STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235423	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Hillman	631 Caring St Hillman, MI 49746

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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 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** 40383 Based on interview and record review, the facility failed to ensure accurate advanced directive information was in place for one Resident (R16) of 13 residents reviewed for advanced directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time). Findings include: The medical record revealed R16 was admitted to the facility on [DATE] with diagnoses of dementia, stroke (cerebrovascular accident), and traumatic brain injury. The Minimum Data Set (MDS) assessment, dated 9/8/2024, indicated R16 was classified with a primary diagnosis of Medically Complex Conditions including taking all nourishment via a tube feeding and had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating severe cognitive impairment. The medical record contained: - An ADVANCE DIRECTIVES / MEDICAL TREATMENT DECISIONS form which indicated a Medical Durable Power of Attorney and full resuscitation (full code) dated 9/1/2021. - A DO-NOT-RESUSCITATE ORDER PATIENT ADVOCATED CONSENT form which indicated do not resuscitate (DNR) dated 4/26/2022. - A DECISION MAKING DETERMINATION FORM which indicated R16 was Incapable of making decisions regarding medical treatment. This determination was based upon: Resident's mental status (explain): Dementia, cerebral hemorrhage, confusion. Resident's diagnosis of: Dementia. This form was signed by the attending physician on 9/28/2024 but no Second Physician Signature, Second Physician Name and Date was present. During an interview on 10/08/24 at 9:15 AM, the Social Service Designee (Staff A) was asked about the advance directive change from full code to DNR for R16. Staff A reviewed the medical record and could not find documentation explaining the change and stated, I see it changed in 2022 and I will look for the notes on the decision. During an interview on 10/08/24 at 9:42 AM, Staff A said, The original declaration of incompetency is determined by two physicians but annually this is reassessed by one. The original declaration of incompetency was not found in the medical record and was requested. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/09/24 at 9:58 AM, the Nursing Home Administrator (NHA) stated, We do not have two doctors evaluating competency (for R16). The NHA explained there was nothing found in the hospital transfer records and no documentation was in the facility records to indicate why the code status had been changed. During an interview on 10/09/24 at 10:06 AM, the Director of Nursing (DON) stated, The code status looks like it was changed in 2021 but there is no documentation. Our general practice is to review the code status but there is no documentation of this review. During an interview on 10/09/24 at 10:30 AM, the Regional Registered Nurse (RN) B said, There was not a policy on resident competency, but presented the facility policy titled 'Residents' Rights Regarding Treatment and Advanced Directives', dated as last reviewed/revised on 1/1/2022. This policy read in part, .Any decision making regarding the resident's choices will be documented in the resident's medical record .

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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** 41978 Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the identification and reporting of potential abuse or neglect for one Resident (#93) of two residents reviewed for abuse, resulting in the potential for unidentified abuse or neglect and further exposure to abusive situations. Findings include: Review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed R93 was admitted to the facility on [DATE] and had diagnoses including dementia, stroke, right side hemiplegia (paralysis of right side of the body), and right hip fracture. Further review of the MDS data revealed R93 was dependent on staff for transfers and required partial/moderate assistance for rolling left and right in bed. The MDS data indicated R93 had short-term memory impairment and moderately impaired cognitive skills for daily decision making. Review of R93's MDS assessment, dated [DATE], revealed R93 expired in the facility on [DATE]. Review of R93's electronic medical record (EMR) revealed an assessment titled, Fall Follow Up, dated [DATE] at 1:24 p.m., for follow-up on R93's fall which occurred [DATE]. Further review of the assessment revealed the following: Additional Comments . order initiated . yesterday [DATE] for hematoma [right] upper arm . [R93] continues with linear scratch with tear to site. Cleansing provided and left open to air as ordered with discoloration/bruising now present by site and some bruising presented also to left forearm since additional fall documented in prior [follow-up] note to be [DATE] . Review of R93's assessments revealed no documentation or assessment related to a fall on [DATE] prior to the additional comments added to the