and the refrigeration temperature logs were maintained, and failed to ensure the paper towels at the kitchen handwash sink were maintained in a sanitary manner, for 1 of 3 kitchen observations. This deficient practice had the potential to affect 81 of 81 residents residing at the facility. B. Based on observation, interview, and record review, the facility failed to ensure resident hall trays were delivered in a sanitary manner for 1 of 1 meal service observation. Findings include:A. During the initial kitchen observation, on 12/9/25 at 9:55 a.m., the following was observed: 1. The November and December 2025 dish machine temperature and sanitation logs lacked documentation as follows: a. The November 2025 logs lacked documentation that the rinse temperature and sanitation readings were completed for the breakfast and lunch meals on 11/1/25, 11/6/25, 11/7/25, 11/11/25, 11/15/26, 11/16/25, 11/19/25, 11/20/25, 11/24/25, 11/25/25, 11/28/25, 11/29/25, and 11/30/25. b. The December 2025 logs, from 12/1/25 through 12/9/25, lacked documentation that the rinse temperature and sanitation readings were completed for the breakfast and lunch meals on 12/1/25, 12/4/25, 12/5/25, and 12/8/25. Both monthly logs reviewed lacked documentation of the wash temperature and all readings for all of the dinner meals for the entire month. 2. Temperature logs for the refrigeration appliances lacked documentation as follows: a. No December 2025 temperature logs were observed for the stand-up refrigerator. b. The December 2025 temperature logs for the stand-up freezer lacked documentation for the evening reading on 12/2/25, the morning reading for 12/4/25, no reading for the day of 12/5/25, the morning reading for 12/7/25, and no reading for the day of 12/8/25. c. No temperature logs were observed for the walk-in refrigerator. d. No temperature logs were observed for the walk-in freezer. During an interview, on 12/9/25 at 10:20 a.m., Dietary Aide 5 indicated she usually completed the temperature logs for the refrigerators and freezers at the end of her shift. She had not completed any of the readings yet on this date. She did not know where the logs were for the stand-up refrigerator, the walk-in refrigerator or the walk-in freezer. 3. The towel dispenser by the hand wash sink was empty. A roll of towels was sitting on table next to the hand wash sink. The roll had visible wet finger marks on towels. At the same time, [NAME] 3 indicated the towel dispenser was not working and had been out for some time. During an interview, on 12/11/25 at 1:47 p.m., the Regional Director of Operations indicated the policy was that temperatures for all refrigeration and the dish machine should be completed each shift. The logs should be kept current daily. During an interview, on 12/12/25 at 3:25 p.m., the Administrator indicated the paper towels should be inside the unit to ensure they were kept clean when not in use. The situation that was found in the kitchen would be considered an infection control risk. On 12/12/25 at 3:21 p.m., the Administrator provided an undated document, titled, Freezer/Refrigeration Temperature Record, and indicated it was the policy currently being used by the facility. The policy indicated, Policy: Temperatures shall be monitored in aal refrigeration and freezer equipment.Procedure: .2. The internal temperature of each piece of refrigeration and freezer equipment shall be recorded twice daily at minimum. The initials of the.employee conducting the temperature checks shall also be recorded on the log.3. The Director of Food and Nutrition Services or (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	designee shall be responsible for posting the logs in the department. On 12/12/25 at 3:21 p.m., the Administrator provided an undated policy, titled, Handwashing, and indicated it was the policy currently being used by the facility. The policy indicated, Policy: .Hand washing facilities will be.equipped with.paper towels. On 12/11/25 at 2:32 p.m., the Regional Nurse Consultant provided a document, with a revision date of November 2022, titled, Food Preparation and Service, and indicated it was the policy currently in use by the facility. The policy indicated, .General Guidelines.3.staff shall adhere to proper hygiene and sanitary practices.Food Preparation Area.4. Appropriate measures are used to prevent cross contamination. B. During observation of meal service on,12/9/25 at 12:31 p.m., Licensed Practical Nurse (LPN) 12 was observed serving hall trays to residents. She was observed touching the outside of the tray cart and delivering and cutting up resident food. No hand sanitation was observed during the tray pass process. On 12/9/25 at 12:49 p.m., LPN 12 was observed to assist a Certified Nurse Assistant (CNA) to pull a resident up in bed. The LPN then washed her hands for less than 20 seconds before continuing to serve meal trays to residents. During an interview, on 12/11/25 at 2:23 p.m., the Director of Nursing (DON) indicated the nurse should have sanitized her hands between serving residents their meal trays. On 12/11/25 at 2:32 p.m., the Regional Nurse Consultant provided a document, with a revision date of November 2022, titled, Food Preparation and Service, and indicated it was the policy currently in use by the facility. The policy indicated, .General Guidelines.3.staff shall adhere to proper hygiene and sanitary practices.Food Distribution and Service.5. Food and Nutrition services staff, including nursing services personnel, wash their hands before serving food to residents.prior to handling food trays. 3.1-(i)(3)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to follow antibiotic stewardship protocol program. This deficient practice had the potential to affect 81 of 81 residents residing at the facility. Findings include:On 12/12/25 at 1:30 p.m., review of the facility infection control program with the Infection Prevention Nurse (IP) indicated, the documentation lacked evidence of antibiotic stewardship tracking and trending. The program lacked documentation of education regarding any trending infections or prevention.12/12/25 at 1:45 p.m., during an interview the IP nurse, he indicated he had been tracking antibiotic stewardship once but had not continued.Review of the Centers for Disease Control and Prevention (CDC) webpage, The Core Elements of Antibiotic Stewardship, accessed online at: https://www.cdc.gov/antibiotic-use/hcp/core-elements/ . Improving antibiotic prescribing and use is critical to effectively treat infections, protect patients from harms caused by unnecessary antibiotic use, and combat antibiotic resistance.On 12/12/25 at 2:00 p.m., the Director of Nursing (DON)provided a document, titled, Antibiotic Stewardship, dated 3/14/23, and indicated it was the policy currently being used by the facility. The policy indicated, .Accountability.2. The Infection Preventionist monitors antibiotic utilization and discusses opportunities for improvement.Tracking.1. The Infection Preventionist/designee(s).a. Reviews culture and sensitivity reports routinely as part of the surveillance of the infection. b. Tracks how often and how many antibiotics are prescribed. C. Tracks how and why antibiotics are prescribed.