STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365048	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Westlake	26520 Center Ridge Rd Westlake, OH 44145

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on record review, observation, interview, and review of the American Nurses Association Code of Ethics, the facility failed to ensure Resident #7's indwelling urinary catheter drainage bag was covered to maintain privacy. This affected one resident (Resident #7) out of two residents reviewed for respect and dignity. The facility census was 103.Findings include:A review of Resident #7's clinical record revealed an admission date of 02/12/25 with diagnoses including vascular dementia with mood disturbance and anxiety, fracture of the fourth cervical vertebra of the neck, nasal bones, wrist and three fingers of the right hand following a fall, osteoarthritis, cerebral infarction (stroke), heart disease secondary to high blood pressure, congestive heart failure, heart arrhythmia, malnutrition, venous insufficiency, anemia, high cholesterol and blood pressure, cataracts, asthma, depression and history of brain cancer.Resident #7's plan of care initiated 04/09/26 indicated Resident #7 had an indwelling urinary catheter due to a stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle; slough may be present on some parts of the wound bed often include undermining and tunneling) contaminated by urine. Interventions on the plan of care indicated to provide catheter care every shift, position the catheter drainage bag below the level of the bladder, check for kinks throughout the shift and as needed, keep the drainage bag covered to preserve dignity, change as ordered, maintain enhanced barrier precautions (EBP) when providing direct care, and report any signs/symptoms of urinary tract infection (UTI).A review of Resident #7's physician orders dated 06/01/26 to 06/30/26 revealed to maintain an indwelling urinary catheter to straight drainage and change for infections, obstruction or when the closed system is compromised. An observation of Resident #7 on 06/04/26 at 9:50 A.M. revealed the door to her room was open, and a urine drainage bag was visible to the staff/visitors from the hallway. The urine drainage bag had approximately 400 milliliters of dark brown urine that was hanging from the bed frame of Resident #7's bed clearly visible from the hallway. An interview with Certified Nursing Assistant (CNA) #118 on 06/04/26 at 9:50 A.M. verified the above observation and stated she was unaware the urine drainage bag should be covered for privacy and dignity.A review of the American Nurses Association Code of Ethics. dated 01/29/25, indicated nurses were responsible for protecting a resident's/patient's dignity, privacy and respect during all aspects of care.This deficiency represents non-compliance investigated under Complaint Numbers 3003589 and 2974482.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of facility policy, the facility failed to ensure a clean, sanitary, and homelike environment for residents. This affected 20 residents (Residents #87, #34, #45, #56, #7, #100, #16, #88, #107, #5, #43, #405, #67, #44, #31, #66, #25, #92, #78, and #13) and had the potential to affect all 103 residents residing in the facility.Findings include:During an observation and interview on 06/08/26 at 1:22 P.M. with Floor Tech #401, the following concerns were identified and verified at the time of the observations:-Floor trim and hand railings throughout the building were dusty and dirty.-Carpet was heavily stained throughout the building, including the following areas: a. Between rooms [ROOM NUMBERS] b. Outside room [ROOM NUMBER] c. Near the 200 Hall nurse's station, staff restroom, and utility room d. Near the staff restroom e. Outside room [ROOM NUMBER] f. Between rooms [ROOM NUMBERS] g. Outside room [ROOM NUMBER] h. Outside nursing station 4-5 i. Outside room [ROOM NUMBER] j. Outside room [ROOM NUMBER] k. Outside room [ROOM NUMBER] l. Hall 400 leading into the dining room m. Between rooms [ROOM NUMBERS] n. Multiple stained areas in the dining room-Dried splatter was present on the wall and floor trim between rooms [ROOM NUMBERS], and on the wall near the 200 Hall nurse's station.