STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425305	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patewood Post Acute	2 Griffith Road Greenville, SC 29607

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure a resident was not served their meals on disposable tableware to protect their dignity, which affected 1 (Resident (R)42) of 2 residents reviewed for dignity concerns. Findings included: Review of an undated facility policy titled, Disposable Dishes and Utensils, indicated, This facility will use single-service items only in extenuating circumstances, such as dish-machine failure, individual resident needs, or other documented reason. Review of an admission Record indicated the facility admitted R42 on 07/21/2024. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of personal history of transient ischemic attack (a brief blockage of blood flow to the brain), cerebral infarction (a stroke) without residual deficits, and dysphagia (difficulty swallowing). Review of a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/28/2026, indicated R42 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated the resident had severe cognitive impairment. The MDS revealed the resident required setup or clean-up assistance with eating. Review of R42's Care Plan Report included a focus area initiated on 07/24/2024, that indicated the resident was at risk for malnutrition due to depression, diabetes, and gastroesophageal reflux disease (GERD). Interventions directed staff to allow the resident adequate time for eating their meals (initiated 07/24/2024). Review of a facility document titled, Resident Detail, for R42, revealed, under the heading, Meal Service Details, included, Alerts: Disposables. The document revealed under the heading, Additional Tray Card Notes, revealed, USE DISPOSABLES WHEN POSSIBLE for breakfast, lunch, and dinner. During a concurrent observation and interview on 05/18/2026 at 12:15 PM, R42 was observed in bed with their lunch meal on an overbed table. The resident's tray card, dated May 18/26 Lunch, revealed, Notes: >USE DISPOSABLE WHEN POSSIBLE; and Alerts: >DISPOSABLES. R42 fed themself the lunch meal with a plastic spoon, received on a disposable plate. R42 responded by shaking their head from left to right when asked if receiving food on a disposable plate with disposable utensils was okay. During a concurrent observation and interview on 05/21/2026 at 8:15 AM, R42 was observed in bed with their breakfast meal on the overbed table. Certified Nursing Assistant (CNA)8 set up the breakfast tray for R42. R42 fed themself the breakfast meal with a plastic spoon, received on a disposable plate. CNA8 stated R42 received their meals on disposable plate ware and tableware because the resident took a while to eat. R42 responded by shaking their head from left to right when asked if receiving food on a disposable plate with disposable utensils was okay. During an interview on 05/21/2026 at 11:00 AM, CNA9 revealed R42 received food on disposable tableware and that she was told by staff that it was because of a family request, but she did not know for sure. CNA9 stated that she never questioned the reason R42 received food on disposable tableware, but the resident's food was served that way for a while. During an interview on 05/21/2026 at 11:22 AM, Family Member (FM)14 stated that when they visited for the past few months, they saw R42's meals were served on disposable plates, but they did not know why; they just thought it was a decision from the kitchen staff. FM14 stated that when at home, R42 was accustomed to receiving food on regular plates, and they would like the resident to receive food on regular plates. FM14 denied that they (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked staff to provide food for R42 with disposable tableware. During an interview on 05/21/2026 at 9:29 AM, Licensed Practical Nurse (LPN)33, who was a unit manager, stated that she noticed the previous day (05/20/2026) at lunch that R42 received food on disposable tableware, but she had not paid much attention before that day and had not noticed it before. LPN33 stated that she did not follow up on the use of disposable tableware for R42, and she did not know the reason the resident received disposable tableware with meals. LPN33 stated she expected all residents to receive food on the same type of tableware and expected disposable tableware to be used only if the dish machine was not working or if there was an infection control issue in the facility, but not for staff convenience. During an interview on 05/21/2026 at 8:51 AM, the Dietary Manager (DM) stated that approximately four months prior, staff informed her that R42 took a long time to eat their meals. She stated that they asked if the dietary staff could provide the resident with disposable tableware and disposable utensils so that the resident could take their time to eat, and staff could throw the disposable tableware away when the resident completed their meal so that dirty dishes were not left in the room. The DM stated that she added the use of disposables to the resident's tray ticket, and the resident had received disposable tableware with meals ever since. ^ During an interview on 05/21/2026 at 9:30 AM, the Director of Nursing (DON) stated she expected disposable tableware would only be used if the dish machine was not functional or if there was an infection control issue in the facility. The DON further stated that she expected all residents to receive a dignified dining experience, and that staff not provide a resident with disposable dishes for staff convenience. The DON also stated that if the resident/family did not request food served on disposables, doing so would be disrespectful to the resident. During an interview on 05/21/2026 at 9:56 AM, the Administrator (ADM) stated he was not aware that R42 received food served on disposable tableware. The ADM stated that he expected all residents to receive their food on regular tableware unless it was a request from the resident/family, or there was a problem with the dish machine or an issue with an infectious disease; otherwise, he expected that all residents have a dignified dining experience and receive their food on regular tableware.

