STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555744	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Siena Skilled Nursing and Rehabilitation Center	11600 Education Street Auburn, CA 95603

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure compliance to the professional standards of practice, manufacturer's guidelines, and facility's policy and procedures (P&P) for one out of six sampled residents (Resident 40) and for a census of 90 residents when:1.Resident 40's delayed-release capsule medication (designed to release the active ingredient later than immediately after administration) was opened and its contents were mixed with other powdered medications. 2.Shared glucometers (a device which measures blood sugar using blood from a fingertip) were not sanitized properly after use.These failures had the potential for unsafe and ineffective medication use for Resident 40, increased risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), potential exposure of residents and staff to germs. and had the potential to negatively affect the residents of the facility's medical conditions.Findings:1.During a medication administration observation which started on 8/11/25 at 10:42 a.m. with Licensed Nurse (LN) 1, LN 1 administered a total of 12 pills to Resident 40 which included 2 capsules of duloxetine (a medication used to treat nerve pain) 20 mg. LN 1 was observed crushing all the tablet medications, after which LN 1 opened all the capsule medications and poured all of its contents to the crushed medications, then mixed all of the medications with yogurt, and then proceeded in administering it to Resident 40. A review of Resident 40's active physician's order, dated 2/15/25, indicated, DULoxetine HCl Capsule Delayed Release Particles 20 MG [milligrams- unit of measurement] Give 2 capsule by mouth one time a day for Pain.A review of Resident 40's duloxetine medication label indicated, DULoxetine HCL DR [delayed release] 20 MG CAP [capsule] .GIVE 2 CAPSULES BY MOUTH DAILY.During a concurrent interview and medication review on 8/11/25 at 12:49 p. m. with LN 1, LN 1 acknowledged the observed medication administration of duloxetine to Resident 40. LN 1 stated it was a medication administration error, and the medication should have been kept in the capsules so it would be absorbed properly, released slowly, and metabolized (being processed) in the right time. During an interview on 8/13/25 at 11:17 a.m. with the Director of Nursing (DON), the DON stated it was not acceptable to open delayed release capsules and administer it to the resident. The DON also stated that delayed release capsules should be absorbed throughout the day and not one time. The DON further stated it would be a risk for ineffective or unsafe use of medication if the medication was not administered in accordance with the manufacturer's guidelines and professional standards of practice. A review of the facility's P&P titled, Medication Crushing Guidelines, dated 2001, indicated, The rationale for not crushing some medications includes: .C. Timed Release Capsules are designed to release medication over a sustained period, usually 8 to 24 hours. The beads within the capsule are designed to dissolve at different times. These formulations are utilized to reduce stomach irritation in some cases and to achieve prolonged medication action in other cases .A review of an online article from Drugs.com titled, Duloxetine, updated 3/3/25, indicated, How should I take duloxetine? .Swallow the capsule whole and do not crush, chew, break, or open it. (https://www.drugs.com/duloxetine.html) 2. During a concurrent observation and interview on 8/11/25 at 11:33 a.m., with LN 2, LN 2 was observed going back to the medication holding a shared glucometer (EvenCare) and stated she just checked a resident's blood glucose (sugar) level using the shared glucometer. LN 2 was then wiped the shared glucometer using one wipe of [Brand name] Germicidal Alcohol Wipes (the wipe with chemicals the facility is using to disinfect surfaces) quickly (approximately 10-15 seconds) to clean the glucometer's outer surface, placed it on top of the medication to let it dry, and then placed it inside the medication cart next to other supplies.During an observation on 8/11/25 at 11:40 a. m., LN 2 was observed checking a resident's blood sugar using a glucometer (EvenCare) which was shared between residents. LN 2 used a new lancet (a sharp piercing device) to pierce the resident's finger to get blood and then applied the blood to the test strip that was attached to the glucometer. After reading the result, LN 6 went out the room, discarded the used lancet and test strip, wiped the shared glucometer using one wipe of [Brand name] Germicidal Alcohol Wipes quickly (approximately 10-15 seconds) to clean the glucometer's outer surface, placed it on top of the medication to let it dry, and then placed it inside the medication cart next to other supplies.During an interview on 8/11/25 at 12:46 p.m. with LN 2, LN 2 confirmed the two subsequent observations of her cleaning the shared glucometer quickly (approximately 10-15 seconds) in between use of residents. LN 2 stated the shared glucometer should have been cleaned for one (1) minute to sanitize it properly and prevent transfer of bloodborne pathogens (infectious microorganisms present in human blood that can cause disease) During an interview on 8/13/25 at 9:58 a.m

