STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195426	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Encore Healthcare and Rehabilitation Center	19110 Crowley-Eunice Hwy Crowley, LA 70526

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews, the facility failed to promote resident's dignity during dining by standing over residents while assisting them to eat for 1 (Resident #67) of 37 sampled residents.Findings: A review of the facility's policy titled, Dining and Meal Service Policy and Procedure with a last review date of 02/09/2025, read in part, The dining experience will be person centered with the purpose of enhancing each individual resident's quality of life and being supportive of each individual's needs during dining. The policy also indicated general guidelines, Appropriate staff will assist as needed to assure adequate intake of food and fluids at the meal while maintain the resident's dignity (staff to sit eye level with resident while assisting to feed).A review of Resident #67's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses that included in part, Alzheimer's Disease, Dysphagia, and Gastro-Esophageal Reflux Disease,A review of Resident #67's MDS (Minimum Data Set) dated 05/20/2025 revealed she had a BIMS (Brief Interview for Mental Status) of 04, indicating her cognition was severely impaired.A review of Resident #67's comprehensive care plan read, I require assistance for ADL's (Activity of Daily Living) impaired cognition with interventions that read in part, I require assistance with feeding.On 07/21/2025 between 12:10 p.m. - 12:20 p.m. an observation was conducted of S9LPN (Licensed Practical Nurse) standing up and feeding Resident #67 while in the dining room for lunch. Resident #67 was seated on her geri-chair. On 07/21/2025 at 12:42 p.m., an interview was conducted with S9LPN. She stated she was feeding Resident #67 in the dining room for lunch. She stated she was standing up while feeding the resident who was sitting down in her geri-chair. She confirmed she should have been sitting next to the resident while feeding her, and not standing over her. 07/22/2025 at 3:11 p.m. an interview was conduct with S3ADON (Assistant Director of Nursing) who confirmed that while feeding residents, the staff should be sitting down in front of the resident and at eye level with the resident.

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure a residents were safe to perform self-administration of medication for 1 (#61) out of 4 residents observed for medication administration. Findings:A review of the facility's policy titled Meds-Self Administration Policy and Procedure which was last reviewed on 02/09/2025, read in part, Policy: To maintain the residents' high level of independence, residents who desire self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the residents and other residents of the facility and there is a prescriber's order to self-administer. 1. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process. 2. For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of an assessment conducted on a quarterly basis or when there is a significant change in condition. Review of Resident #61's health record revealed he was admitted to the facility on [DATE] with diagnosis which included, but were not limited to allergic rhinitis. Review of Resident #61's MDS (Minimum Date Set) assessment with an ARD (Assessment Reference Date) of 05/15/2025, revealed he had a BIMS (Brief Interview for Mental Status) score of 15, indicating his cognition was intact. Review of Resident #61's physician orders revealed an order dated 09/03/2024, for Ipratropium Bromide Nasal Soln (Solution) 0.03% (21 mcg (micrograms)/spray) 1 spray in both nostrils two times a day related to Other allergic rhinitis. On 07/22/2025 at 8:22 a.m., an observation was made of S8LPN (Licensed Practical Nurse) administering medications to Resident #61. S8LPN handed Resident #61 his bottle of Ipratropium nasal spray. The resident then asked S8LPN if he was supposed to administer two sprays in each nostril. S8LPN replied, indicating that one spray in each nostril should be administered. She also responded to the resident stating, I know you like to cheat. Resident #61 was observed spraying two sprays of Ipratropium in each nostril. On 07/22/2025 at 2:10 p.m., an interview was conducted with S8LPN. She confirmed that Resident #61 did administer Ipratropium two sprays in each nostril and should not have. She stated that Resident #61 would not allow her to administer the nasal spray herself and confirmed that the resident was noncompliant with administering the correct dose. She stated that she was not aware of the facility's policy on self-administration of medication by residents. On 07/22/2025 at 2:15 p.m., an interview was conducted with S2DON (Director of Nursing) and S1CN (Corporate Nurse). S1CN confirmed that Resident #61 should have been assessed and care planned for the ability to self-administer his nasal spray and was not. S1CN further confirmed that Resident #61 should have had a physician's order to self-administer his nasal spray and he did not.