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure informed consent was obtained for the administration of psychotropic medications (drugs that affect the brain's chemical makeup to treat mental and emotional disorders), for 5 of 5 resident reviewed for unnecessary medications (Residents 53, 11, 10, 74, and 47). Findings include:1. Resident 53's record was reviewed on 12/10/25 at 1:55 p.m. The profile indicated the resident had been admitted to the facility on [DATE]. The resident was discharged from the facility on 12/10/25. The profile indicated the resident's diagnoses included, but were not limited to, major depressive disorder (a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in activities, significantly impacting daily life for at least two weeks) and unspecified psychosis (a diagnosis used when someone has psychotic symptoms but there's not enough information for a specific diagnosis). A quarterly Minimum Data Set (MDS) assessment, dated 10/30/25, indicated the resident had moderate cognitive deficit and received antipsychotic medication (used to treat psychosis) and antidepressant medications (used to treat depression). A physician's order, dated 3/28/25 and discontinued on 8/7/25, indicated to administer one 30 milligram (mg) capsule of duloxetine hydrochloride (HCl) (antidepressant medication) along with one 60 mg capsule, to equal 90 mg, at bedtime, related to major depressive disorder. A physician's order, dated 8/7/25 and discontinued on 8/14/25, indicated to administer one 60 mg capsule of duloxetine HCl along with one 30 mg capsule, to equal 90 mg for depression for 1 week. A physician's order, dated 8/8/25 and discontinued on 12/10/25, indicated to administer a 10 mg tablet of Lexapro (antidepressant medication), one time daily for depression. A physician's order, dated 8/15/25 and discontinued of 8/22/25, indicated to administer a 30 mg capsule of duloxetine, at bedtime for depression for 7 days. A document, dated 4/1/25 through 4/15/25, titled, Recommendation to Nursing, indicated the resident was taking psychotropic medications and no informed consent was found in the resident record for the following Psychotropic medications: duloxetine. The record lacked documentation of informed consents for the antidepressant medications when they were initiated or increased. A physician's order, dated 5/22/25 and discontinued on 6/5/25, indicated to administer one 3 milligram (mg) tablet of Invega (antipsychotic medication), at bedtime for unspecified psychosis. A physician's order, dated 6/5/25 and discontinued on 6/18/25, indicated to administer two 3 mg tablets of Invega at bedtime for psychosis. A physician's order, dated 6/18/25 and discontinued on 10/23/25, indicated to administer one 3 mg tablet of Invega, at bedtime for psychosis. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated 10/23/25, and discontinued on 11/6/25, indicated to administer one 2.5 mg tablet of olanzapine (antipsychotic medication), one time in the evening for psychosis. The record lacked documentation of informed consents for the antidepressant medications when they were initiated or increased. 2. Resident 11's record was reviewed on 12/11/25 at 11:27 a.m. The profile indicated the resident was admitted to the facility on [DATE]. The profile indicated the resident's diagnoses included, but were not limited to, unspecified mood disorder (a diagnosis for significant mood problems that cause distress but don't fully meet criteria for a specific disorder) and bipolar disorder (a mental health condition causing extreme mood swings, shifting between emotional highs and lows, affecting energy, activity levels, sleep, judgment, and daily functioning, with periods of normal mood in between). A quarterly Minimum Data Set (MDS) assessment, dated 11/11/25, indicated the resident had no cognitive deficit and received antipsychotic (medications used to treat symptoms of bipolar disorder) and antidepressants (medications to treat depression). A physician's order, dated 1/24/25, indicated to administer a 20 milligram (mg) tablet of fluoxetine hydrochloride (HCl) (antidepressant medication), one time daily for depression. The record lacked documentation of informed consent for the antidepressant medication. A physician's order, dated 3/28/25 and discontinued on 8/28/25, indicated to administer 100 mg tablet of quetiapine (antipsychotic medication), at bedtime related to bipolar disorder. A physician's order, dated 8/28/25 indicated to administer 150 mg of quetiapine, every evening for bipolar disorder. The record lacked documentation of informed consent for the initiation and/or increase of the antipsychotic medication. 3. Resident 10's record was reviewed on 12/10/25 at 1:35 p.m. Census information indicated the resident was admitted to the facility on [DATE]. Diagnoses on the resident's profile included, but were not limited to, insomnia (difficulty sleeping) and mania (abnormally elevated, extreme changes in mood). A quarterly Minimum Data Set (MDS) assessment, dated 9/26/25, indicated the resident had a moderate cognitive impairment and received an antidepressant and anticonvulsant during the look back period. A physician's order, dated 6/23/25, indicated administer trazodone (antidepressant sometimes used for insomnia) 50 milligrams (mg) daily at bedtime for insomnia. A physician's order, dated 7/31/25 and discontinued on 11/25/25, indicated administer divalproex sodium (anticonvulsant sometimes used as a mood stabilizer) extended release (ER) 500 mg by mouth twice daily for mania. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The electronic record lacked documentation informed consent was obtained when the trazodone and divalproex sodium were initiated. During an interview, on 12/10/25 at 2:20 p.m., the Director of Nursing (DON) indicated some of the informed consents for psychotropic medications had not been completed. Informed consents should have been obtained when psychotropic medications were initiated or increased. 4. On 10/10/25 at 2:00 p.m., the medical record of Resident 74 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included but was not limited to dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), Chronic Obstructive Pulmonary Disease, (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). The record indicated that a psychotropic medication had been ordered by the physician and a consent to administer the medication had not been obtained from the responsible party. An annual Minimum Data (MDS) assessment, dated 9/11/25, indicated the resident received anti-depressant medication. The medical record indicated the resident was administered Zoloft 25 mg (milligrams) from 1/3/25 to 3/20/25, Zoloft 50 mg from 3/20/25 to 8/7/25, and Zoloft 100 mg from 8/7/25 to 10/23/25. A physician order, dated 10/23/25, indicated to administer Cymbalta Oral Capsule Delayed Release Particles 30 mg (Duloxetine HCl) once daily at bedtime for depression. A physician order, dated 5/10/25, indicated to administer Donepezil HCl oral Tablet 10 mg (Donepezil Hydrochloride) give 1 tablet by mouth in the evening related to unspecified dementia. A pharmacy recommendation, dated 4/15/25, indicated, The resident is currently taking psychotropic medications. No informed consent found in the chart for the following medications: Sertraline. On 12/10/25 at 11:30 a.m., during an interview, the Director of Nursing (DON) indicated the resident's record did not have consents for psychotropic medications. 5. Resident 47's record was reviewed on 12/10/25 at 1:43 p.m. The profile indicated the resident's diagnoses included, but were not limited to, manic episode, severe, without psychotic symptoms (intense euphoria/irritability, high energy, racing thoughts, pressured speech, little sleep, and impulsive/reckless behavior (like spending sprees or risky sex) that significantly impairs functioning, but without hallucinations or delusions), depression (a serious mood disorder causing persistent sadness, loss of interest, and affecting how you think, feel, and live, impacting daily activities, sleep, appetite, and energy), and vascular dementia (a decline in thinking skills from reduced blood flow to the brain, often after strokes or from chronic conditions like high blood pressure, causing issues with memory, planning, judgement, and concentration). Facility census information indicated Resident 47 was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated 9/23/25, indicated the resident had severe cognitive impairment and received anti-psychotic medication during the look back period. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 7/3/25, indicated to administer Seroquel (anti-psychotic medication) 50 mg (milligram) by mouth at bedtime for manic episodes. A physician order, dated 5/29/25 and discontinued on 7/3/25, indicated to administer Seroquel 50 mg by mouth at bedtime for behavioral disturbance. A physician order, dated 1/24/25 and discontinued on 5/29/25, indicated to administer Seroquel 75 mg by mouth at bedtime for behavioral disturbance. A pharmacy recommendation to nursing, dated 4/15/25, indicated Resident 47 received a psychotropic medication and no informed consent was found in the chart for Seroquel. The electronic record lacked documentation of a psychotropic informed consent was obtained for the use of the Seroquel medication. During an interview on 12/20/25 at 2:32 p.m., the Director of Nursing (DON) indicated they had discovered that the facility had not completed all the psychotropic medication informed consents since the new regulation was initiated, and they would make sure they are completed as soon as possible. On 12/20/25 at 3:15 p.m., the Regional Nurse Consultant provided a document with a revised date of February 2025, titled, Psychotropic Medication Use, and indicated it was the policy currently being used by the facility. The policy indicated, .1. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal; a. non-pharmacological alternatives; b. the indications and rationale for recommendation; c. the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings); and d. the resident's/representative right to accept or decline the treatment. 3.1-3(n)(2) 3.1-3(n)(3)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on record review and interviews the facility failed to offer snacks to residents in the evening for 5 of 5 residents reviewed for snacks at bedtime (Residents 27, 28, 42, 87, and 91). Findings include:On 12/11/25 at 2:00 p.m., during resident council meeting the residents indicated they did not receive bedtime snacks and indicated they had a diagnosis of diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high). Review of the medical record of Residents 91, 28, 42, and 87 indicated each resident had a diagnosis of diabetes. On 12/11/25 at 2:15 p.m., during an interview the Administrator indicated the residents should be served snacks daily.On 12/11/25 at 2:23 p.m., during an interview the Director of Nursing (DON) indicated all residents should be offered a snack in the evenings especially the diabetic residents to maintain blood sugar levels through the night. On 12/11/25 during an interview Registered Nurse (RN) 11 indicated snacks were inconsistent. At times they had to go out and buy them for the residents. She indicated snacks should come out every evening. There had been times when they were told the facility did not have them.Review of the Residents medical records indicated Resident 91 had a diagnosis of diabetes. The task report (a daily record of meal and snack intake) indicated the resident had received a bedtime snack 6 times in the last 30 days.The task report of Resident 27 indicated the resident had received a bedtime snack 7 times in the last 30 days.The task report of Resident 28 indicated the resident had received a bedtime snack 5 times in the last 30 days.The task report of Resident 42 indicated the resident had received a bedtime snack 5 times in the last 30 days.The task report of Resident 87 indicated the resident had received a bedtime snack 4 times in the last 30 days.The task report of Resident 91 indicated the resident had received a bedtime snack 9 times in the last 30 days.On 12/11/25 at 2:42 p.m., the Director of Nursing (DON) provided an undated document, titled, Food and Nutrition Services, and indicated it was the policy currently being used by the facility. The policy indicated, .10. Nourishing snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snacks may be scheduled between meals to accommodate the resident's typical eating patterns.3.1-21(e)

