

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Kent County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1443 North Main Jayton, TX 79528	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to provide food that was palatable, attractive and at a safe and appetizing temperature for one of one kitchen reviewing for food and nutrition services. A. Residents #12, #15, and #49 complained the food was served cold. B. 7 of the 9 foods sampled on the meal tray were cold. These failures could place residents at risk of decreased food intake, hunger, unwanted weight loss, and food borne illnesses. The findings included: During an interview on 12/02/2025 at 11:27 AM, Resident #12 stated The food is not good sometimes, I do get cold meals, and it happens most times. The resident stated he ate in the dining and his room sometimes. The resident stated his meals were rarely ever hot or warm enough. During an interview on 12/02/2025 at 11:46 AM, Resident #49 stated The food is off and on, good one day and not the other day, sometimes the food is cold, and it happens always. The resident stated she ate in her room daily. The resident stated her food did not taste good because it was not hot or warm enough. During an interview on 12/02/2025 at 12:12 AM, Resident #15 stated The food is good at times and sometimes not, the food is cold. The resident stated she ate in her room most times. The resident stated this had been an ongoing issue and most meals had been served cold. The resident stated she rarely ever received warm or hot food during meal services. A sample tray was requested on 12/03/2025 at 11:14 AM for all the food forms served and to have the sample trays delivered after the last hall tray were served. During an observation on 12/03/2025 at 12:20 PM, a test tray was provided by [NAME] B, [NAME] C and CNA D. Sample tray findings found by the Surveyor and CNA D were the following: FOOD ITEMS Tempt, TimeRegular Pork (100.28 F)/12:21PMMechanical Pork (105.44 F)/12:21PMPuree Pork (100.96 F)/12:22PMRegular Black-eyed Peas (101.28 F)/12:23PM Puree Black-eyed Peas (100.22 F)/12:23PMRegular Spinach (103.96 F)/12:24PM Puree Spinach (108.68 F)/12:24PM During an interview on 12/04/2025 at 10:13 AM, [NAME] B stated residents never complained that the food was cold, her responsibility was to make sure residents' food was kept and maintained at the right temperature. She stated, Maybe when we take the food out, it stays too long on the cart before the CNA's gets it to the residents. During an interview on 12/04/2025 at 10:29 AM, [NAME] C stated Probably, the cart stays out there too long, occasionally I have seen the cart out there while taking out another one. [NAME] C further stated she reported such to other kitchen staff members, since it was their responsibility to ensure food was served hot. During an interview on 12/04/2025 at 10:39 AM, the DM stated residents never complained that the food was cold. She stated she took temperatures of each food item before it was served to ensure it was at a proper temperature. The DM stated the temperature log was showing lunch was served at proper temperatures. The DM stated she verified the temperatures were adequate right from the steam table. The DM stated this was logged for each meal including at lunch time on 12/03/25. She stated a request of the Food Temperature log was made by the Surveyor. The DM stated she did not know why the test tray contained food that was only slightly warm and/or cold. The DM stated the test tray was served after the last tray was served to the residents. The DM stated she did not know how long it took for nursing staff to distribute residents' room trays. The DM stated if food was not served at a safe temperature, food would no longer be palatable, and residents would get sick. During an interview on 12/04/2025 at 11:09 AM CNA D stated residents did complain about food being cold (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sometimes. She stated, The food is not warm enough/hot because it takes me long to set up the residents while serving their food and maybe because we do use open carts, I suggest we get the closed ones. CNA D stated if food was not served at a safe temperature, residents would not eat, and eventually they would lose weight. During an interview on 12/04/2025 at 11:42 AM, the ADM stated It is not pleasant, especially if some of the residents like their food warm/hot, if food was not served at a safe temperature obviously one can have a food borne disease. The ADM stated it was his expectation that food trays would be served as soon as they were delivered to each hallway. He stated there must have been a communication breakdown between the kitchen and nursing staff. The ADM stated the DM was responsible for the cooks. Record Review of the facility's document on 12/04/2025 titled, Food Temperature Log dated December 2025, revealed the followings: Lunch: Meat (regular)- 175 degrees; Meat (puree)- 138 degrees; Starch Meat (Mechanical)- 188 degrees; Spinach (regular)- 171 degrees; and Spinach (puree)- 170 degrees. Record Review of the facility's undated policy titled, Food Holding and Service revealed the following: Policy Statement: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be held and served according to the state and US Food Codes and HACCP guidelines. Procedures 1. Serve all hot foods at a temperature of 135 F or greater and all cold food at 41 F or less. Adjust the temperature to account for the time the food will be held prior to service on the steam table and on the tray cart. 4. If hot foods drop below 135 F, reheat to 165 F for a minimum of 15 seconds.