STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225282	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of the South Shore	309 Driftway Box 830 Scituate, MA 02066

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement their abuse policy when Resident (#42) was involved in a verbal resident-to-resident altercation with Resident #83. Specifically, the facility failed to ensure facility staff who were aware of the incident reported the altercation to leadership immediately, but not later than 2 hours after the altercation, to allow for reporting, investigating, and implementing measures to prevent potential future altercations. Findings include:Review of the facility's policy titled Abuse - Identification of Types, reviewed 4/1/26, indicated, but was not limited to, the following:-Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.-Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.-Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of mental and verbal abuse include, but are not limited to:i. Harassing a resident;ii. Mocking, insulting, or ridiculing;iii. Yelling or hovering over a resident, with the intent to intimidate;iv. Threatening residentsReview of the facility's policy titled Abuse - Report and Response - No Crime Suspected, reviewed 4/1/26, indicated, but was not limited to, the following:-The facility will report alleged violations related to mistreatment, exploitation, neglect, or abuse including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities within prescribed timeframes.-The facility will ensure that all staff are aware of reporting requirements and to support an environment in which staff and others report all alleged violations of mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.-In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:a. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the Facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.b. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.Resident #42 was admitted to the facility in December 2024 with diagnoses including anxiety, insomnia, depression, panic disorder, and Parkinson's disease. Review of Resident #42's Minimum Data Set (MDS) assessment, dated 1/29/26, indicated the Resident was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #42's progress notes indicated, but was not limited to, the following:-3/26/26: Resident reports being (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbally threatened by his/her roommate overnight. Resident immediately removed from room at time of incident for his/her safety and sense of security, transferred to [Room #] oriented to new room and call light, moved with all belongings. MD made aware. [Name of Town] police contacted and [Police Officer] arrived on scene and took statements. Officer agrees there is no present threat and the aggressor in [sic] unable to carry out his/her threat d/t (due to) visual, cognitive, and physical impairments. Resident reports feeling safe and secure in his/her new room.-4/1/26: Expressing paranoid behaviors stating, Everyone hates me. Attempts to reassure with no effect. Appears comfortable sleeping at this time.-4/2/26: Interdisciplinary Team (IDT) day 5 note s/p (status post) verbal aggression received from patient's roommate on 3/28/26 at 4:15AM. Patient room has been changed since the incident and he/she is being followed by social services for adjustment/smooth transition. Safety maintained. Plan of care ongoing.Review of Resident #42's Care Plan indicated, but was not limited to, the following:Focus: History of verbal altercations with roommatesInterventions: Offer accommodations to both parties when appropriate; provide mediation and encourage compromise between roommates; referral to psych services as neededReview of the facility's Incident Report, dated 3/28/26, indicated Resident #83 threatened to knot [sic] roommates block off. Roommate moved to [Room #]. Further review of the incident report indicated Resident #42 reported that he/she was up coughing in the night and his/her roommate said to him/her shut the f*** up or I'll come over there and punch you in the head. The Incident Report indicated the Residents were separated and Resident #42 was moved to another room and the local police were contacted and an officer arrived at the facility and took statements. Further review of a staff member's statement included with the incident report indicated the staff member walked by and witnessed Resident #83 standing next to his/her bed yelling Get him/her the f*** out of here or I'll knock his/her block off.Review of Resident #83's medical record indicated Resident #83 was admitted to the facility in April 2025 with diagnoses including visual loss, depression, adjustment disorder, and agoraphobia (extreme or irrational fear of entering open or crowded places, of leaving one's own home, or of being in places from which escape is difficult) and was able to ambulate without staff