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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. Based on facility policy review, interview, and record review, the facility failed to ensure residents who self-administered medications were assessed as safe to self-administer medications, which affected 2 (Resident (R)134 and R26) of 3 sampled residents who had medications in their room. Findings included: Review of a facility policy titled, Self-Administration of Medication, revised February 2021, revealed, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The policy revealed, 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self- administering medications is safe and clinically appropriate for the resident. The policy revealed, 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. Review of a facility policy titled, Administering Medications, revised 04/2019, revealed, 27. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. 1. Review of an admission Record revealed the facility admitted R134 on 05/08/2026. According to the admission Record, the resident had a medical history that included but was not limited to a diagnosis of unspecified displaced fracture of surgical neck of left humerus, subsequent encounter for fracture with routine healing. Review of A five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/14/2026, revealed R134 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident had intact cognition. The MDS indicated the resident wore corrective lenses for their vision. Review of R134's Care Plan Report revealed no evidence to indicate the resident self-administered their medications. Review of R134's Order Summary Report, with active orders as of 05/19/2026, revealed an order, dated 05/11/2026, for dorzolamide hydrochloride (HCl)-timolol maleate ophthalmic solution (an ophthalmic glaucoma agent) 2-0.5%, one drop in both eyes two times a day for glaucoma. The Order Summary Report included an order, dated 05/08/2026, for latanoprost ophthalmic solution (an ophthalmic glaucoma agent) 0.005%, one drop in both eyes one time a day for glaucoma. The Order Summary Report revealed no evidence that the resident was able to self-administer their medications. During an interview on 05/18/2026 at 1:09 PM, R134 stated they gave themself two medicated eye drops to treat glaucoma. R134 stated they were dorzolamide-timolol that went in twice a day and latanoprost that went in at night. R134 stated the nurses said it was all right to self-administer the eye drops but also offered to do it for them. During an interview on 05/19/2026 at 4:30 PM, Registered Nurse (RN)22 stated that he knew R134 gave themself the glaucoma eye drops and had since they arrived. RN22 stated he did not tell anyone. (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 05/19/2026 at 4:23 PM, Licensed Practical Nurse (LPN)33, who was a unit manager, stated that R134 should not have been administering the eye drops to themself; the facility went through a process of the doctor writing an order. She stated that then they did an assessment for self-administration, which she completed. She stated that R134 had not been assessed, so the nurses should have been giving the glaucoma eye drops. During an interview on 05/21/2026 at 10:54 AM, Nurse Practitioner (NP)18 stated that it was up to the facility to decide if R134 was able to administer their glaucoma eye drops. During an interview on 05/21/2026 at 3:32 PM, the Director of Nursing (DON) stated that R134 should have been assessed to self-administer medications, or the glaucoma eye drops should have been locked up in the medication cart. During an interview on 05/21/2026 at 3:19 PM, Administrator (ADM) stated that his expectation for residents to self-administer was to have an order for self-administration. 2. Review of an admission Record revealed the facility admitted R26 on 12/09/2021. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of acute respiratory failure with hypoxia, unspecified asthma, and anxiety disorder. Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/15/2026, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. Review of R26's Care Plan Report, revealed no evidence the resident self-administered their medications. Review of R26's Order Summary Report, with active orders as of 5/18/2026, revealed no evidence of an order for miconazole antifungal powder. The Order Summary Report further revealed no evidence that the resident was able to self-administer their medications. During a concurrent observation and interview on 05/18/2026 at 10:27 AM, R26 was sitting up in bed with a three-ounce bottle of Remedy clinical fungal powder (miconazole nitrate 2% antifungal) on the nightstand. R26 stated they self-administered the antifungal powder under their breasts. R26 stated they usually applied the antifungal powder one time a day, every couple of days after showers on Tuesdays and Fridays. R26 stated that the facility did not assess them to self-administer medications but said they wanted to administer the miconazole 2% antifungal powder themself. During a concurrent observation and interview on 05/18/2026 at 2:59 PM, with Licensed Practical Nurse (LPN)25, who was a unit manager, R26 was observed lying supine in bed. A three-ounce bottle of Remedy antifungal powder remained on the resident's nightstand at their bedside.ˆLPN25 stated R26 did not have an order to self-administer the antifungal powder, had not been assessed to self-administer their medications, and the miconazole 2% antifungal powder should not have been left in the resident's room. During an interview on 05/19/2026 at 9:38 AM, Certified Nursing Assistant (CNA)26 stated that R26 applied the miconazole 2% antifungal powder as needed.ˆCNA26 stated it was acceptable for residents to self-administer the miconazole 2% antifungal powder. CNA26 stated that the miconazole 2% antifungal powder was kept in the central supply room, and she could get it for any resident that (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed it. Per CNA26, there were multiple residents that used the miconazole 2% antifungal powder. During an interview on 05/19/26 at 9:47 AM, CNA27 stated that R26 self-administered the miconazole 2% antifungal powder as needed. During an interview on 05/20/2026 at 3:01 PM, LPN28 stated residents were not allowed to and should not self-administer any medications unless they had an assessment completed and a physician's order for self-administration. LPN28 stated there were no residents in the facility that had physician orders to self-administer medications. LPN28 stated she was unaware that R26 had miconazole 2% antifungal powder at their bedside and was unaware the resident was self-administering the antifungal powder. During an interview on 05/21/2026 at 1:12 PM,ˆLPN29 stated that a resident could not self-administer miconazole 2% antifungal powder unless the resident had been assessed to self-administer. LPN29 stated that the miconazole 2% antifungal powder should be kept in the treatment cart; not at the resident's bedside. During an interview on 05/21/2026 at 1:28 PM, the Director of Nursing (DON)ˆstated R26 did not have an assessment to self-administer the miconazole 2% antifungal powder and should not have been allowed to apply the miconazole 2% antifungal powder. The DON stated residents should only be allowed to self-administer their medications after a self-administration assessment and a physician order was completed. During an interview on 05/21/2026 at 2:10 PM, the Administrator stated residents needed an assessment and a physician order to be able to self-administer medications, including antifungal powder.

