STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Care Center	1131 South Mabelle Avenue Fergus Falls, MN 56537

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure proper implementation of the self-administration of medication (SAM) assessments for 2 of 2 residents (R36, R1), reviewed for medication administration. Findings include: R36's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R36 was cognitively intact and diagnoses of diabetes, heart failure, and arthritis and required the assistance of one staff with activities of daily living (ADL's) for transfers and toileting. R36's physician orders dated 8/4/25, revealed the following: - Lidocaine External Patch 4%, apply to back topically two times a day for pain. Apply at bedtime (HS) and remove at morning (AM). R36's electronic medical record (eMAR) dated 7/1/25 to 8/5/25, revealed nursing staff had applied and removed the lidocaine patch daily following physician’s orders. R36's self-administration of medication (SAM) assessment dated [DATE], indicated R36 was able to self-administer medications after the nurse set-up R36’s medications. During an observation on 8/05/25 at 3:45 p.m., trained medication aid (TMA)-C stated R36 was to have a lidocaine patch applied at HS. TMA-C confirmed R36's box of lidocaine patches were sitting out on R36's dresser in R36's room. TMA-C left the room after giving R36's medications, however, did not put R36’s box of lidocaine patches away in the locked medication drawer. During an observation on 8/06/25 at 8:09 a.m., R36 continued to have an open box of lidocaine patches, containing three unopen patches, sitting on top of R36’s dresser in R36’s room. During an observation and interview on 8/06/2025 at 8:52 a.m., R36's lidocaine patches remained in the same position. R36 indicated she had a patch put on at HS and R36 removed the lidocaine patch independently in the AM. (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/06/25 at 8:32 a.m., pharmacy consultant (PC) stated R36 was to have one lidocaine patch on at a time and nursing staff should have only leave one patch out for R36 to apply. PC further stated it was important to follow the SAM assessments to ensure residents are appropriately using medications. During an interview on 8/06/2025 at 9:01 a.m., clinical coordinator (CC)-A confirmed R36's order for lidocaine patches. CC-A indicated R36 was not able to apply them independently but could remove them independently. CC-A revealed the lidocaine patches should have been put away in R36's drawer when they were not being used. CC-A entered R36's room and put the lidocaine patches away in R36's locked medication drawer. During an interview on 8/06/25 at 9:21 a.m., director of nursing (DON) confirmed the above findings and stated it was important for medication staff to put medications away in the appropriate location for safety reasons. DON further stated it was important for medication staff to return to the residents’ room to ensure medications were taken properly. R1's significant change minimum data set (MDS) dated [DATE], revealed R1 had a mild cognitive impairment. R1 had a diagnosis of having an indwelling urinary catheter, heart failure, and hypertension. R1 needed extensive assistance for activities of daily living (ADLs). R1's signed orders dated 6/17/25, had an order for Clotrimazole ointment 1% (antifungal) for cutaneous candidiasis (skin infection), apply to the penis head twice a day, and Miconazole powder (antifungal) to affected red areas topically as needed when the current supply of nystatin powder (antifungal) is exhausted. R1's care plan revised on 6/6/25, revealed R1 is not able to self-administer medications. R1's self-administration of medication assessment dated [DATE], revealed R1 was not able to self-administer medications. During an observation and interview on 8/4/25 at 1:07 p.m., a tube of Clotrimazole cream 1% and Nystatin powder was sitting on the nightstand. R1 indicated that staff would leave the cream and powder on the nightstand for staff to apply. R1 indicated that if the medications were not left out on the nightstand, staff would not apply the cream and powder, as only one person can get out the cream and powder and apply it when they are locked up. During an interview on 8/4/25 at 1:26 p.m., licensed practical nurse (LPN)-A verified R1 did not have an order to self-administer medication. LPN-A verified there was a tube of Clotrimazole cream 1% and Nystatin powder on R1 nightstand. LPN-A locked up the medications in the medication drawer. During an interview on 8:33 a.m., pharmacy consultant indicated Clotrimazole and Nystatin are both antifungal medications and should have a self-administered assessment done to ensure the resident knows how to correctly administer the medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/6/25 at 9:23 a.m., clinical coordinator manager (CCM)-A indicated medications applied by the nurse or trained medical assistant (TMA) should be in the medication drawer. CCM-A indicated that a