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure one out of 18 sampled residents (Resident 22) was assisted with nail care as part of his Activities of Daily Living (ADLs- normal daily functions required to meet basic needs) when Resident 22 had long and jagged fingernails with sharp edges. This failure had the potential for Resident 22 to sustain skin injury and/or to acquire an infection and not achieve his highest practicable well-beingFindings:A review of Resident 22's clinical record indicated Resident 22 was admitted December of 2024 and had diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), heart failure (a serious condition in which the heart does not pump blood as efficiently as it should), need for assistance with personal care, and muscle weakness.A review of Resident 22's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 6/14/25, indicated Resident 22 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 11 out of 15 which indicated Resident 22 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 22's MDS Functional Abilities and Goals, dated 6/14/25, indicated Resident 22 was dependent with toileting hygiene, required substantial/maximal assistance with lower body dressing and putting on/taking off footwear, and needed partial/maximal assistance with upper body dressing and personal hygiene.A review of Resident 22's care plan, dated 6/1/24, indicated, ADL Self-Care Performance Deficit. At risk for altered ADL self care performance r/t [related to] requires assist of 1-2 person assist to start and complete most ADL task .hygiene/grooming, bathing . A review of Resident 22's care plan intervention, dated 6/1/24, indicated, Provide appropriate self performance and support needed during ADL care.During a concurrent observation and interview on 8/11/25 at 9:03 a.m. with Resident 22, in Resident 22's room, Resident 22 had long and jagged fingernails with sharp edges. Resident 22 stated he wanted his fingernails nails to be trimmed short because he likes to play his guitar.During a concurrent observation and interview on 8/12/25 at 9:48 a.m. with Resident 22, in Resident 22's room, Resident 22 still had long and jagged fingernails with sharp edges. Resident 22 confirmed the observation and stated he wants his fingernails to be trimmed short. During a concurrent observation and interview on 8/12/25 at 10:49 a.m. with Certified Nurse Assistant (CNA) 1, in Resident 22's room, CNA 1 confirmed that Resident 22 had long and jagged fingernails with sharp edges. CNA 1 stated it was not acceptable and Resident 22's fingernails should have been trimmed and cut already. CNA 1 asked Resident 22 if he wanted his fingernails trimmed short and Resident 22 replied yes. CNA 1 further stated there was a risk for Resident 22 to scratch himself, infection control issues, and it was unsanitary to have long fingernails. A review of Resident 22's Shower Check Skin Observations sheets indicated the following:8//4/25: .Need clipping: Yes . The sheet was signed by both the CNA and licensed nurse.8/11/25: .Need clipping: Yes . The sheet was signed by both the CNA and licensed nurse.During an interview on 8/13/25 at 9:48 a.m. with the Director of Staff Development (DSD), the DSD stated that residents' nail care should be assessed and done twice a week- on shower days and as needed. The DSD also stated that CNAs could trim the resident's fingernails if they were able to and if a resident has diabetes, the nurses will have to do nail care. The DSD further stated if nail care was not done for a resident, the resident could scratch himself or other residents and it would be a risk for infection. During an interview on 8/13/25 at 11:17 a.m. with the Director of Nursing (DON), the DON stated that nail care should be done as needed and any time that staff would notice the nails need clipping. The DON further stated it would be a risk for skin injury if residents' fingernails were long, jagged, and have sharp edges. A review of the facility's policy and procedures titled, Activities of Daily Living (ADL), Supporting, revised 3/2018, indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care) .