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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, record review, and facility document and policy review, the facility failed to ensure medications were administered by only licensed staff and with a physician's order for 1 (Resident(R)26) of 3 sampled residents who had medications in their room. Findings included: Review of a facility policy titled, Medication and Treatment Orders, revised in July 2016, revealed, 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medication in this state. Review of a facility policy titled, Administering Medications, revised in April 2019, revealed, 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. Review of an admission Record revealed the facility admitted R26 on 12/09/2021. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of acute respiratory failure with hypoxia, unspecified asthma, and anxiety disorder. Review of a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/15/2026, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. During a concurrent observation and interview on 05/18/2026 at 10:27 AM, R26 was sitting up in bed with a three-ounce bottle of Remedy clinical fungal powder (miconazole nitrate 2% antifungal) on the nightstand. R26 stated they self-administered the antifungal powder under their breasts. R26 stated they usually applied the antifungal powder one time a day, every couple of days after showers on Tuesdays and Fridays. Review of R26's Care Plan Report, revealed no evidence to indicate the resident received an antifungal powder. Review of R26's Order Summary Report, with active orders as of 05/18/2026, revealed no evidence of an order for miconazole antifungal powder. Review of an undated facility document titled, Physicians Services Group Standing Orders, indicated, These orders are standard PRN [pro re nata, as needed] orders designed to streamline care delivery and eliminate lag times in patient care. All orders should be cross-referenced with patient allergies. The document revealed no evidence of a standing order for miconazole 2% antifungal powder. During an interview on 05/19/2026 at 9:38 AM, Certified Nursing Assistant (CNA)26 stated that R26 applied the miconazole 2% antifungal powder as needed.ˆCNA26 said she assisted the resident in applying the antifungal powder if the resident asked for assistance. CNA26 stated the miconazole 2% antifungal powder was kept in the facility's central supply room, and she could get it for any resident that needed it. Per CNA26, there were multiple residents that used the miconazole 2% antifungal powder.During an interview on 05/20/2026 at 10:09 AM, the Administrator confirmed there were no standing physician orders for antifungals. During an interview on 05/20/2026 at 3:01 PM, Licensed Practical Nurse (LPN)28 stated no one should have access to miconazole 2% antifungal powder but the CSM, nurse manager, or nurses.ˆLPN28 stated R26 did not have a physician order for miconazole 2% antifungal powder. During an interview on 05/21/2026 at 11:21 AM, the Central Supply Manager (CSM) confirmed the miconazole 2% antifungal powders were placed in the clean utility rooms every Monday, Wednesday, and Friday. The CSM stated he did not know who could use the miconazole 2% antifungal powder; he just placed it in the utility closet.ˆThe CMS did not think the miconazole 2% antifungal cream or powder required a physician's order and was not aware it was a medication. During an interview on 05/21/2026 at 1:12 PM, LPN29 stated that miconazole 2% antifungal powder required a physician's order and had to be applied by a nurse. During an interview on 05/21/2026 at 1:28 PM, the Director of Nursing (DON)ˆstated miconazole 2% antifungal powder could only be applied by a nurse sinceˆit was considered a medication and required a physician order.ˆThe DON stated R26 did not have a physician's order for miconazole 2% antifungal powder. During a follow-up interview on 05/21/2026 at 2:10 PM, the Administrator stated that CNAs were not allowed to administer antifungal powder to residents.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff followed physician's orders for the use of supplemental oxygen for 2 (Resident (R)26 and R114) of 2 sampled residents reviewed for oxygen therapy. Findings included: Review of a facility policy titled, Oxygen Administration, revised 10/2019, revealed, Purpose - The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation - 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review of a facility policy titled, Administering Medications, revised 04/2019, revealed, Policy Statement - Medications are administered in a safe and timely manner, and as prescribed. The policy also indicated, 4. Medications are administered in accordance with prescriber orders, including any required time frame. 1. Review of an admission Record revealed the facility admitted R26 on 12/09/2021. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of acute respiratory failure with hypoxia, unspecified asthma, and anxiety disorder. Review of a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/15/2026, revealed R26 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition.Review of R26's Care Plan Report, included a focus area, initiated 05/18/2026, that indicated the resident required the use of continuous oxygen related to congestive heart failure. Interventions directed staff to: break tasks into sub-tasks and encourage the resident to take frequent rests; change humidification and oxygen tubing as indicated; keep room cool and free of irritants; obtain laboratory testing as ordered and report abnormal findings to the physician; monitor and report signs of hypoxia; and observe oxygen precautions. Review of R26's Order Summary Report, with active orders as of 05/18/2026, included a physician's order for oxygen at 4 liters per minute (L/min) via a nasal cannula (NC, a thin flexible tube to deliver oxygen to the nose) every shift, started 12/13/2024. During a concurrent observation and interview on 05/18/2026 at 10:27 AM, revealed R26 sitting in bed with oxygen in use via a NC. R26 stated the oxygen was supposed to be infused at 4 L/min; however, the observation revealed the oxygen concentrator flow rate was observed at 3 L/min per NC.During an observation on 05/18/2026 at 1:41 PM, revealed R26 sitting in bed with oxygen infusing at 3 L/min via NC. During a concurrent observation and interview on 05/18/2026 at 2:59 PM, Licensed