follow-up dated [DATE] for R93's fall on [DATE]. Review of R93's Wound Evaluation, dated [DATE] at 8:22 a.m., revealed the following: Hematoma . Upper Right Arm (Inner), New - Minutes old . In-house Acquired . Area 3.26 cm2 [centimeters squared]. Length 5.56 cm. Width 3.38 cm . Review of photograph attached to the Wound Evaluation, revealed R93's right upper arm with noted dark purple bruising at the distal portion of the wound located on R93's inner arm, and reddened areas at the superior and lateral portions of the wound. The center portion of the wound was noted to have linear scratches with a round open area located at the lateral portion of the wound. During an interview on [DATE] at 9:25 a.m., the Director of Nursing (DON) was asked if a report or investigation was completed for R93's injuries noted on [DATE]. The DON presented a Statement of Witness, written, signed and dated by Certified Nursing Assistant (CNA) G on [DATE]. Review of the document revealed the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I was in a resident's room getting them ready for breakfast. As I came out of the room . I was told that my [assistance] was needed as [R93] was found on the floor. We were able to get him back into bed . took [vitals] and two nurses were doing the skin assessment. At this time I had left the room. On [DATE] at 10:03 a.m., the Nursing Home Administrator (NHA) reported there was not an investigation initiated related to R93's injuries to his right upper arm and left forearm. The NHA confirmed the injuries were not reported to her or the State Agency (SA). On [DATE] at 2:00 p.m., the NHA presented an Incident Check off List for Nurses, as the summary of the incident related to R93's right upper arm injury. When asked when the form was completed, the NHA reported the DON had just completed the form as of that day, [DATE]. Review of the Incident Check Off List for Nurses, revealed the date of the incident as [DATE]. The time of the incident only listed the time as am [a.m.] The section of the form titled What Happened, was blank. It was noted the form did not include any information of where the resident was found, who found the resident or who, aside from CNA G, was present when the injury or fall was first identified. Further review of the document revealed R93's injuries included injuries to his right foot, a skin tear to his right knee and caught [right] arm, [no] bruises [at] time. Continued review revealed the following: Unwitnessed, [no] abuse verbalized. It was noted the form included no witness statements, including any statement or interview with R93. The form did not list a fall or any mechanism of injury. Review of the facility policy titled, Abuse, Neglect and Exploitation, last reviewed [DATE], revealed the following, in part: Possible indicators of abuse include . Physical injury of a resident, of unknown source . The facility will have written procedures that include: Reporting of alleged violations to the Administrator, state agency . No later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the thorough investigation of potential abuse or neglect for one Resident (#93) of two residents reviewed for abuse, resulting in the potential for unidentified abuse or neglect and further exposure to abusive situations. Findings include: Review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed R93 was admitted to the facility on [DATE] and had diagnoses including dementia, stroke, right side hemiplegia (paralysis of right side of the body), and right hip fracture. Further review of the MDS data revealed R93 was dependent on staff for transfers and required partial/moderate assistance for rolling left and right in bed. The MDS data indicated R93 had short-term memory impairment and moderately impaired cognitive skills for daily decision making. Review of R93's MDS assessment, dated [DATE], revealed R93 expired in the facility on [DATE]. Review of R93's electronic medical record (EMR) revealed an assessment titled, Fall Follow Up, dated [DATE] at 1:24 p.m., for follow-up on R93's fall which occurred [DATE]. Further review of the assessment revealed the following: Additional Comments . order initiated . yesterday [DATE] for hematoma [right] upper arm . [R93] continues with linear scratch with tear to site. Cleansing provided and left open to air as ordered with discoloration/bruising now present by site and some bruising presented also to left forearm since additional fall documented in prior [follow-up] note to be [DATE] . Review of R93's assessments revealed no documentation or assessment related to a fall on [DATE] prior to the additional comments added to the follow-up dated [DATE] for R93's fall on [DATE]. Review of R93's Wound Evaluation, dated [DATE] at 8:22 a.m., revealed the following: Hematoma . Upper Right Arm (Inner), New - Minutes old . In-house Acquired . Area 3.26 cm2 [centimeters squared]. Length 5.56 cm. Width 3.38 cm . Review of photograph attached to the Wound Evaluation, revealed R93's right upper arm with noted dark purple bruising at the distal portion of the wound located on R93's inner arm, and reddened areas at the superior and lateral portions of the wound. The center portion of the wound was noted to have linear scratches with a round open area located at the lateral portion of the wound. On [DATE] at 9:58 a.m., the Director of Nursing (DON) was asked to present all of R93's incident and fall investigations from [DATE] through [DATE]. Review of the reports provided by the DON revealed no investigation related to a fall or injury on [DATE], as referred to in the Wound Evaluation, dated [DATE] at 8:22 a.m. and the Fall Follow Up assessment dated [DATE] at 1:24 p.m. The DON reviewed R93's record and confirmed she could not fully determine the cause of R93's injury based on the information from CNA G's statement or the EMR. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:25 a.m., the DON was asked if a report or investigation was completed for R93's injuries noted on [DATE]. The DON presented a Statement of Witness, written, signed and dated by Certified Nursing Assistant (CNA) G on [DATE]. Review of the document revealed the following: I was in a resident's room getting them ready for breakfast. As I came out of the room . I was told that my [assistance] was needed as [R93] was found on the floor. We were able to get him back into bed . took [vitals] and two nurses were doing the skin assessment. At this time I had left the room. The DON reported she could not find any other investigative documents at that time but would look for more documentation related to the R93's right upper arm injury and to R93 being found on the floor in his room on [DATE] as referenced in the Fall Follow Up, dated [DATE]. On [DATE] at 10:03 a.m., the Nursing Home Administrator (NHA) reported there was not an investigation initiated related to R93's injury to his right upper arm or of the presumed fall on [DATE]. The NHA presented a hospice service progress note, dated [DATE]. Further review of the document revealed the following, in part: Safety: [R93] fell again this [morning], fell out of bed, caught [right] arm in part of bed, skinned first [and] second toes of [right] root and [right] knee. Bed in low position [and] fall mat next to bed. On [DATE] at 2:00 p.m., the NHA presented an Incident Check off List for Nurses, as the summary of the incident related to R93's right upper arm injury. When asked when the form was completed, the NHA reported the DON had just completed the form as of that day, [DATE]. Review of the Incident Check Off List for Nurses, revealed the date of the incident as [DATE]. The time of the incident only listed the time as am [a.m.] The section of the form titled What Happened, was blank. It was noted the form did not include any information of where the resident was found, who found the resident or who, aside from CNA G, was present when the injury or fall was first identified. Further review of the document revealed R93's injuries included injuries to his right foot, a skin tear to his right knee and caught [right] arm, [no] bruises [at] time. Continued review revealed the following: Unwitnessed, [no] abuse verbalized. It was noted the form included no witness statements, including any statement or interview with R93. The form did not list a fall or any mechanism of injury. Review of R93's care plan revealed the following: Resident has . self-care performance deficit related to CVA/TIA [stroke], dementia, generalized weakness, hemiplegia, impaired ability to make self understood, Date Initiated: [DATE] . Bed Mobility: 2 person assist, Date Initiated: [DATE] .Resident has impaired communication related to history of CVA/TIA with dysarthria [difficulty speaking], anarthria [complete loss of speech], dysphonia and aphasia [difficulty understanding and expressing written and spoken language] . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse, Neglect and Exploitation, last reviewed [DATE], revealed the following, in part: Possible indicators of abuse include . Physical injury of a resident, of unknown source . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include . Identifying and interviewing all involved persons, included the alleged victim, alleged perpetrator, witnesses, and other who might have knowledge of the allegations . Providing complete and thorough documentation of the investigation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45123 Based on observation, interview, and record review, the facility failed to implement fall prevention precautions for one Resident (Resident 20) of three residents reviewed for falls. Findings include: Resident 20 (R20) Review of R20's Electronic Medical Record (EMR), revealed a nursing quarterly/significant change evaluation, dated 9/17/24, indicated R20 had one to two falls in the last 90 days. R20 had fallen on 8/28/24. R20 had a risk fall score of 21, indicating a high risk for falls. Review of R20's care plan, dated 8/7/23, read in part, .Focus .has an ADL (activities of daily living) self-care performance deficit related to dementia, generalized weakness .Interventions: High back wheelchair to promote independence and comfort when up in wheelchair. Ambulation: 1 person assistance with a gait belt . uses a