self-administration assessment was important to ensure the resident understands how to administer a medication correctly. CCM-A indicated that locking a medication in a medication drawer is important to ensure the safety of residents and visitors. During an interview on 08/06/2025 at 10:23 a.m., director of nursing (DON) verified that creams and powders should be in a locked drawer unless the resident has a self-administration of medications order and was assessed to ensure they were safe to have the medications at bedside. Facility policy titled Self-Administration of Medications dated 2/21, the interdisciplinary team (IDT) assesses each resident’s cognitive ability and physical abilities to determine whether self-administering of medications is safe and appropriate. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess the use of a low bed as a potential restraint for 1 of 1 resident (R32) reviewed for restraints.Findings include: R32's significant change Minimum Data Set (MDS) assessment dated [DATE], identified R32 had severe cognitive impairment and diagnosis of Parkinson's, hypertension (elevated blood pressure) and arthritis. R32 required extensive assistance for activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R32 had no impairment of upper or lower extremities, had a history of falls, and required a wheelchair for mobility. MDS indicated R32 did not use any restraints. R32's significant change Care Area Assessment (CAA) dated 6/24/25, identified R32 had severe cognitive impairment and was a fall risk and R32 did not use any restraints. Review of R32's quarterly fall assessment dated [DATE], identified R32 had balance problems when walking and standing and was a moderate risk for falls. Assessment did not identify the use of any restraints. Review of R32's current physician orders signed 6/17/25, did not identify an order for a restraint. R32's medical record lacked any evidence a restraint assessment had been completed. R32's care plan revised 7/25/25, identified R32 had a self - care deficit and was at risk for falls related to confusion, impaired balance and limited mobility. Identified 32 had a fall on 7/25/25 and directed staff to ensure R32's bed is in the lowest position at night for safety. Identified R32 transferred using a stand-up lift. R32's progress note dated 7/28/25 at 10:55 a.m., identified on 7/25/25 R32 was found on the floor next to her bed. Identified R32 had attempted to self-transfer from bed. Identified a new intervention after fall was to have bed in lowest position when R32 was in bed. During an observation on 8/4/25 at 6:49 p.m., R32's bed was about 1 ft. off the ground and R32 was sitting at the edge of the bed leaning forward and was yelling I can't get up come help me. Nursing assistant (NA)-A and NA-B entered R32's room and assisted R32 to lie back down in bed and boosted R32 up in the bed. During a joint interview on 8/4/25 at 6:56 p.m., nursing assistant (NA)-A stated R32 attempts to get out of bed on her own and had fallen. NA-A stated the latest intervention was to put R32's bed in the lowest position to keep R32 from getting up and falling. NA-B stated the low bed makes it really hard for R32 to stand up on her own. NA-A and NA-B stated R32 was able to stand on her own even though it was not always safe. NA-A and NA-B stated they were unsure if R32's low bed was a potential restraint. During an interview on 8/5/25 at 8:26 a.m., licensed practical nurse (LPN)-A stated R32 's bed is in lowest position because R32 has had falls trying to self transfer out of bed. LPN-A verified R32 was able to stand up on her own. LPN-A stated she did not feel putting R32's bed in lowest position was a restraint because even though R32 was able to stand on her own it was not safe for R32 to stand on her own. LPN-A verified R32's low bed was not assessed as a potential restraint. During an interview on 8/5/25 at 8:33 a.m., physical therapy assistant (PTA) stated R32 was able to stand up on her own and she should wait for help to stand up. PTA stated R32's bed is in the lowest position so that if R32 attempts to stand up on her own and falls it won't be so far to fall. PTA stated she did not think of the low bed as a potential restraint for R32 because R32 was not aware of the potential of falls when she stood on her own. During an interview on 8/5/25 at 10:08 a.m., director of nursing (DON) verified R32's care plan revealed R32 had falls attempting to self- transfer and the latest intervention was for 32's bed to be placed in the lowest position. DON verified a restraint assessment had not been completed prior to placing R32's bed in the lowest position. DON stated she had not thought of the low bed as a restraint for R32 because even though R32 was able to self transfer she was not always safe during self- transfers. DON further stated she could see how R32's low bed could be a potential restraint. DON stated her expectation was that a restraint assessment would have been completed prior to placing R32's bed in the lowest position. Review of a facility policy titled Restraint Free Environment revised 2025, identified a physical restrain refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body such as placing a resident in a chair that prevents the resident from rising independently.