STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525562	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Manor	310 Fairlane Dr Viroqua, WI 54665

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on document review, interview and policy review, facility failed to ensure that when COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized for 4 of 4 staff reviewed. This has the potential to affect all 46 residents residing within the facility.Facility failed to have documentation of staff COVID-19 vaccination status, that staff were educated about the COVID-19 vaccine, the COVID-19 vaccine was offered and signed consents of accepting the vaccine or declining the vaccine for the following four staff Director of Nursing (DON), Licensed Practical Nurse (LPN)1, Resident Care Assistant (RCA)1 and Certified Nurse Aide (CNA)1 Findings include:Review of the facility's policy titled COVID-19 Vaccinations dated 07/03/2025 revealed, 1. It is the policy of this facility, in collaboration with the medical director, to have an immunization program against infectious diseases in accordance with national standards of practice.3. Residents and staff will be offered immunizations against infectious diseases.5. Copies of the Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) will be given and explained to the staff member.prior to receiving a specified vaccine(s).7. Following assessment for potential medical contraindications, the specified vaccination(s) may be administered.8. Staff.will be required to sign a consent form prior to administration of the vaccine. The completed, signed, and dated record will be filed in the.staff.medical file.Review of the DON, LPN1, CNA1 and RCA1' s employee files and infection control records revealed there was no documentation of the staff's COVID-19 vaccination status, that staff had been educated regarding the COVID-19 vaccine, signed consent form for staff requesting vaccination, or signed declination statement for staff refusing the COVID-19 vaccine.During an interview on 02/26/26 at 3:01 PM, the IP (Infection Preventionist) stated that she had posted informational posters in the break room regarding COVID-19 vaccination; however, she acknowledged she does not document which staff received education, The IP stated that she does not maintain employee records for any staff regarding their COVID-19 vaccination status, consent for vaccination and providing the vaccine or staff's declination of the vaccine.During an interview on 02/27/26 at 12:45 PM, the DON stated she was not aware that the IP was not maintaining documentation for any staff regarding the staff 's COVID-19 vaccination status, education regarding the COVID-19 vaccine, consent, or declination.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to document and respond to residents' grievance regarding removal of their bedrails for five of five residents (R6, R8, R23, R26 and R42). R6, R8, R23, R26 and R42 voiced grievances regarding their bedrails, and the facility did not follow their grievance policy. Findings include: Reviewed facility's undated policy titled, Grievance indicated, Facility will make prompt efforts to resolve grievances a resident may have. The intent of the grievance process is to support each resident's right to voice grievances (e.g., those about treatment, care, management of funds, lost clothing, or violation of rights) and to assure that after receiving a complaint/grievance, the facility actively seeks a resolution and keeps the resident appropriately apprised of its progress toward resolution. 1.Review of R26's admission Record, located in the EMR (electronic medical record) under the Profile tab revealed the resident was admitted to the facility on [DATE]. Review of R26's annual MDS (Minimum data set) with ARD (assessment reference date) of 02/20/23 revealed a BIMS (brief interview of mental status) score of 14 out of 15, indicating the resident was cognitively intact. Interview on 02/24/26 at 3:34 PM, R26 stated the facility removed the side rails. He expressed frustration and stated he was unable to turn himself in bed. 2.Review of R8's admission Record in the EMR under the Profile tab revealed the resident was admitted on [DATE]. Review of R8's annual MDS with an ARD of 01/07/26 and located in the resident's EMR under the MDS tab revealed a BIMS score of 13 out of 15 which indicated the resident was cognitively intact. Interview on 02/24/26 at 3:52 PM, R8 stated the facility removed the side rails. R8 stated he was unable to turn himself in bed, had difficulty sitting on the side of the bed, and feared he may fall without the rails to hold onto. He stated he now must call staff to assist with repositioning and sitting up. 3.Review of R6's undated admission Record located in the resident's EMR under the Profile tab revealed R6 was admitted to the facility on [DATE]. Review of R6's quarterly MDS with an ARD of 12/17/25 and located in the EMR under the MDS tab revealed R6 had a BIMS score of 15 out of 15 which indicated he was cognitively intact. During an interview and observation on 02/24/26 at 11:14 AM, R6 stated, They took my rails away and told me they are not allowed. R6 stated she wanted the bed rails back because she had no use of (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her left hand and she had used her right hand to hold onto the rails for positioning in the bed. R6 stated she had expressed her concerns about the bed rails being removed to the Administrator, Director of Nursing (DON and had asked for a written response regarding the bed rails being removed. R6 stated she had not received anything regarding the rationale for the bed rails being removed. 