-Wood vinyl flooring had holes and dents in the rooms of Residents #87 and #34; Residents #45 and #56; and Residents #7 and #100.-Resident #16's room had dust and debris on the floor vent, scuffed paint by the bed, and an empty bed with multiple wall scuffs.-Resident #88's room had an air-conditioning unit that was not fully sealed, allowing visibility to the outside. The ceiling light was not fully attached.-Residents #107 and #5's room had two holes in the closet wall, a dusty and unattached floor vent, multiple wall scuffs, a metal wall protector not fully attached, stains and splatter on the ceiling, and a very sticky floor. Floor Tech #401 stated housekeeping was using too many chemicals when mopping. A brown hanging object appearing to be a fly trap, containing multiple dead bugs, had been present since Resident #107 moved in.-Residents #43 and #405's room had an extremely sticky floor and black sticky residue on the windowsill. The blinds were broken and bent.-Resident #67's room had splatter on the wall and a window AC unit held together with peeling tape; the front cover was unattached.-Resident #44's room had a wallˆmounted fan with heavy dust buildup that dispersed dust when running.-Residents #31 and #66's room had a nightstand missing trim on all sides, multiple wall scrapes behind the bed, debris on the floor and floor vent, and an unattached vent in the corner.-Residents #25 and #92's room had wall splatter and an extremely dusty floor vent.-Residents #78 and #13's room had dust and debris on the floor vent, an AC unit with a loose cover on the right side, and dried splatter on the wall near Resident #13's bed.Review of the facility's Housekeeping - General Policy (reviewed 04/01/26) stated:- The resident has a right to a safe, clean, comfortable and homelike environment.- The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.This deficiency represents noncompliance investigated under Complaint Numbers 3003589 and 2974482.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure Resident #104's comprehensive care plan included a care plan with individualized interventions to manage Resident #104's behaviors. This affected one resident (Resident #104) out of three residents reviewed for behaviors. The facility census was 103.Findings include:A review of Resident #104's clinical record revealed an admission date of 11/04/25 with diagnoses including adult failure to thrive, dementia with psychotic disturbance, legal blindness, glaucoma, old heart attack, heart arrhythmias, low magnesium level, chronic kidney disease with heart failure, high blood pressure, malnutrition, cognitive communication deficit, prediabetes mellitus, degenerative nervous system disease, headache, anemia, osteoarthritis of both knees, Crohn's disease, high cholesterol, anxiety, depression, degenerative spine disease with lumbar region back pain.A review of Resident #104's plan of care initiated on 11/12/25 indicated Resident #104 resided on the secured memory care nursing unit (Oasis unit) with interventions including Resident #104 planned for a long term stay at the facility and provided services according to her care plan. There was no plan of care with individualized interventions developed on Resident #104's care plan to address Resident #104's physically aggressive behaviors, refusals of care and accusatory behaviors.A review of Resident #104's progress note dated 05/07/26 indicated Resident #104 refused to allow the phlebotomist to draw her blood and was very argumentative when staff attempted to explain the importance of laboratory tests.During interviews with staff on 06/03/26 between 10:30 A.M. and 11:15 A.M., Unit Manager Registered Nurse (UMRN) #114, Certified Nursing Assistant (CNA) #115, CNA #116 reported that Resident #104 displayed behaviors such as falsely accusing staff of stealing personal items and remaining preoccupied with these accusations for several days, refusing care including laboratory blood draws, and hitting or swatting other residents when irritated.During an interview with UMRN #114 on 06/03/26 at 10:41 A.M. verified the above findings and agreed Resident #104 had no interventions in her care plan to address the behaviors she exhibited in the facility.This deficiency was an incidental finding identified during the complaint investigation.

