STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265249	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maries Manor	174 Ballpark Road Vienna, MO 65582

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility staff failed to maintain the kitchen ceiling in good repair to prevent contamination of food items. This failure has the potential to affect all residents. The facility census was 65.1. Observation on 08/12/25 at 11:40 A.M. showed the kitchen with the following: -Ceiling was covered with a white textured, plaster like material;-A 33-inch crack in the ceiling above the end of the steam table with the ceiling sagging on one side of the crack;-A 22-inch crack in the ceiling and areas of white flaking ceiling material above the ware storage rack near the service window;-A 16-inch crack between the prep counter and bakery;-A 3-inch area of white flaking ceiling material above the steam table;-A 4-inch area of white flaking ceiling material above the ceiling mounted utensil hanger;-Two areas of white flaking ceiling material and a sagging, water stained area near the coffee pots.During an interview on 08/12/25 at 1:00 P.M., the Dietary Manager (DM) said he/she was aware of the cracks in the ceiling. The DM said there were issues with small water leaks in the ceiling. The DM said the maintenance director was aware of the ceiling issues.During an interview on 08/13/25 at 11:30 A.M., the maintenance director said he/she was aware of the cracks in the kitchen ceiling. The maintenance director said there was an issue with condensation over the past few weeks and he/she had to wait for the areas to dry before he/she could make repairs.During an interview on 08/14/25 at 12 10 P.M., the administrator said kitchen staff were responsible for telling maintenance about any building issues. The administrator said the kitchen ceiling should not have cracks or flaking areas since the materials could fall into food. The administrator said he/she was not aware of any kitchen ceiling issues prior to the survey. The administrator said the facility did not have a policy related to facility ceiling maintenance but staff followed regulatory guidance.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to appropriately sanitize a multi-use glucometer (a device for monitoring blood sugars) between use for two (Resident #3, and #51) out of five sampled residents. Staff failed to perform appropriate hand hygiene and glove changes in a manner to prevent or reduce the spread of bacteria and other infection causing organisms during blood glucose checks for three (Resident #28, #45, and #51) out of five sampled residents. Staff failed to utilize personal protective equipment (PPE) for two (Resident #7 and #47) out of two sampled residents on enhanced barrier precautions (EBP) during wound care and/or catheter care The facility census was 65.1. Review of the facility's policies showed staff did not provide a policy on glucometer disinfection.Review of the facility's Blood Glucose Monitoring System Manual, undated, showed the manual directs staff as follows:-Meter should be cleaned and disinfected between each patient;-The following products have been approved for cleaning and disinfecting the meter:i. Dispatch hospital cleaner disinfectant towels with bleach;ii. Medline Micro-Kill+ Disinfecting, Deodorizing, Cleaning Wipes with Alcohol;iii. Clorox Healthcare Bleach Germicidal and Disinfecting Wipes;iv. Medline Micro-Kill Bleach Germicidal Bleach Wipes.-To clean meter, use a moist (not wet) lint-free cloth dampened with a mild detergent. Wipe all external areas of the meter including both front and back surfaces until visibly clean;-To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes. Other Environmental Protection Agency (EPA) registered wipes may be used for disinfecting the meter, however these other wipes have not been validated and could affect the performance of your meter;-Wipe all external areas of the meter including both front and back surfaces until visibly wet.2. Observation on 08/13/25 at 11:43 A.M., showed Licensed Practical Nurse (LPN) B obtained Resident #51's blood sugar with the multi-use glucometer, exited the room, and wiped the glucometer with an alcohol pad. LPN B did not use an approved EPA registered healthcare disinfectant for the meter. LPN B then used the glucometer to obtain Resident #3's blood sugar. During an interview on 08/13/25 at 11:50 A.M., LPN B said he/she did know that the multi-use glucometer needs to be cleaned with the Sani-Cloth wipes in the tubs, but they were not available. The LPN said he/she did not ask for any either.3. Review of the facility's Gloves policy, undated, showed staff are directed to wear gloves when it can be reasonably anticipated that hand will be in contact with mucus membranes, nonintact skin, any moist body substances (blood, etc.) Gloves should be changed between residents and between contacts with different body sites of the same resident.4. Observation on 08/11/25 at 12:20 P.M., LPN A entered Resident #45 room, did not wash or sanitize his/her hands, placed gloves on and obtained the resident's blood sugar. LPN A pulled the blood glucose test strip from the glucometer by the blood saturated tip to remove. With the same soiled gloves, the LPN touched his/her computer mouse and computer. Observation on 08/11/25 at 12:24 P.M., LPN A entered Resident #28's room, did not wash or sanitize his/her hands, placed gloves on and obtained the resident's blood sugar. LPN A pulled the blood glucose test strip from the glucometer by the blood saturated tip to remove. With the same soiled gloves, the LPN touched his/her mouse, misc. items on cart and the computer.Observation on 08/11/25 at 12:28 P.M., LPN A entered Resident's #51's room, did not wash or sanitize his/her hands, placed gloves on and obtained t blood sugar. He resident's blood sugar. LPN A pulled the blood glucose test strip from the glucometer by the blood saturated tip to remove. With the same soiled gloves, the LPN touched his/her mouse and computer. During an interview on 08/14/25 at 2:05 P.M., the Director of Nursing (DON) said staff should wash or sanitize hands before and between blood sugar checks. Gloves should be removed after checks and hands washed or at least sanitized. The DON said it is not appropriate to use alcohol pad to clean the glucometer, staff are expected to use the approved disinfectant. The DON said the Sani-Wipes are available and that is what staff should use. The DON said the facility does use agency nurses a lot, but they have been educated. He/She said unknown (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	how good training was if she was not there when they come, but she/he would consider these things to be standard nursing practices. During an interview on 08/14/25 at 2:40 P.M., the administrator said staff are expected to clean their hands between any resident task. The administrator said she would expect staff to follow policy and procedures that pertain to blood sugar checks. 