assistance in his/her room.During an interview on 4/14/26 at 12:46 P.M., Resident #42 said his/her former roommate had threatened to punch him/her a few weeks prior and he/she had moved rooms after the incident. Resident #42 said the police came and spoke with him/her after the incident.During an interview with the Director of Nursing (DON) and the Corporate Nurse on 4/16/26 at 1:46 P.M., the DON said she was not the DON at the time of the incident but recalls hearing about it (she was working as the Assistant Director of Nursing at the time). The DON said she would have reported the incident to the Corporate Nurse to see if it should be reported to the State Survey Agency. The Corporate Nurse said she was not notified of the verbal altercation between Resident #42 and Resident #83 and would have reported the incident to the State Survey Agency if she had been aware. The DON and Corporate Nurse did not know why the incident had not been reported. During an interview on 4/16/26 at 1:54 P.M., the Administrator said he became aware of the situation after the fact because he was not in the building at the time. The Administrator said Resident #42 had wanted the police called and that's why they were notified. The Administrator said he did not report the incident to the State Survey Agency when he became aware of it. During a telephonic interview on 4/16/26 at 2:44 P.M., Nurse #3 said that she was the scheduled weekend supervisor on duty on the day of the incident. Nurse #3 said when the night shift nurse was preparing to leave after her shift, she told Nurse #3 there had been a verbal altercation between Resident #42 and Resident #83 overnight and Resident #42 had moved rooms. Nurse #3 said Resident #83 is able to ambulate independently in his/her room but is legally blind and it is safer for him/her to remain in a familiar environment, which is why Resident #42 was moved to another room. Nurse #3 said when she was made aware of the incident, she went to speak with Resident #42 about the incident, notified facility leadership, called the police, and completed an incident report. Nurse #3 said the night shift nurse on duty had not reported the incident to leadership prior and did not complete an incident report before she left the facility around 7 A.M. On 4/16/26 at (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2:33 P.M., the surveyor attempted to contact the nurse on duty at the time of the incident, but she was unable to be reached and did not return the surveyor's call.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, for one Resident (#42), of 22 sampled residents, the facility failed to ensure an allegation of abuse was reported timely to the state agency as required.Findings include:Review of the facility's policy titled Abuse - Identification of Types, reviewed 4/1/26, indicated, but was not limited to, the following:-Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.-Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.-Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of mental and verbal abuse include, but are not limited to:i. Harassing a resident;ii. Mocking, insulting, or ridiculing;iii. Yelling or hovering over a resident, with the intent to intimidate;iv. Threatening residentsReview of the facility's policy titled Abuse - Report and Response - No Crime Suspected, reviewed 4/1/26, indicated, but was not limited to, the following:-The facility will report alleged violations related to mistreatment, exploitation, neglect, or abuse including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities within prescribed timeframes.-The facility will ensure that all staff are aware of reporting requirements and to support an environment in which staff and others report all alleged violations of mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.-In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:a. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the Facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.b. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.Resident #42 was admitted to the facility in December 2024 with diagnoses including anxiety, insomnia, depression, panic disorder, and Parkinson's disease. Review of Resident #42's Minimum Data Set (MDS) assessment, dated 1/29/26, indicated the Resident was cognitively intact, as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. During an interview on 4/14/26 at 12:46 P.M., Resident #42 said his/her former roommate had threatened to punch him/her a few weeks prior and he/she had moved rooms after the incident. Resident #42 said the police came and spoke with him/her after the incident.Review of the facility's Incident Report, dated 3/28/26, indicated Resident #83 threatened to knot [sic] roommates block off. Roommate moved to [Room #]. Further review of the incident report indicated Resident #42 reported that he/she was up coughing in the night and his/her roommate said to him/her shut the