Practical Nurse (LPN)25, who was a unit manager, revealed R26's oxygen flow rate was set at between 3.5 L/min and 4 L/min, and the oxygen flow rate should have been set at 4 L/min. LPN25 stated that the floor nurses were responsible for monitoring the physician-ordered oxygen flow rate. LPN25 stated she had not checked R26's oxygen flow rate prior to the current observation because she had just taken over for a nurse who had to leave early. LPN25 stated that she expected oxygen to be administered per the physician's order. During a concurrent observation and interview on 05/19/2026 at 9:38 AM, R26 was observed sitting in bed on top of a mechanical lift pad, and the resident did not have oxygen on. The observation revealed NC tubing was lying on the bed behind the resident's back under their right arm. The observation revealed that the oxygen concentrator was turned off. R26 stated that a Certified Nursing Assistant (CNA) had removed the oxygen tubing and turned off the oxygen concentrator because they were getting the resident ready to get up for activities. The observation revealed there were no staff in the room with the resident at that time. During a concurrent observation and interview on 05/19/2026 at 9:41 AM, CNA26 and CNA27 entered R26's room with a mechanical lift. CNA26 stated that she had removed the oxygen from R26's nose to get the resident up from the bed, and that was the normal procedure and what they always did when they got R26 up into the wheelchair. CNA26 stated that R26 did not wear oxygen when they were out of bed, and removing the oxygen to get the resident up was the procedure she had been instructed to do by various nurses. CNA26 stated that CNAs were allowed to remove/turn off a resident's oxygen as needed. During an interview on 05/20/2026 at 3:39 PM, CNA26 stated different nurses had instructed her that when (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26's oxygen saturation (blood hemoglobin oxygen saturation) was below 90% the CNAs could put the resident's oxygen back on, and, other than that, the resident did not need to wear oxygen. CNA26 stated they were not aware of the physician's order requiring R26 to wear the oxygen continuously. CNA26 stated that since 05/19/2026 they had spoken with nursing management and learned that oxygen was considered a medication and could not be applied or removed by a CNA when giving care. During an interview on 05/21/2026 at 1:28 PM, the Director of Nursing (DON) stated that the assigned nurse was responsible for monitoring the resident's oxygen flow rate per the physician's order. The DON stated she expected nurses to round (systematic, scheduled nursing staff visits to check on residents) every two hours and check oxygen flow rates to ensure they were per the physicians' orders, and she expected staff to follow physicians' orders. The DON verified that R26's ordered oxygen flow rate was for 4 L/min via a NC continuously on 05/18/2026 when the resident's oxygen flow rate was observed below 4 L/min. The DON stated R26 would not have been able to change the oxygen flow rate themself. During an interview on 05/21/2026 at 2:10 PM, the Administrator (ADM) stated he expected physicians' orders to be followed. The ADM stated he expected the assigned nurse to monitor oxygen flow rates on rounds each shift and to keep the oxygen flow rate at the physician-ordered rate. 2. Review of an admission Record revealed the facility admitted R114 on 05/27/2025. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of hypoxemia and adult failure to thrive.Review of a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2026, revealed R114 had a BIMS score of 15 out 15, which indicated the resident had intact cognition. Review of R114's Care Plan Report, included a focus area, revised 06/10/2025, that indicated the resident was dependent on oxygen related to hypoxemia. Interventions directed staff to: administer oxygen at 3 liters per minute (L/min) via a nasal cannula (NC, a thin flexible tube to deliver oxygen to the nose) (06/10/2025); keep the room cool and free of irritants (05/28/2025); and obtain laboratory testing as ordered and report abnormal findings to the physician (05/28/2025).Review of R114's Order Summary Report, with active orders as of 05/18/2026, included an order for oxygen at 3 L/min via a NC every shift, started 05/27/2025.During an observation on 05/18/2026 at 9:53 AM, revealed R114 sitting in bed with oxygen in use via a NC, and the oxygen concentrator flow rate was set at 2.5 L/min. R114 stated that the oxygen flow rate was supposed to be set at 2 L/min. During an observation on 05/18/2026 at 1:38 PM, revealed R114 sitting in bed watching television with an oxygen flow rate of 2.5 L/min via a NC. During an interview on 05/18/2026 at 2:54 PM, Licensed Practical Nurse (LPN)25, who was a unit manager, verified R114 had a physician's order for oxygen at 3 L/min via NC continuously to maintain an oxygen saturation (blood hemoglobin oxygen saturation) above 90%.During a concurrent observation and interview with LPN25 on 05/18/2026 at 3:06 PM, R114 was observed sitting in bed with oxygen via a NC in use. LPN25 verified that the flow rate on R114's oxygen concentrator was set at 2 L/min via a NC and stated it should be set at 3 L/min. LPN25 stated she expected all staff to follow physicians' orders for oxygen administration.During an interview on 05/20/2026 at 3:01 PM, LPN28 stated she had been responsible for R114's care on 05/18/2026. LPN28 stated R114 had a physician's order for continuous oxygen at 3 L/min via a NC, and physician's orders were to be followed.During an interview on 05/21/2026 at 1:28 PM, the Director of Nursing (DON) stated that the assigned nurse was responsible for monitoring the resident's oxygen flow rate per the physician's order. The DON stated she expected nurses to round (systematic, scheduled nursing staff visits to check on residents) every two hours and check oxygen flow rates to ensure they were per the physicians' orders, and she expected staff to follow physicians' orders. The DON verified R114's ordered oxygen flow rate was 3 L/min via a NC continuously to keep the resident's oxygen saturation above 90%.During an interview on 05/21/2026 at 2:10 PM, the Administrator (ADM) stated he expected physicians' orders to be followed. The ADM stated he expected the assigned nurse to monitor oxygen flow rates on rounds each shift and to keep the oxygen flow rate at the physician-ordered rate.