4.On 02/26/26 at 10:00AM, the Resident Council meeting was held with five residents, R6, R8, R23, R26 and R42, in attendance. R42, the Resident Council President, stated that the bed rails were taken away because the facility's Administrator stated that the Federal Regulations (F 700) prohibits any use of bed rails. All the residents present were visibly upset and stated that they received no prior notice that the bed rails were being removed. The Resident Council President filed a grievance asking management if there was an intention to remove resident bed rails. All five residents stated that the Administrator never responded to their grievance either verbally or in writing. During an interview on 02/26/26 at 2:17 PM, the Activity Director (AD) stated there was discussion at the December Resident Council Monthly meeting about bedrails being removed sometime in December 2025. The AD stated the process for concerns voiced in Resident Council Meetings was that the concerns were recorded and documented in the minutes if the issue could not be addressed during the meeting. If the concern was not resolved in the meeting, the concern was documented as a grievance, and the grievance form would be initiated. The AD stated the concerns from the previous meeting would be addressed in the next resident council meeting until residents no longer voiced the concern and this would be documented. The AD verified that no process for addressing bed rails concerns were reported back to the resident group. During an interview on 02/26/26 at 2:31 PM, Licensed Practical Nurse (LPN) 3 and LPN4 stated that they had been informed by Administration that all bed rails had to be removed due to regulation. LPN3 and LPN4 stated the bed rails had been removed around 12/25/25. LPN3 and LPN4 stated numerous residents and families had expressed and continued to express concerns to them regarding the rails being removed. Review of a letter from the Administrator to residents and families dated 02/05/26 that was provided by the facility indicated, We would like to share an important update regarding resident safety at [facility name]. In accordance with guideline F700 related to bed rails, [facility name] will no longer be able to offer or use bed rails for residents. As a result, any bed rails currently in place will be removed by our maintenance team . During an interview on 02/27/26 at 12:29 PM, the DON stated R6 came to Administration and asked if they were going to remove bed rails. The DON verified none of the residents currently had bed rails. The DON stated there had been an upheaval from the residents about the rails being removed. During an interview on 02/27/26 at 8:32 AM, the Administrator stated bed rails had been installed on all the beds, and they had all been removed. The Administrator stated they started this process around 01/01/26. The Administrator stated she had met with residents personally including R6; however, denied providing anything in writing to the resident to address her concerns. The Administrator stated the letter dated 02/025/26 was sent to families but not to residents. The Administrator verified that a response should be provided when a grievance was filed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure one of two residents (R43) reviewed for advanced directives had a valid advanced directive in place. R43's Physician's Orders Scope of Treatment (POST) form had not been signed by the Guardian when R43's code status was changed from Full Code to Do Not Resuscitate (DNR). Findings include:Review of the facility's policy titled, Advance Directive, dated 08/2017 revealed, [Facility name] will encourage residents to exercise their right to formulate an advance directive at their option. Staff will inform and educate resident of their rights to accept or refuse medical treatments, refuse to participate in experimental research and to formulate an advanced directive to express their health care wishes .Upon admission, identify if the resident has an advanced directive and if not, determine if the resident wishes to formulate an advanced directives . Examples include a pre-existing medical order for do not resuscitate.POST, or other document directing the resident's health care wishes . All advance directive documents will be reviewed to ensure complete with signatures, etc . All advance directive copies will be obtained and located under the advance directive section in the medical record .During the quarterly RAI process and with any significant changes in condition, [name of facility] staff will: identify, clarify, and review the existing care instructions and whether the resident wishes to change or continue instructions from the advance directive .Review of the R43's