STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675810	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancaster Nursing & Rehabilitation	1515 N Elm St Lancaster, TX 75134

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to provide activities based on the care plan designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 2 (Resident #2 and Resident #20) of 5 residents on the secured unit who were reviewed for activities. The facility failed to provide posted activities to Resident #2 and Resident # 20 on the memory care unit. These failures placed residents at risk of becoming apathetic (marked indifference to the environment), having a depressed mood and a decreased quality of life.Findings included: Review of Resident # 2's Face Sheet dated 01/07/2026 reflected he was a 66 year- old male who was admitted to the facility on [DATE] with diagnoses including COPD(Chronic Obstructive Pulmonary Disease), type II diabetes, acute kidney failure, schizophrenia and unspecified dementia (a group of symptoms that affect a person's ability to think, remember and perform daily activities). Review of Resident #2's MDS dated [DATE] reflected a BIMS score of 4, indicating he had severe cognitive impairment.Review of Resident #2's MDS Assessment, dated 04/14/2025 reflected that it was very important for him to go outside and get fresh air and to participate in religious services. Record Review of Resident #2's care plan dated 12/03/2025 revealed there were no care plans that addressed the resident's preferences related to activities. Review of Resident #20's face sheet dated 01/07/2025 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease with late onset, dementia and major depressive disorder. Review of Resident # 20's MDS dated [DATE] reflected a BIMS of 00 indicating he was severely impaired. Review of Resident #20's admission MDS Assessment, dated 09/04/2025 reflected it was important to him to listen to music and doing favorite activities. Review of Resident # 20's care plan dated 10/23/2025 reflected there were no care plans that addressed the resident's preferences related to activities. In an observation on 01/06/2026 at 10:20 AM in the memory care unit revealed that Resident # 2 was in his wheelchair with his head on the table. Resident # 20 was in a chair with his head down and sleeping. The TV was on and no staff member was present. There was no activity calendar posted in the memory care unit. There was no evidence of activities (puzzles, books, coloring books, pencils, crayons) within the memory care unit. Review of the activity calendar reflected Stretch and Flex was scheduled at 10 AM. In an observation on 01/06/2026 at 2:24 PM in the memory care unit revealed Resident # 2 was in his wheelchair asleep and Resident #20 was in the same chair asleep with music playing. There were no staff members present. Review of the activity calendar reflected Bean Bag Toss was scheduled at 2 PM. In an observation on 01/07/2026 at 11:05 AM Resident #2 was in his wheelchair facing the courtyard and was asleep. Resident #20 was observed in a lounge chair also asleep. There were color sheets and crayons on the dining table, but no one was using them. Review of the activity calendar reflected that Poetry Reading was scheduled at 11 AM. In an observation on 01/07/2026 at 3:11 PM revealed Resident #20 was asleep in a lounge chair; Resident #2 was awake and looking outside into the courtyard. In an observation and interview on 01/07/2026 at 3:13 PM, CNA A was sitting in the dining area looking at an electronic device. She stated she was only on the unit this date and didn't normally work there and couldn't speak to whether or not there were activities provided. Review of the activity calendar revealed that BINGO (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675810	A. Building B. Wing	01/08/2026

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was scheduled at 3 PM. In an interview on 01/08/2026 at 12:37 PM with CNA D revealed she had been working at the facility for a little over 2 months. She stated they do have activities and she thought there were maybe 3 per week. She stated sometimes she will do an activity like listening to music or coloring. She stated she did not know if there was an activity calendar in the dining room. She couldn't recall when the Activity Director was on the memory care unit. She stated the risk of not having activities for the residents was they could become combative with each other or bored with nothing to do. In an interview on 01/08/2026 at 1:20 PM with the Administrator and the Activity Director revealed she had been at the facility since December 2025 and was new to the role. She stated there was not a separate calendar for memory care unit and that her intentions were to create one but had not done that yet. She stated the risk of not having activities for residents in memory care was they would have nothing to do. The administrator stated they have considered having staff on the unit to assist in providing activities, but it had not been implemented yet. She stated there should be activities provided for the memory care residents. Review of Activity Programming Policy Procedure Manual 2011 reflected in part, Resident's or family's expressed needs and interests are included in the development of programs. Input from residents may be done individually or discussed at Resident Advisory Council meeting. Activity programs are based on residents' leisure interests and implemented to meet the needs (physical, cognitive, creative, social, spiritual, independent, and sensory) of the residents.Programs will be geared to maintain functional ADL's, provide social interaction and, at the same time, protect residents from environmental over stimulation.