5.Review of the facility's EBP to infection Control Guidance, undated, showed:-Implement EBP on residents with indwelling medical device including catheters and residents with a wound, regardless of their multidrug-resistance organism (MRDO) status;-When to implement EBP;-High-contact resident care activities: providing hygiene, caring for a resident with an indwelling device, and performing wound care.Review of the Centers for Disease Control (CDC) website, https://www.cdc.gov/hicpac/workgroup/EnhancedBarrierPrecautions.html article, Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities, dated June 2021, showed:-Facilities should develop a method to identify residents with wounds or indwelling medical devices, and post clear signage outside of resident rooms indicating the type of PPE required and defining high risk resident care activities;-Gowns and gloves should be available outside of each resident room, and alcohol-based hand rub should be available for every resident room (ideally both inside and outside of the room).7.Review of Resident #7's admission MDS, dated [DATE], showed staff assessed the resident as-Cognitively intact;-At risk for developing pressure ulcers/injuries;-Has a stage 1 (non-blanchable redness over a bony prominence) unhealed pressure injury;-Has a catheter.Observation on 08/13/25 at 3:55 P.M., showed LPN B entered the resident's room to perform wound and catheter care. Observation showed the LPN did not put on a gown before he/she provided wound and catheter care.8. Review of Resident #47's Annual MDS, dated [DATE], showed staff assessed the resident as:-Cognitively intact;-At risk for developing pressure ulcers/injuries;-Has one [NAME] and arterial ulcers present. Review of the resident's care plan, dated 05/28/25, showed the plan it directed staff to use EBP for wound care.Observation on 08/13/25 at 11:03 A.M., LPN B entered the resident's room to perform would care. He/She did not put on a gown before he/she performed wound care.9. During an interview on 08/13/25 at 4:10 P.M., LPN B said residents with wounds or catheters should be on EBP. He/She said it is standard care for nurses to wear gowns when performing care on any residents on EBP including wound and catheter care. He/She said he/she did not wear a gown because he/she forgot. He/She said wearing PPE is important to prevent the spread of infections. During an interview on 08/14/25 at 1:57 P.M., the DON said residents with wounds and catheters are on EBP. He/She said they should have a PPE tower outside their room and a yellow sticker next to their name on their door to alert staff. He/She said staff have been educated and it is his/her expectation that they wear gowns and gloves when performing care on the residents who are on EBP. He/She said the PPE is to prevent cross contamination. He/She said he/she was not aware staff were not using PPE during care. During an interview on 08/14/25 at 2:30 P.M., the administrator said residents with wounds and catheters should be on EBP. He/She said the DON is responsible for educating the staff and it is his/her expectation that staff use the PPE when providing care to those residents.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, facility staff failed to implement an Antibiotic Stewardship Program with antibiotic use protocols and a system to monitor and track antibiotic use within the facility. The facility census was 65. 1. Review of the facility's policy titled, Antibiotic Stewardship Program , dated 4/10/25, showed: -The Director of Nursing (DON) will be responsible to audit the clinical assessment documentation at the time of the antibiotic prescription. This will include all relevant documents such as the Stop and Watch, Situation, Background, Assessment, Recommendation (SBAR), physician communication, and follow-up with diagnostic testing;-The DON will be responsible for auditing of the completeness of antibiotic prescribing documentation to include dose, route, start date, end date, days of therapy, and indication;-The Antibiotic Stewardship Program team will monitor antibiotic starts by indication;-All patients/residents transferred to or from the facility who are on an antibiotic will have adequate documentation of dose, duration, and indication for the antibiotic. This will aide in determining the appropriateness of treatment based on additional laboratory/clinical data and patient/resident response to treatment. This will also ensure discontinuation in a timely manner.Review of the facility's antibiotic stewardship program showed facility staff did not track antibiotic trends.During an interview on 08/12/25 at 2:12 P.M., the DON said the person who was responsible for the facility's Antibiotic Stewardship Program left two weeks ago. He/She said the binder provided is all the documentation he/she has for tracking and trending antibiotics and infections. He/She said their MDS Coordinator and himself/herself are both certified as an infection preventionist but neither have the time to fill the position, so no one is currently fulfilling the role.During an interview on 08/14/25 at 2:30 P.M , the administrator said the previous Assistant director of nursing (ADON) was responsible for maintaining the ASP. He/She said he/she was not aware that the Antibiotic Stewardship Program was not being completed.

