STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675837	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kruse Village Senior Living Community	1700 E Stone St Brenham, TX 77833

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to properly store, prepare, and distribute food under sanitary conditions in accordance with professional standards for food service safety for one of one kitchen.The facility failed to ensure Dietary Aide C used proper hand hygiene between tasks on 05/05/2026. This failure could place residents who ate food from the kitchen at risk for foodborne illness.Findings include:Observation on 05/05/2026 at 11:50 am, revealed Dietary [NAME] C was wearing gloves when she obtained a disinfectant rag out of the disinfectant water container. She touched the rag with all of her fingers on her right hand. Dietary [NAME] C cleaned the food prep area with the disinfectant rag. She placed the rag into the disinfectant container. Dietary [NAME] C reached for an ink pen and began to write information on small pieces of paper. She never changed her gloves during these tasks. Dietary [NAME] C began to place food in a silver container with aluminum foil on top of the containers from the food prep area to the rolling kitchen utility cart. One of the containers with aluminum foil came loose on one side of the container. Dietary [NAME] C placed the aluminum foil on the corner of the silver container and the tip of her fore finger and middle finger touched inside the container, however, did not touch the food. Dietary [NAME] C continued to wear the same gloves. She obtained 2 large containers of spices and a lid to the top of one of the spice containers was loose. Dietary [NAME] C touched the top of the spice container with her middle and ring finger on her right hand as she was placing the top on the spice container. She carried the 2 spice containers to another area of the kitchen (right side of the kitchen and placed it on a shelf). Dietary [NAME] C removed her gloves and washed her hands. She placed new gloves on her hands.Interview on 05/05/2026 at 12:05 pm, Dietary [NAME] C stated she did not change her gloves when she used the disinfectant rag. She stated she did touch the containers of the food and moved the containers from the food prep table to the rolling cart. Dietary [NAME] C stated she was expected to remove her gloves, wash her hands and place new gloves on her hands anytime she touched anything considered contaminated. She stated the disinfectant rag was considered contaminated. Dietary [NAME] C stated she was not a nurse and could not say what may happen to a resident if bacteria was transferred to their food. She did not answer any other questions related to hand hygiene, possibility of transferring bacteria to resident food, and when she touched the container of spices. She stated she had been in-serviced on hand hygiene but did not recall the date.Interview on 05/06/2026 at 8:00 am, the Administrator stated she expected gloves to be changed, hands washed anytime staff touch contaminated items. She stated disinfectant rag and ink pen was considered contaminated. She stated there was a possibility if there was bacteria in food, a resident may develop a food borne illness. The Administrator stated the Dietary Manger was responsible for all protocols in the kitchen and she was responsible to monitor the Dietary Manager. Interview on 05/07/2025 at 10:45 am, the Dietary Manager stated if a staff did not directly touch food the staff was not required to change their gloves. The Dietary Manager stated Dietary [NAME] C did touch the disinfectant rag, touched container of food and the spice containers. She demanded the surveyor to quote the TEFER and the health department guidelines. The Dietary Manager stated she wanted more proof from the surveyor of what the Dietary [NAME] C did wrong with wearing gloves. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Dietary Manager demanded proof from the surveyor, in a loud tone. The surveyor stopped the interview and exited the kitchen.Record review of Dietary [NAME] C's orientation training, dated 04/30/2026, reflected training was completed on the following Sanitation Tasks (signed by the Dietary Manager and Dietary [NAME] C):Prevention of cross contaminationHand HygieneUse of GlovesSanitation buckets Record review of the facility's in-service on Sanitation/ Gove usage, dated 02/12/2026 given by the Dietary Manager reflected the following:Gloves should be removed and hands should be washed after each task.Do not reuse gloves.Hands should be washed after using the bathroom, changing task, eating/drinking, smoking, etc. Record review of the Facility's Policy on Hand Hygiene for Kitchen and Dietary Department, dated 05/2026, reflected All kitchen and dietary staff must adhere to strict hand hygiene practices to prevent foodborne illness, cross-contamination, and compliance violations under CMS regulations and state health codes. Handwashing occurs at designated sinks only, using soap and warm water for a minimum for 20 seconds. Hand sanitizer is permitted only after handwashing and never a substitute. Purpose: To ensure food safety in the Skilled Nursing Facility dietary department by minimizing pathogen transmission (the process by which infectious agents-such as bacteria, viruses, fungi, or parasites-move from a reservoir (an infected person, animal, or environmental source- to a susceptible host. This spread occurs through direct contact or indirect contact- contaminated objects) during food preparation, handling, service, as required for surveyor review during kitchen inspections.Scope: Applies to all dietary/kitchen personnel, including cooks, aides, servers, and managers in the food service area.When to Perform Hand Hygiene: Staff must wash their hands immediately:Upon entering the kitchen or starting a shift.Before donning gloves or handling clean utensils/equipment.Before preparing or serving ready-to-eat foods.After using the restroom, coughing, sneezing, eating, drinking, or touching face/hair/body.Between tasks or glove changes. Review of the Facility's Protocol for Hand Hygiene is from the Texas Food Establishment Rules, not dated, reflected S228.38. Hands and Arms. S228.38 (b)(3) S228.38 (d)(9).