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) level 1 residents with mental illness were provided with a PASRR level 2 evaluation for 1 of 3 residents (Resident #34), reviewed for resident assessment.Resident #34's PASRR level 1 screening form did not reflect mental illness, and the resident did not have a PASRR level II evaluation.This could place residents at risk of not receiving necessary specialized services to meet their individual needs. The findings were:Record review of Resident #34's quarterly MDS assessment, dated 12/06/2025, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident's BIMs score was 15 indicating the resident's cognition is intact. His diagnoses included Bipolar Disorder (mental condition marked by alternating periods of elation and depression), Generalized Anxiety Disorder (disorder characterized by feelings of worry, anxiety, or fear that are enough to interfere with one's daily activities), Hypertension (a condition in which the blood against the artery wall is too high), and Seizures (a sudden burst of electrical activity in the brain).Record review of Resident #34's PASARR level 1 screening, dated 05/31/2025, reflected the resident did not have a serious mental illness and serious mental illness was checked as no.Record review of Resident #34's Care Plan dated 11/20/2025 reflected:06/02/2025: The resident was taking antidepressants to assist with his diagnosis of Depression.Give antidepressant medications ordered by physician. Monitor/document side effects and effectiveness. Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance.06/022025: The resident was taking medications to assist with Mood Disorder.Staff to Monitor/record occurrence of for target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol.11/20/2025: The resident was taking medications for Anxiety.Give anti-anxiety medications ordered by physician. Monitor/document side effectsand effectiveness. The resident is taking Anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia, falls, broken hips and legs. Monitor for safety.An interview on 01/08/2026 at 12:34 PM with MDS Nurse A revealed he did not know why Resident #34 had a negative PASRR level 1 screening. MDS Nurse A stated, he was responsible for ensuring the accuracy of PASARRs and was not aware that it was coded incorrectly. He said the resident was at risk of delay in services and not having correct care and management with a negative PASARR level 1 screening.An interview on 01/08/2026 at 1:43 PM with the DON revealed she did not know why Resident #34 had a negative PASARR Level 1 screening. She said the MDS staff were responsible for checking for accuracy and the resident was at risk of not receiving services he could qualify for.Review of the facility policy, PASRR Level 1 Screen Policy and Procedure, dated 03/06/2019, reflected: The PL1 Screening Form is completed by the RE (referring entity) using the paper copy of the PL1Screening Form.The Facility will review the PL1 Screening Form for completion and correctness prior to admissionand submit the PL1 form per regulations. The Type of admission is reviewed for correctness.Ensure the Name, SS number, Medicare/Medicaid numbers and DOB is correct. The Date of thePL1 is correct (i.e. correct day, month and year) and review each item on the PL1 to ensureaccuracy and prevent a regulatory problem.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene, for 2 (Resident #2 and Resident #20) of 10 residents reviewed for ADLs. The facility failed to provide nail care for Resident #2 and Resident #20. This failure placed residents who required assistance with ADLs at risk of a decline in their quality of life.Findings included: Review of Resident # 2's Face Sheet dated 01/07/2026 reflected he was a 66 year- old male who was admitted to the facility on [DATE] with diagnoses including COPD(Chronic Obstructive Pulmonary Disease), type II diabetes, acute kidney failure, schizophrenia and unspecified dementia (a group of symptoms that affect a person's ability to think, remember and perform daily activities). Review of Resident #2's MDS dated [DATE] reflected a BIMS score of 4, indicating he had severe cognitive impairment. Review of Resident #2's Care Plan revised on 01/06/26 reflected that Resident #2 has an ADL Self Care performance deficit and needed assistance with personal hygiene as required. Review of Resident #20's face sheet dated 01/07/2025 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease with late onset, dementia and major depressive disorder. Review of Resident # 20's MDS dated [DATE] reflected a BIMS score of 00 indicating he was severely impaired. Review of Resident #20's Care Plan revised on 10/22/2025 reflected that Resident #20 had an ADL Self Care