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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. A. Based on observation, record review, and interview, the facility failed to ensure a catheter (tube inserted into the bladder to drain urine) bag did not come in contact with an unclean surface for 1 of 1 residents reviewed for catheters (Resident 10). B. Based on observation, interview, and record review, the facility failed to ensure hand hygiene was performed during the medication pass for 4 of 4 residents reviewed on the medication pass (Residents 92, 93, 96, and 39). Findings include: A. On 12/9/25 at 11:13 a.m., Resident 10 was observed lying in bed. The resident's catheter draining bag was hanging from the side of the bed and was resting on the bottom leg bar of the bedside table. On 12/11/25 at 9:40 a.m., Resident 10 was observed lying in bed. The resident's catheter draining bag was hanging from the side of the bed and was resting on the bottom leg bar of the bedside table. Resident 10's record was reviewed on 12/10/25 at 1:35 p.m. Diagnoses on the resident's profile included, but were not limited to, vascular dementia (a decline in thinking skills caused by conditions that damage blood vessels, restricting blood flow and oxygen to the brain, often after strokes or mini-strokes) and retention of urine. A quarterly Minimum Data Set (MDS) assessment, dated 9/26/25, indicated the resident had a moderate cognitive impairment and an indwelling urinary catheter. A care plan, initiated on 7/9/25, indicated the resident had an indwelling urinary catheter. A physician's order, dated 7/16/25, indicated the resident had a urinary catheter, and it was to be changed every 30 days and as needed. During an interview, on 12/11/25 at 1:56 p.m., the Regional Nurse Consultant indicated the resident's catheter bag should not have been in contact with the bedside table leg. Catheter bags should not have been in contact with areas not considered clean. On 12/11/25 at 2:19 p.m., the Director of Nursing (DON) provided a document titled, Catheter Care, Urinary, last revised in August 2022, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Preparation.Infection Control.2. Be sure the catheter tubing and drainage bag are kept off the floor. B. During a continuous medication pass observation, on 12/12/25 from 11:47 a.m. to 11:58 a.m., the following was observed: Registered Nurse (RN) 15 prepared and administered medication to Resident 92. The nurse pulled up his scrub pants on 2 different occasions while in the resident room along with wiping his forehead. RN 15 did not perform hand hygiene before or after administering the resident their medication. The RN returned to the medication cart and prepared medication for Resident 93. He went into the resident's room and administered the resident their medication. The nurse pulled up his scrub pants twice, wiped his forehead, and under his nose. While the RN was walking down the hallway he took hand sanitizer out of his pocket for his hands and used it. The RN returned to the medication cart and prepared medication for Resident 96. The nurse went into (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's room to administer their medication and while waiting for the resident to take their medication he pulled up his scrub pants and wiped his mustache. RN 15 did not perform hand hygiene after administering the resident their medication. The RN returned to the medication cart and prepared medication for Resident 39, while he was obtaining the medication from the cart, he pulled up his scrub pants. RN 15 proceeded to the resident's room to administer the medication and no hand hygiene was performed before or after the administration of the resident's medication. During an interview, on 12/12/25 at 3:04 p.m., the Regional Nurse Consultant indicated that it was the expectation of the facility that staff would perform hand hygiene before and after administering medication to each individual resident. On 12/15/25 at 9:55 a.m., the Administrator provided an undated document, titled, Administering Medications, and indicated it was the policy currently being used by the facility. The policy indicated, . 25. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. 3.1-18(a)

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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 interview, the facility failed to ensure the physician signed and dated a pharmacy recommendation for psychotropic medications, failed to ensure behavior documentation was available to justify an increase in psychotropic medication dosage, and failed to ensure documentation to justify the declination of psychotropic medication dosage reductions for 3 of 5 residents reviewed for unnecessary medications (Residents 53, 11, and 10). Findings include:1. Resident 53's record was reviewed on 12/10/25 at 1:55 p.m. The profile indicated the resident's diagnoses included, but were not limited to, major depressive disorder (a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in activities, significantly impacting daily life for at least two weeks). A quarterly Minimum Data Set (MDS) assessment, dated 10/30/25, indicated the resident had moderate cognitive deficit and received antidepressant medications (used to treat depression). A pharmacy recommendation, with a printed date of 3/21/25, indicated to consider a dose reduction of the resident's duloxetine (antidepressant medication) from the current administered dose of 60 milligrams (mg) at bedtime to 40 mg at bedtime, for major depressive disorder. The document indicated the recommendation had been marked as declined. A handwritten note on the document, signed by the psychologist, indicated the resident was actively depressed and hurting and recommended the duloxetine be increased to 90 mg at bedtime. A physician's order, dated 3/28/25, indicated to administer one 30 milligram (mg) capsule of duloxetine hydrochloride (HCl) (antidepressant medication) along with one 60 mg capsule, to equal 90 mg, at bedtime, related to major depressive disorder. The pharmacy recommendation lacked a signature and date of review by the attending physician. 