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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. Based on observation, interview, review of the Nursing Rights of Medication Administration, and review of the facility policy, the facility failed to ensure that nursing services were provided in accordance with professional standards of practice when one licensed practical nurse (LPN) #110 did not follow accepted nursing standards for the preparation and administration of medications for two residents (Resident #19 and Resident #30) of five residents observed for medication administration. The facility census was 103.Findings include:On 06/03/26 at approximately 8:30 A.M., during a medication administration observation, LPN #110 was observed retrieving a cup of crushed medications and a 30ˆmilliliter (ml) cup of liquid medication from the medication cart for Resident #30. LPN #110 stated she had dispensed, crushed, and stored the medications earlier that morning. She then administered the liquid medication and the crushed medications mixed in pudding. LPN #110 acknowledged that preˆpreparing medications and storing them in the cart was not consistent with facility policy or nursing standards of practice.On 06/03/26 at approximately 8:35 A.M., during a second observation, LPN #110 was again seen retrieving a cup of crushed medications from the medication cart for Resident #19. She stated she had crushed and prepared these medications earlier that morning. She administered the crushed medications mixed in pudding. LPN #110 again confirmed that preparing medications in advance and storing them in the cart was not in accordance with nursing standards or facility policy.When asked to identify the medications she had administered to Residents #19 and #30, LPN #110 was unable to identify them without returning to the electronic medical record and reviewing the medication list she had preˆpoured. This practice is inconsistent with professional nursing standards that require medications to be prepared and administered immediately prior to giving them to ensure accuracy and adherence to the five rights of medication administration.An interview with Unit Manager Registered Nurse (UMRN) #114 on 06/03/26 at 3:30 P.M. confirmed that LPN #110's practices did not meet professional standards. UMRN #114 stated that LPN #110 should not have preˆprepared or stored medications in the medication cart and confirmed that these actions were inconsistent with nursing standards and facility expectations.A review of the nursing standard of practice titled Nursing Rights of Medication Administration: dated 09/04/23 revealed the five rights are essential safety checks that healthcare professionals use to prevent medication errors and ensure effective treatment. Each right represents a verification step before administering any medications. The following are the five rights of medication administration:1. Right Patient: Confirm the patient's identity using at least two identifiers, such as full name and date of birth , to prevent mix-ups, especially in settings with multiple patients.2. Right Drug: Ensure the medication being administered matches the prescription exactly. Check the label against the order, verify it is not a look-alike or sound-alike drug, and confirm the patient has no known allergies,3. Right Dose: Verify that the amount of medication corresponds to the prescribed dose. Dose errors are common and can range from minor to life-threatening depending on the drug 4. Right Route: Administer the medication via the prescribed method, whether oral, intravenous, injection, topical, or other. Using the wrong route can cause serious harm.5. Right Time: Give the medication at the correct time and frequency. Some medications require administration with food, on an empty stomach, or at consistent intervals to maintain therapeutic levels. Following these rights helps reduce adverse drug events and ensures patient safety. While additional rights such as right documentation, right indication, and right patient response exist, the original five remain the global standard in clinical practice.A review of the policy titled General Dose Preparation and Medication Administration, effective 12/01/07, indicated that medications must be prepared for only one resident at a time immediately prior to administration, using required checks, and must not be left unattended. LPN #110 failed to follow these professional standardsThis deficiency represents non-compliance investigated under Complaint Numbers 3003589 and 2974482

