STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675969	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Settlers Ridge Care Center	1280 Settlers Ridge Rd Celina, TX 75009

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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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 5 of 5 residents (Resident #33, #57, #10, #65, and #16) reviewed for comprehensive care plans.The facility failed to ensure Resident #33, #57, #10, #65 and #16's comprehensive care plan addressed their goals, needs, strengths, medical, nursing, mental, and psychosocial needs.This deficient practice could place residents at risk for not receiving proper care and services due to inaccurate care plans.Findings included:Record review of Resident #33's MDS assessment dated [DATE], reflected an [AGE] year-old female, admitted to the facility on [DATE], with a BIMS score of 4 which indicated severe cognitive impairment. Diagnoses included: Chronic Heart Failure (the heart can't pump blood as well as it should, causing fatigue, swelling, and shortness of breath), Type 2 Diabetes (a condition where the body can't properly use sugar for energy, leading to high blood sugar and possible complications), Alzheimer's Disease (a brain disease that slowly destroys memory and thinking skills, making it hard to do everyday tasks), Anxiety Disorder (excessive worry or unease), and Depression (feelings of severe sadness. Inability to initiate activity). Record Review of Resident #33's Order Summary dated 04/01/2026, reflected Resident #33 was admitted to hospice on 02/01/2026. Record Review of Resident #33's comprehensive care plan dated 04/01/2026, reflected Resident #33 had 3 identified goals related to Activities, personal preferences, and Advance Directive preference. Record review of Resident #57's MDS assessment dated [DATE], reflected an [AGE] year-old female, admitted to the facility on [DATE]. The Resident's MDS assessment did not include the BIMS score, as staff selected 0, which indicated the resident was never or rarely understood, which directed the assessment to skip to the staff assessment for mental status. The staff assessment indicated the Resident had short and long-term memory problems and was severely cognitively impaired. The Resident had diagnoses that included: Adult Failure to Thrive (significant decline in physical, cognitive, and emotional health, often leading to weight loss, malnutrition, and reduced functional ability), Dysphagia (difficulty swallowing liquids and/or solid food and drink), Dementia ((severe decrease in memory and intellectual functioning that can occur in the later stages of Parkinson's), and Bipolar Disorder (mood swings between high-manic and low depressive moods). Record Review of Resident #57's MAR dated 03/01/2026 - 03/31/2026, reflected the Resident refused prescribed medication on 3/1/2026, 3/24/2026, 3/26/2026, and 3/28/2026. The MAR also reflected the resident's vitals were not obtained due to resident refusal on 3/4/2026, 3/9/2026, 3/10/2026, 3/13/2026, 3/14/2026, 3/19/2026, 3/20/2026, 3/23/2026, 3/24/2026, 3/28/2026, 3/30/2026, and 3/31/2026. Record Review of Resident #57's Comprehensive Care Plan dated 04/01/2026, reflected the plan did not address the resident's refusal of care and discharge planning or options. Record review of Resident #10's MDS assessment dated [DATE], reflected a [AGE] year-old female, admitted to the facility on [DATE]. The Resident's MDS assessment did not include the BIMS score, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as staff selected 0, which indicated the resident was never or rarely understood, which directed the assessment to skip to the staff assessment for mental status. The staff assessment indicated the Resident had short and long-term memory problems and was severely cognitively impaired. The Resident had diagnoses that included: Alzheimer's Disease (a brain disease that slowly destroys memory, thinking, and the ability to carry out daily tasks), Dysphagia (difficulty swallowing liquids and/or solid food and drink), and Moderate protein-calorie malnutrition (a form of undernutrition characterized by insufficient intake of protein and calories). Record Review of Resident #10's MAR dated 03/01/2026 - 03/31/2026, reflected the Resident refused prescribed medication on 03/03/2026, 03/11/2026, 03/12/2026, 03/14/2026, 03/15/2026, 