f*** up or I'll come over there and punch you in the head. The Incident Report indicated the Residents were separated and Resident #42 was moved to another room and the local police were contacted and an officer arrived at the facility and took statements. Further review of a staff member's statement included with the incident report indicated the staff member walked by and witnessed Resident #83 standing next to his/her bed yelling Get him/her the f*** out of here or I'll knock his/her block (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	off.Review of the Health Care Facility Reporting System (HCFRS, a web-based system that health care facilities must use to report incidents and allegations of abuse, neglect, and misappropriation) failed to indicate the incident on 3/28/26 was reported to the state agency within the required timeframe. During an interview with the Director of Nursing (DON) and Corporate Nurse on 4/16/26 at 1:46 P.M., the DON said she was not the DON at the time of the incident but recalls hearing about it (she was working as the Assistant Director of Nursing at the time). The DON said she would have reported the incident to the Corporate Nurse to see if it should be reported to the State Survey Agency. The Corporate Nurse said she was not notified of the verbal altercation between Resident #42 and Resident #83 and would have reported the incident to the State Survey Agency if she had been aware. The DON and Corporate Nurse did not know why the incident had not been reported. During an interview on 4/16/26 at 1:54 P.M., the Administrator said he became aware of the situation after the fact because he was not in the building at the time. The Administrator said Resident #42 had wanted the police called and that's why they were notified. The Administrator said he did not report the incident to the State Survey Agency when he became aware of it. During a telephonic interview on 4/16/26 at 2:44 P.M., Nurse #3 said that she was the weekend supervisor on duty on the day of the incident. Nurse #3 said when the night shift nurse was leaving after her shift, she told Nurse #3 there had been a verbal altercation between Resident #42 and Resident #83 and Resident #42 had moved rooms. Nurse #3 said at that time, she spoke with Resident #42 about the incident, notified facility leadership, called the police, and completed the incident report.

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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. Based on observation, interview, and record review, the facility failed to ensure one Resident (#2), in a total sample of 22 residents, received assistance with activities of daily living (ADLs). Specifically, Resident #2 was not provided set-up and supervision with eating as the assessments indicated. Findings include:Resident #2 was admitted to the facility in February 2026 with diagnoses of Lewy Body Dementia (a brain disorder that can lead to problems with thinking, movement, behavior, and mood) and essential tremors. Review of the Minimum Data Set assessment, dated 3/16/26, indicated Resident #2 scored 6 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had severely impaired cognition and indicated Resident #2 needed supervision or touching assist with eating. Review of the care plans indicated Resident #2 required set-up/supervision assistance by one staff with eating (dated 4/9/26). Review of the assessment titled Interdisciplinary Team (IDT): Decision to Support Section GG, dated 3/13/26, indicated Resident #2 needed supervision or touching assistance for eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). On 4/14/26 at 8:32 A.M., the surveyor observed Resident #2 in bed with his/her eyes closed. A breakfast tray with eggs, bacon, toast and hot cereal was on the overbed table in front of the Resident. The meal had not been eaten. The surveyor observed Resident #2 with eyes closed and meal unchanged at 8:47 A.M., 8:58 A.M., and 9:08 A.M. At 9:17 A.M., the meal plate was gone from the overbed table. During an interview on 4/14/26 at 10:10 A.M., the spouse of Resident #2 said the Resident had dementia and staff would sit with the Resident to help eat and remind the Resident to drink fluids. On 4/14/26 at 12:41 P.M., the surveyor observed Resident #2 in the small dining room receive his/her lunch meal of a hot dog in a bun, an oval dish of baked beans and a small dish of coleslaw. There were no staff members present for the first ten minutes of the observation. Resident #2 was observed pulling open the foil top of a juice container. The hot dog was no longer in the bun and Resident #2 was observed attempting to find the open part of the bun to put the hot dog in and was unable to locate it. The hot dog bun was lying on the side and Resident #2 pushed the hot dog down into the side of the bun to get it into the bun. The Resident then went back to eating coleslaw and dropped the dish into the baked beans, which mixed the