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review, the facility failed to ensure resident had the right to be treated with respect and dignity, including the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 2 of 4 residents (Resident #3 and #48) observed for physical restraints. Resident #3 and #48 failed to have physician orders for position change alarm (chair alarm) for fall prevention. This failure puts residents at risk of being restrained without justification of the need for a restraint. Findings included: Resident #3 Record review of Resident #3's face sheet, dated 12/3/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (decline in cognitive abilities), muscle weakness, unsteadiness on feet, anxiety (feeling of fear and worry), hypertension (high blood pressure), and major depression disorder (mental health condition that causes a persistently low or depressed mood and loss of interest in activities). Record review of Resident #3's Comprehensive Minimum Data Set, dated [DATE], revealed Resident #3 had a BIMS score of 05 which indicated Resident #3's cognition was severely impaired. Section P revealed no chair alarm in use. Record review of Resident #3's care plan, dated 10/15/2025, revealed a care plan for falls related to weakness, history of falls and dementia. Interventions revealed the resident was able to manipulate the chair/bed pressure alarm physically, turn the alarm off, and the alarm was discontinued. Record review of Resident #3 physician orders dated 12/3/25 revealed no order for position change alarm (chair alarm). During an observation on 12/3/2025 at 03:00 PM Resident #3 was up in wheelchair. Position change alarm (chair alarm) was in place and turned on. During an observation on 12/4/2025 at 09:00 AM Resident #3 was up in wheelchair. Position change alarm (chair alarm) was in place and turned on. Resident #48 Record review of Resident #48's face sheet, dated 12/4/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (decline in cognitive abilities), muscle wasting and atrophy left lower leg (decrease in muscle mass and strength), anxiety (feeling of fear and worry), hypertension (high blood pressure), and major depression disorder (mental health condition that causes a persistently low or depressed mood and loss of interest in activities). Record review of Resident #48's Comprehensive Minimum Data Set, dated [DATE], revealed Resident #48 had a BIMS score of 0 which indicated Resident #48's cognition was severely impaired. Section P revealed no chair alarm in use. Record review of Resident #48's care plan, dated 06/06/2025, revealed a care plan for falls related to confusion. No care plan for position change alarm (chair alarm). Record review of Physician Orders dated 12/4/25 revealed no orders of position change alarm (chair alarm). During an observation on 12/3/2025 at 03:30 PM Resident #48 was up in reclined Geri-chair (medical recliner) with position change alarm in place and turned on. During an observation on 12/4/2025 at 09:00 AM Resident #48 was up in reclined Geri-chair (medical recliner) with position change alarm in place and turned on. During an interview on 12/4/25 at 09:20 AM with the DON, he stated position change alarms were used as an intervention for falls. He stated the position change alarms alerted the staff when the resident changed position. He stated the resident should have had an order for the position change alarm. The DON reviewed Residents #3 and #48 physician orders. He stated Residents #3 and #48 did not have a physician order for the position change alarm. During an interview on 12/4/25 at 11:06 AM with the ADM, he stated position change alarms were used as an intervention for falls. He stated position change alarms should have an order. He stated all staff had received training on the position change alarm policy and procedures. He stated the facility did not have a system to monitor position change alarms, and they needed to develop a system. He stated he did not think position change alarms would be considered a restraint. He stated he was not aware Residents #3 and #48 did not have a physician order for the position change alarm. He stated the potential negative outcome of (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placing a position change alarm without a physician order could be not following physician orders and the physician not being notified. During an interview on 12/4/25 at 11:29 AM with the DON, he stated they did not have a specific system for monitoring position change alarms. He stated the DON and ADON reviewed physician orders for updates. He stated all staff received training on position change alarm policy and procedures. He stated his expectations were for position change alarms to have a physician order documenting the need. He stated he was not aware Residents #3 and #48 did not have a physician order for the position change alarm. He stated the purpose of a physician order would be to make the physician aware of the position change alarm usage. He stated the potential negative outcome of not having a physician order could be placing a position change alarm without the physician knowledge and the resident or family not being notified. Restraint policy requested from facility on 12/8/25 at 4:26 pm via email. ADM responded on 12/8/25 at 9:27 pm with the following I've attached the only thing I've found pertaining to fall alarms, which is located on the second page & listed as #8 under the Resident-Centered Approaches to Managing Falls and Fall Risk section. Record review of the provided facility policy titled Falls and Fall Risk, Managing with a revised date of March 2018 revealed the following: Policy Statement: Based on previous and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident-Centered Approaches to Managing Falls and Fall Risk.8. Position-change alarms will not be used as the primary or sole intervention to prevent falls but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner.		