03/16/2026, 03/21/2026, 03/24/2026, 03/26/2026, 03/27/2026, 03/28/2026, 03/29/2026, and 03/30/2026. The MAR also reflected the resident's vitals were not obtained due to resident refusal on 03/06/2026, 03/28/2026, and 03/29/2026. Record Review of Resident #10's Comprehensive Care Plan dated 04/01/2026, reflected the plan did not address the resident's refusal of care and discharge planning or options. Record review of Resident #65's MDS assessment dated [DATE], reflected an [AGE] year-old male, admitted to the facility on [DATE]. The Resident's MDS assessment did not include the BIMS score, as staff selected 0, which indicated the resident was never or rarely understood, which directed the assessment to skip to the staff assessment for mental status. The staff assessment indicated the Resident had short and long-term memory problems and was severely cognitively impaired. The Resident had diagnoses that included: Cerebral infarction (a type of stroke caused by a blocked blood vessel in the brain, leading to brain tissue damage), Vascular Dementia (severe decrease in memory and intellectual functioning that can occur in the later stages of Parkinson's), Major Depressive Disorder (severe, persistent sadness and loss of interest that interferes with daily life), and Anxiety Disorder (excessive worry or unease). Record Review of Resident #65's Physician Orders dated 04/01/2026, reflected the following orders: Consult for Psychiatry to evaluate and treat and Alprazolam .5 MG tablet by mouth twice a day (to treat anxiety). Record Review of Resident #65's Comprehensive Care Plan dated 04/01/2026, reflected the plan did not address mental health needs for depression and anxiety and discharge planning or options. Record review of Resident #16's MDS assessment dated [DATE], reflected a [AGE] year-old male, admitted to the facility on [DATE]. The Resident's BIMS score was 8 which indicated moderate cognitive impairment. The Resident had diagnoses that included: Alzheimer's Disease (a brain disease that slowly destroys memory, thinking, and the ability to carry out daily tasks), Type 2 Diabetes (a condition where the body can't properly use sugar for energy, leading to high blood sugar and possible complications), and Depression (persistent sadness and loss of interest that interferes with daily life). Record Review of Resident #16's Comprehensive Care Plan dated 04/01/2026, reflected the plan did not address discharge planning or options. In an interview on 04/01/2026 at 11:50 AM with the MDS Nurse, she reported she was responsible for completing resident care plans in collaboration with other nursing staff. She stated she got behind on completing resident care plans and was in the process of auditing each resident care plan to ensure they were accurate and complete. She stated she is completing 1-2 resident care plans a day. In an interview on 04/01/2026 at 12:00 PM with the DON, she stated she looked over Resident #33's care plan and acknowledged it was not complete. The DON stated the facility opened a new part-time position that would be responsible for care plans. She stated this position is publicly posted and no applicant had met the requirements. She stated a care plan should include any pertinent information to the resident's care, medications, and treatments. The DON acknowledged that Resident's #57 and #10 both had a history of refusing medications and vital sign readings. She also acknowledged that the refusal of care should be addressed in the care plans. She stated the risk to residents with inaccurate or incomplete care plans was that PRN staff would not be up to date on resident care. Record Review of the Facility Care Plan Process dated March 27, 2023, reflected in part: The interdisciplinary team will coordinate with the resident and their legal representative an appropriate care plan for the resident's needs or wishes based on the assessment (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and reassessment process within the required timeframes. The team directs care planning toward attaining and maintaining the highest optimal physical, psychosocial, functional status including Advance Directives, and signs the approved Plan of Care. The Plan of Care identifies the date, problem, goals - measurable and realistic, time frames for achievement, interventions, discipline specific services, and frequency, and discharge options.