2. Resident 11's record was reviewed on 12/11/25 at 11:27 a.m. The profile indicated the resident's diagnoses included, but were not limited to, bipolar disorder (a mental health condition causing extreme mood swings, shifting between emotional highs and lows, affecting energy, activity levels, sleep, judgment, and daily functioning, with periods of normal mood in between). A quarterly Minimum Data Set (MDS) assessment, dated 11/11/25, indicated the resident had no cognitive deficit and received antipsychotic medication (used to treat symptoms of bipolar disorder). A pharmacy recommendation, with a printed date of 8/25/25, indicated the resident was due for a trail dose reduction of her order for Seroquel (antipsychotic medication) 100 milligrams (mg) at bedtime for bipolar disorder. The document indicated the physician had marked the recommendation had been declined. A handwritten note on the document, signed by the psychologist, indicated the resident's mood was not great and to increase the Seroquel to 150 mg at bedtime. The recommendation was signed and dated by the physician on 8/28/25. A physician's order, dated 8/28/25, indicated to administer 150 mg of quetiapine, every evening for bipolar disorder. A Medication Administration Record (MAR), dated July and August 2025, indicated the resident was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitored every shift for behaviors including, but not limited to, depression and withdrawal, insomnia, refusal of care, and falsely accusing staff. Each shift indicated the resident had no behavior documented. The record lacked any psychologist visit notes from 3/27/25 to 10/2/25, or any other documentation of behavior concerns by the resident. During an interview, on 12/12/25 at 11:46 a.m., the Regional Nurse Consultant indicated they had reached out to the psychologist for any notes to justify the increase in the resident's Seroquel. He had indicated he could not provide any further documentation. 3. Resident 10's record was reviewed on 12/10/25 at 1:35 p.m. Census information indicated the resident was admitted to the facility on [DATE]. Diagnoses on the resident's profile included, but were not limited to, insomnia (difficulty sleeping) and mania (abnormally elevated, extreme changes in mood). A quarterly Minimum Data Set (MDS) assessment, dated 9/26/25, indicated the resident had a moderate cognitive impairment and received an antidepressant and anticonvulsant during the look back period. A physician's order, dated 6/23/25, indicated administer trazodone (antidepressant sometimes used for insomnia) 50 milligrams (mg) daily at bedtime for insomnia. A physician's order, dated 7/31/25 and discontinued on 11/25/25, indicated administer divalproex sodium (anticonvulsant sometimes used as a mood stabilizer) extended release (ER) 500 mg by mouth twice daily for mania. A gradual dose reduction (GDR) request from the pharmacist was dated 10/27/25. The request indicated the resident received divalproex sodium 500 mg twice daily and requested the medication be decreased to 375 mg twice daily. The psychologist wrote on the form not to reduce the medication. A nurse wrote on the form, Declined per [physician's name] as recommended by [psychologist's name]. The physician did not document a justification for the GDR declination or sign the form. A Medication Administration Record (MAR), dated November 2025, indicated the resident was monitored every shift for behaviors including physical aggression, agitation, mania, anxiety, resisting care, refusing to change clothes, refusing treatments, and sleeplessness. Each shift indicated the resident had no behaviors. A document titled, Behavior Meeting, was dated 11/21/25. The document indicated the resident was reviewed and increase Depakote [divalproex sodium] 500 mg TID [three times daily]. The behavior meeting lacked documentation of why the divalproex sodium was increased, including what behaviors the resident exhibited. A physician's order, dated 11/25/25, indicated administer divalproex sodium delayed release 500 mg by mouth three times daily for mania. A progress note, dated 11/25/25, indicated the resident was reviewed in the behavior meeting with a recommendation to increase the divalproex sodium to three times daily for mania. The note lacked (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation of why the divalproex sodium was increased, including what behaviors the resident exhibited. A MAR, dated December 2025, indicated the resident was monitored every shift for behaviors including physical aggression, agitation, mania, anxiety, resisting care, refusing to change clothes, refusing treatments, and sleeplessness. Each shift indicated the resident had no behaviors. During an interview, on 12/11/25 at 10:36 a.m., the Regional Nurse Consultant indicated the resident's physician normally agreed with the psychologist regarding GDR requests, but the physician did not always document or sign the forms. During an interview, on 12/11/25 at 11:12 a.m., the Regional Nurse Consultant indicated the resident was reviewed in the behavior meeting, and the medication was increased. She was unable to find any documentation of the resident's behaviors. Behaviors should have been monitored and documented on the MAR. During an interview, on 12/11/25 at 11:34 a.m., Psychologist 14 indicated the resident's medication was increased because his mood was becoming accelerated and falls had increased. The behaviors should have been documented by the facility staff, but sometimes there were issues with documentation. On 12/11/25 at 11:12 a.m., the Regional Nurse Consultant provided a document titled, Tapering Medications and Gradual Dose Reduction, last revised April 2025, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Statement.2 Residents who use psychotropic medications received gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these medications. Policy Interpretation and Implementation: 1. Gradual Dose Reduction (GDR) refers to the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed at a lower dose or if a medication can be discontinued.Documentation – Gradual Dose Reduction: 1. Gradual dose reduction attempts are documented in the medical record. The documentation includes.2. Physician documentation contains the rationale for why GDR attempts are clinically contraindicated