(d) When to Wash. Food employees shall clean their hands and exposed portions of theirarms as specified under subsection (b) immediately before engaging in food preparationincluding working with exposed food, clean equipment and utensils, and unwrapped single serviceand single-use articles.S228.44(2);(5) after handling soiled equipment or utensils;(6) during food preparation, as often as necessary to remove soil andcontamination and to prevent cross contamination when changing tasks;(7) when switching between working with raw food and working with ready-to-eatfood;(8) before donning gloves to initiate a task that involves working with food;and(9) after engaging in other activities that contaminate the hands.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview, and record review the facility failed ensure the comprehensive care plan, consistent with resident rights, included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for one of five residents (Resident #41) reviewed for care plans completion. The facility failed to ensure Resident #41's care plan was completed to reflect Resident #41 had a pacemaker.This failure could place residents at risk of not receiving appropriate interventions to meet their medical needs. Findings include:Record review of Resident # 41's face sheet, dated 05/05/2026, reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with a diagnoses of presence of cardiac pacemaker (a small, battery-powered medical device implanted under the skin, usually near the collarbone, to treat abnormal heart rhythms or heart failure), chronic atrial fibrillation, unspecified (an irregular and often very rapid heart rhythm. It can lead to blood clots in the heart. The condition also increases the risk of stroke, heart failure and other heart-related complications), biventricular heart failure (a serious condition where both the left and right ventricles- lower chambers- of the heart are weakened, failing to pump blood efficiently), and acute chronic combined systolic -congestive- and diastolic- congestive heart failure (a severe, emergency situation where the heart cannot effectively pump- systolic or fill- diastolic, leading to sudden worsening of fluid buildup - acute- on top of long-term -chronic- heart issues. Systolic -pressure measures arterial pressure during heart contractions, while diastolic measures pressure when the heart rests between beats)Record review of Resident #41's Quarterly MDS, dated [DATE], reflected Resident #41 had a BIMS score of 8 indicating her cognition was moderately impaired. She was assessed to have a diagnosis of presence of cardiac pacemaker and heart failure. Record review of Resident #41's Comprehensive Care Plan dated 04/08/2026 did not reflect Resident #41 had a pacemaker and a pacemaker transmitter.In an interview on 03/04/2026 at 11:50 a.m. the MDS Coordinator stated Resident #41 had a pacemaker and a pacemaker transmitter. She stated it was not documented on Resident#41's comprehensive care plan. The MDS Coordinator stated she missed documenting it on the care plan. She stated the purpose of having a Comprehensive Care Plan was to inform staff how to give the care each resident needed such as physical, behaviors, emotional, activities, type of diet and any other interventions to prevent falls or any injuries. She stated she was responsible to monitor the care plans to ensure they were correct and completed on time. The MDS Coordinator stated the information the CNAs follows on Kardex came from the care plan. She stated if a resident needed certain type of care or had behaviors and it was not care planned, the CNAs or nurses would not have that information to know what type of care to give the residents.In an interview on 03/04/2026 at 12:40 p.m. the DON stated her expectations was the care plan to be revised as needed. She stated Resident #41's pacemaker and pacemaker transmitter were expected to be care planned. She stated the care plan for each resident was a communication tool for all staff to know exactly what type of care and needs each resident needed. She stated anytime a health issue is documented on the MDS it was expected to be care planned.In an interview on 05/07/2026 at 8:20 am the Administrator stated her expectations of care plans was the IDT discuss care of each resident and if there was a change with anything including resident preferences the care plan was expected to be revised. She stated the IDT was expected to ensure the resident's information to give appropriate care to each resident was documented on the care plan whether it was physical, emotional, resident preference, activities, etc. The Administrator stated the