

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555204	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2026
NAME OF PROVIDER OR SUPPLIER Childrens Hc Org No CA Saratoga Pediatric Subacute		STREET ADDRESS, CITY, STATE, ZIP CODE 13425 Sousa Lane Saratoga, CA 95070	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement specific, individualized and resident-centered care plans for the side or bed rails (adjustable rigid bars attached to the side of a bed) of twelve, (Residents 16, 19, 4, 27, 5, 1, 29, 6, 32, 14, 24 and 12), out of thirty-three residents in the facility, when these twelve residents who used side rails did not have specific, individualized and resident-centered care plans for their side rails. These failures had the potential for these residents to be at risk, for not being properly monitored and provided with the appropriate interventions with regards to their use of side rails, which could compromise their safety and quality care. Findings: 1. During the observation of Resident 16, on 2/5/26 at 12:55 p.m., Resident 16 was in his wheelchair inside his room, comfortable and not talking. Resident 16 had bilateral (both sides) padded upper side rails that were up. Review of Resident 16's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident), indicated, Resident 16 was admitted to the facility on [DATE], with the principal diagnosis of anoxic brain damage (occurs when the brain is completely deprived of oxygen, causing brain cells to begin dying within roughly four minutes), not elsewhere classified. Review of Resident 16's order summary report dated 2/6/26 indicated, Resident 16 had an order of hospital bed with padded upper side rails for safe sleep or rest environment every shift for seizure (abnormal electrical activity in the brain causing changes in awareness and muscle control) precautions, ordered on 7/2/25. Review of Resident 16's care plans indicated, Resident 16 did not have a specific, individualized, resident-centered care plan for the side rails. During the concurrent review of Resident 16's care plans and interview with minimum data set coordinator (MDSC) on 2/9/26 at 10:44 a.m., MDSC verified that Resident 16 did not have a specific, individualized and resident-centered care plan for the side rails. 2. During the observation of Resident 19, on 2/4/26 at 1:17 p.m., Resident 19 was up in his wheelchair inside his room, comfortable and not talking. Resident 19 had four padded half side rails that were up. Review of Resident 19's admission record indicated, Resident 19 was readmitted to the facility on [DATE], with the principal diagnosis of diffuse traumatic brain injury (a severe brain injury caused by rapid shaking, twisting, or acceleration-deceleration of the head, leading to widespread tearing of nerve fibers or axons), with loss of consciousness of unspecified duration, sequela (any complication or condition that results from a pre-existing illness, injury, or other trauma to the body). Review of Resident 19's order summary report dated 2/6/26 indicated, Resident 19 had an order of high, low bed with all 4 side rails up with full paddings for safe sleep or rest environment every shift, ordered on 8/9/24. Review of Resident 19's care plans indicated, Resident 19 did not have a specific, individualized, resident-centered care plan for the side rails. During the concurrent review of Resident 19's care plans and interview with MDSC on 2/9/26 at 11:11 a.m., MDSC verified that Resident 19 did not have a specific, individualized and resident-centered care plan for the side rails. 3. During the observation of Resident 4, on 2/5/26 at 1:03 p.m., Resident 4 was up in her wheelchair on her way to school, comfortable and not talking. Resident 4 had 2 padded bilateral upper half side rails that were up. Review of Resident 4's admission record indicated, Resident 4 was readmitted to the facility on (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], with the principal diagnosis of cerebral palsy (group of conditions that affect movement and posture), unspecified. Review of Resident 4's order summary report dated 2/6/26 indicated, Resident 4 had an order of hospital bed with padded upper side rails to prevent injury during seizure every shift, ordered on 8/8/24. Review of Resident 4's care plans indicated, Resident 4 did not have a specific, individualized, resident-centered care plan for the side rails. During the concurrent review of Resident 4's care plans and interview with MDSC on 2/9/26 at 11:11 a.m., MDSC verified that Resident 4 did not have a specific, individualized and resident-centered care plan for the side rails. 4. During the observation of Resident 27, on 2/4/26 at 1:22 p.m., Resident 27 was up in her wheelchair, comfortable and not talking. Resident 27 had upper side rails that were up. Review of Resident 27's admission record indicated, Resident 27 was readmitted to the facility on [DATE], with the principal diagnosis of traumatic subarachnoid hemorrhage (occurs when trauma, such as falls or motor vehicle accidents, causes bleeding into the subarachnoid space, often presenting with a severe, sudden headache) with loss of consciousness of unspecified duration, subsequent encounter. Review of Resident 27's order summary report dated 2/6/26 indicated, Resident 27 had an order of hospital bed with upper side rails for safe sleep or rest environment every shift, ordered on 2/5/26. Review of Resident 27's care plans indicated, Resident 27 did not have a specific, individualized, resident-centered care plan for the side rails. During the concurrent review of Resident 27's care plans and interview with MDSC on 2/9/26 at 11:11 a.m., MDSC verified that Resident 27 did not have a specific, individualized and resident-centered care plan for the side rails. 