for the resident. On 12/11/25 at 11:29 a.m., the Regional Nurse Consultant provided a document titled, Psychotropic Medication Use, last revised February 2025, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Statement: Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Policy Interpretation and Implementation: 1. Psychotropic medication is any medication that affects brain activity associated with mental processes and behavior.Behavioral and Other Non-Pharmacological Interventions: 1. Behavioral and other non-pharmacological approaches are used (unless contraindicated) to minimize or eradicate the need for medications, permit the lowest possible dose if indicated, and support efforts at gradual dose reduction.Adequate Indications for Psychotropic Medication Use.3. The clinical rationale for the use of psychotropic medication, or a change from one type of psychotropic to another, is documented in the medical record. a. Documentation must include that behavioral (non-pharmacological) interventions were attempted but not successful, and these interventions were deemed clinically contraindicated. b. Alternatively, documentation from a physician must describe that alternative treatments are clinically contraindicated and the rationale for this conclusion. 3.1-48(b)(2)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a notice of transfer or discharge and bed hold policy was provided to the resident who was transferred to the hospital for 1 of 2 residents reviewed for hospitalization (Resident 12). Findings include:Resident 12's record was reviewed on 12/12/25 at 10:21 a.m. Census information indicated the resident was hospitalized from [DATE] to 10/10/25. A significant change Minimum Data Set (MDS) assessment, dated 9/3/25, indicated the resident was cognitively intact. A progress note, dated 10/6/25 at 3:40 a.m., indicated the resident was found sitting on the floor in his room. The resident denied pain and was assisted back to the chair. A progress note, dated 10/6/25 at 3:13 p.m., indicated the resident complained of pain to the right hip, and an x-ray was ordered by the physician. A progress note, dated 10/6/25 at 9:02 p.m., indicated the facility received the x-ray results and, and an order was received to send the resident to the emergency room (ER). A report was called to the ER. A progress note, dated 10:19 p.m., indicated the resident left in an ambulance for the treatment of a fractured right hip related to a fall. A progress note, dated 10/10/25, indicated the resident returned to the facility. Progress notes lacked documentation a notice of transfer or discharge and a bed hold policy was provided when the resident was transferred to the hospital. The electronic record lacked documentation a notice of transfer or discharge or bed hold policy was provided with the hospitalization on 10/6/25. During an interview, on 12/12/25 at 1:33 p.m., the Regional Nurse Consultant indicated when a resident was transferred to the hospital a packet should have been sent with them which included the notice of transfer or discharge and the bed hold policy. On 12/12/25 at 1:30 p.m., the Regional Nurse Consultant provided a document titled, Transfer or Discharge, Emergency Acute Care, last revised in April 2025, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Statement: Residents transferred to an acute care setting for emergency treatment are provided with a notice of transfer and are permitted to return to the facility. Policy Interpretation and Implementation.2. When a resident is temporarily transferred to an acute care facility, a notice of transfer is provided to the resident and resident representative as soon as practicable before the transfer.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) (screening assessment to determine if a resident has a serious mental illness) was completed accurately for 1 of 2 residents reviewed for PASRR (Resident 2). Findings include:Resident 2's record was reviewed on 12/11/25 at 10:47 a.m. Census information indicated the resident was admitted to the facility on [DATE]. Diagnoses on the resident's profile included, but were not limited to, unspecified dementia (general term for a decline in cognitive function severe enough to interfere with daily life, affecting memory, thinking, and social abilities) of unspecified severity with other behavioral disturbance and unspecified psychosis (disconnection from reality with false beliefs and experiencing things that are not real) not due to a substance or known physiological condition. A Notice of PASRR Level I (screening required for all residents entering a long-term care facility to determine if there is a serious mental illness present) Screen Outcome, dated 12/14/24, indicated the resident did not require a level II PASRR (a comprehensive evaluation process for individuals identified as having serious mental illness or intellectual disabilities when applying for admission to a long-term care facility) assessment because there was no serious mental illness found on the level I PASRR assessment. The attached assessment lacked documentation of the resident's diagnosis of psychosis. A comprehensive Minimum Data Set (MDS) assessment, dated 9/42/25, indicated the resident was not considered by the state to be a level II PASRR but had a diagnosis of psychotic disorder other than schizophrenia (a serious mental health disorder that affects how a person thinks, feels, and behaves, often leading to a distorted perception of reality). During an interview, the Social Services Director (SSD) indicated she was not sure why the psychosis diagnosis was not included on the resident's Level I PASRR. On 12/11/25 at 1:23 p.m., the SSD provided a document titled, PASRR Completion Policy, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Statement: The Center will make sure that all admissions have the appropriate Patient Assessment and Resident Review (PASRR) completed. Practice Guidelines: 1. Center Administrator will designate either the Admissions Director or Social Worker to make sure that the PASSRR [sic] and/or Level of Care (LOC) is done on all potential residents. If the referral indicates anything which might constitute an SMI [serious mental illness] or ID [intellectual disability], the PASRR must be completed prior to admission. If the resident is deemed ?hospital exempted' that must be clearly documented in the transfer documents prior to admission from the acute care facility. 