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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. Based on record review and interview, the facility failed to develop a person-centered comprehensive plan of care for 3 (#9, #73, #75) out of a final sample of 37 residents as evidenced by:1. Failing to develop a plan of care for Resident #9's hospice status, and;2. Failing to develop a resident centered comprehensive care plan for Resident #73 and #75.On 07/23/2025, a review of the facility's policy titled, Care Plan Policy and Procedure with a last reviewed date of 02/09/2025 read in part; A comprehensive person-centered care plan will be completed according to the RAI (Resident Assessment Instrument) manual upon admission, significant change, annual and as needed. Resident #9A review of Resident #9's EMR (Electronic Medical Record) revealed an admission date of 07/23/2020 with diagnoses that included, Hemiplegia and Hemiparesis Following Cerebral Infarction, Acute Kidney Failure, and Hypertensive Heart Disease. Review of Resident #9's MDS (Minimal Data Assessments) assessments revealed a comprehensive assessment indicating hospice services completed on 06/05/2025.Review of Resident #9's physician's orders revealed an order to admit to hospice services. Review of Resident #9's person-centered care plan failed to reveal the resident had a plan of care to reflect the Resident's hospice status. Resident #73Review of Resident #73's EMR revealed an admission date of 05/19/2025 with diagnoses that included, Pneumonitis, Paroxysmal Atrial Fibrillation, and Anxiety Disorder. Review of Resident #73's MDS assessments revealed an admission MDS assessment was complete on 05/30/2025.Review of Resident #73's person-centered care plan revealed it was incomplete.Resident #75Review of Resident #75's EMR revealed an admission date of 06/16/2025 with diagnoses that included, Pneumonia, Sepsis, and Paroxysmal Atrial Fibrillation. Review of Resident #75's MDS assessments revealed an admission MDS assessment was complete on 06/22/2025.Review of Resident #75's person-centered care plan revealed it was incomplete. On 07/23/2025 at 10:35 a.m., a concurrent records review and interview was conducted with S6MDS. S6MDS stated person-centered care plans should be updated and/or completed according to the RAI manual which is no later than 7 days after the completion of a comprehensive assessment. Resident #7's records reviewed at this time. S6MDS confirmed the resident had been admitted to hospice services and her last MDS comprehensive assessment was on 06/05/2025 making the current plan of care, which failed to include a hospice plan, overdue. Interview and records review continued for Resident #73. S6MDS viewed and confirmed Resident #73 admission MDS assessment was completed 05/30/2025. S6MDS viewed Resident #73's person-centered care plan and confirmed it was not complete and was overdue. Further interview and records review done with S6MDS for Resident #75. S6MDS viewed Resident #75's admission MDS assessment and confirmed it was completed on 06/22/2025. She then viewed Resident #75's person-centered care plan and confirmed it was not complete and was overdue.

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	195426	A. Building B. Wing	07/23/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming for 1 (#25) out of 37 sampled residents. Findings:Review of Resident #25's electronic medical record revealed she was admitted on [DATE] with diagnosis included, but not limited to, Vascular Dementia, Psychotic Disturbance, Cognitive Communication Deficit, Anxiety and Major Depression.Review of Resident #25's quarterly MDS (Minimum Data Set) dated 06/24/2025 revealed her BIMS (Brief Interview for Mental Status) score was 5, indicating her cognition was severely impaired. Review of Resident #25's current Care Plan Report read in part, I require staff assistance for ADL's (Activities of Daily Living) due to Impaired Cognition. Assist me with hygiene and grooming tasks. On 07/22/2025 at 8:57 a.m., Resident #25 was observed in the Beauty Shop. She had multiple hairs growing on her chin approximately 1/2 inch long. On 07/22/2025 8:58 a.m., S7HairDresser observed Resident #25's hair on her chin and she confirmed the resident's hair on her chin was long and should have been cut. On 07/22/2025 at 9:05 a.m., an interview with S4CNASupervisor (Certified Nursing Assistant Supervisor) confirmed Resident #25's hairs on her chin were long and needed to be cut. She stated the residents get a shower on Mondays, Wednesdays and Fridays and staff should have ensured that the residents were groomed on these days. On 07/22/2025 at 9:10 a.m., S1CN (Corp Nurse) confirmed the resident had poor cognition and the staff were to groom the residents that required assistance with grooming. She stated S4 C.N.A. Supervisor should have ensured Resident #25 did not have overgrown facial hair on her chin.