performance deficit and required staff participation with personal hygiene as required. Observation on 01/06/2026 at 10:22 AM revealed Resident #2 was in his wheelchair in the dining room. His nails on both hands were about 1/2 inches long with a black substance underneath the nails. He did not answer when asked if his nails not being clipped bothered him or not. Resident #20 was also in the dining room and his nails were approximately 1/2 inches long with a black substance underneath the nails. He also did not respond to the question about his nails being clipped. In an observation on 01/07/2026 at 2:10 PM revealed Resident #2 and Resident #20 were in the dining room and their nails had not been clipped. In an interview on 01/07/2026 at 2:15 PM RN B revealed that if the resident was a diabetic, it was his responsibility to clip the nails. He stated that it had been around 3 weeks since he had trimmed the resident's nails and that it was his bad that they had not been clipped. He stated that Resident #2 and Resident # 20 were both diabetics. He stated the risk to the resident of not having their nails trimmed was the nails could get infected. In an interview on 01/08/2026 at 2:46 PM with the DON revealed that it was her expectation that the nurse clips the fingernails if the resident was a diabetic. She stated that the podiatrist will trim the toenails. She stated the risk to the residents was they could get skin tears, bacteria could get under the nails and cause an infection. Review of the facility's current policy and procedure Nail Care, undated, reflected in part: Nail management is the regular care of the fingernails to promote cleanliness, to prevent infection and injury from scratching. Goals: Nail care will be performed regularly and safely.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, for 3 of 5 Residents (Resident#12, Resident#8 and Resident#17), reviewed for respiratory care. The facility failed to ensure that Resident#8, oxygen tubing's was changed and dated per physician orders. The facility failed to ensure that Resident#12, and Resident#8's Oxygen tubing's, were bagged in a plastic bag and stored in a drawer which was consistent with professional standards.The facility failed to ensure that Resident#17's nebulizer mask was bagged in a plastic bag and stored in a drawer which was consistent with professional standards. This failure had the potential to affect residents receiving oxygen therapy by increasing their risk of health - associated infections. 1.) Record review of Resident #12's MDS Assessment, dated 12/23/2025 reflected the resident was a [AGE] year-old male, had a BIMs score of 01 indicating he was cognitively impaired. The resident had diagnoses which included Coronary Artery Disease, Heart Failure and Non-Alzheimer's Dementia. Record review of Resident #12's Comprehensive Care Plan revealed a care plan for Congestive Heart Failure Date Initiated: 12/22/2025 Facility intervention includes: Monitor/document/report to MD PRN any s/sx of Congestive Heart Failure: dependent edema of legs and feet, periorbital edema, SOB upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, cracklesand wheezes upon auscultation of the lungs, Orthopnea, weakness, and/or fatigue,increased heart rate (Tachycardia) lethargy and disorientation. Record review of Resident #12's Active 12/22/2025 Oxygen at 2 l/m to 4 l/m per nasal cannula every 1 hour as needed for SOB. 1/6/2026 at 11:05AM Observation of Resident# 12 revealed the oxygen tubing was not dated or labeled and hanging on the concentrator. Oxygen tubing was bagged in a plastic bag and stored in a drawer. 2.) Record review of Resident #8's Quarterly MDS Assessment, dated 12/23/2025, reflected the resident was a [AGE] year-old male, had a BIMs score of 09 indicating he was moderately cognitively impaired. The resident had diagnoses which included anemia, pneumonia, Asthma, Chronic Obstructive Pulmonary Disease, and respiratory failure. Record review of Resident #8's Comprehensive Care Plan, reflected [NAME] requires Oxygen Therapy Date Initiated: 01/05/2026: Facility interventions include usual oxygen delivery method after the meal. Monitor for s/sx of respiratory distress and report to MD PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis(sweating), Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. Notify the nurse if the oxygen is off the resident Oxygen at 2-4____lpm per nasal canula to keep spo2 above 94% Record review of Resident #8's Physician orders start date 05/30/2025 reflected CHANGE 0XYGEN TUBING Q NIGHT SHFFT every night shift every Sat PLEASE PUT DATE ON TUBING Verbal Active. Record review of Resident #8's Physician orders start date 09/03/2025 reflected Continuous Oxygen at 2LPM Via: Nasal Cannula every shift. 1/6/2026 at 11:17AM Observation of Resident# 8 revealed the oxygen tubing was not dated and was on the resident's nightstand. Oxygen tubing was bagged in a plastic bag and stored in a drawer. 