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	425305	A. Building B. Wing	05/21/2026

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Patewood Post Acute	2 Griffith Road Greenville, SC 29607

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review, and facility policy review, the facility failed to ensure safe insulin administration for 1 (Resident (R)88) of 2 residents reviewed for insulin administration. Specifically, Licensed Practical Nurse (LPN)30 failed to verify R88's insulin order prior to preparing insulin for administration and failed to immediately document the insulin administration. The facility also failed to follow a procedure to ensure staff accurately acquired, received, and administered medicated eye drops for 1 (R72) of 25 sampled residents.Findings included: 1. Review of a facility policy titled, Administering Medications, revised April 2019, indicated, Policy Statement - Medications are administered in a safe and timely manner and as prescribed. The policy also specified, 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. The policy also specified, 22. The individual administering the medication initials the resident's MAR [Medication Administration Record] on the appropriate line after giving each medication and before administering the next ones. The policy also revealed, 23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered; b. The dosage; c. The route of administration; d. The injection site (if applicable): and g. The signature and title of the person administering the drug. Review of an admission Record indicated the facility admitted R88 on 05/06/2026. According to the admission Record, the resident had a medical history that included but was not limited to a diagnosis of Type 2 diabetes mellitus without complications.Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/13/2026, revealed R88 had a Brief Interview for Mental Status (BIMS) score of 14 out 15, which indicated the resident was cognitively intact. The MDS revealed R88 received insulin seven days of the 7-day look-back period.Review of R88's Care Plan Report included a focus area, initiated 05/06/2026, that indicated the resident had diabetes mellitus. Interventions directed staff to administer diabetes medication as ordered by the doctor and to monitor and document for side effects and effectiveness.Review of R88's Order Summary Report, with active orders as of 05/20/2026, revealed an order, dated 05/09/2026, for Humalog (insulin lispro) Solution 100 units per milliliter (units/ml), to inject Humalog per the sliding scale, and if blood glucose was 251 - 300 to administer six units of insulin.During a medication administration task observation and concurrent interview on 05/20/2026 at 5:16 AM, Licensed Practical Nurse (LPN)30 stated R88's blood glucose was 253. LPN30 opened the medication cart that was not equipped with a computer, stated R88 took insulin lispro (a fast-acting insulin), and removed an insulin lispro bottle, dated 05/10/2026, from the medication cart. LPN30 stated R88 received six units of insulin. LPN30 stated they knew the residents, and they did not look at the computer when giving medications, as they had the residents' physicians' orders in their (LPN30's) head. The observation revealed LPN30 did not look at R88's medication orders to verify the medication sliding scale. LPN30 stated she did not use the computer to verify the insulin as she knew her residents and knew that R88 should get about six units based on a blood glucose of 253. LPN30 stated that she was not concerned about medication changes as she would have been notified. The observation revealed LPN30 removed the insulin lispro and drew up six units of insulin lispro and then started to walk toward R88. The observation revealed LPN30 was stopped and asked to verify the insulin orders, and she stated she would verify them if she needed to. The observation revealed LPN30 disposed of the insulin, went to a computer in the dining area and verified the needed insulin was six units, returned to the medication cart, drew up the insulin, and administered the insulin to R88. After administering the insulin to R88, LPN30 did not check off in the records that she gave the insulin; instead, she walked to the nurse's station and printed the census report. LPN30 stated that she recorded all residents' medication as given once she completed the medication (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration.During an interview on 05/21/2026 at 11:23 AM, Nurse Practitioner (NP)18 stated that insulin dosage should be verified at the time of drawing up insulin, and it was poor practice on the nurse's part to draw up insulin without verifying the order on the computer.During an interview on 05/21/2026 at 11:46 AM, the Consultant Pharmacist (CP) stated her expectation was that the medication order be reviewed prior to giving medication and that blood glucose and the units of insulin administered were documented in the computer at the time they were given. During an interview on 05/21/2026 at 2:39 PM, LPN33, who was a unit manager, stated her expectation was that the physician's order should be checked and to never go by memory when a resident's blood glucose was checked. LPN33 stated the nurse needed to double-check the orders to see if the order had changed. During an interview on 05/21/2026 at 3:19 PM, the Administrator (ADM) stated the nurse should have looked on the computer to verify the order before giving the insulin.During an interview on 05/21/2026 at 3:32 PM, the Director of Nursing (DON) stated her expectation was that the nurse should verify the insulin order, document the blood glucose, and document the administration of insulin afterwards. The DON stated the nurse should keep the computer with them to verify the orders and should never give insulin without looking at the order. 2. Review of a facility policy titled, Medication and Treatment Orders, revised July 2016, revealed, Orders for medications and treatments will be consistent with principles of safe and effective order writing. The policy specified, 11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available.Review of an undated facility policy titled, Pharmacy Services revealed, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. The policy revealed, 4. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. The policy revealed, 5. Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. The policy revealed, 7. Medications are received, labeled, stored, administered and disposed of according to all applicable state and federal laws and consistent with standards of practice. Review of a facility policy titled, Instillation of Eye Drops, revised January 2014, specified, The purpose of this procedure is to provide guidelines for instillation of eye drops to treat medical conditions, eye infections and dry eyes. The policy revealed, Reporting included 1. Notify the supervisor if the resident refuses the care, and 2. Report other information in accordance with facility policy and professional standards of practice. Review of a five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/02/2025, revealed R72 and a Brief Interview for Mental Status (BIMS) score of 14 out 15, which indicated the resident had intact cognition. The MDS indicated the resident had impaired vision and wore corrective lenses.Review of R72's CAA [Care Area Assessment] Worksheet, with an ARD of 10/02/2025, revealed R72 had glaucoma, diabetic retinopathy, decreased visual acuity, and a visual field deficit. The CAA further indicated that the resident wore glasses to correct their vision.Review of a quarterly MDS, with an ARD of 04/22/2026, revealed R72 had a BIMS score of 14 of 15, which indicated the resident had intact cognition. The MDS indicated that the resident wore corrective lenses for their vision.Review of R72's Care Plan Report included a focus area initiated 02/17/2025, that indicated the resident was at risk for complications of diabetes. Interventions directed staff to administer the resident's medications as ordered (initiated 02/17/2025). During an interview on 05/18/2026 at 10:03 AM, R72 stated they had not had eye drops for glaucoma in the last week.During an interview on 05/19/2026 at 10:21 AM, R72 stated they had not received their eye drops. The resident stated they had asked different nurses about their eye drops, and they said the staff stated there was an issue with the pharmacy and had not gotten them yet. R72 stated they would go blind eventually if they did not get the eye drops. Review of R72's Progress Notes included a note, dated 05/06/2026 and electronically signed by Nurse Practitioner (NP)34, that revealed the order dated 09/11/2025 for latanoprost solution 0.005%, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one drop in both eyes at bedtime for glaucoma, was an active order.Review of R72's May 2026 Medication Administration Record revealed a transcription of an order, dated 09/11/2025, for latanoprost solution 0.005%, instill one drop in both eyes at bedtime (9:00 PM) for glaucoma. The MAR indicated that staff documented a 9, Other/See Nurses Notes, which indicated the medication was not given, on 05/06/2026, 05/10/2026, 05/11/2026, 05/12/2026, 05/16/2026, 05/17/2026, 05/18/2026, and 05/19/2026. Review of R72's Progress Notes revealed staff documented that latanoprost solution 0.005% was on order, awaiting, or ordered, on 05/07/2026 (1:07 AM), 05/10/2026, 05/11/2026, 05/12/2026, 05/16/2026, 05/17/2026, 05/18/2026 and 05/19/2026.During an interview on 05/20/2026 at 5:03 AM, Licensed Practical Nurse (LPN)2, who documented on R72's MAR that the eye drops were not given on 05/06/2026, 05/12/2026, and 05/19/2026, stated she had worked two nights, and that she would not have followed up with the pharmacy or physician because the day shift staff stated that R72's eye drops were on order.During a phone interview on 05/20/2026 at 3:56 PM, Registered Nurse (RN)21, who documented on R72's MAR that the eye drops were not given on 05/10/2026, 05/11/2026, 05/16/2026, 05/17/2026, and 05/18/2026, stated they were waiting for the eye medication for R72, and that she passed the information on to the day shift nurse to get an order. RN21 stated she did not contact the physician, NP, or the pharmacy to let them know the medication was out since day shift staff told her that the drops were on order.During an interview on 05/19/2026 at 2:34 PM, RN22 stated they called the pharmacy if they ran out of medications for a resident. RN22 further stated that they could also scan a sheet and fax it over to the pharmacy. RN22 stated there was no consistent staffing on the medication cart and that he did not inform the LPN33, who was a unit manager, or NP18 of R72's missing eye drops because they were not given during his shift.During an interview on 05/19/2026 at 4:20 PM, LPN33 stated the electronic medical record (EMAR) showed a dropdown box that turned grey if the medication was ordered, and that the nurse should have called the pharmacy for the status of the medication and made her aware of the missing medication. She stated that the nurse had a code 9 that showed up on the EMAR if the medication was not available, and the nurses documented the information on a progress note. LPN33 stated she expected to see notes that the pharmacy and provider were notified, not the progress note that said awaiting or on order.During a telephone interview on 05/21/2026 at 11:46 AM, the Consultant Pharmacist (CP) stated her expectation was that staff administer R72's medication as ordered, and if they could not find it, look in the refrigerator first, then call the pharmacy.During an interview on 05/21/2026 at 3:32 PM, the Director of Nursing (DON) stated the nurses should notify the leadership team if they had pharmacy issues.During an interview on 05/21/2026 at 10:54 AM, NP18 stated they had books for the staff to document concerns, and there was no documentation that R72 was missing eye drops. NP18 stated they were not made aware of missing eye drops until 05/20/2026. NP18 stated that R72 was on latanoprost prior to coming into the facility, and that the medication was continued.During an interview on 05/21/2026 at 3:19 PM, the Administrator (ADM) stated his expectation was for the nurses to document accurately, call the pharmacy to get the medication before they ran out or if they could not find it, and to notify the physician and family of the situation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview, record review, and facility policy review, the facility failed to ensure residents were free from significant medication errors, which affected 1 (Resident (R)72) of 25 sampled residents. Specifically, the facility failed to provide prescription eye drops per the physician orders for R72. Findings included: Review of a facility policy titled, Administering Medications, revised April 2019, indicated, Medications are administered in a safe and timely manner and as prescribed. The policy further indicated, 4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include, which included a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication of food interactions; and c. Honoring resident choices and preferences, consistent with his or her care plan. Review of a facility policy