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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 review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen safety. The facility failed to ensure food in the facility's dry storage, and refrigerator areas were labeled and dated according to guidelines. The facility failed to seal lids securely on containers in the refrigerator area and dry storage pantry. These deficient practices could affect residents who received meals or snacks from the kitchen and place them at risk for cross contamination and other food-borne illnesses.Findings Included: 3/31/2026 Dry Pantry area revealed 12 plastic round maroon bowls had plastic lids that were unsealed, exposed to the air, not labeled and not dated. 3/31/2026 Walk-in refrigerator revealed 1 clear plastic container with a red cracked lid unsealed and exposed to the air. 9:12am on 3/31/26-Brief tour of the kitchen and interview with Director of Nutritional Services revealed, the facility has 1 kitchen and 1 main dining room. Conducted a brief walk through the walk-in freezer, walk-in refrigerator, and dry pantry. Surveyor observed a clear hard plastic container with a red cracked lid was on the top wire shelf in the walk-in refrigerator. Surveyor observed 12 unlabeled and undated plastic round maroon bowls with plastic lids that were not securely on the bowls on the shelf in the dry pantry.Interview on 3/31/26 at 9:30am with The Director of Nutritional Services stated the Dietitian comes weekly on Tuesday's and is responsible for the resident assessments, therapeutic menus, and kitchen in-services. Returning visit to the kitchen on 4/1/26 at 11:30am to observe the kitchen The Dietitian and Director of Nutritional Services were present. Surveyor observed walk-in freezer, observed walk-in refrigerator and dry pantry. Surveyor observed the 12 unlabeled and undated plastic round maroon bowls with plastic lids that were not securely on the bowls remained on the shelf in the dry pantry.Interview on 4/1/26 at 11:45am with The Dietitian stated she does periodic kitchen walkthroughs looking for sanitary conditions. Returning visit to the kitchen on 4/2/26 at 10:12am both The Dietitian and Director of Nutritional Services were present. Observed walk-in freezer. Observed walk-in refrigerator and dry pantry with the Dietitian. Interview on 4/2/26 at 10:40am with Director of Nutritional Services stated if there was a case of food poisoning, he would look to see if there were any causes of cross contamination in the kitchen. Record review of the facility's policy, Food Storage effective August 1, 2018, and Revised February 6, 2024: April 8, 2025, revealed, Policy: Sufficient storage facilities are provided to keep food safe, wholesome, and appetizing. Food is stored, prepared and transported at an appropriate temperature and by methods designed to prevent contamination.Storeroom:Air-tight containers or bags are used for all opened packages of food. All containers are accurately labeled with the item and the date opened.Refrigerator:All foods are covered, labeled, and dated. Defrosting meat, eggs, and milk shakes are labeled with the date pulled for thawing. Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to maintain essential equipment in operating condition by failing to maintain walk-in refrigerator and walk-in freezer coolant fans for 1 of 1 kitchens reviewed for equipment in operating condition. The facility failed to maintain the coolant fans in the walk-in freezer and in the walk-in refrigerator for operating condition.The facility's failure to maintain coolant fans in operating condition had the potential to place all residents at risk for cross-contamination and increased risk of foodborne illness. Findings Included:Walk-in refrigerator revealed dripping liquid from the coolant fan within the refrigerator. Walk-in freezer revealed ice build up on the coolant fan within the freezer. Observations of the kitchen during the brief initial tour of the kitchen on 03/31/26 at 9:12am revealed the following: 9:12am-Brief tour of the kitchen and interview with Director of Nutritional Services revealed, the facility has 1 kitchen and 1 main dining room. Conducted a brief walk through the walk-in freezer, and walk-in refrigerator. Surveyor observed the coolant fan unit mounted on the ceiling of the refrigerator was actively dripping water onto the shelving below. Drops of water were observed going into a clear container and outside the clear container on food items.Interview on 3/31/26 at 9:30am with The Director of Nutritional Services stated the Dietitian comes weekly on Tuesday's and is responsible for the resident assessments, therapeutic menus, and kitchen in-services.Returning visit to the kitchen on 4/1/26 at 11:30am to observe the kitchen. The Dietitian ran the Low Temperature dishwasher as a periodic test, the dishwasher rose to 120 degrees, within normal range.The coolant fan in the freezer was leaking a clear liquid substance into a rectangular clear durable