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility policy, the facility failed to ensure physician orders for daily weights were updated and implemented for Resident #105, failed to ensure Resident #106's weight was obtained to ensure an accurate weight was obtained, and failed to ensure a physician order was obtained prior to the application of a wound dressing to Resident #24's wound. This affected two residents (Resident #105 and #106) of three residents reviewed for weight loss and one resident (Resident #24) out of three residents reviewed for wound care. The facility census was 103. Findings include: 1. Record review for Resident #105 revealed resident was admitted on [DATE] and discharged on 05/18/26 with diagnosis that included: heart failure with preserved ejection fraction, history of subsegmental pulmonary embolism and bilateral deep vein thrombosis (on therapeutic lovenox), chronic kidney disease III, history of roux-en-y gastric bypass complicated by chronic diarrhea and malnutrition, cirrhosis with ascites and anasarca, chronic anemia with known cecal tubulovillous adenoma, remote CVA and chronic dizziness, repeated falls, hyperkalemia, hypocalcemia, chronic respiratory failure with hypoxia, severe protein calorie malnutrition, type 2 diabetes, chronic diastolic heart failure, myocardial infraction typeII, memory deficit following cerebral infraction and major depressive disorder. Review of Resident #105 Weight Summary in the vital tab revealed the following weights:-02/01/26: 158.8 pounds (Lbs)-03/04/26: 121.0 Lbs-03/12/26: 122.0 Lbs-03/24/26: 107.2 Lbs-04/01/26: 106.9 Lbs-04/09/26: 106.0 Lbs-04/16/26: 111.0 Lbs-04/26/26: 121.6 Lbs A physician order dated 03/31/26 directed staff to obtain daily weights for Resident #105. Registered Nurse Unit Manager (RNUM) #404 signed the order on 03/31/26 acknowledging receipt. A corresponding progress note dated 03/31/26 documented that the nurse practitioner had placed an order for daily weights. Review of Resident #105's the medication administration record (MAR) for March and April 2026 revealed no daily weight orders had been entered. Review of the vital signs tab in the electronic medical record confirmed weights continued to be obtained weekly instead of daily as ordered. During an interview on 06/09/26 at 3:46 P.M., the Assistant Director of Nursing (ADON) #403 confirmed these findings. 2. A review of Resident #106's clinical record revealed an admission date of 01/26/26 with diagnoses including traumatic subdural hemorrhage, depression, meniscus of the knee joint tear, enlarged prostate, glaucoma, transient ischemic attack, stroke, respiratory disease, diabetes mellitus, heart failure, high blood pressure, obstructive sleep apnea, high cholesterol, cleft hard palate with cleft lip. A review of Resident #106's admission nutrition/dietary progress note dated 01/27/26 showed an admission weight of 182 pounds. The dietitian recommended a protein supplement to support wound healing, a Med Pass supplement to address poor appetite, and noted Resident #106's preference to receive fruit with all meals. The dietitian further documented that the resident was at risk for malnutrition due to chronic disease and that his weight should be monitored. A review of Resident #106's weight change note dated 03/03/26 identified an 8.8% weight loss in 30 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days, decreasing from 182 pounds (02/01/26) to 166.4 pounds (03/01/26). The dietitian recommended obtaining another weight for accuracy and planned to follow up on 03/05/26. Record review showed the follow^up weight was never obtained. Resident #106 was discharged to the hospital on [DATE]. In an interview on 06/04/26 at 8:53 A.M., Nutrition Associate #117 stated he had requested a repeat weight on 03/03/26 for verification, but the weight was not obtained before discharge. He confirmed no follow^up dietary assessment occurred after 03/03/26. During an interview on 06/08/26 at 3:45 P.M., the Director of Nursing (DON) acknowledged the findings and stated nursing staff had not been informed that an additional weight was needed. Review of the facility policy titled Nutritional Intake (reviewed 09/05/25) showed the facility is required to ensure residents maintain acceptable nutritional parameters and receive appropriate monitoring and interventions based on comprehensive assessment. 