STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525098	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waunakee Valley Senior Living	801 Klein Dr Waunakee, WI 53597

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 38725 Based on interview and record review, the facility did not follow through with the appropriate steps of the Preadmission Screening and Resident Review (PASRR) process for 1 of 5 residents (R48) reviewed. R48 did not have a PASRR level II completed. This is evidenced by: Per the facility, they do not have a PASRR Policy and Procedure, but they follow the Wisconsin PASRR QRG (Quick Reference Guide) process. Surveyor was also given the Forward Health Update dated November 2023 that the facility references. The Wisconsin PASRR QRG documents the following in verbiage and a flow diagram: What is a PASRR: Preadmission Screening and Resident Review (PASRR) is a federal requirement established to identify individuals with mental illness and/or intellectual developmental disability to ensure appropriate placement in the community or a nursing facility. Purpose: The purpose of a Level I screen is to identify individuals whose total needs require that they receive additional services for their intellectual disabilities or serious mental illness. Who Requires a PASRR: All residents admitting to the campus must have a level I PASRR screen completed whether they might have a diagnosis of mental illness (MI) or Intellectual/Developmental Disability (ID/DD) or not. When to complete: Prior to admission .On or before the last day of a short-term exemption . Short Term Exemption process .If is determined that the individual will need to stay beyond the short-term exemption period, a Level II screen must be completed . R48 admitted in April of 2024. R48 has the following diagnoses: bipolar disorder, major depressive disorder, PTSD (Post Traumatic Stress Disorder), adjustment disorder, and other anxiety disorders. R48's PASRR level I was completed with a documented 30-day exemption. R48 did not have a level II completed. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 5:23 PM, Surveyor interviewed DSS C (Director of Social Services). Surveyor asked DSS C if a level II PASRR should be completed if a resident stays longer than their anticipated 30 days, DSS C said yes. Surveyor asked DSS C should R48 have had a PASRR II completed, DSS C stated I'm sure I did a level II but if I don't have a copy of it in here then it is too late to call and get it. They send it back to me in an email, so I don't know if I missed it or not.

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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 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** 49434 Based on interview and record review, the facility did not ensure residents receive treatment and care in accordance with professional standards of practice when experiencing a change in condition for 2 of 2 residents (R52 and R305) reviewed for quality of care. R52 and R305 has documented nursing assessments completed and signed by Licensed Practical Nurse (LPNs), which are required to be completed or signed off by a Registered Nurse (RN). Evidenced by: Surveyor requested a facility policy outlining RN assessments, facility staff stated they were unable to provide this policy. N9 Wisconsin Nurse Practice Act states, in part: N6.03 Standards of practice for registered nurses. An R.N. shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention, and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis . N6.04. Standards of Practice for the licensed practical nurses . (e)Perform the following other acts when applicable: 1. Assist with the collection of data . Example 1 R52 was admitted to the facility on [DATE], with diagnoses that include, in part: fracture of right femur, periprosthetic fracture around internal prosthetic left hip joint (fracture around artificial hip joint), malignant neoplasm of prostate, and secondary malignant neoplasm of bone. R52's Admission Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 12/19/24, indicates that R52 has a Brief Interview of Mental Stats (BIMS) score of 14 out of 15, indicating that he is cognitively intact. R52's progress notes include, in part: On 11/27/24 at 10:25 PM, a progress note is written that includes a complete head-to-toe assessment along with teaching and training provided to the resident. This note is signed by LPN F (Licensed Practical Nurse) with no record of a RN (Registered Nurse) co-signature or notification. On 11/28/24 at 4:10 PM, a progress note is written that includes a complete head-to-toe assessment along with teaching and training provided to the resident. This note is signed by LPN F with no record of a RN co-signature or notification. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/29/24 at 5:00 AM, a progress note is written that includes a complete head-to-toe assessment along with teaching and training provided to the resident. This note is signed by LPN F with no record of a RN co-signature or notification. On 11/30/24 at 9:26 AM, a progress note is written that includes a complete head-to-toe assessment along with teaching and training provided to the resident. This note is signed by LPN K with no record of a RN co-signature or notification. Example 2 R305 was admitted to the facility on [DATE] with diagnoses that include, in part: primary cancer of right lower lobe of lung, hypertension (high blood pressure), lung cancer metastatic to brain, impaired mobility and ADLs (Activities of daily living), and weakness. R305's was a new admission and did not have a comprehensive Minimum Data Set (MDS) completed at the time of survey. R305's progress notes include, in part: On 1/18/25 at 11:07 AM, a progress note is written that includes a complete head-to-toe assessment along with teaching and training provided to the resident. This note does include findings of pain, with a complete pain assessment. This note is signed by LPN F with no record of a RN co-signature or notification. On 1/19/25 at 7:14 AM, a progress note is written that includes a complete head-to-toe assessment along with teaching and training provided to the resident. This note does include findings of pain, with a complete pain assessment. This note is signed by LPN F with no record of a RN co-signature or notification. On 1/20/25 at 4:26 PM, a progress note is written that includes a complete head-to-toe assessment along with teaching and training provided to the resident. This note is signed by LPN I with no record of a RN co-signature or notification. On 1/23/25 at 2:59 PM, Surveyor interviewed LPN I. Surveyor asked LPN I if a resident falls, does he pick the patient up before speaking to a RN. LPN I states he will assess for injuries than notify family, physician, and DON B (Director of Nursing) after getting the resident off the floor. Surveyor asked LPN I if LPNs are allowed to assess residents. LPN I states, no. On 1/23/25 at 3:51 PM, Surveyor interviewed RN L. Surveyor asked RN L if when a resident falls, should the resident ever be picked up without the LPN discussing their findings with an RN. RN L states, LPNs cannot assess. On 1/23/25 at 4:25 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if the facility does daily nursing assessments. DON B indicates, they do skilled documentation that are standing orders. Surveyor asked DON B what skilled documentation or nursing assessments look like. DON B indicates, they are the head-to-toe assessments under the skilled document template. Surveyor asked DON B if LPNs can assess residents. DON B indicates, she believes with RN oversight they can assess and would need to report it to an RN if there are new findings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 4:45 PM, Surveyor interviewed DON B. DON B provided Surveyor with the State Nursing Practice Act, detailed above, and indicated that assessments are reviewed during the Weekly Skilled/Medicare Meeting. Surveyor asked DON B if LPNs can do the skilled nursing head-to-toe assessments. DON B indicates LPNs can do observations. Surveyor advised DON B that Surveyor has reviewed several head-to-toe assessments without an RN co-sign or note stating an RN was consulted regarding LPN findings. DON B indicates she would expect the head-to-toe assessments to be co-signed by and RN or that the LPN note that their findings were discussed with an RN.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review, the facility did not provide behavioral health services to ensure the highest practicable mental and psychosocial well-being for 1 of 2 residents (R11) reviewed. R11 admitted to the facility with a history of depression. The facility failed to offer R11 services related to this diagnosis even after R11's husband passed away in [DATE]. This is evidenced by: The National Institutes for Health states, in part: .Depression, even severe depression, can be treated. It's important to seek treatment as soon as you begin noticing signs . A doctor can rule out medical possibilities through a physical exam, learning about your health and personal history, and lab tests. If a doctor finds there is no medical condition that is causing the depression, he or she may suggest a psychological evaluation and refer you to a mental health professional . The State Operations Manual, Appendix PP states, in part: Providing behavioral health care and services is an integral part of the person-centered environment. This involves an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident. Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities . In addition to the facility-wide approaches that address residents' emotional and psychosocial well-being, facilities are expected to ensure that residents' individualized behavioral health needs are met Although people experience losses, it does not necessarily mean that they will become depressed. Depression (major depressive disorder or clinical depression) is a common and serious mood disorder. Symptoms may include fatigue, sleep and appetite disturbances, agitation, and expressions of guilt, difficulty concentrating, apathy, withdrawal, and suicidal ideation . R11 was admitted to the facility on [DATE], with diagnosis that include, in part: Parkinsonism (a group of neurological disorders that affect movement), Essential Hypertension (high blood pressure), Depression, unspecified, Chronic fatigue, unspecified, Repeated falls, and Dysphagia (difficulty swallowing). R11's most recent Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] states in part, R11 has a Brief Interview for Mental Status (BIMS) of 10 out of 15, indicating that R11 has a moderate cognitive impairment. Section D0150 of R11's MDS indicates feeling down, depressed, or hopeless ,d+[DATE] days. Section D0700 of R11's MDS states sometimes for social isolation. R11's Comprehensive Care Plan, states, in part: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Problem: Resident demonstrates altered mood due to recent life losses and admission to the facility. Date Initiated: [DATE]. Goal: Resident's altered mood will not result in uncompensated depression. Target Date: [DATE]. Approach/Interventions: Encourage healthy reminiscing contacts as appropriate. Start Date: [DATE]. Meds per orders. Start Date: [DATE]. Observe resident's adjustment to facility, rehab program, daily activity, etc. Start Date [DATE]. Offer routine schedules and consistency of care. Start Date: [DATE]. Refer to psych services as needed. Start Date: [DATE]. Problem: [Resident Name] recently experienced the death and dying of her spouse. Resident is progressing through the stages of grief. Date Initiated: [DATE]. Goal: [Resident Name's] grief will not result in significant weight loss or gain, the inability to participate in ADLs (Activities of Daily Living), isolation, listlessness, etc. Target Date: [DATE]. Approach/Interventions: Encourage resident to continue to eat meals in the dining room with other residents. Start Date: [DATE]. Encourage resident to participate in structured activities and individual leisure activities. Start Date: [DATE]. Monitor for increased signs and symptoms of depression through the PHQ (Patient Health Questionnaire) PRN (as needed). Start Date [DATE]. Observe resident's mood, affect, and behaviors with all hands-on care and contacts. Start Date: [DATE]. Provide supportive counseling contacts PRN. Start Date [DATE]. Refer to psych services as needed. Start Date: [DATE]. R11's Physician Orders state, in part: -Trazodone tablet; 100 mg (milligram): 1 tablet at HS (bedtime). Start Date: [DATE]. -Resident has a dx (diagnosis) of Parkinson's disease. Nursing is to monitor for increased tremors, stiffness/rigidity, bradykinesia (slowness of movement), or impaired balance/coordination. Nursing to coordinate care with neurology for medication adjustments/management as needed. Administer medications as ordered. Start Date: [DATE]. R11's Treatment Administration Record (TAR) states, in part: Target Behavior - Depression monitor for s/s (signs/symptoms) of crying, weeping, self-isolation, refusal of cares. At the end of each shift mark frequency - how often behavior occurred and intensity - how resident responded to redirect. Start Date [DATE] . -R11's TAR indicates yes for depression 16 times in [DATE], all marked as difficult to redirect. -R11's TAR indicates yes for depression 5 times in [DATE] marked as difficult to redirect and 2 marked as easily altered. -R11's TAR indicates yes for depression 1 time in [DATE], marked as easily altered. -R11's TAR indicates yes for depression 5 times in [DATE], all marked as difficult to redirect. -R11's TAR indicates yes for depression 6+ times in [DATE], marked as difficult to redirect. -R11's TAR indicates yes for depression 4+ times (one entry only indicated many not a number for frequency) in [DATE], all marked as difficult to redirect. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:20 AM, a Nursing Progress Note entered by LPN F (Licensed Practical Nurse) states, in part: Continues with poor appetite, sleeping for longer periods, daytime fatigue, frequently observed falling asleep at meal, recent loss of spouse which has contributed to overall decline, resident has made comments to writer, I'm ready to die. I was only living for my husband and now he is gone so what is the point . family is supportive and visit several times per week. POA (Power of Attorney) is kept informed of resident decline . On [DATE] a Nurse Practitioner (NP) Note states, in part: . More labile since the passing of her husband . she has now had some weight loss in the SNF (skilled nursing facility) particularly since the passing of her husband . when I asked about her teeth, she said what's the point?. We explored that today and we talked about dying. She said, in her own words, that she is okay with dying . and has a sense of readiness about death . Assessment/Plan for poor sleep: continue trazodone 75 mg HS . (Of note, R11's MDS indicated being depressed ,d+[DATE] times, her TAR indicated many instances of depression, her Care Plan noted depression, and she verbalized wanting to die on two separate occasions; however, she was not prescribed any medication to expressly help with her depression. R11 was prescribed trazodone, which is categorized as an anti-depressant but was being