5. During the observation of Resident 5, on 2/5/26 at 1:00 p.m., Resident 5 was laying in bed, comfortable and not talking. Resident 5 had padded upper side rails that were up. Review of Resident 5's admission record indicated, Resident 5 was readmitted to the facility on [DATE], with the principal diagnosis of nontraumatic intracerebral hemorrhage, intraventricular (a severe, often fatal stroke subtype where blood leaks from ruptured brain vessels into the ventricle primarily caused by chronic hypertension or cerebral amyloid angiopathy). Review of Resident 5's order summary report dated 2/6/26 indicated, Resident 5 had an order of hospital bed with padded upper side rails for safe sleep or rest environment every shift, ordered on 12/29/25. Review of Resident 5's care plans indicated, Resident 5 did not have a specific, individualized, resident-centered care plan for the side rails. During the concurrent review of Resident 5's care plans and interview with MDSC on 2/9/26 at 12:08 p.m., MDSC verified that Resident 5 did not have a specific, individualized and resident-centered care plan for the side rails. 6. During the observation of Resident 1, on 2/4/26 at 12:21 p.m., Resident 1 was laying in bed, confused and not talking. Resident 1 had padded four side rails that were up. Review of Resident 1's admission record indicated, Resident 1 was readmitted to the facility on [DATE], with the principal diagnosis of myotonic muscular dystrophy (common, inherited, multisystem genetic disorder characterized by progressive muscle wasting, weakness and delayed relaxation or myotonia). Review of Resident 1's order summary report dated 2/6/26 indicated, Resident 1 had an order of high, low bed with all four side rails up with full paddings for safe sleep, rest or play environment every shift, ordered on 10/29/25. Review of Resident 1's care plans indicated, Resident 1 did not have a specific, individualized, resident-centered care plan for the side rails. During the concurrent review of Resident 1's care plans and interview with MDSC on 2/9/26 at 12:30 p.m., MDSC verified that Resident 1 did not have a specific, individualized and resident-centered care plan for the side rails. 7. During the observation of Resident 29, on 2/4/26 at 12:56 p.m., Resident 29 was in bed, comfortable and not talking. Resident 29 had padded upper side rails that were up. Review of Resident 29's admission record indicated, Resident 29 was readmitted to the facility on [DATE], with the principal diagnosis of necrotizing enterocolitis (serious, often fatal, neonatal gastrointestinal disease where the intestinal wall becomes inflamed, dies and can rupture, often affecting premature infants within the first few weeks of life), unspecified. Review of Resident 29's order summary report dated 2/9/26 indicated, Resident 29 had an order of hospital bed with padded upper side rails to prevent injury during seizure every shift, ordered on 12/6/24. Review of Resident 29's care plans indicated, Resident 29 did not have a (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	specific, individualized, resident-centered care plan for the side rails. 8. During the observation of Resident 6, on 2/4/26 at 1:10 p.m., Resident 6 was in bed, comfortable and not talking. Resident 6 had padded upper side rails that were up. Review of admission record of Resident 6 indicated, Resident 6 was admitted to the facility on [DATE], with the principal diagnosis of diffuse traumatic brain injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, sequela. Review of the order summary report of Resident 6 dated 2/9/26 indicated, Resident 6 had an order of hospital bed with padded upper side rails for safe sleep or rest environment every shift, ordered on 7/31/24. Review of the care plans of Resident 6 indicated, Resident 6 did not have a specific, individualized, resident-centered care plan for the side rails. 9. During the observation of Resident 32, on 2/4/26 at 1:14 p.m., Resident 32 was sleeping in bed and appeared comfortable. Resident 32 had padded upper side rails that were up. Review of Resident 32's admission record indicated, Resident 32 was admitted to the facility on [DATE], with the principal diagnosis of anoxic brain damage (occurs when the brain is completely deprived of oxygen, causing brain cells to begin dying within roughly four minutes), not elsewhere classified. Review of Resident 32's order summary report dated 2/9/26 indicated, Resident 32 had an order of hospital bed with padded upper side rails for safe sleep or rest environment every shift, ordered on 3/20/25. Review of Resident 32's care plans indicated, Resident 32 did not have a specific, individualized, resident-centered care plan for the side rails. 