1/6/2026 at 1:34PM interview with RN A revealed that oxygen tubing was supposed to be changed on Saturday night shift. She stated she usually checked the oxygen tubing to make sure they were dated. She stated she was not aware that Resident# 8's oxygen tubing was not dated. She stated the importance of dating oxygen tubing was to track its age so it can be replaced according to the recommended schedule. She stated that she had been in serviced on infection control and oxygen tubing care. 3.) Record review of Resident #17's Quarterly MDS Assessment, dated 12/3/2025, reflected the resident was a [AGE] year-old male, had a BIMs score of 14 indicating he was cognitively intact. The resident had diagnoses which included anemia(low red blood cells), Heart Failure(the heart can't pump enough (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen-rich blood to meet the body's needs), Asthma a chronic lung condition causing inflamed, narrowed airways, leading to symptoms like wheezing, coughing, chest tightness, and shortness of breath, often worsening at night or with exercise), Chronic Obstructive Pulmonary Disease (COPD), (Chronic Obstructive Pulmonary Disease (COPD) is a progressive lung condition causing airflow obstruction, leading to shortness of breath, cough (often with mucus), and wheezing, primarily from lung damage due to smoking or irritant exposure). Record review of Resident #17's Comprehensive Care Plan, Date Initiated 08/07/2023, Revision 01/17/2024 has COPD (Chronic Obstructive Pulmonary Disease (COPD) is a progressive lung condition causing airflow obstruction, leading to shortness of breath, cough (often with mucus), and wheezing, primarily from lung damage due to smoking or irritant exposure) r/t Smoking receives Symbicort Inhalation Aerosol, Albuterol Sulfate HFA Inhalation Aerosol Solution. Facility interventions: Monitor/document for anxiety. Offer support, encourage resident to vent frustrations and fears. Reassure. Give PRN medications for anxiety as ordered. Monitor/document/report to MD PRN any s/sx of respiratory infection: Fever, Chills, increase in sputum (document the amount, color, and consistency), chest pain, increased difficulty breathing (Dyspnea), increased coughing, and wheezing Record review of Resident #17's Physician orders start date 07/20/2023 reflected, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML inhale orally every 4 hours as needed for SOB or Wheezing via nebulizer. 1/6/2026 at 11:30AM Observation of Resident# 17 revealed nebulizer mask was not dated and was on the night stand it was not bagged and stored in a drawer. 1/6/2026 at 1:02PM interview with RN B revealed that he was Resident#12 and Resident#17's nurse. He stated that he was not aware that Resident #12's oxygen tubing and Resident #17's nebulizer mask were not dated. He stated that he usually checked the oxygen tubing to make sure they were dated. He stated that the oxygen tubing and nebulizer masks were changed every week on Saturday night and PRN. He stated it was important to date all tubing so that everyone track when the tubing was last changed. He stated that it was important to change tubing every week, and store tubing and nebulizer masks in plastic bags and place in the drawers to prevent contamination and infections. He stated that he had been in serviced on infection control and oxygen tubing care. 1/7/2026 at 4:30PM interview with the DON revealed her expectation was the nurse assigned should check the oxygen tubing and nebulizer masks as part of overall assessment make sure, they are functioning properly. She stated the facility policy was to change oxygen tubing when they become dirty or contaminated. She stated that the tubing should be stored in plastic bags in the drawers to prevent them from getting contaminated. She stated the risk to the resident if tubing was not stored in sanitary ways, was infection. She stated that the nurses had been in serviced on infection control and oxygen tubing care. She stated that when tubing is changed the nurse should document the treatment administration record. Record review of the facility policy titled Oxygen Administration Revised 02/13/ 2017 reflected: GoalsThe resident will maintain oxygenation with safe and effective delivery of prescribed oxygen.The resident will maintain an effective breathing pattern with administration of oxygen.The resident will be free from infection. ProcedureBecome familiar with the type of oxygen administration, medical diagnosis, and reason for oxygen, intermittent or continuous use of oxygen, amount to be delivered.Change the tubing (including any nasal prongs or mask) that is in use on one patient when it malfunctions or becomes visibly contaminated.Oxygen concentrators should be cleaned according to manufacturer recommendations.Change or clean oxygen concentrator filters according to manufactures' recommendations.