STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225445	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Affinity Healthcare	1102 Washington Street Braintree, MA 02184

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on record review and interview, the facility failed to ensure Advance Directives (written documents that instruct health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) were formulated and maintained in the medical record for one Resident (#106), out of a total sample of 25 residents. Specifically, the facility failed to ensure Advanced Directives were reviewed, documented, valid, and maintained in the medical record. Findings include: Review of the facility's policy titled Advanced Directives, dated as last revised ,d+[DATE], indicated but was not limited to the following: -Advanced directives will be respected in accordance with state law and facility policy. -Information about whether or not the resident has executed an advanced directed shall be displayed in the medical record. -The plan of care will be consistent with his or her documented treatment preferences and/or advanced directives. -Advanced Directive- a written instruction for health care, recognized by state law, relating to the provisions of health care. -Do Not Resuscitate- indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy (HCP), or representative has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used. -The staff will inform emergency medical personnel of a resident's advanced directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made. Review of the Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) website (https://www.molst-ma.org) indicated but was not limited to the following: (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: 225445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All clinicians in any setting should talk about advanced care planning with patients and document patients' preferences as appropriate. Such discussions may result in filling out a MOLST form, if medically indicated and desired by the patient. -Filling out the MOLST form: Both Sections D and E (Patient and Clinician Signature) must be fully complete and legible for page 1 to be valid. -The MOLST form should be kept with the patient, easy to find, and taken with the patient outside of the home. -Copy the MOLST form for the patient's medical record. -MOLST requires a physician, nurse practitioner, or physician assistant signature to be valid. This signature confirms that the MOLST accurately reflects the signing clinician's discussion with the patient. --The MOLST form should be filled out and signed only after an in-depth conversation between the patient and the clinician signer. -If any section is not completed, there is no limitation on the treatment indicated in that section. -The form is effective immediately upon signature. Photocopy, fax, or electronic copies of a properly signed MOLST are valid. -Send this form with the patient at all times. -If no form is completed, no limitations on treatment are documented, full treatment may be provided. Resident #106 was admitted to the facility in February 2023 with diagnoses which included myocardial infarction, heart disease, and Parkinsons disease. Review of the Minimum Data Set (MDS) assessment for Resident #106 indicated he/she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating he/she was cognitively intact. Review of the electronic medical record for Resident #106 indicated he/she made his/her own medical decisions and his/her HCP was not invoked and he/she was a Do Not Resuscitate/Do Not Intubate (DNR/DNI). Review of the Physician's Orders indicated the following: -DNR/DNI ([DATE]) Further review of the electronic medical record failed to indicate a MOLST or DNR form had been scanned into the medical record. Review of the paper medical record failed to indicate a MOLST or DNR form had been completed and maintained as part of the medical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Comprehensive Care Plan indicated but was not limited to the following: -ADVANCED DIRECTIVES: DNR/DNI, Self-Responsible, HCP on file ([DATE]) -Follow MOLST form as ordered. ([DATE]) Review of the Nursing, Social Service, and Physician progress notes from admission through [DATE] failed to indicate a discussion regarding a MOLST had occurred, a MOLST was signed, or that the resident wished to be a DNR/DNI. Further review of the progress notes indicated but were not limited to the following: -[DATE] Social Service Note: Advanced Directives: None. Full Code and is self-responsible at this time. -[DATE] Social Service Note: Met to discuss plan of care. In attendance were social worker, unit manager, program director, and rehab director. HCP was present via phone call and resident was present. He/she has a HCP but it is not activated at this time and is a full code status. -[DATE] Nurses Note: Resident was seen by physician today. Resident consented to medication change. -[DATE] Physician Progress Note: late entry for [DATE]: seen for falls. The progress notes failed to indicate a discussion had occurred regarding advanced directives or that advanced directives were formulated, implemented, and placed in the medical record. During an interview on [DATE] at 11:15 A.M., Unit Manager #3 said there was not a MOLST in Resident #106's chart and she did not know where it was. She said the form should be in the medical record. Additionally, she said he/she has been to the