wheelchair for ambulation/transfer .Focus .is at risk for falls/injury related to generalized weakness, high risk of falls, history of falls, impaired cognition with decreased safety awareness .Interventions .Floor alarm mat to right side of bed when resident is in bed, so that staff know when resident is attempting to get self out of bed and staff can intervene to provide appropriate assistance for transfers . On 10/7/24 at 10:30 AM, an observation was made of the Assistant Director of Nursing (ADON) pushing R20 in their wheelchair from the east end nurses' station to their room without foot pedals. R20 was observed holding their feet up out in front of their wheelchair barely off the ground and nearly touching the floor. On 10/7/24 at 10:35 AM, an interview was conducted with the ADON, who was asked when they were with R20 in their room if R20 had foot pedals and replied, Yes. The ADON confirmed that R20's foot pedals were in a bag on the back of R20's wheelchair. The ADON was then asked if they should have put them on and replied, Yes. On 10/8/24 at 10:05 AM, an observation was made of R20 in his room. R20 was sitting on the side of their bed with both feet planted on their fall alarm mat. R20 was observed attempting to get up by pushing their arms on the bed mattress. R20 was unsuccessful and began to attempt to get up a second time. R20's floor alarm mat failed to alarm during R20's attempts to get up out of bed both times. On 10/8/24 at 10:07 AM, Registered Nurse (RN) E was alerted by this Surveyor that R20 was attempting to get out of bed and their floor alarm mat was failing to alarm. RN E walked down the east end hall towards R20's room and stopped at another resident's room to briefly talk with them, and then proceeded to R20's room. RN E asked R20 if they needed anything and R20 replied, 'Need to use the bathroom.' (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/24 at 10:20 AM, an interview was conducted with RN E, who was asked why R20's floor alarm mat failed to alarm and replied, I am not sure. It should have alarmed when R20 was trying to stand up. RN E was asked if they knew how the floor alarm mats worked and replied, I am not exactly sure. I will get maintenance to look at the alarm. On 10/8/24 at 10:25 AM, an interview was conducted with Certified Nurse Aide (CNA) F, who was asked if they knew how the floor alarm mats worked and replied, No. On 10/8/24 at 10:27 AM, an interview was conducted with CNA D, who was asked if they knew how the floor alarm mats worked and replied, I think so. CNA D went into R20's room with this Surveyor to inspect R20's floor alarm mat. CNA D stated that, The floor mat alarm was acting like it was a hit or a miss when the floor alarm mat alarmed. I think they have a delay after they alarm for a few seconds. On 10/9/24 at 12:27 PM, an interview was conducted with the Director of Nursing (DON), who was asked if the cordless alarm mat was the best intervention for R20 and replied, Well, I am not too sure about them yet. They are new. I am not sure exactly how they work or how they reset. I need to get one in my office to look at it closer. I do not know why (R20's) did not go off if (R20) had both feet on the mat and was attempting to get up. The DON was asked if residents needed foot pedals applied to their wheelchairs during transport to a different location and replied, Yes. Staff should be applying foot pedals to prevent accident or injury. Review of policy titled, Fall Prevention Program, dated 10/26/23, read in part, Policy: Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls .Policy Explanation and Compliance Guidelines .5. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a.) Interventions will be monitored for effectiveness .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 41978 Based on interview and record review, the facility failed to administer a blood pressure altering medication within ordered parameters for one Resident (#19) or five residents reviewed for unnecessary medications, resulting in the unwarranted administration of the medication and the potential for adverse side effects. Findings include: Resident #19 (R19) Review of R19's Medication Administration Records (MARs) for September 2024 through October 9, 2024, revealed the following physician order: Midodrine HCL [medication used to treat symptomatic low blood pressure] 10 MG [milligram]. Give 0.5 tablet by mouth three times a day for low blood pressure . hold SBP > 100 [when the top number of the blood pressure is greater than 100] . adjusted per [attending physician] . Start Date: 7/29/2024 . Further revealed the medication was administered outside of the ordered parameters on nine occasions per documentation on the MARs: 9/05/2024, 8:00 a.m., blood pressure 131/81. 9/05/2024, 5:00 p.m., blood pressure 103/67. 9/07/2024, 5:00 p.m., blood pressure 100/64. 9/08/2024, 5:00 p.m., blood pressure 101/62. 9/09/2024, 8:00 a.m., blood pressure 101/62. 9/26/2024, 8:00 a.m., blood pressure 121/63. 9/27/2024, 8:00 a.m., blood pressure 109/56. 9/28/2024, 5:00 p.m., blood pressure 116/71. 