titled, Instillation of Eye Drops, revised January 2014, specified, The purpose of this procedure is to provide guidelines for instillation of eye drops to treat medical conditions, eye infections and dry eyes. The policy revealed, Reporting included 1. Notify the supervisor if the resident refuses the care, and 2. Report other information in accordance with facility policy and professional standards of practice. Review of a facility policy titled, Medication and Treatment Orders, revised July 2016, revealed, Orders for medications and treatments will be consistent with principles of safe and effective order writing. The policy specified,11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. Review of an admission Record indicated the facility admitted R72 on 02/13/2025. According to the admission Record, the resident had a medical history that included but was not limited to a diagnoses of type 2 diabetes mellitus (a disease where the body cannot use insulin properly resulting in high blood sugar levels that can cause damage to other body systems and organs) with diabetic mononeuropathy (localized nerve damage to one nerve caused by diabetes), noninfective gastroenteritis (inflammation of the stomach and intestines not caused by bacteria) and colitis (chronic inflammation of the bowel), and hypertension (high blood pressure). Review of a five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/02/2025, revealed R72 and a Brief Interview for Mental Status (BIMS) score of 14 out 14, which indicated the resident had intact cognition. The MDS indicated the resident had impaired vision and wore corrective lenses.Review of R72's CAA [Care Area Assessment] Worksheet, with an ARD of 10/02/2025, revealed R72 had glaucoma, diabetic retinopathy, decreased visual acuity, and a visual field deficit. The CAA further indicated that the resident wore glasses to correct their vision.Review of a quarterly MDS, with an ARD of 04/22/2026, revealed R72 had a BIMS score of 14 out 15, which indicated the resident had intact cognition. The MDS indicated that the resident wore corrective lenses for their vision. Review of R72's Care Plan Report included a focus area initiated 02/17/2025, that indicated the resident was at risk for complications of diabetes. Interventions directed staff to administer the resident's medications as ordered (initiated 02/17/2025). Review of R72's March 2026 Medication Administration Record [MAR] revealed a transcription of an order, dated 09/11/2025, for latanoprost (an ophthalmic glaucoma agent) solution 0.005%, instill one drop in both eyes at bedtime (9:00 PM) for glaucoma. The MAR indicated that staff documented a 9, Other/See Nurses Notes, which indicated the medication was not given, on 03/16/2026, 03/18/2026, 03/20/2026, 03/21/2026, 03/22/2026, 03/24/2026. 03/25/2026, and 03/27/2026.Review of R72's Progress Notes revealed staff documented that latanoprost solution 0.005% was ordered, on order, awaiting delivery, awaiting, awaiting supply, or Awaiting pharmacy, on 03/16/2026, 03/20/2026, 03/21/2026, 03/22/2026, 03/25/2026, and 03/27/2026. During an interview on 05/18/2026 at 10:03 AM, R72 stated they had not had eye drops for glaucoma in the last week. During an interview on 05/19/2026 at 10:21 AM, R72 stated they had not received their eye drops. The resident stated they had asked different nurses about their eye drops, and they said the staff stated (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was an issue with the pharmacy and had not gotten them yet. R72 stated they would go blind eventually if they did not get the eye drops. Review of R72's Progress Notes included a note, dated 05/06/2026 and electronically signed by Nurse Practitioner (NP)34, that revealed the order dated 09/11/2025 for latanoprost solution 0.005%, one drop in both eyes at bedtime for glaucoma, was an active order.Review of R72's May 2026 Medication Administration Record revealed a transcription of an order, dated 09/11/2025, for latanoprost solution 0.005%, instill one drop in both eyes at bedtime (9:00 PM) for glaucoma. The MAR indicated that staff documented a 9, Other/See Nurses Notes, which indicated the medication was not given, on 05/06/2026, 05/10/2026, 05/11/2026, 05/12/2026, 05/16/2026, 05/17/2026, 05/18/2026, and 05/19/2026. Review of R72's Progress Notes revealed staff documented that latanoprost solution 0.005% was on order, awaiting, or ordered, on 05/07/2026 (1:07 AM), 05/10/2026, 05/11/2026, 05/12/2026, 05/16/2026, 05/17/2026, 05/18/2026 and 05/19/2026. During an interview on 05/20/2026 at 5:03 AM, Licensed Practical Nure (LPN)2, who documented on R72's MAR that the eye drops were not given on 05/06/2026, 05/12/2026, and 05/19/2026, stated she had worked two nights, and that she would not have followed up with the pharmacy or physician because the day shift staff stated that R72's eye drops were on order. During a phone interview on 05/20/2026 at 3:56 PM, Registered Nurse (RN)21, who documented on R72's MAR that the eye drops were not given on 05/10/2026, 05/11/2026, 05/16/2026, 05/17/2026, and 05/18/2026, stated they were waiting for the eye medication for R72, and that she passed the information on to the day shift nurse to get an order. RN21 stated she did not contact the physician, NP, or the pharmacy to let them know the medication was out since day shift staff told her that the drops were on order. During an interview on 05/19/2026 at 2:34 PM, RN22 stated they called the pharmacy if they ran out of medications for a resident. RN22 further stated that they could also scan a sheet and fax it over to the pharmacy. RN22 stated there was no consistent staffing on the medication cart and that he did not inform the LPN33, who was a unit manager, or NP18 of R72's missing eye drops because they were not given during his shift.During an interview on 05/19/2026 at 4:20 PM, LPN33 stated the electronic medical record (EMAR) showed a dropdown box that turned grey if the medication was ordered, and that the nurse should have called the pharmacy for the status of the medication and made her aware of the missing medication. She stated that the nurse had a code 9 that showed up on the EMAR if the medication was not available, and the nurses documented the information on a progress note. LPN33 stated she expected to see notes that the pharmacy and provider were notified, not the progress note that said awaiting or on order. LPN33 stated R72's eye drops were for glaucoma and primarily given at bedtime, and without the medication, the resident could potentially lose vision. During a telephone interview on 05/21/2026 at 11:46 AM, the Consultant Pharmacist (CP) stated her