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded to include the use of safety alarms for 1 of 1 residents (R17) reviewed for MDS. Findings include R17's significant change in status MDS dated [DATE], identified R17 had medically complex conditions, hypertension, anxiety, and depression. R17 needed extensive assistance with activities of daily living (ADLs). R17 did not use a bed alarm, chair alarm, floor mat alarm, or motion sensor alarm. R17's care plan was revised on 7/25/24, revealing R17 had audible wheelchair and silent bed and recliner alarms. R17's signed orders dated 6/17/25, revealed R17 had orders to monitor the placement and function of the bed and recliner alarm, and the audible wheelchair alarm every shift for fall intervention; the order start date was 2/6/24.During an observation on 8/4/25 at 6:48 p.m., R17 was in the living room area next to the dining room, with a chair alarm on the back of the wheelchair. During an observation on 8/5/25 at 8:05 a.m., R17 was lying down in bed, the bed was low to the floor with a floor mat and a bed alarm attached to the bed. During an observation on 8/5/25 at 12:10 p.m., R17 was not in the room, but the alarm strip was on the bed. R17 was in a wheelchair, sitting in front of the television with an alarm on the back of the wheelchair. During an observation on 8/6/25 at 7:10 a.m., R17 was in a low bed with a bed alarm attached to the bed. During an interview on 8/5/25 at 12:15 p.m., registered nurse (RN)-E, verified R17 has had a bed alarm and a chair alarm since RN-E started working at the facility about a year ago.During an interview on 8/5/25 at 2:17 p.m., MDS coordinator verified the MDS was not coded for a bed alarm or a chair alarm. The MDS coordinator viewed the Kardex and the care plan and verified R17 did have a bed alarm and chair alarm and should have been coded on the MDS. The MDS coordinator indicated the process was to review the assessments, care plan, and care conference notes when completing an MDS. The MDS coordinator indicated at times she would perform a visual assessment on a resident, but did not have a visual assessment when completing R17's MDS. During an interview on 8/5/25 at 2:52 p.m., RN-F viewed R17's care plan and Kardex and verified R17 had a bed alarm and chair alarm and should have been coded on the MDS. During an interview on 8/6/25 at 10:21 a.m., director of nursing (DON) expectation would be for the MDS coordinator to review the care plan. DON verified the bed alarm and chair alarm were located in R17's care plan. DON's expectation would be for the MDS to be coded correctly. Review of the facility policy titled Resident assessments dated October 2023, revealed information in the MDS assessment will consistently reflect information in the progress notes, plans of care, and resident observations/interviews.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure recommended splint or alternative devices were utilized to help prevent further contractures and stiffness for 1 of 1 residents (R11) reviewed for range of motion (ROM). Findings include:R11's annual Minimum Data Set (MDS) assessment dated [DATE], identified R11 had severe cognitive impairment and had diagnoses of cerebral palsy (irregular brain development that affects movement and posture), seizure disorder, and malnutrition. Indicated R11 required extensive assistance of staff for activities of daily living (ADLs) including transfers and toileting. R11's care plan revised 7/26/23, identified R11 had limited physical mobility related to the disease process. Additionally, R11 had the potential for skin impairment related to decreased mobility. R11's care planned interventions included:- Apply small towel roll in between left elbow and shoulder and small roll in left palm web space.- Left Hand Contractures: Place foam roll in palm of left hand between thumb and palm to prevent skin breakdown. Remove and check skin every two hours and as needed. R11's treatment administration record (TAR) dated 7/1/25 to 8/5/25, identified R11 was to apply a small towel roll in between left elbow and shoulder and small roll in left palm web space Monday, Wednesday, and Friday.R11's Kardex dated 8/5/25 revealed the following:- Left Hand Contractures: Place small towel/washcloth as resident will tolerate in left palm between thumb and palm every two hours and as needed.