hospital a few times so perhaps it went with them. She said she was unsure why the form was not in the chart or where it was and deferred further questions to the Director of Social Services. During an interview on [DATE] at 11:15 A.M., the Director of Social Services said the MOLST form was not in the medical record, and it should be. She said she did not recall reviewing one with him/her and did not know where the MOLST was. During an interview on [DATE] at 11:56 A.M., the Director of Social Services said she did not have a copy of the MOLST in the Social Service office either. She said she put a call out to the physician to inquire about the MOLST. During an interview on [DATE] at 12:45 P.M., the Director of Nurses (DON) said she spoke to the physician, and he did not recall this particular case, but usually the provider would have the discussion, document, and write the orders. She said however, there are no notes regarding this in the medical record. On [DATE] at 11:00 A.M, the surveyor observed that there was a MOLST form flagged in the chart for physician review. The MOLST form was signed/initialed by Resident #106, dated [DATE], and indicated he/she wanted to have CPR attempted and did not want to be intubated. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:03 A.M., Resident #106 was in bed sleeping and unavailable for interview. During an interview on [DATE] at 11:07 A.M., Unit Manager #3 said there should be a current/valid MOLST in the medical record. She said a new one was completed yesterday after it was pointed out that he/she did not have one. She said the physician is coming in tomorrow to review and sign it. Review of the medical record indicated Resident #106 remained a DNR/DNI status at this time. During an interview on [DATE] at 9:58 A.M., Social Worker #3 said she did not know where the MOLST was, so she went over it to have Resident #106 sign a new one and he/she wants CPR. She said she flagged it for the physician to review. Additionally, she said the MOLST should be in the medical record as it needs to go everywhere with him/her. She said usually she would scan the original into the electronic medical record and put several copies in the paper medical record. She said that way, when they are sent to the hospital, copies are easily accessible to provide to the ambulance drivers (EMTs) because without the form indicating DNR, the EMT's would provide CPR if needed. During an interview on [DATE] at 10:38 A.M., the DON said there should be a copy of the MOLST in the medical record. She said the EMTs would do CPR without a valid MOLST if they were transporting the resident and he/she went into cardiac arrest. Additionally, she said there should be a physician's progress note indicating the discussion. She said the Social Worker re-did the MOLST on Tuesday and the physician is coming in today to review it and write the orders. Review of a progress note written on [DATE] by Social Worker #3 indicated when Resident #106 was admitted to the facility there was no MOLST, but the hospital discharge summary indicated DNR/DNI. The facility was unable to provide a copy of the MOLST indicating his/her wishes for DNR/DNI status, a progress note indicating the discussion had occurred, or confirmation the order entered into the medical record on [DATE] was a valid order based on a valid MOLST.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 36542 Based on observation and interview, the facility failed to ensure the residents' environment was clean, comfortable, and homelike. Specifically, the facility failed to ensure the resident common areas (activity rooms, pub/parlor/dining rooms) were maintained in good repair (without holes, painted) and homelike on units M2 and B2. Findings include: Review of the facility's policy titled Resident Right-Safe/Clean/Comfortable/Homelike Environment, dated as last revised September 2021, indicated but was not limited to the following: -It is the policy of the facility to provide a safe, clean, comfortable homelike environment in such a manner to acknowledge and respect resident rights -Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior During all days of survey (9/19-9/26/24), the surveyor observed the following: Unit B2: -the unit hallway had multiple areas where hand sanitizer pumps had been removed, revealing unpainted torn drywall -the dining room had a hole in the wall approximately three inches long by one and a half inches high, with crumbling dry wall. -the walls in the dining room were painted white and light blue with visible marks, nicks, food debris. -the door frame when exiting the dining room was observed with chipped paint and dark in color on the white paint with brown smudges on the right side of the door frame at eye level and at the top of the door frame. -the activity room was observed to have a medium blue paint with multiple areas of scraped off paint, revealing white wall throughout multiple levels of the room. -the wall air conditioner in the activity room had gray dust/debris on the front and top and the vent was pointed at the ceiling. The textured ceiling in front of the air conditioner had black particles of debris. -the activity room floor level baseboard heater had a gap between the tile floor and the heater, the gap had brown dirt and trash. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/25/24 at 3:05 P.M., Life Enrichment Specialist #1 was in the B2 unit dining room and said he was not sure how long the hole had been in the wall, but it had been there for some time. He said he was not sure if the common area rooms had been painted anytime recently. Unit M2: - the unit hallway had multiple areas of scraped off paint and areas of unpainted patches of plaster; the walls were visibly dirty and discolored with visible liquid streaks and corners with broken plaster. -the unit fire extinguisher had trash and torn up sugar packets wrappers between the extinguisher and the wall. The wall around the extinguisher was visibly dirty with dark streaks. - the pub/parlor had painting tape around the chair rail, outlets and baseboard, there was one coat (with visible bleed through) of blue paint on the lower section of the walls. The painting tape around the base board was scratched up with wear and tear. The blue paint had visible scuffs and scratches. During an interview on 9/25/24 at 3:24 P.M., Life Enrichment Specialist #2 said the staff had previously been utilizing another room for activities for residents and when they switched to using the pub/parlor the facility staff had started painting it but were unsure when it would be finished. During an interview on 9/25/24 at 4:05 P.M., the Housekeeping Manager said there was one housekeeping staff member assigned to each unit and they were responsible for dry and wet mopping resident rooms and cleaning resident bathrooms. She said there was one additional staff member who buffed the unit hallway floors. She said the unit housekeeper was responsible for wiping down the walls and high touch areas (handrails) on the units daily. She said the walls should not be visibly dirty. She said the housekeeping staff should have been cleaning under the baseboard heater in the B2 activity room and any trash that was observed between the wall and the fire extinguisher. She said the maintenance staff were responsible for cleaning the air conditioners and her staff had not noticed the debris on the B2 activity room ceiling. During an interview on 9/26/24 at 7:30 A.M., the Corporate Manager said he was responsible for plant operations and there were currently two staff in the maintenance department. He said the facility previously had a Director of Maintenance until June 2024. He said the current maintenance staff continued to work on crisis management for the facility (plumbing, electric, safety concerns) and there were not enough staff to address painting. He said the previous brand of hand sanitizer was changed which required new dispensers with a different method of installation which was why the dispensers were now in different spots, leaving unpainted exposed dry wall. He said he knew there was a hole in the B2 dining room as it was on his rounding list and that holes in walls, with the appropriate number of staff, should be fixed within a day. He said the previous Director of Maintenance, who left the facility in June (over three months prior to survey) had started painting the M2 pub/parlor and the room had not been finished.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 48084 Based on record review and interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) assessments were completed for one Resident (#106), out of a total sample of 25 residents. Specifically, the facility failed for Resident #106, to accurately code the use of anticoagulant (blood thinner to prevent blood clots) and antiplatelet (stops platelets from clumping together and forming blood clots) medications on 11 out of 11 MDS assessments reviewed. Findings include: Review of the facility's policy titled Resident Assessment Instrument, dated September 2021, indicated but was not limited to the following: -This assessment will provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacities and assist staff to identify health problems for care plan development. -Completion of the MDS: The assessment must include at least the following: N: Medications. -The assessment will accurately reflect the resident's status. Resident #106 was admitted to the facility in February 2023 with diagnoses which included myocardial infarction, heart disease, and Parkinson's disease. Review of the most recent MDS assessment for Resident #106 indicated he/she had been taking anticoagulant medication. Review of the Physician's Orders indicated Resident #106 was not taking an anticoagulant. Further review of the Physician's Orders indicated the following: -Clopidogrel Bisulfate 75 milligrams (mg) (Plavix- antiplatelet) give one tablet by mouth one time a day (2/14/23) Further review of the MDS assessments indicated Resident #106 was: -08/18/23, taking an anticoagulant. -11/15/23, taking an anticoagulant and not taking an antiplatelet. -11/21/23, not taking an antiplatelet. -12/03/23, taking an anticoagulant and not taking an antiplatelet. -01/25/24, taking an anticoagulant and not taking an antiplatelet. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	-02/10/24, taking an anticoagulant and not taking an antiplatelet. -05/11/24, taking an anticoagulant and not taking an antiplatelet. -06/01/24, taking an anticoagulant and not taking an antiplatelet. -06/12/24, taking an anticoagulant and not taking an antiplatelet. -06/26/24, taking an anticoagulant and not taking an antiplatelet. -08/10/24, taking an anticoagulant and not taking an antiplatelet. During an interview on 9/26/24 at 8:37 A.M., the MDS Nurse said the MDSs are wrong. She said Resident #106 is on Plavix, which is an antiplatelet, and has never been on an anticoagulant. She said all the MDSs would need to be modified. During an interview on 9/26/24 at 10:45 A.M., the Director of Nurses (DON) said she had already spoken to the MDS Nurse and all the MDSs are wrong and would need to be modified as Resident #106 is not on an anticoagulant and only on an antiplatelet.