expectation was that staff administer R72's medication as ordered, and if they could not find it, look in the refrigerator first, then call the pharmacy. The CP further stated that vision could decrease without the medication.During an interview on 05/21/2026 at 3:32 PM, the Director of Nursing (DON) stated the nurses should notify the leadership team if they had pharmacy issues and stated the side effects for not receiving glaucoma drops would be a discussion to have with the provider.During an interview on 05/21/2026 at 10:54 AM, NP18 stated they had books for the staff to document concerns, and there was no documentation that R72 was missing eye drops. NP18 stated they were not made aware of missing eye drops until 05/20/2026. NP18 stated that R72 was on latanoprost prior to coming into the facility, and that the medication was continued. NP18 stated the eye medication was used to prevent or slow the worsening of eye disease.During an interview on 05/21/2026 at 3:19 PM, the Administrator (ADM) stated his expectation was for the nurses to document accurately, call the pharmacy to get the medication before they ran out or if they could not find it, and to notify the physician and family of the situation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on facility policy review, record review, observation, and interview, the facility failed to ensure medications were stored safely and securely for 2 (Resident (R)3 and R119) of 8 residents reviewed during the medication administration task and 1 (R120) of 3 sampled residents who had medications in their room. Findings included: Review of a facility policy titled, Storage of Medications, revised November 2020, indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. The policy further indicated, 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 1. Review of an admission Record indicated the facility admitted R3 on 04/17/2026. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of spondylosis with myelopathy and polyneuropathy. Review of R3's Order Summary Report, with active orders as of 05/21/2026, included an order, dated 04/17/2026, for acetaminophen (a miscellaneous analgesic) oral tablet 325 milligram (mg), two tablets every six hours for pain. The Order Summary Report included an order, dated 04/27/2026, for gabapentin oral capsule 300 mg, one capsule two times a day for neuropathy. Review of an admission Record indicated the facility admitted R119 on 03/22/2026. According to the admission Record, the resident had a medical history that included but was not limited to diagnoses of acquired absence of right leg below the knee and gastro-esophageal reflux disease (GERD) without esophagitis.Review of R119's Order Summary Report, with active orders as of 05/20/2026, included an order, dated 04/23/2026, for gabapentin capsule 100 mg, one capsule by mouth two times a day for neuropathy/right lower extremity phantom limb pain. The Order Summary Report included an order, dated 04/08/2026, for famotidine (a gastrointestinal agent) oral tablet 20 mg, one tablet by mouth every morning and at bedtime for GERD. During an observation of the 200 Hallway on 05/20/2026 at 4:36 AM, two medication cups were observed stacked on a medication cart with medications in them. During an interview at the time of the observation, Licensed Practical Nurse (LPN)2 stated that it was not her medication cart and stated that medications should never be left out and unattended on the cart. LPN2 stated the cart was LPN30's, and she was on break. LPN2 stated that the medication in the first cup contained two tablets and one capsule, and the second medication cup contained one capsule and one tablet. The medication cart was locked, and no residents were observed in the area. During an interview on 05/20/2026 at 4:44 AM, LPN30 stated that she pulled the medications prior to going on break and confirmed the medication in one cup was two acetaminophen and one gabapentin for R3 and one gabapentin and one famotidine in the second cup for R119. LPN30 stated that she should not have pulled the medication prior to going on break but had one hour before and one hour after to administer the medication and wanted to have it ready when she came back from break.2. Review of an admission Record indicated the facility admitted R120 on 04/17/2026. According to the admission Record, the resident had a medical history that included but was not limited to a diagnosis of unspecified bilateral pre-glaucoma.Review of R120's five-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/23/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition.Review of R120's Order Summary Report, with active orders as of 05/21/2026, included an order, dated 04/16/2026, for timolol maleate ophthalmic (an antiglaucoma) solution 0.5 %, instill one drop in both eyes two times a day for glaucoma. During an interview on 05/20/2026 at 1:28 PM, R120 stated that the nurse brought in eye drops and placed them on their bedside table when they (R120) were in the bathroom. The resident stated that they administered the medication that day to themselves, and they were waiting for the nurse to come back and get them. The resident stated that the staff typically administered the medication to them (R120), but they did not that day. The resident stated that they took timolol maleate ophthalmic. During an interview on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425305	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patewood Post Acute	2 Griffith Road Greenville, SC 29607

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/20/2026 at 2:35 PM, Registered Nurse (RN)24 stated she left the timolol eye drops in R120's room on the bedside table. She stated that she knew she should not have left the medication.During an interview on 05/21/2026 at 11:23 AM, Nurse Practitioner (NP)18 stated her expectation was to give one medication at a time and secure them.During a telephone interview on 05/21/2026 at 11:46 AM, the Consultant Pharmacist (CP) stated that the expectation was for staff to administer medication to one resident at a time and keep medication in a locked cabinet. During an interview on 05/21/2026 at 2:39 PM, Licensed Practical Nurse (LPN)33, who was a unit manager, stated that her expectation was to have the medications secured on a medication cart.During an interview on 05/21/2026 at 3:19 PM, the Administrator stated that the expectation was for medications to be locked in the medication cart.During an interview on 05/21/2026 at 3:32 PM, the Director of Nursing (DON) stated that nurses were expected to not leave medication at a resident's bedside and to secure the medication.