- Place small towel/ washcloth as resident will tolerate between left elbow and shoulder. Notify nurse if noted skin alternation. During an observation on 8/4/25 at 12:18 p.m., R11 was lying in bed with eyes closed. R11 left hand was tightly closed with thumb pressed against palm of hand and four fingers placed over thumb. Additionally, R11's left arm was bent up at the elbow. R11 was able to move right hand open and closed. R11 is non-verbal and unable to answer any questions. R11 did not have a washcloth or foam roll placed in R11's left hand and left elbow.During an observation on 8/4/25 3:30 p.m., R11 remained in a similar position as noted above.During an observation on 8/4/25 at 7:02 p.m., R11 was resting in bed with music playing. R11 had a gown on and was covered with a thin blanket. R11 did not have a washcloth or foam roll placed in R11's left hand and left elbow.During an observation on 8/5/25 at 8:20 a.m., R11 was resting in bed covered with a blanket. R11 was listening to music with R11's eyes closed. R11 did not have a washcloth or foam roll placed in R11's left hand and left elbow.During an observation and interview on 8/5/25 to 9:47 a.m., registered nurse (RN)-E entered R11's room to provide medications. RN-E stated R11 did not have a brace for R11's left hand. RN-E further stated staff were to be doing range of motion (ROM) on R11's upper extremities to help reduce further contractures. RN-E provided ROM on R11 after completing medication administration. RN-E completed ROM, cleaned up supplies, left R11's room, and charted ROM in R11's TAR.During an interview and observation on 8/5/25 at 11:06 a.m., rehabilitation director (RD) revealed passive range of motion (PROM) of R11's upper extremities was an order from occupational therapy (OT). RD further revealed R11's left hand was contracted when R11 was admitted to the facility and R11 could not use a brace. RD indicated OT ordered the use of a washcloth in place of a brace. RD further indicated R11 had an order to place a washcloth in the left hand and left elbow Monday, Wednesday, and Friday. RD reviewed R11's care plan and stated another intervention was listed for staff to place a foam roll in R11's left hand and monitor every two hours. RD confirmed the correct order should have been to place a washcloth in R11's hand and elbow Monday, Wednesday, and Friday. RD entered R11's room to evaluate R11's left hand to see if contractors had gotten worse. RD stated there had not been much change in R11's left hand and left arm. RD indicated R11 would still benefit from having a washcloth placed in R11's hand and elbow as tolerated Monday, Wednesday, and Friday.During an interview on 8/5/25 at 11:22 a.m., registered nurse (RN)-F and RD reviewed R11's orders and care plan. RN-F confirmed the current orders and care plan interventions for R11 and indicated RN-F was unaware what exact orders staff should have been following. RN-F indicated RN-F would contact the clinical coordinator to confirm the correct orders for R11. During a follow-up interview on 8/5/25 at 2:13 p.m., RN-F indicated the clinical coordinator stated R11 should have had the foam roll intervention removed from the care plan. RN-F further indicated the correct order was currently listed on the TAR and staff should have been following the current order.During an interview on 8/5/25 at 2:33 p.m., director of nursing (DON) confirmed the above findings and stated she expected staff to follow the plan of care to ensure residents do not have a decline in care. DON further stated it is important residents continue to keep the highest level of ROM as possible. Facility policy titled restorative nursing services revised 7/17, resident will receive restorative nursing care as

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and document review, the facility failed to ensure required nurse staffing information was consistently posted on a daily basis. This had the potential to affect all 90 residents, staff, and visitors who may wish to view the information. Findings include: On 8/4/25 at 11:19 a.m., the facility staff posting was sitting on a desk across from the elevator. The staff posting was dated 8/2/25 with a census of 88. During an interview on 8/4/25 at 11:24 a.m., director of nursing (DON) confirmed the date and census on the staff posting were incorrect. DON indicated the process was to update the nurse staff posting daily. The DON removed the Saturday staff posting, and behind was the Sunday staff posting. Monday's staff posting was located behind Sunday's. Monday was then placed on the counter, which was the current schedule, but had the incorrect census of 88. DON indicated the scheduler is responsible for creating the daily staff posting. The charge nurse was responsible for updating the staff posting with changes regarding resident census or staffing changes. During an interview on 8/4/25 at 12:00 p.m., the scheduler indicated the normal process is to create the nurse staff posting for the following day between 2:00 p.m. and 3:00 p.m. and post it behind the current staff posting. The scheduler indicated on Fridays, she would create the Saturday, Sunday, and Monday schedules and would post them behind Friday, as the scheduler does not work weekends. If there was an admission for the day, the scheduler would not put it on the current census, but would make changes for the following day's staff posting. The scheduler indicated the