3.1-16(d)(1)(A)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents were provided assistance with activities of daily living (ADLs) to ensure good hygiene for 3 of 4 residents reviewed for ADLs (Residents 10, 2, and 90). Findings include: 1. On 12/9/25 at 11:12 a.m., Resident 10 was observed lying in bed with untrimmed facial hair and long untrimmed fingernails with dark debris underneath them. On 12/9/25 at 9:40 a.m., Resident 10 was observed lying in bed with untrimmed facial hair and long untrimmed fingernails with dark debris underneath them. Resident 10's record was reviewed on 12/10/25 at 1:35 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 9/26/25, indicated the resident had a moderate cognitive impairment, required substantial/maximal assistance from staff with personal hygiene, had a diagnosis of moderate vascular dementia (a type of dementia caused by reduced blood flow to the brain, leading to cognitive impairment and memory loss), and indicated the resident had no behaviors including rejection of care. A care plan, initiated on 6/24/25, indicated the resident required staff assistance with ADLs related to impaired cognition and poor activity endurance. The shower/bathing task document in the electronic record indicated the resident had not refused showering or bathing in the last 30 days. Progress notes, dated November and December 2025, lacked documentation the resident was offered or refused shaving and nail care. Shower sheets indicated the resident received a shower on 11/8/25, 11/12/25, 11/19/25, 11/22/25, and 12/7/25. The documents lacked documentation the nail care or shaving was offered or refused with the showers. During an interview, on 12/11/25 at 10:55 a.m., the Regional Nurse Consultant indicated nail care and shaving should have been provided with showers and as needed. 2. On 12/9/25 at 11:26 a.m., Resident 2 was observed with untrimmed facial hair growth. At the same time, he indicated he wanted to have a mustache but wanted the rest of the facial hair shaved every day. The resident indicated he was shaved last about a week ago. On 12/11/25 at 1:30 p.m., Resident 2 was observed lying in bed with untrimmed facial hair growth on his face. At the same time, the resident indicated he had not been shaved for six days. The resident indicated he wanted to keep the mustache but wanted the rest of his face shaved at least every other day. Resident 2's record was reviewed on 12/11/25 at 10:47 a.m. A comprehensive Minimum Data Set (MDS) assessment, dated 9/4/25, indicated the resident was cognitively intact, had a diagnosis of unspecified dementia (a decline in cognitive function severe enough to interfere with daily life, affecting memory, thinking, and social abilities), and had no behaviors including rejection of care. A care plan, last revised on 10/15/25, indicated the resident required assistance with ADLs related to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weakness. Progress notes, dated 11/11/25 to current, lacked documentation the resident was offered or refused shaving. The shower/bathing task document in the electronic record indicated the resident had not refused showering or bathing in the last 30 days. Shower sheets indicated the resident received a shower on 11/18/25 and 12/2/25. The documents lacked documentation the resident was offered or refused shaving with the showers. During an interview, on 12/11/25 at 10:55 a.m., the Regional Nurse Consultant indicated shaving should have been provided with showers and as needed. On 12/11/25 at 1:54 p.m., the Regional Nurse Consultant provided a document titled, Shaving the Resident, last revised in February 2018, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: The purpose of this procedure is to promote cleanliness and to provide skin care.Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed.4. Any problems or complaints made by the resident related to the procedure. 5. If the resident refused the treatment, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data. Reporting: 1. Notify the supervisor if the resident refuses the procedure. 3. On 12/10/2025 9:13 a.m., during initial observation noted Resident 90 had brown debris caked under fingernails. On 12/11/25 at 11:28 a.m., the medical record of Resident 90 was reviewed. The resident was admitted to the facility on [DATE], admission diagnosis included but were not limited to, chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), and congestive heart failure (CHF) (a condition that develops when your heart doesn't pump enough blood for your body's needs). An admission Minimum Data Set (MDS) assessment, dated 10/31/25, indicated the resident had limited cognition and she was dependent for upper body assistance and showers. A care plan, dated 10/27/25, indicated the resident required staff to assist with activities of daily living due to poor activity endurance. Interventions included but were not limited to, bathe per resident preference 2 times week and as needed, set up and assist with shower 2 times week and as needed. On 12/11/25 at 10:30 a.m., during general observation and interview noted the resident still had caked on debris under her nails. She indicated she did receive showers sometimes and she guessed she should clean her nails. On 12/11/25 at 10:35 a.m., during an interview Certified Nurse Aide (CNA) 8 indicated the residents were provided a shower two three times per week and indicated the staff should clean the residents nails when providing showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/25 at 10:45 a.m., during an interview Registered Nurse (RN) 6 indicated the residents should have nails cleaned on shower days and as needed. Shower records reviewed and indicated the resident was provided 4 showers from 11/1/25 to 11/30/25 and no showers were provided from 12/1/25 to 12/11/25. On 12/15/25 at 12:34 p.m., the Director of Nursing (DON) provided an undated document, titled, Bath, Shower, Tub, and indicated it was the policy currently being used by the facility. The policy indicated, .Documentation 1. The date and time the shower/tub bath was performed.5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. On 12/11/25 at 11:16 a.m., the Director of Nursing (DON) provided an undated document, titled, Fingernails/Toenails, Care of, and indicated it was the policy currently being used by the facility. The policy indicated, .General guidelines.1. Nail care includes daily cleaning and regular trimming. 