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to ensure two out of 18 sampled residents (Resident 20 and Resident 77) received appropriate pain management services consistent with professional standards of practice, facility's policy and procedure (P&P), and physician's order when Resident 20 and Resident 77's pain medication orders were not consistently followed.This failure had the potential for Resident 20 and Resident 77 to develop medication dependence (the inability of the individual to function normally in the absence of the drug), overdose, not achieve pain relief, and not attain their highest practicable well-being. Findings:1. A review of Resident 20's clinical record indicated Resident 20 was admitted June of 2025 and had diagnoses that included urinary tract infection (UTI- an infection in the bladder/urinary tract), difficulty in walking, and need for assistance with personal care.A review of Resident 20's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 7/5/25, indicated Resident 20 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 20 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 20's MDS Health Conditions indicated Resident 20 received scheduled and as needed pain medications and non-medication intervention for pain. During an interview on 8/11/25 at 8:59 a.m. with Resident 20, in Resident 20's room, Resident 20 stated he had UTI and kidney stones that was why he was experiencing pain a lot in his back and had been given pain medications for it.A review of Resident 20's Care Plan Report, initiated 6/9/25, indicated, .At risk for pain r/t [related to] generalized body pain, decreased mobility. A review of Resident 20's care plan intervention, initiated 1/7/25, indicated, Administer analgesia [pain relief] medication(s) as ordered by Physician .A review of Resident 20's physician's order, dated 6/29/25, indicated, oxyCODONE HCl [a controlled pain medication] Oral Tablet 5 MG [milligrams- unit of measurement] .*Controlled Drug [medications with high potential for abuse or addiction]* Give 1 tablet by mouth every 12 hours as needed for Severe pain 8-10/10 [numeric pain scale from 1 to 10; 1 being the lowest and 10 being the highest form of pain].A review of Resident 20's medication administration records (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of July 2025 indicated Resident 20 received 1 tablet of oxycodone which was indicated for 8-10 level of pain (severe pain) on the following occasions:7/3/25 at 10 p.m.- pain level was 77/4/25 at 5:22 p.m.- pain level was 77/5/25 at 7:37 a.m.- pain level was 77/5/25 at 11:02 p.m.- pain level was 77/8/25 at 6:21 p.m.- pain level was 67/9/25 at 7:03 a.m.- pain level was 77/10/25 at 8:36 a.m.- pain level was 77/10/25 at 9:20 p.m.- pain level was 67/13/25 at 8:13 p.m.- pain level was 67/14/25 at 8:07 a.m.- pain level was 67/14/25 at 8:08 p.m.- pain level was 77/15/25 at 8:29 a.m.- pain level was 77/15/25 at 8:15 p.m.- pain level was 77/16/25 at 8 a.m.- pain level was 77/16/25 at 8:48 p.m.- pain level was 67/17/25 at 8:16 a.m.- pain level was 77/18/25 at 9:21 a.m.- pain level was 77/18/25 at 9:30 p.m.- pain level was 5During a concurrent interview and record review on 8/12/25 at 2:05 p.m. with Licensed Nurse (LN) 3, Resident 20's clinical records were reviewed. LN 3 confirmed that Resident 20's pain medication orders were not consistently followed. LN 3 stated that nurses should follow the physician's order when administering pain medication. LN 3 further stated it would be a risk for controlled drug dependence or respiratory issues if the physician's order was not followed.2. A review of Resident 77's clinical record indicated Resident 77 was admitted July of 2025 and had diagnoses that included aftercare following joint replacement surgery (a care provided after a surgery that involves bones, muscles, and joints), osteoarthritis (a deteriorating disease that causes pain, stiffness, and swelling where two or more bones meet), and need for assistance with personal care.A review of Resident 77's active physician's order, dated 7/21/25, indicated, Resident [Resident 77] is Capable Of Understanding Rights, Responsibilities, And Informed Consent. A review of Resident 77's MDS Health Conditions indicated Resident 77 received as needed pain medications and non-medication intervention for pain. During an interview on 8/12/25 at 2:45 p.m. with Resident 77, in Resident 77's room, Resident 77 stated he has been experiencing pain and has been taking pain medications for it.A review of Resident 77's Care Plan Report, revised 7/25/25, indicated, Resident [Resident 77] is receiving pain medication therapy r/t [related to] Left KTA [sic] [total knee arthroplasty (TKA)- knee replacement surgery] . A review of Resident 77's care plan intervention, initiated 7/25/25, indicated, Administer ANALGESIC medications as ordered by Physician .A review of Resident 77's physician's order, dated 7/22/25, indicated, HYDROcodone-Acetaminophen [Norco- a medication for pain which contains a combination of hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever] Oral Tablet 5-325 MG [milligrams-