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, administering, and securing of 1 medication on 1 medication cart of 2 medication carts reviewed for pharmacy services.The facility failed to ensure proper storage and disposal of Resident#11's tramadol 50 hcl mg (controlled medication) by taping a narcotic medication and retaining a discontinued narcotic in medication cart. These failures could place residents at risk of medication error due to administration of medication without physician order and at risk of pills contamination due to broken seals.Findings included: Review of Resident #11's Quarterly MDS Assessment, dated 12/12/25, reflected the Resident#11 was a [AGE] year-old male and had a BIMs score of 13 considered intact or normal. The resident had diagnoses which included hypertension (high blood), Anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood, resulting in pallor and weariness), heart failure (a condition when the heart muscle doesn't pump blood as well as it should), renal insufficiency (means the kidneys aren't working at full capacity, filtering waste and fluids less effectively), hemiplegia (is paralysis that affects only one side of your body), cerebral vascular Accident (a serious medical event where blood flow to part of the brain is suddenly interrupted, causing brain cells to die from lack of oxygen and nutrients, potentially leading to permanent disability or death). Review of Resident #11's Comprehensive Care Plan, dated 12/09/2025, reflected [NAME] requires pain management (chronic) pain r/t Lupus (a chronic autoimmune disease where the immune system mistakenly attacks healthy tissues and organs, causing inflammation affecting skin, joints, kidneys, brain, heart, and lungs).Date Initiated: 02/28/2019 Revision on: 02/01/2022: Interventions included to Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Review of Resident #11's active physician orders Dated: [DATE], reflected the resident had no active orders for tramadol hcl oral tablet 50 mg. Review of Resident #11's discontinued physician orders reflected Tramadol hcl oral tablet 50 mg give 1 tablet by mouth every 8 hours as needed for pain was discontinued 6/19/2025. An observation on 01/06/2026 at 11:45 AM of the Nurses Cart station1 revealed the medication blister pack for Resident #11's Tramadol hcl oral tablet 50 mg had 1 blister seal broken. The damaged blister had the pill still inside secured with tape at the time the surveyor inspected the medication cart; the count for Resident#11 Tramadol hcl oral tablet 50 mg, the actual number of pills counted was 24. In an interview on 06/10/26 at 11:50 AM, RN A stated she was unaware when the blister pack seal was broken and stated that Resident#11 had not taken the medication (Tramadol hcl oral tablet 50 mg) for a while. She stated that the risk of a damaged blister would be potential for drug diversion and contamination of the medication. She stated the nurses were responsible for checking the medication blister packs for broken seals during the count of narcotics during the change of shift. She stated she did not see the broken blister during the count. RN A stated discontinued narcotics should be removed from the nurse cart as soon as they were discontinued and given to the DON. She stated she had been in serviced on medication storage. In an interview on 01/06/26 at 3:29PM with ADON revealed she audited the 100-hall medication cart weekly. She stated the last time she audited the medication cart was two weeks prior to the recertification survey. She stated she was not aware Resident#11's Tramadol 50 mg was secured with taped. She stated that no narcotics should be taped due to risk of infection. She stated that medication with broken bubble seal should be wasted and witnessed by two nurses. She stated no medication without orders should be in the cart be because it could lead to medication errors. In an interview on 01/07/26 at 1:04 PM, the DON stated if the blister pack seal was broken on any controlled medications the pill should be discarded witnessed by two nurses. The DON stated it was not acceptable to keep a pill in a blister pack that was opened. She stated that if a blister pack seal (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was broken it should not be tapped over with tape. The DON stated all discontinued controlled narcotics should be removed from the cart immediately and given to her for secure storage until it is destroyed by the pharmacist. The DON stated the risk would be losing the medication because the seal was broken and having medication that has been discontinued could lead to medication error when the medication is given without an order. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON and wound nurse audit the medication carts weekly, then the pharmacy consultant checks the medication room and the medication cart every other month and the last time the audited the carts was in November 2025.She stated the nurses had been in serviced on medication storage and that narcotics were not to be taped if the blister seal was broken. Review of the facility's policy Medication Storage in the Facility edited P&P v3-2025 reflected the following: Medications and biologicals are stored safely, securely, and properly following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff. members lawfully authorized to administer medications.Procedure[Pharmacy] dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers. Transfer of medications from one container to another is done only by a pharmacist.9. Each States rule vary on securing the classes of controlled substances the facility will adhere to their individual State's rules as it relates, some states require that ALL classes of controlled substances be stored in the lock-box located in the medication cart to adhere to the required double locked/secured storage.13. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exists.