3. A review of Resident #24's clinical record revealed an admission date of 12/15/25 with diagnoses including Alzheimer's disease, dementia, type 2 diabetes mellitus, cutaneous abscess of right axilla, methicillin susceptible staphylococcus aureus infection, hypertensive (high blood pressure) chronic kidney disease, high cholesterol, anemia, hypothyroidism, major depressive disorder, hypertensive heart disease, and osteoarthritis. Review of the June 2026 physician orders revealed no active order for wound dressing application to the right axilla. The previous wound treatment order had been discontinued on 06/02/26. An observation on 06/08/26 at 9:30 A.M. showed Registered Nurse (RN) #114 applying calcium alginate and a border gauze dressing to the resident's right axilla wound. RN #114 removed the prior dressing dated 06/07/26 and discarded it. During an interview 06/08/26 at 11:35 A.M., RN #114 confirmed Resident #24 did not have a current physician order for the wound treatment she applied. Review of the facility's policy titled Wound Assessment and Wound Report (revised 11/30/23) requires staff to verify the treatment order at the bedside and specifies that a valid treatment order must be in place for all products applied to a wound. This deficiency represents non-compliance investigated under Complaint Number 3003589.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure staff documented bladder retraining program interventions as outlined in Resident #105's plan of care. This failure affected one resident (Resident #105) out of three residents reviewed for incontinence care. The facility census was 103.Findings include:Record review for Resident #105 showed she was admitted on [DATE] and discharged on 05/18/26 with multiple chronic and complex medical conditions, including heart failure with preserved ejection fraction, pulmonary embolism, bilateral deep vein thrombosis (on therapeutic Lovenox), chronic kidney disease III, a history of Rouxˆenˆ Y gastric bypass with chronic diarrhea and malnutrition, cirrhosis with ascites, chronic anemia, remote CVA, chronic dizziness, repeated falls, hyperkalemia, hypocalcemia, chronic respiratory failure with hypoxia, severe proteinˆcalorie malnutrition, type II diabetes, chronic diastolic heart failure, myocardial infarction type II, memory deficits following cerebral infarction, and major depressive disorder. Review of the Evaluation for Bowel and Bladder Training dated 11/18/25 showed the resident scored a 10, indicating she was a candidate for toileting, timed voiding, or scheduled voiding.Review of the care plan dated 11/19/25 documented that Resident #105 was incontinent of bladder. Interventions included a Bladder Retraining Program directing staff to offer and assist with toileting upon rising, before and after meals, at bedtime (HS), and as needed (PRN).Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] showed Resident #105 required moderate assistance with toileting and was frequently incontinent of bowel and occasionally incontinent of bladder. The assessment indicated no for a trial urinary toileting program.During an interview on 06/08/26 at 4:57 P.M., MDS Nurse #402 reported that Resident #105 was not on a bladder or bowel toileting program. She stated that she does not determine who is on such programs; she only enters information into the MDS. She further stated that the Bladder Retraining Program listed in the care plan was only a care plan header and not an active toileting program.During an interview on 06/08/26 at 5:25 P.M., the Director of Nursing (DON) also stated the intervention was only a care plan header and confirmed the resident was not on a bladder retraining program. The facility was unable to provide documentation showing that incontinence care was provided as directed in the care plan.This deficiency represents non-compliance investigated under Complaint Numbers 3003589 and 2974482.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, interview, and review of the facility policy, the facility failed to ensure a medication error rate of less than 5 percent. This affected two residents (Resident #19 and Resident #30) out of five residents observed during medication administration. The facility census was 103.Findings include:An observation of three licensed nurses (Licensed Practical Nurse (LPN) #110, LPN #111, and LPN #112) administering medications to five residents (Resident #19, Resident #27, Resident #30, Resident #31, and Resident #55) revealed 36 opportunities for medication errors, with 20 errors observed. This resulted in a medication error rate of 56 percent.1. A review of Resident #30's clinical record revealed an admission date of 12/30/22 with diagnoses including cerebral palsy, dementia, epilepsy, functional dyspepsia, contracted right wrist, fracture of thoracic vertebra number 11 and 12, anxiety, eye disease, constipation, allergic rhinitis, cervicalgia, constipation, malnutrition, severe intellectual disabilities, gastroesophageal reflux disease, iron deficiency anemia, insomnia, and partial intestinal obstruction.A review of Resident #30's care plan indicated impaired cognitive ability/thought processes related to dementia. The resident lived on the memory care unit, was nonverbal except for crying out, and required