coleslaw into the beans. Resident #2 was observed with a shaking arm as he/she attempted to bring their cup to their mouth. The coleslaw and baked beans were covered in liquid. At 12:47 P.M., the surveyor observed Resident #2 attempting to open a relish packet with his/her fork, then attempt to squeeze the relish onto the hotdog, which was resting on the side of bun, but nothing was coming out. The Resident then picked up a napkin, tore a corner away, tried to squeeze the napkin over the hotdog and sighed when nothing came out. The Resident picked up the hot dog and bun and attempted to eat it (plain). At 12:51 P.M., the surveyor observed Resident #2 attempt to push the hot dog further into the side of the bun with his/her fork. Certified Nursing Assistant (CNA) #1 entered the small dining room with another resident and sat with the other resident while the resident ate. At 12:57 P.M., Nurse #1 entered the small dining room and said the Resident's food was floating in cranberry juice. CNA #1 replied that must be how Resident #2 liked it. Nurse #1 left the room and CNA #1 continued to sit with the other resident. At 1:02 P.M., Resident #2 picked up the whole hot dog with a fork and started to bite it. At that time, the surveyor observed the original baked bean dish to now have less baked beans, coleslaw and drenched in liquid. The surveyor left the room at 1:05 P.M., 24 minutes after Resident #2 received their food. On 4/15/26 at 8:33 A.M., the surveyor observed Resident #2 receive his/her breakfast tray in his/her room. At 8:40 A.M., the Resident was observed in their room alone with a breakfast tray on the overbed table (eggs, toast, cut up pieces of sausage). The Resident was not eating and says he/she was not much of a breakfast person. At 9:00 A.M., the Resident had eaten a half piece of toast, a small amount of eggs and small amount of sausage. Review of the Speech Therapy progress notes indicated the following:4/1/26: presented with decreased appetite, requiring (moderate (mod)-) maximum (max) cues/encouragement for (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intake4/7/26: functional swallowing tolerated when meal setup, including cut solids into bite-sized4/8/26: significant difficulty with self-feeding; improved intake with one-to-one feeding, likely related to cognitive factors as well as motor impairments including slowed movements and tremors4/15/26: demonstrated functional swallowing, hot dog on a bun with thin liquids; min-mod environmental cues were provided to facilitate application of safe swallowing strategies During an interview on 4/15/26 at 4:36 P.M., Speech Therapist #1 said he had observed Resident #2 at lunch the previous day and the Resident did well with eating. The Speech Therapist said he had gotten there at the end of lunch and the Resident had already eaten the hot dog and he had not watched the Resident eat the hot dog. He said yes, the baked beans had been mixed with coleslaw and covered in liquid, but the Resident had eaten it, so it wasn't a problem. When the surveyor inquired about the Resident's ability to self-feed, the Speech Therapist said the facility would work on better supervising the Resident's behavior of mixing foods together. Review of the medical record failed to indicate Resident #2 had any behaviors. During an interview on 4/16/26 at 8:56 A.M., Occupational Therapist #1 said Resident #2 has fluctuating cognition, can self-feed at times but starts to have tremors with fatigue. She said there were times when the Resident cognitively could not figure out what to do next. During an interview on 4/16/26 at 10:42 A.M., CNA #2 said Resident #2's cognition can fluctuate. She said the Resident does not have a big appetite and the staff should be setting up the meals when provided to the Resident. She said the hot dog should have been cut in half and set-up as the Resident wanted it so that it would be easier for the Resident to manage. She said Resident #2 can become shaky at times when he/she was tired and she usually provided the Resident with cups with lids to avoid spills. During an interview on 4/16/26 at 10:47 A.M., CNA #1 said Resident #2 needs help with eating sometimes, but they were just happy the Resident was eating on 4/14/26 and that was why she hadn't obtained another staff member to help the Resident while she supervised the other resident eating. She said the Resident probably needed more set-up with the food to make sure everything was ready to eat. During an interview on 4/16/26 at 3:39 P.M., the Rehabilitation (Rehab) Service Manager said if there had been any changes in the level of assistance needed since the assessment in March 2026 then the rehab team would have updated the unit staff. She said there were no changes in the level of assistance (set-up, supervision) for eating since the Resident assessment on 3/13/26. During an interview on 4/17/26 at 8:51 A.M., Unit Manager #1 said Resident #2 received set-up assistance with meals and could eat on his/her own. She said Resident #2 did have a tremor in their hands at times. She said the assessment that indicated the Resident was set-up with supervision for meals was accurate. She said this would allow the staff to assist if additional things were needed like condiments, drinks or to provide cueing. She said there should have been a staff member in the small dining room to supervise and assist as needed. She said the staff were now starting to get the Resident out of bed for breakfast.