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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** Based on interview, and record review, facility staff failed to maintain professional standards of practice when staff failed to transcribe a treatment order for one resident (Resident #7) and accurately transcribe a medication order for a Fentanyl patch (to treat pain) for one resident (Resident #75) out of two sampled. The facility census was 65.1. Review of the Facility's Wound Care Treatment policy, undated, showed there must be a specific order for the treatment. 2. Review of Resident #7's admission Minimum Data Set (MDS), a federally mandated assessment tool, 06/30/25, showed staff assessed the resident as:-Cognitively intact;-At risk for developing pressure ulcers/injuries;-Has a stage 1 unhealed pressure injury (initial stage of skin and tissue damage caused by prolonged pressure).Review of the resident's Initial and Weekly wound documentation, dated 06/30/25, showed:-Resident admitted with stage 1 decubitus ulcer right inner buttock;-Treatment: Optifoam (a brand of foam dressing used for wound care) for protection.Review of the resident's Physician Order Sheet (POS), dated 06/30/25, showed the record did not contain an order for Optifoam treatment.Review of the resident's Treatment Administration Record (TAR), dated 06/30/25, showed the record did not contain a treatment for Optifoam. During an interview on 08/14/25 at 2:01 P.M., the Director of Nursing (DON) said when a resident admits to the facility, the nurse who admits him/her is expected to contact the doctor to verify orders. The DON said he/she is responsible to check and review orders are correct. The DON said he/she is unsure why the treatment order was never put in the resident's chart, but the expectation would be the order was put in the resident's chart and on their TAR. The DON said he/she was not aware the order was not put in, but also did not check to verify, it must have been missed. During an interview on 08/14/25 at 2:35 P.M., the administrator said the floor nurse who gets the order or does the admission should put treatment orders in the resident's electronic medical record (EMR). Once in, any nurse can see this order and make sure the treatment is done. The DON is responsible to review and verify orders are correct in the residents' EMR. 3. Review of the facility's Telephone Order Processing policy, undated, showed the following: -Obtain the telephone order from prescriber and write telephone order on the physician's order form;-Record date and time order was received and write order on telephone order form exactly as written on physician's order form. 4. Review of Resident #75's Annual MDS, dated [DATE], showed staff assessed the resident as:-Cognitively intact;-Experienced frequent pain. Review of the resident's plan of care, updated on 07/15/25, showed staff assessed the resident with a knee amputation due to a wound infection. Review showed the nurse will monitor pain levels, give medications as ordered by the physician, evaluate and record/report effectiveness and any adverse side effects. Review of the resident's POS, dated 06/26/25 through 08/13/25, showed an order for a Fentanyl patch 25 microgram (mcg)/hour every 72 hours as follows:-Special instructions to apply one patch every 72 hours;-Frequency of once a day every four days;-Order date of 06/26/25. Review of the residents Medication Administration Record (MAR), dated 06/26/25 through 08/13/25, showed the following order: -Fentanyl patch; 72 hour; 25 mcg/hr;-Special instructions to apply one patch every 72 hours;-Frequency of once a day every four days. Review of the resident's MAR, dated 06/26/25 through 08/13/25, showed staff documented they administered the Fentanyl patch every 96 hours instead of every 72 hours.During an interview on 08/14/25 at 11:39 A.M., the MDS Coordinator said he/she was the nurse who obtained the Fentanyl telephone order from the prescribing physician, and the nurse who entered the Fentanyl order into the facility's electronic MAR system. The MDS Coordinator said he/she entered the Fentanyl order incorrectly and instead of listing the repeat cycle as two days, he/she listed the repeat cycle as every three days. He/She said due to this error, the electronic MAR scheduled the Fentanyl patch to be replaced every 96 hours instead of every 72 hours. The MDS Coordinator said he/she just identified the error on 08/13/25 and called the prescribing physician who verified the order is to replace the Fentanyl patch every 72 hours. He/She said the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility started using the electronic MAR's a couple of months ago and are still getting used to the electronic system. During an interview on 08/14/25 at 1:58 P.M., the DON said the nurse who receives a medication telephone order is the one responsible to ensure the order is entered correctly into the residents POS and MAR. He/She expects facility staff to enter medication orders correctly. The DON said he/she runs a report daily to review new orders and said he/she did not realize the Fentanyl patch order was entered incorrectly until 08/13/25. During an interview on 08/14/25 at 2:27 P.M., the administrator said the nurse who receives a medication telephone order is the one responsible for entering the order. The administrator said he/she expects for the orders to be entered accurately and to follow up with the prescribing physician if any clarification is needed. He/She said staff should be running a report to double check whether orders are entered accurately.