10. During the observation of Resident 14, on 2/4/26 at 1:14 p.m., Resident 14 was in bed, calm, comfortable and not talking. Resident 14 had four padded side rails that were up. Review of Resident 14's admission record indicated, Resident 14 was readmitted to the facility on [DATE], with the principal diagnosis of other encephalitis (dangerous inflammation of the brain, usually caused by viral infections or autoimmune reactions) and encephalomyelitis (inflammation of the brain and spinal cord, often caused by autoimmune responses to infections or rarely, vaccinations, predominantly affecting children). Review of Resident 14's order summary report dated 2/9/26 indicated, Resident 14 had an order of hospital bed with all four side rails up with full paddings to prevent injury during seizure every shift, ordered on 6/27/25. Review of Resident 14's care plans indicated, Resident 14 did not have a specific, individualized, resident-centered care plan for the side rails. 11. During the observation of Resident 24, on 2/5/26 at 12:48 p.m., Resident 24 was in bed, calm, comfortable and not talking. Resident 24 had four padded side rails that were up. Review of Resident 24's admission record indicated, Resident 24 was readmitted to the facility on [DATE], with the principal diagnosis of respiratory failure (condition where there's not enough oxygen gas or too much carbon dioxide or non-flammable gas in the body), unspecified with hypoxia (low levels of oxygen in the body tissues). Review of Resident 24's order summary report dated 2/9/26 indicated, Resident 24 had an order of hospital bed with all four side rails up with full paddings to prevent injury during seizure every shift, ordered on 8/9/24. Review of Resident 24's care plans indicated, Resident 24 did not have a specific, individualized, resident-centered care plan for the side rails. 12. During the observation of Resident 12, on 2/5/26 at 12:55 p.m., Resident 12 was in the wheelchair, calm, comfortable and not talking. Resident 12 had bilateral upper side rails that were up. Review of Resident 12's admission record indicated, Resident 12 was readmitted to the facility on [DATE], with the principal diagnosis of facioscapulohumeral muscular dystrophy (rare genetic, progressive muscle disorder causing weakness primarily in the face, shoulders, upper arms and lower legs, typically appearing before age [AGE]). Review of Resident 12's order summary report dated 2/9/26 indicated, Resident 12 had an order of hospital bed with upper side rails and winged mattress to prevent injury during seizure every shift, ordered on 2/17/25. Review of Resident 12's care plans indicated, Resident 12 did not have a specific, individualized, resident-centered care plan for the side rails. During the concurrent review of the care plans of Residents 29, 6, 32, 14, 24 and 12 and interview with MDSC on 2/10/26 at 10:03 a.m., MDSC verified that these residents did not have specific, individualized and resident-centered care plans for their side rails. During the interview with the administrator (ADM) on 2/10/26 at 3:25 p.m., he (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acknowledged that the residents should have a separate, specific, individualized and resident-centered care plans for their side rails and would follow up on these concerns. Review of the undated facility policy titled, Interdisciplinary Care Plans indicated, Each child will have an interdisciplinary care plan . after comprehensive assessments are completed . to provide an individualized care plan for each child to identify and document treatment and services appropriate to the patients' needs, strengths, goals and limitations . Long term and short term goals will be established with expected outcomes and time frames identifying the expected completion .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents' environment remained free of accident hazards to prevent avoidable accidents, in order to provide safe environment for residents when there were missing logs in their laundry dryer lint tray cleaning monitoring sheet for February 2026. These failures had the potential for causing fire accident that might result in injury and harm to the thirty-three residents residing in the facility. Findings: During the laundry room observation on 2/10/26 at 11:05 a.m., there were missing logs in the dryer lint tray cleaning monitoring sheet for February 2026, that included the removal of the dryer lint (a collection of fine fabric and yarn pieces that accumulate in a dryer's filter while clothes were being dried). There were logs missing for the nocturnal shift (NOC, the overnight, third shift of the facility), which would start from 10:00 p.m. at night until 5:00 a.m. in the morning. The NOC shift laundry staffs missed to log in the dryer lint tray cleaning monitoring sheet for the following dates: 2/2/26, 2/3/26, 2/4/26, 2/5/26, 2/6/26 and 2/9/26, for their 2 large dryers. During the interview with maintenance director (MDIR) on 2/10/26 at 11:07 a.m., MDIR verified that they have morning shift, from 5:00 a.m. to 1:30 p.m., afternoon shift, from 1:30 p.m. to 10:00 p.m. and NOC shift, from 10:00 p.m. to 5:00 a.m. staffs that would do laundry. MDIR further verified that laundry staffs should check, clean or replace the dryer lints if needed, after using the dryers to avoid overheating. He then verified the missing signature logs of the NOC shift laundry staffs for the dryer lint tray cleaning monitoring sheet for February 2026. MDIR then stated that there should be no missing signature logs of the laundry staffs in the dryer lint tray cleaning monitoring sheet to ensure that they checked, cleaned or replaced if needed, the dryer lints after using the dryers for safety. He then continued that he would remind the laundry staffs about this concern. Review of the undated facility's policy titled, Laundry Procedure indicated, . Check for lint and clean accordingly to avoid fire.