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure all drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. Specifically, the facility failed:1. To ensure two of two medication carts on the secured unit were locked when not in direct supervision of the licensed nurse; and2. For Resident #85, to ensure the Resident's lactase enzyme (medication that helps break down lactose, preventing symptoms like gas, bloating, and diarrhea when consuming dairy), albuterol inhaler (a medication that relaxes muscles in the airways, increasing airflow to the lungs, commonly used to treat conditions like asthma and chronic obstructive pulmonary disease), and analgesic balm (topical pain relief medication) were stored securely. Findings include:Review of the facility's policy titled Storage and Expiration Dating of Medications and Biologicals, revised 06/30/25, indicated but was not limited to the following: -Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. 1. On 4/15/26 at 9:49 A.M., the surveyor observed Nurse #2 preparing medications on the [NAME] Unit South. She left the medication cart unlocked, unattended and not in her sight in the hallway and entered a resident's room. A resident was observed self-propelling by the unlocked, unattended cart. During an interview on 4/15/26 at 3:40 P.M., Nurse #2 said the medication cart should have been locked when she walked away from the cart. Nurse #2 said she usually brings the cart to the resident's door to remain in her line of sight during the medication pass. On 4/15/26 at 9:37 A.M., the surveyor observed an unlocked, unattended medication cart on the [NAME] Unit East, positioned up against the wall in the hallway. There were no nursing staff in the vicinity of the unlocked cart. On 4/15/26 at 9:39 A.M., the surveyor observed two Certified Nursing Assistants (CNA) walking by the unlocked, unattended medication cart. On 4/15/26 at 9:45 A.M., the surveyor observed a staff member ambulating a resident by the unlocked, unattended medication cart. During an observation with an interview on 4/15/26 at 9:46 A.M., the surveyor observed Nurse #4 exit a resident's room and approach the unlocked, unattended medication cart. Nurse #4 then pulled the lock open with her fingers and opened the cart. She said the medication cart is half locked, that is why she does not need the key to open the drawers. During an interview on 4/15/26 at 12:59 P.M., Unit Manager #1 said the medication carts must be fully locked when not in the nurse's view. During an interview on 4/21/26 at 12:19 P.M., the Director of Nursing (DON) said medication carts should always remain locked when not in use. She said for the medication cart to be secure the lock must be opened with a key and not just pulled open. (continued on next page)

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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	2. Resident #85 was admitted to the facility in December 2024 with diagnoses including dementia, chronic obstructive pulmonary disease, and chronic respiratory failure. Review of Resident #85's Minimum Data Set (MDS) assessment, dated 3/6/26, indicated the Resident was moderately cognitively impaired, as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. The surveyor made the following observations of unsecured medications: -4/14/26 at 10:41 A.M.: Two Lactaid (lactase enzyme) tablets and an albuterol inhaler on Resident #85's overbed table and a tube of analgesic balm on the Resident's nightstand -4/15/26 at 2:49 P.M.: Eight Lactaid tablets on Resident #85's overbed table -4/16/26 at 9:40 A.M.: Nine Lactaid tablets on Resident #85's overbed table. Review of Resident #85's Physician's Orders indicated, but was not limited to, the following: -Albuterol sulfate 2 puffs inhale orally every six hours as needed for shortness of breath (SOB) and wheezing (2/3/26) -Lactase oral tablet Give 3000 units by mouth every 24 hours as needed for lactose intolerance (2/3/26) Resident #85's Physician's Orders failed to include an order for analgesic balm. During an interview on 4/16/26 at 9:40 A.M., Resident #85 said he/she self-administers Lactaid tablets himself/herself with meals as needed. During an interview on 4/16/26 at 11:35 A.M., Nurse #2 said Resident #85 should not have medication at his/her bedside. During an interview on 4/16/26 at 11:47 A.M., the DON said Resident #85 should not have any medications left unsecured in his/her room.