plastic container sitting on the top shelf just below the coolant fan mechanical motor. Interview on 4/1/26 at 11:45am The Dietitian stated she does periodic kitchen walkthroughs looking for sanitary conditions.Returning visit to the kitchen on 4/2/26 at 10:12am to observe the kitchen, both The Dietitian and Director of Nutritional Services were present observing the walk-in freezer. Frost was observed on the coolant fans in the freezer. The Dietitian stated the frozen ice melts off during the day. Observed walk-in refrigerator still dripping liquid from the coolant fan. The Dietitian stated every 2-3 days the Maintenance Director has to has to drain the coolant fan. Interview on 4/2/26 at 10:45am The Dietitian stated there would be no harm to the residents because the food items are always washed regardless including food like oranges.Interview at 10:40am with Director of Nutritional Services stated if there was a case of food poisoning, he would look to see if there were any causes of cross contamination in the kitchen. Interview at 11:00am with [NAME] B stated 2 days or so the walk-in refrigerator coolant fan has to be drained. [NAME] B stated that not washing hands can cause cross contamination. Interview on 4/2/26 at 12:26pm Maintenance Director said he worked at the facility for 3 years. Maintenance Director on 4/1/2026 said he cleaned the coolant fan drain and blew out the drain on the coolant fan. The Maintenance Director said he will blow out the coolant fan again. Maintenance Director said due to the humidity levels it is hard to keep up with the condensation, causing the reason for the issue with the coolant fans. The Maintenance Director stated he does not call out contract commercial maintenance for repairs with refrigeration and HVAC repairs, but instead he fixes things himself. The Maintenance Director stated the refrigerator door was left open too long on the freezer which caused ice to develop. Record review of the facility's policy, Food Storage effective August 1, 2018, and Revised February 6, 2024: April 8, 2025, revealed, Policy: Sufficient storage facilities are provided to keep food safe, wholesome, and appetizing. Food is stored, prepared and transported at an appropriate temperature and by methods designed to prevent contamination.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a therapeutic diet that take into account the resident's clinical condition for one (Resident #86) of six residents reviewed for diet status and maintenance. The facility failed to offer Resident #86 the right diet as indicated in the residents' physician orders. These failures could increase the resident's risk for aspiration and choking. Record Review of Resident #86's admission MDS dated [DATE] reflected Resident #86's admission date of 03/18/26. She was [AGE] year-old female with active diagnoses included: acute respiratory failure with hypoxia, pneumonia, and pleural effusion (buildup of excess fluid between the layers of the pleura outside your lungs), malnutrition (imbalance between the nutrients your body needs to function and the nutrients it gets) and dysphagia (difficult swallowing). Nutrition and swallowing status reflected the resident had loss of liquids/solids from mouth when drinking or eating, holding food in the mouth/cheeks or residual food in mouth after meals, coughing or choking during meals or swallowing medications, and complaints of difficulty or pain with swallowing. Resident #86 was required to eat mechanically altered diet - require change in texture of food or liquids (e.g puree food, thickened liquids). Record Review of Resident #86's physician order revealed an order for puree consistency diet with an order date of 03/31/26 and status as active (current). Record Review of Resident #86's comprehensive plan of care dated, 03/24/26 revealed the following, Problem; [Resident #86] at risk for weight changes due to poor PO intake, malnutrition, failure to thrive, she refused a G-tube (is a medical device inserted through the abdominal wall directly into the stomach to provide nutrition, fluids, and medication when oral intake is insufficient) placement for nutrition at the hospital prior to admitting to the facility. Intervention: provide diet as ordered. In an observation and interview on 03/31/26 at 1:04 PM during lunch meal it was revealed that Resident #86 was in her room up in the wheelchair. The resident was served puree diet meal, but fruit cobbler was not pureed, she was served a regular diet. The resident had not eaten the puree food, and she was observed taking a few bites of the fruit cobbler which was regular consistency. RN E went into the room and witnessed and confirmed the resident was served a regular diet dessert, left the room and she stated she was to confirm with dietary. No choking or coughing was noted with the resident. In an interview on 03/31/26 at 1:12 PM with RN E When RN E reviewed the resident's clinicals record, she stated the resident was supposed to be eating only puree diet. She checked the