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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 record review and interview, the facility failed to develop a comprehensive care plan to meet the highest practicable physical, mental, psychosocial well-being for 2 of 22 residents (Residents #3 and Resident #48) reviewed for care plans. Residents #3 and 48 did not have a care plan for position change alarm (chair alarm). This failure could place residents at risk of not receiving the care required to meet their individual needs. Findings include: Resident #3 Record review of Resident #3's face sheet, dated 12/3/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (decline in cognitive abilities), muscle weakness, unsteadiness on feet, anxiety (feeling of fear and worry), hypertension (high blood pressure), and major depression disorder (mental health condition that causes a persistently low or depressed mood and loss of interest in activities). Record review of Resident #3's Comprehensive Minimum Data Set assessment, dated 01/11/25, revealed Resident #3 had a BIMS score of 05 which indicated Resident #3's cognition was severely impaired. Section P revealed no chair alarm in use. Record review of Resident #3's care plan, dated 10/15/2025, revealed a care plan for falls related to weakness, history of falls and dementia. Interventions revealed the resident was able to manipulate the chair/bed pressure alarm physically, turn the alarm off, and the alarm was discontinued. During an observation on 12/3/2025 at 03:00 PM, Resident #3 was up in wheelchair. Position change alarm (chair alarm) was in place and turned on. During an observation on 12/4/2025 at 09:00 AM, Resident #3 was up in wheelchair. Position change alarm (chair alarm) was in place and turned on. Resident #48 Record review of Resident #48's face sheet, dated 12/4/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include dementia (decline in cognitive abilities), muscle wasting and atrophy left lower leg (decrease in muscle mass and strength), anxiety (feeling of fear and worry), hypertension (high blood pressure), and major depression disorder (mental health condition that causes a persistently low or depressed mood and loss of interest in activities). Record review of Resident #3's Comprehensive Minimum Data Set, dated [DATE], revealed Resident #48 had a BIMS score of 0 which indicated Resident #48's cognition was severely impaired. Section P revealed no chair alarm in use. Record review of Resident #48's care plan, dated 06/06/2025, revealed a care plan for falls related to confusion. No care plan for position change alarm (chair alarm). During an observation on 12/3/2025 at 03:30 PM, Resident #48 was up in reclined Geri-chair with position change alarm in place and turned on. During an observation on 12/4/2025 at 09:00 AM, Resident #48 was up in reclined Geri-chair with position change alarm in place and turned on. During an interview on 12/4/25 at 09:20 AM with the DON, he stated the position change alarm should be care planned. DON record review Residents #3 and #48 care plans and stated position change alarm had not been care planned. During an interview on 12/4/25 at 11:06 AM with the ADM, he stated the position change alarms was used as an intervention for falls. He stated position change alarms should be care planned. He stated all staff had received training on the position change alarm policy and procedure. He stated the facility did not have a system to monitor position change alarms and they needed to develop a system. He stated he did not think position change alarms would be considered a restraint. He stated he was not aware Residents #3 and #48 did not have a care plan for the position change alarm. He stated the purpose of the care plan was a customized plan of care for each resident. He stated the potential negative outcome of the position change alarm not being care planned could be the resident's interventions not put into place. During an interview on 12/4/25 at 11:29 AM with the DON, he stated the purpose of the care plan was a customized care plan that was individualized needs for the residents. He stated the care plan was used to get to know the residents and what their needs were. He stated the MDS nurse was responsible for care planning. He stated the MDS nurse was off and not in the facility today (12/4/25). He stated they did not have a specific system for monitoring position change alarms. He (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the DON and ADON reviewed care plans for updates. He stated all staff received training on how to use the care plan. He stated his expectations was for all position change alarms to be care planned. He stated he was not aware Residents #3 and #48 did not have a care plan for position change alarm. He stated the potential negative outcome of position change alarms not being care planned could be miscommunication and not providing interventions for the residents. Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered, revised [DATE], reflected:Policy Statement - A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Policy Interpretation and Implementation.2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.8. The comprehensive, person-centered care plan will: .b. Describe the services that are to be furnished to attain or maintain the residents' highest practical physical mental and psychosocial well-being.c. Describe services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights including the right to refuse treatment.g. Incorporate identified problem areas.h. Incorporate risk factors associated with identified problems.j. Reflect the resident's expressed wishes regarding care and treatment goals.k. Reflect treatment goals, timetables and objectives in measurable outcomes; .9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan.10.Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.11.Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.a., when possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers.b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident.13. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.14. The Interdisciplinary Team must review and update the care plan:a. When there has been a significant change in the residents' condition.b. When the desired outcome is not met.c. When the resident has been readmitted to the facility from a hospital stay; andd. At least quarterly, in conjunction with the required quarterly MDS assessment.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored and maintained in accordance with currently accepted professional standards for 1 of 2 medication carts (Medication Cart 2) reviewed. The facility failed to ensure 11 loose pills in Medication Cart 2 were properly labeled or stored. This failure could place residents at risk for medication errors and drug diversion. The findings include: During an observation of Medication Cart 2 with LVN A and the DON on [DATE] at 10:02AM, 11 loose pills were found in the second drawer. During an interview on [DATE] at 10:21 AM with LVN A, she stated she had been trained to check the medication carts daily for loose pills and weekly for expired items. She stated the person receiving the cart was responsible for making sure the carts were clean and free of loose pills. She stated her last training on the medications carts was in [DATE]. She stated the potential negative outcome could be the residents running out of medication. She stated if she saw a pill in there or dropped a pill into the cart, she would take it out and discard the pill so there would be no risk of giving a resident the wrong medication. She stated nursing staff are expected to check the narcotic counts, keep the carts clean and up to date, and make sure they were stocked. During an interview on [DATE] at 11:13 AM with the DON, he stated he had been able to identify the pills found in Medication Cart 2. He stated the 2 yellow oval pills with H126 printer on the front were Pantoprazole Sodium Delayed- Release 40mg each (medication used to treat and prevent acid reflux). The 3 yellow capsules with 470 printed, were Gabapentin 300mg (medication to treat nerve pain). The 1 large white oval pill was Potassium Chloride 20 meq (supplement to treat low potassium). The small white round pill was metoprolol 25mg (medication used to treat high blood pressure). The 1 small round maroon colored pill was an AZO (over the counter medication used to treat urinary tract burning sensations). The 1 blue capsule was duloxetine delayed release 30mg (medication used to treat depression or anxiety). The 1 pink tablet was levothyroxine 50mcg (medication used to treat low thyroid), and the 1 small round yellow pill was Eliquis 2.5mg (medication used to help prevent blood clots). During an interview with the ADM on [DATE] 09:08 AM, he stated staff were trained to check the carts for cleanliness, narcotic counts and the nurses should be checking the carts together before the off going nurse leaves. He stated if loose pills were in the cart, staff should report it to their DON and destroy the medication in the medication room. He stated a potential negative outcome of loose pills being in the cart could be giving residents the wrong medication, or medication not being properly labeled. During an interview with the DON on [DATE] at 9:46 AM, he stated staff were trained to check the carts for narcotic count, cleanliness, and address any concerns before the off going nurse left. He stated training occurred twice a year and in-services as needed. He stated his expectation of staff was to dispose of any loose pills in the pill destruction box in the medication room after confirming it was not a narcotic. He stated a potential negative outcome of loose pills could be residents running out of medication. He stated if staff dropped a pill into the medication cart, they were not to pull it out and administer it to the resident. He stated any pills that were dropped should be destroyed to prevent any medication errors or giving any wrong medications to any residents. Record review of the facility's policy titled Medication Labeling and Storage last revised 2001, revealed; Medication and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Medication Labeling: 1. Labeling of medications and biologicals dispensed by the pharmacy is consisted with applicable federal and state requirements and currently accepted pharmaceutical practices. 2. The medications label includes, at a minimum; a. medication name b. prescribed dose. C. strength. Expiration date, when applicable; e. resident's name; f. route of administration and g. appropriate instructions and precautions.		