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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 - Potential for minimal harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, facility staff failed to destroy medications weekly and failed to store the medication behind a lock cabinet for 27 residents (Resident #2, #10, #26, #29, #30, #31, #32, #37, #42, #46, #53, #56, #59, #65, #66, #67, #68, #76, #77, #80, #81, #82, #83, #84, #85, #86, and #87). The facility census was 65.1. Review of the facility's Storage of Medications policy, undated, showed the following guidelines: -All medications for residents must be stored at or near the nurse's station in a locked cabinet, a locked medicine room, or one or more locked mobile medication carts;-Medications must be stored in the container in which they were received;-Drugs must be stored in an orderly manner in cabinets, drawers, or carts. Review of the facility's Destruction of Medications policy, undated, showed the following guidelines:-The facility will destroy and dispose of medications in a safe manner and in accordance with applicable law;-All medications not returned to the issuing pharmacy will be destroyed;-When a medication has been discontinued, the Nurse/Certified Medication Technician (CMT) will discontinue the medication on the physician order sheet and the medication administration record (MAR);-The Nurse/CMT will document the amount of medication to be discontinued on the MAR;-The Nurse/CMT will then log the medication on the individual resident's destruction of record to include the date the medication discontinued, the prescription number, and amount left on card or bottle;-The medication may then be placed in the locked cabinet for destruction;-Medications will be destroyed at least weekly. 2. Observation on 08/13/25 at 1:56 P.M., showed the Minimum Data Set (MDS) Coordinator's office unlocked. Observation showed the MDS Coordinators office with an unlocked closet that contained one small cardboard box, one small blue plastic container, one large cardboard box, one large trash bag, one small grocery bag with a plastic container inside, and one small trash bag that all contained resident medications. 3. Observation on 08/13/25 at 1:58 P.M., showed the MDS office closet contained the following:-23 tablets of Mirtazapine (anti-depressant) with a pharmacy fill date of 02/18/23 and 48 tablets of Quetiapine (anti-psychotic) with a pharmacy fill date of 01/05/24 for Resident #2; - Nine tablets of Metformin (to treat type 2 diabetes) with a pharmacy fill date of 11/25/23 and four tablets of Glipizide (to treat type 2 diabetes) with a pharmacy fill date of 01/13/24 for Resident #10;-21 tablets of Atorvastatin (to treat high cholesterol) with a pharmacy fill date of 11/10/23 for Resident #26; -28 tablets of Citalopram (anti-depressant) with a pharmacy fill date of 06/15/23 for Resident #29;- 14 capsules of Fluoxetine (anti-depressant) with a pharmacy fill date of 01/24/23 and five tablets of Atorvastatin with a pharmacy fill date of 11/15/23 for Resident #30;- 30 capsules of Celecoxib (anti-inflammatory) with a pharmacy fill date of 09/21/23 for Resident #31; - 24 tablets of Mirtazapine with a pharmacy fill date of 12/19/23 and five tablets of Citalopram with a pharmacy fill date of 02/3/23 for Resident #32;- 29 tablets of Trazadone (anti-depressant) with a pharmacy fill date of 12/19/22 for Resident #37; - 30 tablets of Famotidine (to treat heartburn) with a pharmacy fill date of 11/1/23 for Resident #42;- 18 tablets of Metformin with a pharmacy fill date of 05/11/23 for Resident #46; - 21 tablets of Levocetirizine (to treat allergies) with a pharmacy fill date of 06/30/23, three tablets of Levocetirizine with a pharmacy fill date of 11/2/23, and nine tablets of Sertraline (anti-depressant) with a pharmacy fill date of 01/12/23 for Resident #53;- 30 tablets of Warfarin (to treat blood clots) with a pharmacy fill date of 02/12/24 and 26 capsules of Fluoxetine with a pharmacy fill date of 02/16/24 for Resident #56;- 15 tablets of Escitalopram (anti-depressant/anti-anxiety) with a pharmacy fill date of 02/7/23 for Resident #59;- Six tablets of Atorvastatin with a pharmacy fill date of 01/3/24, 30 tablets of Sertraline with a pharmacy fill date of 02/13/23, and 15 tablets of Zoloft (anti-depressant) with a pharmacy fill of 01/16/23 for Resident #65;- Nine tablets of Lurasidone (anti-psychotic) with a pharmacy fill date of 11/21/23 for Resident #66;- 30 tablets of Famotidine with a pharmacy fill date of 09/13/23 for Resident #67;- 30 tablets of (continued on next page)