resident records and stated the resident had a diagnosis of dysphagia and that was the reason why she was on puree diet. RN E stated she was supposed to check the tray before being served to the resident, but she did not because by the time she came to the hall the resident had already been served. RN E stated the resident was at risk of choking if she ate regular diet meal. In an interview on 04/01/26 at 12:28 PM with Regional Dietary Consultant, she stated she was made aware of Resident #86 being served a regular dessert. She stated it was a facility wide responsibility to check the food trays when they were being served, from the kitchen and then when they were being served on halls. Regional Dietary Consultant stated when serving meals the staff were to check to make sure the ticket matched the meals that were served. She stated the resident was at risk of getting pneumonia if she was served the wrong diet. In an interview on 04/01/26 at 01:36 PM with the Dietary Aide revealed he was the one who served the meals from the kitchen to the hall trays. The Dietary Aide stated it was an overlook and he missed to see that the resident had a regular desert. After the incident the dietary aide stated he was in-serviced on making sure the meals being served matched the meal ticket in the tray and making sure they were checked correctly. The dietary aide stated the resident was at risk for choking if she was not served the right meal. In an interview on 04/02/26 at 11:15 AM with Housekeeper revealed he was the one who served Resident #86 the lunch meal tray on 03/31/26 that had the regular diet desert. He stated he normally assisted with serving the trays on the halls. He stated he did not check the ticket with the meals the resident was served to make sure the resident (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was served the right meal. The housekeeper stated previously he had not been in-serviced on serving meal trays on the hall, but after the incident he had been in-serviced and educated to make sure the nurse checked the meal trays before they meals were served to the residents. In an interview on 04/02/26 at 11:28 AM with the DON she stated she was made aware of Resident #86 being served the regular dessert instead of puree. She stated the staff were expected to check the trays before being served to the residents. The nurses or aides on the halls were to check the tickets and make sure the tickets matched the meals that were served. The DON stated Resident #86 was served by the housekeeper and seemed like the meal trays were not checked by the nurse before being served. The housekeeper was in-serviced on making sure the meal trays were checked by the nurses before being served. The DON stated Resident #86 was at risk for aspiration from being served the wrong diet. Review of the facility policy revised 02/06/24 and titled Nutrition Services reflected, Tray line positions and set up procedures should promote an efficient and accurate meal service. Each tray will be checked for; correct name, room number and diet order.

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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 interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 5 Residents reviewed for medication administration (Resident #26). The facility failed to ensure Resident #26 swallowed his medication before the staff member left the resident's room. This failure could place Residents at risk for missed doses, ineffective treatment, and potential decline in condition.Findings Included:Record review of Resident #26's Quarterly MDS Assessment, dated 03/23/26, reflected the Resident was a [AGE] year-old male with a BIMs score of 11 indicating he was moderately cognitively impaired. His diagnoses included: Coronary Artery Disease (a condition where the arteries that supply blood to the heart become narrowed or blocked by plaque, a buildup of fatty deposits, cholesterol, and other substances), Hypertension (blood pressure is consistently too high, which can strain the heart and blood vessels), and Peripheral Artery Disease (blood has trouble getting to your legs or arms because the blood vessels or arteries are narrowed or blocked). Record review of Resident #26's Comprehensive Care Plan dated 04/02/2026, reflected the plan did not address any goals or interventions to self-administer medications. Record review of Resident #26's Physician's Orders, dated 04/01/2026 through 04/30/2026, reflected there were no orders for Resident #26 to self-administer medications. During observation and interview with Resident #26 in his room on 03/31/26 at 9:36 AM, resident was observed lying in bed, awake and alert. He stated he needed just a minute to talk as he was finishing up taking his medication. The Resident was observed taking a drink and swallowing an unknown medication. He stated the nurse who gave him the medication just brought it before the surveyor walked in and then the nurse left. He said the nurse did not stay to watch him swallow the