undated admission Record in the Electronic Medical Record (EMR) under the Profile tab revealed R43 was admitted to the facility on [DATE]. Review of the R43's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/04/26 in the EMR under the MDS tab revealed R43 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated the resident was moderately cognitively impaired. Review of R43's Order for Appointment of Successor Guardian of the Person dated 11/20/15 in the EMR under the Misc [Miscellaneous] tab revealed Family Member (F) 2 was R43's legal guardian.Review R43's POST dated 04/24/25 and located in the resident's paper chart under the Advance Directive tab revealed the form had been signed by the Physician Assistant (PA); however, it had not been signed by F2, R43's guardian. The POST form indicated R43's status was DNR.Review of R43's current physician Order Summary Report dated 02/26 in the EMR under the Orders tab revealed the DNR physician order originated on 09/28/25. During an interview on 02/26/26 at 2:20 PM, Licensed Practical Nurse (LPN) 3 reviewed R43's paper chart and stated there was a POST form signed by the PA on 04/24/25 that indicated R43's code status was DNR. LPN3 stated the form had not been signed by F2, R43's guardian. LPN3 stated that F2 should have signed the POST form. During an interview on 02/26/26 at 2:29 PM, Social Services (SS) 2 stated it was her responsibility to ensure the POST forms were complete upon admission, but after that time if changes were made, she would not be aware of it. SS2 stated she did not review POST forms after the initial POST was completed at admission. SS2 reviewed R43's paper chart and stated she did not know where the original POST form was, but it should be in the paper chart. SS2 stated the POST dated 04/24/25 was not signed by F2, R43's guardian, therefore was not valid without the responsible party signature. On 02/26/26 at approximately 4:30 PM, the surveyor requested from the Administrator to review a signed and valid POST for R43. During an interview on 02/27/26 at 9:59 AM, the Administrator stated R43's guardian had requested the code status be changed from Full Code to DNR and that was why the POST form with DNR was signed by the PA on 04/24/25 and placed into R43's paper chart. The Administrator stated the social service department was responsible for getting the resident/guardian signatures for the POST forms. The following additional documents were provided to the surveyor by the Administrator:Review of R43's POST, form dated 10/17/23 revealed R43's previous code status was Full Code, and the form was signed by the PA and F2.Review of R43's Physician's History and Physical, dated 02/22/24 revealed, I spoke with Guardian [F2] over the phone. All questions (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	answered to satisfaction. Requesting a call back with any changes in clinical status. Requested DNR.Review of R43'sCare Plan Notes and Social Service Notes from 05/09/24 - 02/27/26 revealed no documented evidence that R43's code status had been reviewed. During an interview on 02/27/26 at 11:29 AM, F2 stated the Physician had talked to her a while ago about changing the code status from Full Code to DNR and she had decided over the course of time that DNR was the best option. F2 stated she attended most Care Plan meetings but did not remember staff discussing R43's code status. During an interview on 02/27/26 at 12:25 PM, the Director of Nursing (DON) stated Social Service staff were responsible for ensuring POST forms were completed and placed in the paper chart upon admission. If changes were made later, the resident/decision maker would sign the new form along with the Physician and it would be placed into the paper chart. The DON stated she attended some Care Plan meetings but did not remember staff discussing code status at the meetings. The DON stated the POST form for R43 should have been signed and placed into the paper chart. During an interview on 02/27/26 at 12:46 PM, the Administrator stated that POST forms should have both signatures (Physician and resident/responsible party) before being placed in the chart. The Administrator stated there had not been an auditing process in place to review advanced directives.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview, record review, and policy review, the facility failed to ensure 2 of 3 Residents (R58 and R59) reviewed for beneficiary notices received the Skilled Nursing Facility (SNF) Advanced Beneficiary Notice (ABN) of Non-Coverage forms when skilled therapy was being discontinued.This failure did not allow residents/responsible parties to decide whether to receive the care that might not be paid for by Medicare if they chose to assume financial responsibility for R58 and R59.Findings include:Review of the Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) Form CMS-10055, dated 2020, provided by the facility, and served as the facility's policy for completion of the SNF ABN revealed, Medicare requires SNFs to issue the SNF ABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: not medically reasonable and necessary; or is considered custodial. SNF ABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility.1. Review of R58's admission Record, from the electronic medical record (EMR) Profile tab, showed an admission date of 01/19/26 with diagnoses due to aspiration pneumonia. Review of R58's EMR Census tab showed he started Medicare A benefits on 01/19/26 with an end date of 01/30/26.Review of the form titled Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) showed R58 was not issued a SNF ABN that advised the cost of skilled services if he desired to continue when Medicare discharged from skilled services. 