charge nurse could make revisions to the care plan but ultimately it was the MDS Coordinators responsibility to ensure the care plan was completed and correct. She sated the IDT consisted of the following disciplines: DON, Social Worker, MDS Coordinator, Dietary Manager, Activity Director, Resident and Family. She stated staff had been in-serviced on how to document on (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the care plan; however, she did not recall the date of the in-service.Review of the facility's Care Plan Policy, dated 11/24/2025, reflected Residents receiving services will have a care plan in place. Care plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the residents' needs and preferences. A care plan is a document that outlines the specific medical and rehabilitative services a patient needs and who will provide them. Developed by a team of healthcare professionals with input from the patient and/or their family, it is based on a comprehensive assessment of the patient's health status and helps guide their stay in the community. Care plans will be revised, if needed, based on resident assessments and monitoring.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents treatment and care in accordance with professional standards of practice for 1 of 5 residents (Resident #41) reviewed for quality of care. The facility failed to ensure that nursing staff ensured the pacemaker was being transmitted on Resident #41. This failure could place residents at risk for not being provided the care and treatment to meet their needs. Findings included: Record review of Resident # 41's face sheet, dated 05/05/2026, reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with a diagnoses of presence of cardiac pacemaker (a small, battery-powered medical device implanted under the skin, usually near the collarbone, to treat abnormal heart rhythms or heart failure), chronic atrial fibrillation, unspecified (an irregular and often very rapid heart rhythm. It can lead to blood clots in the heart. The condition also increases the risk of stroke, heart failure and other heart-related complications),biventricular heart failure (a serious condition where both the left and right ventricles- lower chambers- of the heart are weakened, failing to pump blood efficiently), and acute chronic combined systolic -congestive- and diastolic- congestive heart failure (a severe, emergency situation where the heart cannot effectively pump- systolic or fill- diastolic, leading to sudden worsening of fluid buildup - acute- on top of long-term -chronic- heart issues. Systolic -pressure measures arterial pressure during heart contractions, while diastolic measures pressure when the heart rests between beats).Record review of Resident #41's Quarterly MDS, dated [DATE], reflected Resident #41 had a BIMS score of 8 indicating her cognition was moderately impaired. She was assessed to have a diagnosis of presence of cardiac pacemaker and heart failure.Record review of Resident #41's Comprehensive Care Plan dated 04/08/2026 did not reflect Resident #41 had a pacemaker and a pacemaker transmitter.Observation on 05/05/2026 at 11:03 am revealed an unplugged pacemaker monitor located on the floor of Resident #41's room. Resident #41 was not in her room.Interview on 05/05/2026 at 11:15 am Resident #41 did not respond to questions appropriately. She stated she was going to town with her mother.Interview on 05/05/2026 at 1:00 pm the DON stated her expectations for Resident # 41's pacemaker monitor was to be plugged in at all times. She stated any resident with a pacemaker needed to be transmitted via monitor. She stated if the pacemaker monitor was not plugged in there was a possibility Resident #41 may have heart issues without the staff knowing it. The DON stated she did not know why the monitor was not plugged in the electrical outlet. She stated no one had reported to her any issues with Resident #41's pacemaker monitors not being plugged in or found on the floor.Interview on 05/05/2026 at 1:30 pm the Primary Care Physician stated Resident #41 had not had any change of condition reported to him from the nursing staff. He stated Resident #41 had multiple heart issues and if she was having any changes with her heart the symptoms would be shown immediately related to her history with congestive heart failure (a chronic, progressive condition where the heart muscle becomes too weak or stiff to pump blood efficiently, causing blood and fluid to back up into the lungs, legs, and other tissues).Interview on 05/05/2026 at 1:50 pm LVN H stated it had been a busy day, and he did not recall if the pacemaker monitor was unplugged when he entered Resident #41's room to administer medication.Interview on 05/06/2026 at 8:40 am the DON stated she tested the pacemaker monitor on 05/05/2026 and the pacemaker was working and did transmit. She stated she contacted the cardiologist office and someone (she did not ask the person's name) stated there was no issue with the transmission and Resident #41 did not have any concerns about her heart or the pacemaker. Interview on 05/06/2026 at 8:45 am the Medical Assistant from the Cardiologist Office stated transmission came through on 05/05/2026 and there were no concerns. She stated Resident #41's chronic atrial fibrillation was well controlled. The Medical Assistant stated she had set up an appointment for Resident #41's routine checkup for 05/12/2026. She stated at this time there was