assistance with all activities of daily living.During an observation on 06/03/26 at 8:30 A.M., Licensed Practical Nurse (LPN) #110 was seen administering medications to Resident #30. LPN #110 failed to follow the five rights of medication administration. She retrieved a cup of crushed oral medications and a 30-milliliter (ml) cup of liquid medication from the medication cart. She stated she had dispensed and crushed the medications earlier that morning, then administered the liquid medications and the crushed medications mixed in pudding to Resident #30. LPN #110 acknowledged that preparing medications ahead of time and storing them in the medication cart was not consistent with facility policy or nursing standards of practice. When asked to identify the medications administered, she reviewed Resident #30's electronic medical record and listed the morning medications she had pre-poured and stored, which included:Ativan 0.5 milligrams (mg) (antianxiety) oral tabletRisperdal oral solution 1.0 ml (antipsychotic)Cholecalciferol 2,000-unit oral capsule (Vitamin D3 supplement)Divalproex 125 mg delayed-release sprinkles (antiepileptic), two capsulesDocusate sodium 100 mg tablet (stool softener)Gabapentin 100 mg oral tablet (anticonvulsant)Lactulose 10 grams/15 ml, 30 ml oral solution (laxative)Linaclotide 290 microgram (mcg) oral capsule (gastrointestinal agent)Loratadine 10 mg oral tablet (antihistamine)Senna 8.6 mg oral tablet (stimulant laxative)Tizanidine 2 mg oral tablet (muscle relaxant)Acetaminophen 500 mg, two tablets (analgesic)Phenobarbital 97.2 mg oral tablet (anticonvulsant)A review of Resident #30's physician orders dated 06/01/26 to 06/30/26 confirmed these medications were scheduled for morning administration.An interview on 06/03/26 at 3:30 P.M. with Unit Manager Registered Nurse (UMRN) #114 confirmed the above findings and that LPN #110 should not have prepared medications in advance.2. A review of Resident #19's clinical record revealed an admission date of 05/17/19 with diagnoses including Alzheimer's disease, dementia, seizures, dystonia, major depressive disorder, diabetes mellitus type 2, fatigue, abnormal involuntary movements, incisional hernia, abnormal auditory perceptions, anxiety, allergic rhinitis, gastroesophageal reflux disease, vitamin D deficiency, and constipation.indicated severe cognitive impairment. The resident was rarely or never understood and had a Brief Interview for Mental Status (BIMS) score of 99.During an observation on 06/03/26 at 8:35 a.m., LPN #110 was seen administering medications to Resident #19 and again failed to follow the five rights of medication administration. She obtained a cup of crushed oral medications from the medication cart and stated she had dispensed and crushed them earlier that morning. She then administered the crushed medications mixed in pudding to Resident #19. LPN #110 acknowledged that preparing medications in advance and storing them in the medication cart was not consistent with facility policy or nursing standards of practice. When asked to identify the medications administered, she reviewed Resident #19's electronic medical record and listed the following morning medications she had pre-crushed and stored:Sertraline hydrochloride 25 mg tablet (antidepressant)Sertraline 50 (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mg tablet (antidepressant)Depakote sprinkles delayed-release 125 mg capsule (anticonvulsant/mood stabilizer)Docusate sodium 100 mg oral tablet (stool softener)Loratadine 10 mg tablet (antihistamine)Senna 8.6 mg oral tablet (stimulant laxative)Alprazolam 0.25 mg tablet (antianxiety)A review of Resident #19's physician orders dated 06/01/26 to 06/30/26 confirmed these medications were scheduled for morning administration.An interview on 06/03/26 at 3:30 P.M. with UMRN #114 verified the findings and stated LPN #110 should not have prepared medications ahead of time.A review of the facility's policy titled General Dose Preparation and Medication Administration, effective 12/01/07, indicated staff were required to follow facility procedures, applicable law, and the State Operations Manual (SOM) when administering medications. The policy stated:- Dose preparation areas must be well lit, and medication carts must be clean and organized.- Medications must be prepared for only one resident at a time, using the three-way check (medication, medication administration record (MAR), and prescription label).- Staff must avoid touching medications with bare hands.- Any medication not in protective packaging or dropped must be discarded according to policy.- Staff must not leave medications unattended.This deficiency represents non-compliance investigated under Complaint Numbers 3003589 and 2974482.