2. Review of R59's admission Record, from the EMR Profile tab showed an admission date of 12/19/25 with medical diagnoses of sepsis due to pneumonia, urinary tract infection, and paroxysmal atrial fibrillation. Review of R59's EMR Census tab showed R59 started Medicare A benefits on 12/19/25 with an end date of 01/16/26.Review of the form titled NOMNC and Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) showed R59 was not issued a SNF ABN that advised the cost of skilled services if he desired to continue when Medicare discharged from skilled services. Interview on 02/26/26 at 11:30 AM, Social Services (SS)2 verified that no ABN had been issued to R58 or R59. SS2 stated, The facility has not issued ABN Forms.During an interview on 02/26/26 at 1:29 PM, SS2 stated SS2 was not aware of the SNF ABN form or the need to issue to residents in the event they were staying in the facility beyond the termination of skilled services. During an interview on 02/27/22 at 2:57 PM, the Administrator stated SS2 brought to her attention during the survey that SS2 was not doing SNF ABN notice. The Administrator stated she had spoken with the SS2 that it is required for SS2 to compete the SNF ABN notice. The Administrator stated if a resident were to stay in the facility for a post Medicare stay, the resident should be issued the SNF ABN so the resident would know they could pay for continued services if desired.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure all incidents and/or allegations of abuse were reported immediately but no later than two hours to the State Survey Agency (SSA) for two of three residents (R55 and R43) reviewed for abuse.Allegations were made that R9 hit R43 on 05/03/25 and R9 hit R55 on 05/08/25; these instances were reported to the State Agency more than eight months later on 02/19/26. Findings include:Review of the Vulnerable Adult' policy dated 11/03/25 and provided by the facility read, All residents have the right to be free from neglect, verbal, sexual, and mental abuse . Residents must not be subjected to abuse by anyone, including but not limited to: facility staff, other residents . Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish . All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately, but not later than two hours after the allegation is made .1. Review of R9's undated admission Record in the Electronic Medical Record (EMR) under the Profile tab revealed R9 was admitted to the facility on [DATE] with diagnoses which included dementia with agitation and anxiety disorder.Review of R43's undated admission Record in the Electronic Medical Record (EMR) under the Profile tab revealed R43 was admitted to the facility on [DATE] with diagnoses which included schizophrenia and intellectual disability.Review of the facility' Investigation Summary, dated 05/03/25, provided by the facility, revealed [Certified Nursing Assistant (CNA) 3] was in room [ROOM NUMBER] when she heard resident yelling out.[CNA3] was in the middle of performing peri care. It took about a minute to be able to safely leave the resident to investigate the yelling. When CNA [3] arrived in sunroom resident [R43] was in the middle of the sunroom and resident [R9] was in the purple-colored chair with her wheelchair by the pink colored chair. [R43] explained to [CNA3] that [R9] had hit her on her right upper arm and was trying to push her wheelchair into the hallway. [CNA3] stayed with both residents in the sunroom until another CNA [CNA4] arrived.The other CNA [CNA4] on the hall was unaware of any screaming that occurred. When she came out of another resident's room, the [CNA3] that heard the screaming told her that [R9] slapped [R43] . [CNA4] told [CNA3] to tell the nurse right away. [The] Nurse [was] working the hallway in the nurses' station at the time of the incident. She did not hear any noises or yelling. [R43] stated that [R9] walked from her wheelchair to a purple chair. On the way [R9] said that [R9] slapped her on the right upper arm and tried to push her wheelchair into the hallway. The Investigation Summary dated 05/03/25 indicated the State Agency had not been notified of the allegation.Review of the facility's Misconduct Incident Report dated 02/18/26 and provided by the facility revealed, .staff were directed by the Chief Executive Officer in place at that time not to submit the required external report to the Department of Health Services. As a result, mandatory reporting component was not completed. Since that time there has been a change in leadership, and the former Chief Executive Officer is no longer employed by the organization.During an interview on 02/25/26 at 2:46 PM, CNA4 stated she was working on 