no reason for any concern with Resident #41's pacemaker or her heart condition.Interview on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/06/2026 at 8:50 am the DON stated her expectations were for the staff to check Resident #41 ?s pacemaker monitors every time a staff enters the room. She stated if the light was not on the monitor or if the monitor was unplugged, she expected the nurse supervisor and herself to be notified immediately. She stated she did not know how Resident #41's pacemaker monitor became unplugged. The DON stated Resident #41 was not interviewable and did not respond to the questions about the pacemaker monitor appropriately. Interview on 05/06/2026 at 9:15 am LVN Charge Nurse A stated the pacemaker monitor was plugged when she entered Resident #41's room on 05/06/2026. She stated, When I went into [Resident #41's] room the pacemaker monitor was always plugged in except for one time and that was almost a month ago. LVN Charge Nurse A stated, I in-serviced the staff on ensuring [Resident #41's] pacemaker monitor was always plugged into the electric outlet. She stated sometimes when the staff moved Resident #41's bed the monitor would come unplugged, but the staff would always plug it back into the outlet. LVN Charge Nurse A stated she was not completely certain what could happen if the pacemaker monitor was not plugged in for a very long period of time. She stated Resident #41 showed signs and symptoms of heart issues immediately due to having a lot of heart problems. LVN Charge Nurse A stated Resident #41 would have shortness of breath and become very dizzy. Requested the in-service LVN Charge Nurse A completed with the staff about the heart monitor being unplugged and it was not provided at time of exit.Interview on 05/07/2026 at 9:30 am LVN D stated he had given care to Resident #41 as a nurse and as a CNA numerous times since she was admitted to the facility approximately 6 months ago. He stated when he had entered Resident #41's room the pacemaker monitor has always been plugged in and sitting on her bedside table. He stated no one had mentioned to him of Resident #41's pacemaker monitor being unplugged. Interview on 05/07/2026 at 9:45 am CNA E stated she had given care to Resident #41 when she was first admitted to the facility for several weeks. She stated when she gave care to Resident #41 her pacemaker monitor was always plugged in and was located on the bedside table. CNA E stated no one had reported to her of finding Resident #41's pacemaker unplugged.Interview on 05/07/2026 at 10:00 am LVN Charge Nurse F stated she had given care to Resident #41 several times. She stated Resident #41's pacemaker monitor was always plugged in, and the light on the monitor was showing it was on and was working appropriately. She stated no one had reported to her of Resident #41 pacemaker monitor being unplugged. Review of the facility's policy of Nursing Services: Quality of Resident Care (General), revised on February 2023 reflected Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility ensures that each resident receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Quality resident care is comprised of an approach that meets the physical, psychological, social, and spiritual needs of the facility's residents, as determined through use of the nursing process.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for two of four residents reviewed for catheter care (Resident #5). The facility failed to ensure Resident #5's catheter was secured to his body with a catheter secure device per the care plan and physician's orders. This failure to secure catheters placed residents with urinary catheters at risk for traumatic removal and catheter acquired infections.Findings included:Record review of Resident #5's face sheet, dated 05/05/2026, reflected an [AGE] year-old-male admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, stage 3 unspecified (the kidneys are moderately damaged, with a 40-70 percent reduction in function. The exact substage is not defined), neuromuscular dysfunction of bladder, unspecified (a condition where nerve damage disrupts communication between the brain and bladder muscles, leading to inability to control urination), paraplegia, incomplete (a spinal cord injury that causes partial loss of motor function or sensation below the injury site, affecting only the legs and lower body).Record review of Resident #5's Annual MDS Assessment, dated 03/06/2026 reflected Resident #5 had a BIMS score of 15 indicating his cognition was intact. He was dependent on staff for the following ADLs: showers, toileting hygiene, lower body dressing, and transfers. Resident #5 was assessed to have an indwelling catheter.Record review of Resident #5's Comprehensive Care Plan, dated 03/16/2026, reflected Resident #5 had a potential for complications with bowel and bladder related to current medical and physical status. Resident #5 had supra pubic catheter (a thin, flexible, hollow tube inserted into the bladder through a small surgical incision in the lower abdomen, just above the pubic bone, rather than through the urethra (a muscular elastic tube connecting he urinary bladder to exterior environment) 22 French with 10 balloon (Date initiated 09/25/2023 and revised on 4/19/2024) Interventions (date initiated on 3/13/2026) Resident #5 had catheter: 22 French/10 mL. Silicone catheter, position catheter bag, and tubing below the level of the bladder. Check that