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15214 Based on observation, record review, and staff interview, the facility failed to ensure for one Resident (#35) with a gastrostomy tube, of a total sample of 25 residents, that medications were administered in accordance with the physician's order and Professional Standards of Practice. Specifically, the facility failed to ensure Nurse #3 followed the physician's order when administering each of the Resident's medications via the gastrostomy tube (GT). Findings include: Review of the [NAME] Skill Checklist for Taylor's Clinical Nursing Skills. A Nursing Process Approach, 5th Edition, Skill 5-2 Administering Medications via a Gastric Tube, the following standard included but was not limited to the following: 10. Prepare medication. Pills: Using a pill crusher, crush each pill one at a time. Dissolve the powder with water or other recommended liquid in a liquid medication cup, keeping each medication separate from the others. Keep the package label with the medication cup, for future comparison of information. During an interview on 9/24/24 at 9:29 A.M., the surveyor observed Nurse #3 preparing and administering medications to Resident #35. Nurse #3 said that all of the Resident's GT medications were to be crushed and administered via the GT in warm water. On 9/24/24 at 9:30 A.M., the surveyor observed Nurse #3 pouring each of the Resident's morning medications, which included the following: - Lasix (diuretic) 20 milligrams (mg) VGT (via GT) in the AM - Aspirin 81 mg VGT in AM -Docusate sodium (stool softener) 100 mg give 2 caps by mouth (sic) in the AM -Fluoxetine Hcl (hydrochloride) (antidepressant) 60 mg VGT once daily -Metoprolol (antihypertensive) 25 mg 0.5 tab VGT two times a day -Multivitamin with minerals 1 VGT once daily -Vitamin D3 25 micrograms (mcg) VGT daily (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the administration of the medications, the surveyor observed Nurse #3 place all the above medications in a small plastic crushing bag, crush the medications with a pill crusher, place all of the powdered medications in a plastic medication cup, and took them to the Resident's bedside. Nurse #3 then added 5 ml of warm water to the cup of multiple crushed medications, mixed the medications in the water, administered all the medications together via the GT, and flushed the tube with an additional 5 ml of water. Review of the Medication Administration Record (MAR) indicated the physician's order for administering the Resident's GT medications as follows: -Mix each medication with 5 milliliters (ml) of water and mix each medication separately During an interview on 9/24/24 at 9:35 A.M., Nurse #3 said she failed to follow the physician's order which indicated to mix and administer each medication separately in 5 ml of water. During an interview on 9/25/24 at 8:00 A.M., the Director of Nursing (DON) said that Nurse #3 should have followed the physician's order to prepare each GT medication separately in 5 ml of water, and not mix and administer them together via the GT.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 36542 Based on interviews and record reviews, the facility failed to ensure a monthly medication regimen review was completed once per month for five out of five Residents (#3, #13, #117, #79, and #88) selected for unnecessary medication review and one out of one Resident (#94) reviewed for medication side effects. Specifically, the facility failed to have a licensed pharmacist conduct a drug regimen review for each resident in the months of May, June, July, and August 2024. Findings include: Review of the facility's pharmaceutical services contract indicated for Pharmacy Consulting Services- At the facility's written request, the Pharmacy shall arrange for a third party consultant pharmacist to provide pharmacy consulting services to the facility. The facility and such pharmacy consultant shall contract directly with each other and the Pharmacy shall have no other duties, responsibilities or liability with respect to such pharmacy consultant. During the entrance conference on 9/19/24 on 9:30 A.M., the Administrator said the facility had entered new ownership effective 4/1/24 and the Administrator and the Director of Nurses had started working at the facility in May 2024. 1. Resident #3 was admitted to the facility in January 2019. Review of the paper and electronic medical records for Resident #3 indicated a drug regimen review was completed on 4/4/24 and then again on 9/23/24. There was no documentation to indicate the drug regimen review had been conducted by a licensed pharmacist in May, June, July or August 2024. Review of the medical record on 9/24/24 indicated the pharmacist consultant had completed the drug regimen review on 9/23/24 and had recommendations. During an interview on 9/24/24 at 1:15 P.M., the Director of Nurses (DON) said the drug regimen review had just been completed and had not been reviewed by the physician at this time. 41106 2. Resident #13 was admitted to the facility in September 2022. Review of the paper and electronic medical records for Resident #13 indicated a drug regimen review was completed on 4/4/24 and then again on 9/23/24. There was no documentation to indicate the drug regimen review had been conducted by a licensed pharmacist in May, June, July or August 2024. Review of the medical record on 9/24/24 indicated the pharmacist consultant had completed the drug regimen review on 9/23/24 and had recommendations. During an interview on 9/24/24 at 11:05 A.M., Unit Manager #4 said he has not seen any pharmacy reviews for a while and he has not seen a pharmacist in the building. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	46862 3. Resident #117 was admitted to the facility in November 2023. Review of the medical record for Resident #117 failed to indicate a medication regimen review was completed in May, June, July, and August 2024. During an interview on 9/24/24 at 10:17 A.M., Unit Manager #2 said the paper pharmacy reviews were in Resident #117's medical record. Unit Manager #2 reviewed the paper medical record and did not find any pharmacy reviews for May 2024, June 2024, July 2024 or August 2024. During an interview on 9/24/24 at 10:35 A.M., the DON said the facility came under new ownership in April 2024. The DON said she was not aware that the previous owner had hired a consultant pharmacist to complete pharmacy reviews, as the pharmacy did not have a pharmacist come into the facility. The DON said no pharmacy reviews were completed from May 2024 through August 2024. 49424 4. Resident #79 was admitted to the facility in June 2022. Review of the paper and electronic medical record for Resident #79 indicated a drug regimen review was completed on 4/3/24 and then again on 9/18/24. There was no documentation to indicate the drug regimen review had been conducted by a licensed pharmacist in May, June, July, or August 2024. 15214 5. Resident #88 was admitted to the facility in August 2022. During an interview on 9/25/24 at 11:36 AM, Nurse #2 said that the pharmacist reviews each resident's drug regimen monthly, and the monthly pharmacy reviews are kept in the medical record. Record review indicated that the most recent MRR by the consultant pharmacist was on 9/18/24. Further record review indicated that there were no MRRs by the consultant pharmacist from May 2024 to August 2024. During an interview on 9/24/24 at 9:45 AM, the DON said that the facility had changed ownership in April 2024 and that the monthly MRRs had not been conducted by the consulting pharmacy from May 2024 to August 2024. 6. Resident #94 was admitted to the facility in May 2021. Record review indicated that the most recent MRR by the consultant pharmacist was on 9/18/24. Further record review indicated that there were no MRRs by the consultant pharmacist from May 2024 to August 2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Affinity Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1102 Washington Street Braintree, MA 02184	

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/24/24 at 9:45 AM, the DON said that the facility had changed ownership in April 2024 and that the monthly MRRs had not been conducted by the consulting pharmacy from May 2024 to August 2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
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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 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. 41106 Based on observations and interview, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with accepted professional standards of practice prior to administration for 1 of 4 medication carts reviewed. Specifically, the facility failed to: -For Residents #47, #82, and #117, ensure staff did not pre-pour medications and store them in the medication cart; and -Ensure Schedule II-V controlled substance medications were maintained in a separately locked, permanently affixed compartment. Findings include: Review of the facility's policy titled General Guidelines for Medication Administration, dated September 2018, indicated but was not limited to the following: -Medications are administered as prescribed in accordance with good nursing principles and practices, and only by persons legally authorized to administer. -Medications are administered at the time they are prepared. Medications are not prepared either in advance of medication pass or for more than one resident at a time. On 9/25/24 at 10:57 A.M., the surveyor and Nurse #1 observed the medication cart on Unit M2 and observed in the top drawer, three plastic pill cups which each contained multiple medications. Two of the pill cups were not labeled, the third cup had a piece of paper lying on top with Resident #117's first name only. During an interview on 9/25/24 at 10:59 A.M., Nurse #1 said he pre-poured the medications because the three residents come back from group at 11:00 A.M. and want their medications right away. He said Resident #82's pill cup contained oxycodone (schedule II drug). Nurse #1 said he should not have pre-poured the medication and the Oxycodone should be stored in the narcotic box (under double lock). Review of the narcotic book indicated Nurse #1 signed out the following Oxycodone but was not limited to the following: -Resident #47 had one Oxycodone 10 milligram (mg) signed out on 9/25/2024 at 11:00 A.M. by Nurse #1. -Resident #82 had one Oxycodone 15 mg signed out on 9/25/2024 at 11:00 A.M. During an interview on 9/25/24 12:11 P.M., the Director of Nurses (DON) said she expects the nurses not to pre-pour medication and all narcotics to be stored under double lock (narcotic box).