charge nurse would change the nurse staff posting on the weekends and make any updates regarding changes related to staffing or the census. A review of the facility policy, titled Posting Direct Care Daily Staffing Numbers, dated August 2022, revealed the facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. The information recorded on the form shall include the name of the facility, current date, the resident census at the beginning of the shift for which the information is posted, twenty four hour shift schedule operated by the facility, the shift for which the information is posted, the type and category of nursing staff working during that shift who are paid by the facility, the actual time worked during that shift for each category and type of nursing staff and the total number of licenses and non-licenses nursing staff working for the posted shift.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure medications were labeled appropriately to include administration directions, insulin pens were dated and not expired and failed to dispose of expired eye drops per manufacturer recommendation's for 9 of 9 residents (R47, R69, R92, R36, R40, R73, R19, R10, R13) reviewed during medication storage and administration. Finding include: R47's medication review report signed [DATE], included orders for Thera Tears (for dry eyes) solution 0. 25%, install one drop in both eyes four times a day for dry eyes. During an observation and interview on [DATE] at 3:31 p.m., a bottle of Thera Tears 0.25% eye drops was in R47's medication drawer. The bottle had no name, label, or date opened. The directions on the bottle from the manufacturing company indicated to install 1-2 drops in the affected eye as needed. Registered nurse (RN)-B indicated the box the eye drops came in was thrown after it was verified with the EMAR. RN-B checked the EMAR and indicated R47 receives Thera Tears four times a day, which was different than what was written on the bottle. RN-B indicated staff would follow the orders on the MAR and not on the bottle. During an observation and interview on [DATE] at 9:10 a.m., RN-C verified there was no name or directions on the R47 Thera Tears eye drop bottle. RN-C indicated the directions are on the EMAR and would follow the directions on the EMAR. RN-C indicated the family would bring R47's eye drops; that is why there is no name or label on the eye drop bottle. R69 R69's medication review report signed [DATE], included orders for latanoprost 0.005%, install one drop in both eyes one time a day for glaucoma. During an observation and interview on [DATE] at 3:34 p.m., R69 had a bottle of latanoprost (glaucoma) 0. 005% eye drops in the medication drawer. There was no date of when the medication was opened, RN-B indicated the facility has a list of medications and when they expire on the medication cart from the pharmacy. RN-B verified the eye drops were open, and the EMAR indicated the eye drops expire 5/26. During an observation and interview on [DATE] 9:12 a.m., RN-C verified R69 latanoprost 0.005% eye drops had no date of when it was opened or when it expired on the eye drop bottle. RN-C indicated the process was to write on the eye drop when it was opened. RN-C indicated latanoprost normally expires in 28-40 days after being opened. RN-C indicated staff would write in the MAR when a medication expires. RN-C looked at the EMAR and showed the EMAR had the latanoprost expiring 5/26. (continued on next page)

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	245463	A. Building B. Wing	08/06/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:23 a.m., clinical coordinator manager (CCM)-A indicated staff should date eye drops after opening. CCM-A was under the assumption that latanoprost eye drops expire 28 days after opening. CCM-A indicated staff should throw the eye drops if not dated when opened, and to order new eye drops from the pharmacy. CCM-A indicated it is important not to administer a medication when it has expired, to ensure the medication is working at its full strength. CCM-A checked with the pharmacy and confirmed the latanoprost eye drops were filled on [DATE], which indicates the medication had not expired. CCM-A indicated she would date the medication with the correct expiration date. CCM-A also provided a list of medications and expiration dates that the facility uses, and according to the list, latanoprost was good for six weeks after opening and being unrefrigerated. CCM-A also indicated the facility had labels with the resident names and room number for medications that were brought in by family and should have been applied to R47 eye drops. R92 R92’s Medication Review Report signed undated, revealed the following: - Artificial Tears Ophthalmic Solution1.4% instill one drop in both eyes as needed for dry eyes four times a day (QID). - Artificial Tears Ophthalmic Solution 1.4% instill one drop in both eyes three times a day for cataract evaluation until [DATE]. R92’s eMAR dated [DATE] to [DATE], revealed the following: - Ketorolac Tromethamine Ophthalmic Solution 0/5% instill one drop in both eyes one time a day for cataracts for 14 days starting [DATE]. - Ketorolac Tromethamine Ophthalmic Solution 0/5% instill one drop in both eyes one time a day for cataracts for 14 days starting [DATE]. - Prednisolone Acetate Ophthalmic Suspension 1% instill one drop in both eyes one time a day for cataract surgery for 21 days starting [DATE]. - Prednisolone Acetate Ophthalmic Suspension 1% instill one drop in both eyes one time a day for cataract surgery for 21 days starting [DATE]. - Refresh Tears Ophthalmic Solution (Carboxymethylcellulose Sodium) instill one drop in right eye three times a day for dry eyes starting [DATE]. - Refresh Tears Ophthalmic Solution (Carboxymethylcellulose Sodium) instill one drop in right eye as needed for dry eyes starting [DATE]. - Moxifloxacin HCL Ophthalmic Solution 0.5% instill one drop in both eyes four times a day for cataract surgery for seven days starting [DATE]. During an observation/interview on [DATE] at 3:45 p.m., RN-B opened R92’s locked medication drawer in R92’s room. Located in a cup in R92’s drawer revealed the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Refresh Tears Ophthalmic Solution (Carboxymethylcellulose Sodium) with R92’s name and prescription number (Rx). Eye drops lacked boxed packaging and instructions. - Moxifloxacin Ophthalmic Solution 0.5% with R92’s name and Rx number. Eye drops lacked boxed packaging and instructions. - Prednisolone Acetate Ophthalmic Suspension and lacked R92’s name, Rx number, boxed packaging, and instructions. RN-B confirmed the above findings and stated eye drops should be in the boxed packaging labeled with resident’s name, Rx number, and directions. R36 R36's Medication Review Report signed [DATE], included orders for Lantus Solo Star Subcutaneous solution Pen-injector 100 unit/ML (insulin Glargine) inject 8 units subcutaneously once a day for diabetes. R36's electronic medical record (eMAR) dated [DATE] to [DATE], identified R36 was currently receiving 8 units of Lantus insulin injection one time a day at bedtime. During an observation/interview on [DATE] at 3:33 p.m., trained medication aid (TMA)-C reviewed insulin pen with surveyor and confirmed the pen was not dated. TMA-C indicated TMA-C was aware pens were only good for 28 days after they were opened. TMA-C took the pen to registered nurse (RN)-F who confirmed the insulin pen was undated. RN-F discarded the insulin pen in the sharp’s container. R40 R40's Medication Review Report signed [DATE], included orders for Lantus Solo Star Subcutaneous solution Pen-injector 100 unit/ML(insulin Glargine) inject 14 units subcutaneously once a day for diabetes. R40's current medication administration record (MAR) identified R40 was currently receiving 14 units of Lantus insulin injection at bedtime daily. R73 R73's Medication Review Report signed [DATE], included orders for Latanoprost Solution 0.005% one drop to each eye once per day for glaucoma. R73's MAR identified R73 was currently receiving Latanoprost Solution 0.005% one drop to each eye once per day. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on [DATE] at 3:33 p.m., registered nurse (RN)-D confirmed R40's insulin pen in the locked drawer was not dated and R73's Latanoprost Solution 0.005% eye drops had an expiration date of [DATE]. RN removed the insulin pen from R40's locked medication drawer and the eye drops from R73's locked medication drawer and brought them to the medication room to be destroyed. RN-D verified Lantus insulin pen was good for 28 days and stated her expectation was R40's insulin pen would have been dated when it was opened. RN-A further stated her expectation was R73's eye drops were thrown away on or before the expiration date to ensure the medications were effective. R19 R19's Medication Review Report signed [DATE], included orders for Silicon Oil (Sil-Optho) prosthetic lubricant- one drop to left prosthetic eye twice a day for lubrication as needed. Artificial tear solution- instill one drop in right eye as needed for dry eye, and one drop in right eye five times a day for dry eye. Muro 128 ointment 5%- instill one application in right eye one time a day for corneal abrasion to right eye. During observation on [DATE] at 3:33 p.m., registered nurse (RN)-A confirmed R19 had a bottle of Sil-Optho not labeled, a bottle of Eye Relief not labeled, and a tube of Muro 5% not labeled. RN-A removed the medications from R19's medication locked drawer and brought to medication room, then indicated they would be destroyed. R10 R10's Medication Review Report signed [DATE], included order for Nitrogycerin Sublingual (below tongue) 0.4 milligram (MG)- give one tablet sublingually as needed for chest pain. Give one dose every five minutes for chest pain. Do not exceed three doses in 15 minutes. During observation on [DATE] at 3:44 p.m., RN-A confirmed R10 had two bottles of nitroglycerine, one with a label which included R10's name only and one not marked. RN-A stated they both