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility had a medication error rate of 14.29% when 4 medication errors out of 28 opportunities were observed during medication pass for two of ten residents (Residents 8 and Resident 16). These failures had the potential to compromise the health and safety of the residents. Findings: During a medication pass on 2/6/26 at 2:16 p.m., licensed vocational nurse (LVN) A was observed preparing two medications for seizures for Resident 8. Included in the medications were a tablet of topiramate 25 milligrams (mg, unit of measurement) dissolved in 3 milliliter (ml, unit of measurement) of water and 3 ml of levetiracetam. On 2/6/26 2:20 p.m., LVN A was observed that he combined and administered topiramate dissolved in 3 ml of water and 3 ml of levetiracetam 100mg/ml all at once via G-Tube (a tube surgically inserted through the abdomen into the stomach to administer nutrition and medications.) During an interview with LVN A on 2/6/26 at 2:25 p.m., LVN A confirmed that he combined the medications topiramate and levetiracetam in a purple syringe and administered them to Resident 8. LVN further stated that he did not flush between administering each medication, but only did so before and after the final administration. During a medication pass on 2/9/26 at 4:58 p.m. registered nurse (RN) B was observed preparing medication for Resident 16. The medications included were a tablet of glycopyrrolate 1 mg and two and a half tablets of tizanidine 2 mg. RN B crushed both glycopyrrolate and tizanidine together, dissolved them in 10 ml of water, and then administered the mixture to Resident 16 via G-tube. During an interview with RN B on 2/9/26 at 5:16 p.m., she confirmed that one tablet of glycopyrrolate and two and a half tablets of tizanidine were crushed together and administered to Resident 16. She further stated that she only separates medication when administering narcotics. During a concurrent interview and record review with RN C on 2/10/26 at 1:54 p.m., RN C stated that medication via G-tube should be administered separately and flush with water in between. RN C further stated that there would be a possible drug to drug interaction if medications are mixed together. A review of the facility's policy and procedure (P&P) titled, Medication Administration Enteral Tubes, dated 2007, the P&P indicated, Crushed medications are not mixed together. The standard of practice is that crushed medications should not be combined and given all at once via feeding tube. Each medications is administered separately to avoid interaction and clumping. The enteral tubing is flushed with water between each medication to avoid physical interaction of the medications.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an expired medication was removed from one of four medication carts inspected for one of thirteen sampled residents (Resident 3); and, three expired control solutions (liquid solution used to verify that a blood sugar machine and test strips are working accurately together) were not removed from an active use supply area of a medication room. These failures had the potential for the residents to receive expired medication and/or be inaccurately assessed for blood sugar. Findings: During an inspection of the medication room with the infection control preventionist (IP) on [DATE] at 10:41 a.m., the IP confirmed one Assure dose control solution had expired on 2025-03-09 and two [NAME] control solution had expired on 2025-10-10 and 2025-08-10 and stated that the solutions should be discarded. During an inspection of the medication cart (Med Cart B) with the IP on [DATE] at 10:55 a.m., Resident 3's medication hydralazine (medication to treat hypertension) was found in the medication compartment. The IP confirmed the discard date was [DATE] and stated that it should be removed from cart. A review of Resident 3's clinical record indicated, Resident 3 had active order of Hydralazine HLC oral tablet 10 mg via J-tube (jejunostomy tube) every 6 hours as needed for hypertension. During an interview with the minimum data set coordinator (MDSC) on [DATE] at 1:30 p.m., the MDSC stated that expired medication should not be stored in the medication cart. She further stated that an expired control solution could lead to false calibration or inaccuracies. The facility's policy titled Medication Storage Storage of Medication, dated 2027, indicated, Medications and biological are stored properly, following manufacture's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration . Outdated, contaminated, discontinued or deteriorated medications . are immediately removed from stock, disposed of according to procedures for medication disposal .		