3.1-38(a)(3)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a pharmacy recommendation was implemented as requested and approved by physician for 1 of 5 residents reviewed for unnecessary medications (Resident 47). Findings include: Resident 47's record was reviewed on 12/10/25 at 1:43 p.m. The profile indicated the resident's diagnoses included, but were not limited to, manic episode, severe, without psychotic symptoms (intense euphoria/irritability, high energy, racing thoughts, pressured speech, little sleep, and impulsive/reckless behavior (like spending sprees or risky sex) that significantly impairs functioning, but without hallucinations or delusions), depression (a serious mood disorder causing persistent sadness, loss of interest, and affecting how you think, feel, and live, impacting daily activities, sleep, appetite, and energy), and vascular dementia (a decline in thinking skills from reduced blood flow to the brain, often after strokes or from chronic conditions like high blood pressure, causing issues with memory, planning, judgement, and concentration). Facility census information indicated Resident 47 was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated 9/23/25, indicated the resident had severe cognitive impairment and received anti-psychotic and diuretic medication during the look back period. Review of pharmacy recommendation, dated 6/24/25, indicated Resident 47 received medications that should have routine laboratory monitoring. Please indicate one or [NAME] of the following: CBC (complete blood count), Vitamin D and CMP (complete metabolic panel) now and every 6 months. TSH (thyroid stimulating hormone), LFT's (liver function test), A1C (measures average blood sugar levels), Lipid Panel (test that measures lipid (fats) in your blood) now and every 6 months, Ferritin (protein that stores iron), Total Iron now and every 6 months. The physician marked the form as agree and signed and dated the form on 7/3/25. The electronic health record lacked documentation of the labs being drawn and lacked a physician order for repeat labs in 6 months. During an interview on 12/11/25 at 11:03 a.m., the Regional Nurse Consultant indicated she was unable to find where Resident 47's labs had been drawn as recommended and agreed upon by the physician and there was no order to repeat the labs in 6 months. The facility did not follow the pharmacy recommendation that the physician agreed upon. On 12/11/25 at 11:23 a.m., the Regional Nurse Consultant provided a undated document, titled, Medication Regimen Reviews, and indicated it was the current policy being used by the facility. The policy indicated, .1. The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication.4. The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication.d. inadequate monitoring for adverse consequences.12. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it.15. Copies of medication regimen review reports, including physician responses, are maintained as a part of the permanent medical record.b. Staff performance in complying with regulatory requirements related to medication utilization and monitoring.3.1-25(i)

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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 observation, interview, and record review, the facility failed to ensure expired medications were disposed of for 1 of 1 medication storage rooms reviewed and 1 of 5 medication carts reviewed for medication storage (Residents 23 and 10). Findings include: 1. On 12/12/25 at 10:00 a.m., the rehab unit medication storage room refrigerator contained an opened Humalog (insulin medication) pen with an open date of 10/5/25 and a use by date of 11/3/25. The insulin pen contained a label that indicated it was for Resident 23. The cart also contained an opened Lantus (insulin mediation) pen with an open date of 11/2/25 and a use by date of 12/2/25. The insulin pen contained a label that indicated it was for Resident 23. During an interview, on 12/12/25 at 10:02 a.m., the Regional Nurse Consultant indicated she was not aware of who or why the insulins pens were placed in the medication storage room refrigerator. She indicated the insulin pens were expired and should have been disposed of properly. Resident 23's record was reviewed on 12/12/25 at 10:29 a.m. The profile indicated the resident's diagnosis included, but were not limited to, type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A physician order, dated 4/27/25 with a discontinued date of 12/8/25, indicated to administer Humalog Kwik Pen subcutaneous (under the skin) solution pen injector 100 unit/ml (milliliter). Inject subcutaneously per sliding scale four times a day. A physician order, dated 12/8/25, indicated to administer Lantus Solostar subcutaneous solution pen injector 100 unit/ml. Inject 30 units subcutaneously two times a day. 2. On 12/12/25 at 10:15 a.m., the ICF (intermediate care facility) insulin medication cart contained an opened bottle of irrigation solution. The bottle had an open date of 10/31/25. The bottle contained a label that indicated it was for Resident 10. During an interview, on 12/12/25 at 10:18 a.m., the Regional Nurse Consultant indicated she irrigation solution was expired and should have been disposed of. The solution was good for 30 days once opened. Resident 10's record was reviewed on 12/12/25 at 10:35 a.m. The profile indicated the resident's diagnosis included, but were not limited to obstructive and reflux uropathy (blocks urine flow, causing backup and potential kidney damage). A physician order, dated 10/12/25, indicated to administer Sodium Chloride Irrigation solution 0.9%; use 120 ml(milliliter) irrigation every shift for Foley (indwelling catheter) cath irrigation. On 12/12/25 at 10:42 a.m., the Regional Nurse Consultant provided a document, dated March 2023, titled, Medication Storage in the Facility, and indicated it was the policy currently being used by the facility. The policy indicated, .14. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled, or without secure closures will be immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures, and reordered form the pharmacy if a current order exists.On 12/15/25 at 9:55 a.m., the Administrator provided an undated document, titled, Administering Medications, and indicated it was the policy currently used by the facility. The policy indicated, .12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container 3.1-25(0)