utilized to help R11 with her insomnia, not depression). On [DATE] at 10:43 AM, a Nursing Progress Note entered by LPN F states, in part: staff report resident is sleeping more during the day, writer observed resident falling asleep at breakfast . On [DATE] at 6:42 AM, Nursing Progress Note entered by LPN F states, in part: resident signed on with Agrace Hospice effective [DATE] . On [DATE] at 3:31 PM, Nursing Progress Note entered by LPN F states, in part: weight obtained . shows weight loss . poor appetite . declines to eat most meals or only takes a couple bites, is no longer drinking entire nutritional supplement . signed on with hospice . NP updated . (Of note, R11's care planned goals and interventions were not updated or personalized despite her continued decline and depression). On [DATE] at 6:47 PM, Surveyor interviewed CNA E (Certified Nursing Assistant), and asked if she had noticed a change in R11's mood or behavior. CNA E stated she did notice that R11 has been more tired, quieter, and not eating as much. CNA E stated that when she notices a resident change or decline, she notifies LPN F. On [DATE] at 6:50 PM, Surveyor interviewed LPN I, who stated that R11 has had a gradual decline since March (when her husband passed away), and a steadier decline recently. LPN I indicated that R11's family is very involved in her care and takes her out frequently, which helps with her mood. On [DATE] at 6:54 PM, Surveyor interviewed LPN F, who stated R11 has good days and bad days, and on bad days she doesn't want to eat much. LPN F stated that R11 went through the normal grief process when her husband died . LPN F stated that recently R11 had not been wanting to drink much or drink her supplement, and R11 told her she is just not hungry anymore. LPN F indicated that R11's depression did not manifest in much crying, but for her, she becomes more aggressive and lashes out when she is depressed. Surveyor asked LPN F if she would consider R11's decline a change in condition. LPN F stated she would. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 6:57 PM, Surveyor interviewed CNA G, who stated that R11 has declined over the past few months, and that her appetite has decreased. Surveyor asked CNA G how depression was manifested in R11. CNA G indicated that R11 was refusing to get up in the morning, decreased appetite. CNA G stated that she had not noticed any crying or weeping, just an overall general decline. Surveyor asked CNA G who she would report resident changes in condition to. CNA G stated that she would always report those to LPN F. On [DATE] at 7:00 PM, Surveyor interviewed CNA H, who stated that R11 has had a slow decline, including poor appetite, very tired, going to bed earlier and getting up later. CNA H stated that R11 has expressed sadness and that she still misses her husband. Surveyor asked CNA H who she would notify of a resident change in condition such as poor appetite and increased tiredness. CNA H stated she would inform the nurse and that the nurse would follow-up. On [DATE] at 4:20 PM, Surveyor interviewed DSS C (Director of Social Services), and asked her what interventions were put in place to support R11 with her grief and depression. DSS C stated that informal contacts had been made to help with the grief process. DSS C stated that she asked hospice if they could provide grief services, but they had recommended an outside service, which they did not pursue. DSS C said that she would informally stop in and touch base with her. Surveyor asked DSS C if she had made a referral for a psychiatric evaluation, per R11's care plan. DSS C stated that she had not. On [DATE] at 5:41 PM, Surveyor interviewed Interim NHA A (Nursing Home Administrator) and asked her if she would expect the care planned interventions for R11 to be implemented and followed. NHA A replied yes, that was her expectation. Surveyor pointed out to NHA A that neither the psychiatric evaluation nor the referral to counseling services had been provided to R11. NHA A indicated that was unacceptable. On [DATE] at 7:50 PM, Surveyor interviewed DON B (Director of Nursing) about R11's depression and decline. Surveyor asked if R11's behaviors of decreased appetite, increased sleep, and statements of wanting to die would be considered clinical depression. DON B replied yes. Surveyor asked DON B if R11's care plan should have been updated and personalized to support R11's continued depression. DON B replied yes, that would be her expectation. Surveyor asked DON B if an anti-depressant medication had ever been offered to R11 to assist with her depression. DON B stated that she had not been employed by the facility when R11's husband passed away; however, she reviewed R11's EHR (Electronic Health Record) and confirmed that R11 had never been on an antidepressant, other than trazodone for sleep. Despite R11's continued gradual decline, the facility failed to recognize her obvious signs of depression, develop, and implement a person-centered care plan for depression, or provide her with social service and behavioral support, until being signed on with hospice services on [DATE].