should have R10's name and instructions attached. R13 R13's Medication Review Report signed [DATE], included orders for Breztri Aerosphere Inhalation Aerosol 160-9-4.8 microgram (MCG-ACT)- two puffs inhale orally two times a day for wheezing. Muro 128 ointment 5%- instill one drop in both eyes at bedtime for dry eye 1/4 strip in both eyes. During observation on [DATE] at 3:57 p.m., trained medication aide (TMA)-A indicated R13's two Brezti inhalers were not labeled. One was in her medication drawer, and one was on her bedside table. TMA-A stated there was a box for the inhaler with the label on it at one time, but it was not in R13's drawer anymore. R13 also had a Muro 5% eye ointment with no label. TMA-A indicated the Muro had a label, but it was not on it anymore. TMA-A also stated no expiration date was found on the Muro ointment. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on [DATE] at 8:32 a.m., consultant pharmacist (CP)-A indicated all medications should have a pharmacy label with the resident's name and instructions. CP-A indicated if the medication was too small for a full label, she would expect the medication to be labeled with the resident's name and instructions to see electronic medication administration record (EMAR) for directions. CP-A stated if the medication was received in a box, the medication should be stored in the box which would contain the pharmacy label. CP-A stated it was important for medications to be labeled correctly to assure used correctly and for correct resident. CP-A indicated Xalatan/latanoprost eye drops expired 42 days or six weeks after opened. They should be labeled with date opened, and destroyed once expired. CP-A stated insulin pens should be dated when first used, and destroyed after manufactures recommended dates of how long the pens should be used, which was usually 28 days. CP-A indicated eye drops, and insulin pens should be dated when opened, and not used after expiration date per manufactures instructions. During interview on [DATE] at 9:14 a.m., director of nursing (DON) indicated her expectation was all medications would be labeled with resident's name, expiration date and directions for use. If the medication was not large enough for the full label, it should be kept in the box it came in. DON indicated the facility had labels they could use that had the resident's name and to refer to chart for direction of use. DON stated labels on medications were important to follow the rights of medication administration and safety. DON stated the facility had a shortened expiration date form, provided by pharmacy, which indicated which eye drops had shortened expiration dates after opened. DON stated her expectation was the eye drops were labeled when opened and disposed of when expired. DON stated insulin pens should also be dated when opened and disposed of when expired. DON indicated most insulin pens were to be disposed of after 28 days. DON stated it was important to dispose of medications after expiration as the medication may not be as effective after expired. The facility policy titled Medication Labeling And Storage revised 2/23, identified medications were stored in packaging, containers or other dispensing systems they were received. The policy identified medication labels included medication name, prescribed dose, strength, expiration date when applicable, resident's name, route of administration, and appropriate instructions and precautions. If medication containers had missing, incomplete, improper or incorrect labels, contact pharmacy for instructions regarding returning or destroying those items.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure food stored in the refrigerators and freezers were labeled, dated and discarded properly. This deficient practice had the potential to affect all 89 residents who received food from the refrigerators, freezers and the kitchen.Findings include:On 8/4/25 at 9:44 a.m., during the kitchen tour with the cook the following concerns were identified. Walk in cooler-half container of sour cream without notation of an opened date and an expiration date of 6/20/25.Fridge in kitchen-1/4 container of mustard with an expiration date of 7/28/25.-1/2 bottle of barbeque sauce without notation of an opened date and no expiration date.During an interview on 8/4/25 at 10:20 a.m., cook verified the above findings during the kitchen tour. [NAME] stated her expectation was all opened food should have been dated and thrown away on or before the expiration date to prevent food-borne illness. During an interview on 8/4/25 at 10:30 a.m. dietary manager (DM) stated her expectation was all food should have been dated when it was opened and thrown away after the shelf life or the expiration date to prevent food-borne illness.Review of a facility policy titled Food Storage updated 3/23/25, identified leftover foods should be stored in covered containers or wrapped and clearly labeled, dated and monitored to assure that foods are consumed by their safe use by dates, or frozen.