10/05/2024, 8:00 a.m., blood pressure 102/60. Further review of R19's electronic medical record (EMR) revealed no corresponding physician notification or order to administer the Midodrine10mg outside of the ordered parameters. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/09/24 at 9:39 a.m., the Director of Nursing (DON) reviewed R19's September 2024 and October 2024 MARs and confirmed the medication was administered outside of the ordered parameters. The DON stated the physician should be notified and a new order obtained if the resident's condition warrants administration outside of ordered parameters. Review of the facility policy titled, Medication Administration, last reviewed 1/17/2023, revealed the following, in part: Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on interview and record review, the facility failed to attempt a gradual dose reduction (GDR) for a psychotropic medication for one Resident (R27) of five residents reviewed for unnecessary medications. Findings include: Review of R27's medical record, revealed an admitted on 5/6/2020 with diagnoses which included major depressive disorder and anxiety disorder. A review of R27's Minimum Data Set (MDS) assessment dated [DATE], revealed a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating fully intact cognition. The medical record noted active Physician's Orders, dated 3/1/22 included: Fluoxetine HCl Capsule 40 mg (milligrams), one tablet a day for depression and busPIRone HCl tablet 10 mg one tablet three times a day for anxiety. During an interview on 10/08/24 at 9:42 AM, the Social Service Designee (Staff A) was asked about the process for GDRs and specifically for the documentation for R27. Staff A stated, The last GDR for busPIRone was on 2/2/2023 and they would look for further documentation on GDRs for R27. During an interview on 10/09/24 at 11:56 AM, the Director of Nursing (DON) stated, There was no GDR documentation for R27. During an interview on 10/09/24 at 12:30 PM, the Nursing Home Administrator (NHA) and Regional Clinical Consultant Registered Nurse (RN) B confirmed there was no GDR information for R27 that was found. The care plan for R27 included, Resident takes psychotropic/mood stabilizer medication as evidenced by antianxiety use, antipsychotic use. Date Initiated: 08/17/2023 Revision on: 08/17/2023. During an interview on 10/09/24 at 2:04 PM, the DON and NHA confirmed there was no GDR tracking that was taking place. The facility policy titled Use of Psychotropic Drugs and Gradual Dose Reductions, dated as reviewed/revised on 10/24/2022, read in part: .Gradual Dose Reduction (GDR) is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued . Reducing the need for and maximizing the effectiveness of medications shall be considered for all residents who use psychotropic drugs. Therefore, dose reductions and behavioral interventions are part of medication management. This policy pertains to gradual dose reductions . [NAME] the first year, a GDR will be attempted annually .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235423	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Hillman	631 Caring St Hillman, MI 49746

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 - Some	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. 41978 Based on observation, interview and record review, the facility failed to ensure appropriate labeling of inhaled medications in one (East Hall) of two medication carts reviewed for medication storage, resulting in the potential for unrecognized expiration of medications, decreased medication efficacy and adverse side effects of expired medications with the potential to affect all 18 residents residing on the East Hall. Findings include: On 10/08/2024 at 8:33 a.m., the East Hall medication cart was reviewed with Registered Nurse (RN) E. Observation of stored inhaled medications revealed an open box containing a Proair HFA inhaler (inhaled medication used to treat wheezing and shortness of breath). Further observation revealed the inhaler had 27 of 200 doses remaining. The inhaler or the box the inhaler was housed in was not labeled with a resident name, open date or expiration date. Upon inspection, RN E reported she could not determine who the inhaler belonged to, if the medication was expired, or when the medication would expire. Further review of the East Hall medication cart with RN E revealed an open Breztri Aerosphere inhaler (inhaled medication used to decrease swelling in the lungs) with 50 of 120 doses remaining. Further review revealed writing in red ink on the outside of the inhaler. The writing was smudged and ineligible. The resident's name, open or expiration date could not be determined. RN E confirmed she could read the smudged writing on the inhaler. Review of the facility policy titled, Medications and Biologicals - Labeling of, last reviewed 6/220/2024, revealed the following, in part: All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices. Medication labels must be legible at all times . Labels for medication designed for multiple administrations (such as inhaler, eye drops), the label with identify the specific resident for whom it was prescribed .