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on observation, interview, and record review, the facility did not ensure residents are free of significant medication errors for 1 of 1 out of 14 sampled residents (R52). R52 had an order for abiraterone (used to treat prostate cancer that has spread to other parts of the body) 1000 mg (milligrams) to be administered once a day by mouth. This medication has precise administration instructions, that it needs to be taken with a full glass of water and on an empty stomach. Residents are instructed not to eat anything for at least two hours before and one hour after taking this medication. This medication was administered late on 11/30/24 and 12/1/24. Evidenced by: The facility policy, titled, Medication Administration Times, dated 12/17/24, states, in part: . Purpose: To ensure medication is administered in resident centered fashion and documented in medical record. Procedures . Unless a specific times is designated by the attending physician medications shall be administered at the following times . According to the National Library of Medicine, abiraterone must be taken as a single dose, once daily, and on an empty stomach. Instructions include not eating two hours before taking the medication and not eating for one hour after taking the medication. (Source: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0a84f388-a8b4-4065-93a6-1c663c99d265) R52 was admitted to the facility on [DATE], with diagnoses that include, in part: fracture of right femur, periprosthetic fracture around internal prosthetic left hip joint (fracture around artificial hip joint), malignant neoplasm of prostate, and secondary malignant neoplasm of bone. R52's Admission Minimum Data Set, with Assessment Reference Date (ARD) of 12/19/24, indicates that R52 has a Brief Interview of Mental Stats (BIMS) score of 14 out of 15, indicating that he is cognitively intact. R52's Physician Orders indicates: abiraterone 250 mg tablet; Amount to Administer: 4 tabs; oral; Once a Day; 10:00 AM-11:00 AM. Start date: 11/28/24. End date: 12/20/24 (DC (Discharge) Date). R52's Medication Administration Record states, in part: 11/30/24 - Abiraterone administered at 11:05 AM 12/1/24 - Abiraterone administered at 11:24 AM This resulted in two significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 2:54 PM, Surveyor interviewed LPN F (Licensed Practical Nurse). Surveyor asked LPN F if medications need to be administered at a certain time. LPN F indicates that most medications have a four-hour time block that they can administer the medications, but some are more specific. Surveyor asked LPN F if medications should be administered according to physician order. LPN F indicates, medications should be administered according to physician order. On 1/23/25 at 2:59 PM, Surveyor interviewed LPN I. Surveyor asked LPN I if medications need to be administered at a certain time. LPN I indicates that most some medications have a wider time frame and some medications are more specific. Surveyor asked LPN I if medications should be administered according to physician order. LPN I states, yes. On 1/23/25 at 4:25 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if medications have a time frame to be administered in if they are not PRN (as needed). DON B, states yes. Surveyor asked DON B if she expects medications to be administered on time. DON B states, yes. Surveyor asked DON B if medications should be administered according to physician order. DON B states, yes. Surveyor asked DON B about R52's late medication administrations, and if these medications should have been administered on time. DON B indicates, yes and it should have been reported to administrative staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525098	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waunakee Valley Senior Living	801 Klein Dr Waunakee, WI 53597

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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. 42038 Based on observation, interview, and record review, the facility did not ensure all drugs and biologicals were stored in accordance with currently accepted professional principles. This occurred for 1 of 3 medication carts observed. During the three-day survey, 1 of 3 medication carts was left unattended, unlocked, and out of view of staff. Evidenced by: The facility policy titled Medication Storage in the Facility revised 10/2019 states in part .B. Only licensed nursed, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access . On 1/21/25 at 9:18 AM, Surveyor observed the medication cart located on A wing to be sitting in the hallway unlocked. On 1/21/25 at 9:19 AM, Surveyor observed LPN J (Licensed Practical Nurse) exit another room on the hallway and approach the medication cart. Surveyor asked LPN J what the process is when they leave the medication cart, LPN J stated that they are to make sure the pills are locked up. Surveyor asked LPN J if the medication cart was locked when they left it, LPN J stated no. On 1/23/25 at 4:23 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the expectation was for nurses when they leave their medication carts, DON B stated that the cart should be locked, and the nurses should take their keys with them. Surveyor asked DON B if she would have expected LPN J's cart to be locked when they left to go into another room, DON B stated yes.