medication. He said the nurse usually would stay to watch but sometimes doesn't. The resident reported he did not have any difficulty swallowing his medication. During an interview on 3/31/26 at 9:57 AM with RN F, she reported she was responsible for administering medications to Resident #26. She reported she gave Resident #26 his medication and stepped out of the room because someone was calling for her in the hallway. She stated she did not witness Resident #26 swallow his medication. She stated she usually would stay in the room to visually confirm the Resident swallows his medication. She stated the Resident is cognizant but could not see. RN F stated Resident #26 did not have orders to take medications without supervision. RN F stated the risk to residents if they were not supervised while taking medications was that they might not take all of their medications. During an interview with the on 04/02/2026 at 11:30 AM with the DON, she reported there were no allowances or orders for Resident #26 to take unsupervised medication. The DON stated the facility policy was that a staff administrating medication to a resident was to stay with the resident until the medication was swallowed. She stated staff are to visually confirm the resident swallowed the medication. Review of Facility's Policy/Procedure - Nursing Services titled: Medication Administration General Guidelines dated 01/2024 reflected: The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store drugs and biologicals in locked compartments based on the needs of one of five residents (Resident #16) reviewed for medication storage.The facility failed to ensure Resident #16 did not have unsecured Glipizide 10 MG tablet (an oral medication used to treat Type 2 Diabetes) in his room.This failure could place residents at risk for compromised medication efficacy, unsafe administration, and increased harm to residents.Findings Included:Record review of Resident #16's MDS assessment dated [DATE], reflected a [AGE] year-old male, admitted to the facility on [DATE]. The Resident's BIMS score was 8 which indicated moderate cognitive impairment. The Resident had diagnoses that included: Alzheimer's Disease (a brain disease that slowly destroys memory, thinking, and the ability to carry out daily tasks), Type 2 Diabetes (a condition where the body can't properly use sugar for energy, leading to high blood sugar and possible complications), and Depression (persistent sadness and loss of interest that interferes with daily life). Record review of Resident #16's Care plan dated 04/01/2026, reflected the plan did not address any goals or interventions related to the medication that was at bedside or orders to self-administer medications.Record review of Resident #16's active Physician's Orders, dated 04/01/2026 through 04/30/2026, reflected an active order for Glipizide 10 MG Tablet to be taken 1 tablet by mouth twice a day at 7AM and 8PM.Record review of Resident #16's Physician's Orders, dated 04/01/2026 through 04/30/2026, reflected there were no orders for Resident #16 to self-administer medications.During observation and interview with Resident #16 in his room on 03/31/26 at 9:37 AM, resident was observed lying in bed, awake and alert. A round, white pill was observed on the floor between his bed and his roommate's bed. Resident #16 reported the pill had been on the floor for several days and was probably his. He stated he took his medication this morning. He reported he was not sure if he had missed a dose of medication recently.During an interview on 3/31/26 at 9:57 AM with RN F, she reported she was responsible for administering medications to Resident #16. She identified the pill in Resident #16's room as Glipizide. She stated the medication was used to treat diabetes and belonged to Resident #16. She stated she knew it was his because his roommate did not have diabetes and Resident #16 did. She stated she was not sure how it ended up on the floor. She stated it could have fallen out of the resident's mouth. She stated she could only assume it fell out because she did not see it happen. She stated she had stayed this morning to make sure the Resident swallowed the medication. RN F destroyed the medication, she stated she would then notify the DON and the resident's physician.During an interview with the on 04/02/2026 at 11:30 AM with the DON, she reported there were no allowances or orders for Resident #16 to have medication unsecured in his room. She stated any missed medication doses are documented and addressed by notifying the MD. She denied Resident #16 having any complications of a missed diabetes medication dose. The DON also denied any other residents having complications of missed medication doses.Review of the facility's policy Storage of Medication Revised January 12, 2020, reflected the following: Staff will store medications in accordance with standard practice guidelines. Refer to the Pharmerica Nursing Care Center Pharmacy Policy & Procedure Manual regarding bedside medication storage.