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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Many	Sertraline with a pharmacy fill date of 02/7/24 and six tablets of Sertraline with a pharmacy fill date of 01/11/24 for Resident #68;- 28 tablets of Risperidone (anti-psychotic) with a pharmacy fill date of 02/06/24, 27 tablets of Metoprolol Tartrate (to treat high blood pressure) with a pharmacy fill date of 07/16/24, and 30 tablets of Metoprolol Tartrate with a pharmacy fill date of 06/21/24 for Resident #76;- 27 tablets of Citalopram with a pharmacy fill date of 01/06/23 for Resident #77;- 19 tablets of Citalopram with a pharmacy fill date of 02/15/23 for Resident #80;- 21 tablets of Risperidone with a pharmacy fill date of 10/23/23 and 15 tablets of Risperidone with a pharmacy fill date of 01/17/24 for Resident #81;- 17 tablets of Bupropion (anti-depressant) for with a pharmacy fill date of 02/26/24 for Resident #82;- 30 tablets of Mirtazapine with a pharmacy fill date of 11/7/22 for Resident #83;- 17 tablets of Escitalopram with a pharmacy fill date of 09/06/23 for Resident #84;- 30 tablets of Amantadine (to treat Parkinson's) with a pharmacy fill date of 12/26/22 for Resident #85;- 22 tablets of Valacyclovir (anti-viral) with a pharmacy fill date of 10/23/23, 20 tablets of Benztropine (anti-cholinergic) with a pharmacy fill date of 01/23/24, and four capsules of Celecoxib with a pharmacy fill date of 11/20/23 for Resident #86;- Four tablets of Metformin with a pharmacy fill date of 09/23/23, 30 tablets of Metformin with a pharmacy fill date of 11/01/23, 14 tablets of Rexulti (anti-psychotic) with a pharmacy fill date of 10/31/23, and 14 tablets of Rexulti with a pharmacy fill date of 11/15/23 for Resident #87. 4. Observation on 8/13/25 at 2:13 P.M., showed the MDS office closet contained one plastic container half full of loose tablets and capsules wrapped in a grocery bag. 5. Observation on 8/13/25 at 2:14 P.M., showed the MDS office closet contained one trash bag and one box filled with numerous over the counter medications. 6. Observation on 8/13/25 at 2:23 P.M., showed the MDS office closet contained one large trash bag filled with nicotine patches and multiple medication cards with various medications. 7. During an interview on 08/13/25 at 1:56 P.M., the MDS Coordinator said the medications had been in the closet for at least a year, and the medications are waiting to be destroyed. The MDS Coordinator said he/she is not sure how the medications got in there and said the medications should have been destroyed. He/She said the medications require two nurses for destruction and when he/she had gone to find the pill buster, the medication room did not have the pill buster. During an interview on 8/14/25 at 1:58 P.M., the Director of Nursing (DON) said he/she was not aware there were any medications stored in the MDS office. The DON said he/she does not know how the medications ended up in the MDS office and the medications should not have been stored in that office. The DON said he/she expects discontinued or expired medications to be destroyed or sent back to the pharmacy within a couple of days. The DON said he/she is responsible to ensure the medications are either destroyed or sent back to the pharmacy. During an interview on 8/14/25 at 2:27 P.M., the Administrator said he/she is uncertain how the medications got into the MDS office. The Administrator said he/she should have checked the MDS office closet and that this shouldn't have happened. The Administrator said he/she would expect for staff to destroy or return medications to the pharmacy monthly.