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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 - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview, and record review the facility failed to ensure safe and effective pharmaceutical services for a census of 90 residents when:1. Resident 6's controlled drug (drug with potential for abuse) uses and removal signed out from the Controlled Drug Record (CDR- a paper log of controlled drug removal for administration to resident) were not documented in their Medication Administration Record (MAR-a legal document that list administered drugs); and,2. Discontinued non-controlled medications (pharmaceutical preparations that can only be obtained through a medical practitioner's prescription and dispensed by a pharmacist but are not considered controlled substances under the Controlled Substance Act) and those which remained in the facility after discharge of the patient were destroyed in accordance with state regulations.This failed practice may contribute to unsafe controlled and non-controlled medication handling, and risk of controlled drug diversion.Findings:1. A review of Resident 6's clinical record indicated Resident 6 was admitted April of 2023 and had diagnoses that included multiple fractures (a break in the continuity of a bone), chronic (long term) pain, osteoarthritis (a deteriorating disease that causes pain, stiffness, swelling where two or more bones meet, and polyneuropathy (a multiple nerve condition that can cause pain, numbness, tingling, or weakness in the body).A review of Resident 6's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 6/17/25, indicated Resident 6 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 10 out of 15 which indicated Resident 6 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 6's MDS Health Conditions, dated 6/17/25, indicated Resident 6 received scheduled and as needed pain medications and non-medication intervention for pain. A review of Resident 6's active physician's order, dated 7/5/25, indicated, HYDROcodone-Acetaminophen [Norco] Oral Tablet [a medication for pain which contains a combination of hydrocodone; a controlled pain medication, and Acetaminophen; a potent pain reliever] 10-325 MG [milligrams- unit of measurement] .Give 1 tablet by mouth every 6 hours as needed for moderate (4-6/10) to severe (7-10/10) pain [numeric pain scale from 1 to 10; 1-3 is mild pain, 4-6 is moderate pain, 7-10 is severe pain] .A random audit of Resident 6's MAR and the CDR for hydrocodone-acetaminophen, for July and August 2025, indicated nursing staff did not document Norco administration on the MAR when signed out from CDR as follows: 1 tablet on 7/15/25 at 4 a.m., 1 tablet on 7/28/25 at 7:50 p.m., and 1 tablet on 8/2/25 at 9:30 p.m.During a concurrent interview and record review on 8/13/25 at 9:07 a.m. with the Behavioral Health Nurse Director (BHND), Resident 6's CDR and MAR were reviewed. The BHND confirmed the finding of Norco being signed out of the CDR but was not accurately documented on the MAR on three occasions. The BHND stated the nurse probably forgot to sign the MAR and that Norco administration should be both signed out in the CDR and signed in the MAR.During an interview on 8/13/25 at 9:48 a.m. with the Director of Staff Development (DSD), the DSD stated that nurses should always sign off the CDR and MAR when administering controlled medications. The DSD further stated there would be a risk for controlled drug diversion (unlawful channeling of regulated pharmaceuticals from legal sources to the illicit marketplace) or issues with proper handling of controlled drugs if the CDR and MAR are not both signed.During an interview on 8/13/25 at 11:17 a.m. with the Director of Nursing (DON), the DON stated she would expect the nurse to sign both the CDR and MAR when administering controlled medications. The DON further stated that there would be a patient safety issue and risk for drug diversion if the MAR is not properly signed.A review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, indicated, 21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document/initial and circle the MAR space provided for that drug and dose. 22. The individual administering the medication documents/initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 2. During a concurrent interview and record review on 8/13/25 at 10:11 a.m. with the Director of Nursing (DON), the non-controlled