05/08/25 when R43 alleged that R9 hit her. CNA4 stated she did not see what occurred and was working with a different resident at the end of the hall when she heard R43 yell. CNA4 reported that R43 was sitting near a table in her wheelchair. CNA5 said she heard screaming from R43 who reported R9 was hitting her. CNA4 stated she was not able to get to R43 right away because she was providing care to a different resident. During an interview on 02/25/26 at 4:11 PM, CNA3 stated she was working on 05/08/25 and heard [R43] yelling. CNA3 stated she went into the hallway and R43 reported to her that R9 hit her. R9 was on the opposite side of the room and had walked herself over there or used her wheelchair. During an interview on 02/27/26 at 12:05 PM, the Director of Nursing (DON) stated this allegation was not reported to the State Agency because the Administrator at the time decided not to report it. The DON (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated R4'3s allegation of being hit was an allegation of physical abuse. 2. Review of R55's undated admission Record in the EMR under the Profile tab revealed R55 was admitted to the facility on [DATE]with diagnoses which included dementia. R55 passed away and her closed record was reviewed. Review of the Investigation Summary dated 05/08/25 and provided by the facility revealed, [R9] wheeled herself to the activity room where other residents were watching TV. [Activity Assistant (AA)] asked [R9] if she wanted to participate and [R9] responded no. [R9] then wheeled up to another resident [R55] and started to hit her wheelchair. [AA] stepped in between the two residents. [AA] asked [R9] to stop and [R9] told staff to 'get out of here.' [R9] wheeled away from [R55] but stayed in the activity room. [AA] went back to leading activity. [R9] wheeled back and hit [R55] on the right arm under the shoulder. [AA] went to the nurses' station and got nurse [Licensed Practical Nurse (LPN)6]. [LPN6] was told when arriving at activity room that [R9] had slapped [R55]. [R55] was wheeling around the activity room. [Licensed Practical Nurse (LPN)6] directed [R9] out of the activity room and towards the resident's room. [LPN6] notified 400 nurse of the incident and started one-on-one with [R9] . State agency not contacted. Review of the Misconduct Incident Report dated 02/18/26 and provided by the facility revealed, staff were directed by the Chief Executive Officer in place at that time not to submit the required external report to the Department of Health Services. As a result, mandatory reporting component was not completed. Since that time there has been a change in leadership, and the former Chief Executive Officer is no longer employed by the organization.During an interview on 02/27/26 at 12:09 PM, the Director of Nursing (DON) stated she was working on 05/08/25 when the incident occurred between R9 and R55. The DON stated R9 was initially smacking the arm of R55's wheelchair, then AA moved R9 but R9 came back and hit R55. The DON stated R9 was very mobile in her wheelchair at the time.During an interview on 02/25/26 at 3:16 PM, Social Services (SS)2 stated abuse allegations went to the Administrator and DON. SS2 stated if an allegation involved abuse, it should be reported to the State within two hours. During an interview on 02/27/26 at 2:11 PM, the [NAME] President (VP) of Health Services stated the Administrator (current during the survey) was a student in May 2025 and was training at the facility. The VP of Health Services stated the Previous Administrator in place in May 2025 and decided not to report the 05/03/25 or the 05/08/25 incidents to the State Agency. The VP of Health Services stated once the Previous Administrator left and was no longer an employee, current administration staff reviewed the incidents on 05/03/25 and 05/08/25 and felt there were allegations of abuse and the incidents were reported in February 2026.

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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 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 observation, interview, and facility policy review, the facility failed to ensure one of one medication storage room was free of expired COVID-19 tests.This practice fails to ensure that biologicals stored in the medication storage room efficacy is maintained.Findings include:Review of the facility's policy titled Medication Administration Policy reviewed 02/2019, revealed under procedure, 3.Check that medication are labeled with open date and not expired before administrating.On 02/26/26 at 10:54 AM, Surveyor observed the only medication storage room with the facility's Infection Preventionist (IP). Surveyors' observation revealed three of three boxes of iHealth COVID -19 Antigen Rapid Test with expiration dates of 09/02/25. The IP confirmed at this time that the tests were expired. Observation revealed one box of COVID-19 tests was opened and three tests had been used. The IP stated three test from the expired boxed were used the previous day. During an interview on 02/26/2026 at 10:56 AM, the IP stated it was her expectation there would not have been any expired medications and/or biologicals in the facility.