anchor is in place, tubing is not kinked, is off the floor, below the bladder and in a privacy bag. Record review of Resident #5's Consolidated physician's orders reflected an order date 08/21/2023 Catheter: check placement of leg strap every shift and prn.Record review of Resident #5's MAR for the months of April 2026 and May 2026 reflected an entry for catheter care every shift and PRN. Use catheter anchor and check placement every shift. Observation on 05/05/2026 at 1:00 pm Resident #5 was observed to have a supra pubic catheter. Resident #5 did not have a secure catheter. Interview on 05/07/2026 12:55 pm LVN G stated Resident #5 should have a secure catheter. She stated the nurses were in charge of monitoring catheters. LVN G stated she did observe Resident #5 catheter was not secured on 05/05/26. Interview on 05/07/2026 at 1:20 pm LVN G stated there was a possibility the catheter may pull out if not anchored and a possibility of infection around the stoma area. Interview on 05/07/2026 at 10:30 am the Director of Nurses stated she expected the nurses to follow physician's orders and care plan. She stated if Resident #5's catheter was not anchored there was a potential the pubic catheter could be pulled, irritate the stoma (a surgically created opening on the abdomen that allows waste (stool or urine) to leave the body, bypassing a diseased or damaged section of the intestine or bladder), the stoma site may erode related to the tubing against the edge of the stoma and cause an infection. She stated Resident #5 pubic catheter was expected to be anchored at all times. Record review of the facility Catheter Care policy, revised on 10/2022, reflected Proper care will be provided for the management of a foley catheter to drain urine from the bladder and to prevent reflux of urine back into the bladder. The catheter may be anchored or stabilized to prevent urethral tension. It is recommended to anchor on the upper thigh in women or the abdomen in men.

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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 observations, interviews, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 3 medication carts (Medication Cart #1) reviewed for medication storage.The facility failed to ensure Medication Cart #1 was locked and medications were secured.This failure could place residents at risk of having unauthorized access to prescriptions, biologicals, and over-the counter medications.Findings included Observation on 05/07/2026 at 7:42 a.m. revealed the locking mechanism was protruding outward (indicated the medication cart was unlocked) on Medication cart #1 located on 400 hall near room # 404. There was not any staff in the hallway or at the nurses desk near the entrance to 400 hall. The door to room [ROOM NUMBER] was closed. Med- Aide B exited room [ROOM NUMBER] at 7:46 am.Interview on 05/07/2026 at 7:46 am Med-Aide B stated she forgot to lock the medication cart. She stated the door was closed to room [ROOM NUMBER] and she was unable to view the medication cart. She stated all medication carts were to be locked except when a nurse was obtaining medications from the cart. Med Aide B stated if a resident did ingest medications the resident was allergic to there was a possibility the resident may have a reaction and possibly die. She stated a resident also had a potential of overdosing on medications or giving the medications to another resident. Med Aide B stated she had been in-serviced on locking medication carts; however, she did not recall the date of the in-service. She stated there were all types of medications prescribed by the physician in Medication Cart #1 except for narcotics.In an interview on 05/07/2026 at 9:30 a.m. LVN D stated the medication cart was to always be locked except when he was dispensing medications from the medication cart. He stated anytime a nurse or med-aide walked away from the medication cart it was to be locked. LVN D stated there was a possibility a resident may take medications from the cart. He stated if a resident ingested medications there was a possibility for an allergic reaction and possibly may need to go to the hospital for further evaluation. He stated he had been in-serviced on locking medication carts, however, he did not remember the date.In an interview on 05/07/2026 at 10:30 a.m. the Director of Nurses stated her expectation was for all medication carts to be locked when the nurse was not administering medications. She stated the staff had been in-serviced on securing the medication carts when not in use. The Director of Nurses stated she did not know the exact date of the in-service. She stated residents, other staff, and visitors would have access to the medications in the unlocked medication cart. She stated if a resident ingested medications not prescribed to them there was a potential the resident may have an allergic reaction or may need to be admitted to the hospital. She stated it was the nurse or medication aide's responsibility to ensure the medication cart was locked when not dispensing a resident's medication. The Director of Nurses stated she was expected to monitor the nursing staff.Record review of the facility Medications, Labeling, and Storage Policy, revised on 11/2024, reflected Storage requirements: Locked med carts/ rooms; temperature monitored (68-77 degrees F, 36-46 degrees F fridge/freezer) with logs. Med Carts: locked when unattended; cleaned weekly; emergency kit stocked.