medication disposition logbook was reviewed. The DON confirmed that she was the only one signing the destruction of non-controlled medication. The DON stated, I'm the only one signing [the non-controlled medication disposition logbook] when I'm alone destroying the meds [medications]. During an interview on 8/13/25 at 11:17 a.m. with the DON, the DON stated that the state regulation for non-controlled medication disposition should be followed.A review of the facility's P&P titled, Discarding and Destroying Medications, revised 6/2025, indicated, 3. Non-controlled .substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled and stored in accordance with the facility's policies and procedures (P&P), and accepted professional principles for a census of 90 when:1. A total of three loose pills were found in medication cart A;2. Two opened Trelegy Ellipta inhalers (a prescription medication used to treat airflow obstruction in adults) had no opened date label; and,3. Seven expired lubricating jelly (used to reduce friction during medical procedures involving the insertion of instruments or devices into the body) were stored in station 1 crash cart (a mobile medical cart used to store and transport life-saving equipment and medications for rapid response to critical situations). These failures had the potential for diversion of the loose medications, and for residents to receive medication that was expired or with unsafe or reduced potency.Findings:1. During a concurrent observation and interview which started on [DATE] at 2:13 p.m. with Licensed Nurse (LN) 1, of medication cart A, a total of three loose pills were found inside the second and third-right drawer of the medication cart. LN 1 confirmed the observation. LN 6 stated there should not be loose pills inside a medication cart because staff would not know what medication those are anymore and they want to keep the medication carts clean.During an interview on [DATE] at 11:17 a.m. with the Director of Nursing (DON), the DON stated that there should not be loose pills inside the medication carts because staff would not know what medications are those and because of infection control concerns.A review of the facility's P&P titled, Medication Labeling and Storage, dated 2001, indicated, 1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received .2. During a concurrent observation and interview which started on [DATE] at 2:13 p.m. with LN 1, of medication cart A, an opened Trelegy Ellipta inhaler was found stored in the medication cart with no opened date label. LN 1 confirmed the observation. LN 1 stated the inhaler should have an opened date label so staff would know when to discard it. LN 1 further stated that the efficacy of the medication would be affected if the inhaler was not discarded on the right time.During a concurrent observation and interview which started on [DATE] at 3:07 p.m. with LN 4, of medication cart B, an opened Trelegy Ellipta inhaler was found stored in the medication cart with no opened date label. LN 4 confirmed the observation. LN 4 stated the inhaler should have been labelled with the date it was opened to know when to discard it.During an interview on [DATE] at 11:17 a.m. with the Director of Nursing (DON), the DON stated that she would expect opened inhalers to have an open date label so staff would know when to discard it. A review of the facility's P&P titled, Medication Labeling and Storage, dated 2001, indicated, 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.A review of the facility document titled. INHALERS, published 3/2025, indicated, .Trelegy Ellipta .DISCARD INSTRUCTIONS .Discard 6 wks [weeks] after removal from foil tray .3. During a concurrent observation and interview which started on [DATE] at 1:47 p.m. with LN 5, of the station 1 crash cart, seven expired lubricating jellies were found stored in the crash cart. LN 5 confirmed the observation. LN 5 stated that crash carts should not have expired supplies because it could cause irritation or other side effects if used during medical emergencies.During an interview on [DATE] at 11:17 a.m. with the Director of Nursing (DON), the DON stated that expired lubricating jellies should not be stored in crash carts. The DON further stated it was a safety issue for residents and there was a risk for irritation or other side effects of expired lubricant.A review of the facility's P&P titled, First Aid Treatment/Emergency Crash Cart, revised 1/2024, indicated, 6. A first aid kit/emergency crash cart shall be maintained at each nurse's station for use in treating minor injuries . 7. The director of nursing service (or designee) is responsible for ensuring the first aid kits/emergency crash carts are inspected regularly and that adequate supplies are on-hand at all times.