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	195426	A. Building B. Wing	07/23/2025

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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 observations, interviews, and record review, the facility failed to provide pharmaceutical services, including accurate administration of all drugs and accurately documenting controlled medication reconciliation as evidenced by:1 (#9) of 4 (#9, #36, #41, and #61) residents observed for administration of drugs, the facility failed to ensure Resident #9's Nifedipine was administered per manufacturer's recommendations, andin Med Cart C the facility failed to ensure Resident #79's controlled medication reconciliation was accurately maintained.Findings: Resident #9: A review of the facility's policy titled Medication Administration-General Guidelines which was last reviewed on 02/09/2025, read in part, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices. vi. Tablet Crushing/Capsule Opening: Crushing tablets may require a physician's order. 1. Long-acting or enteric-coated dosage forms should not be crushed; an alternative should be sought. Review of Resident #9's health record revealed she was admitted to the facility on [DATE] with a diagnosis which included, but were not limited to essential (primary) hypertension and hypertensive heart disease without heart failure. Review of Resident #9's physician orders revealed an order dated 04/30/2025 for Procardia XL oral tablet extended release 24 hour 90 mg (milligrams) (Nifedipine) Give 1 tablet by mouth one time a day. Reference: https://labeling.pfizer.com/showlabeling.aspx?id=542 On 07/22/2025 at 7:46 a.m., an observation was made of S9LPN (Licensed Practical Nurse) administering medications to Resident #9. S9LPN was observed administering Nifedipine extended release to Resident #9 after crushing it. On 07/22/2025 at 1:51 p.m., an interview was conducted with S9LPN. She confirmed that she had administered Nifedipine extended release to Resident #9 crushed and should not have. On 07/22/2025 at 2:15 p.m., an interview was conducted with S2DON (Director of Nursing) and S1CN (Corporate Nurse). S1CN confirmed that Nifedipine Extended Release should not have been administered crushed to Resident #9. Resident #79: A review of the facility's policy titled, Medication – Controlled Substances Policy and Procedure with a last review date of 02/09/2025, read in part, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. The policy also indicated general guidelines, When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): a. date and time of (continued on next page)

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	195426	A. Building B. Wing	07/23/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration (MAR, Narcotic Record); b. amount administered (Narcotic Record); c. remaining quantity (Narcotic Record); and d. initials of the nurse administering the dose, completed after the medication is administered (MAR, Narcotic Record). A review of Resident #79's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, Malignant Neoplasm of Colon and Secondary Malignant Neoplasm Liver and Intrahepatic Bile Duct. A review of Resident #79's physician's orders revealed a start date of 07/22/2025: Oxycodone-Acetaminophen Tablet 7.5-325 mg (milligram) Controlled Drug Give 1 tablet by mouth four times a day for pain. A review of Resident #79's Oxycodone-Acetaminophen Tablet 7.5-325 mg administration details in the EHR (electronic health record) revealed the controlled drug was administered on 07/23/2025 at 12:09 p.m. A review of the facility's form labeled, Individual Patient's Narcotic Record, for Resident #79 failed to reveal the administration of Oxycodone-Acetaminophen Tablet 7.5-325 mg on 07/23/2025 at 12:09 p.m. On 07/23/2025 at 1:21 p.m., a controlled drug count and interview was conducted with S10LPN (Licensed Practical Nurse). A review of Resident #79's Individual Patient's Narcotic Record, for Oxycodone-Acetaminophen Tablet 7.5-325 mg give 1 tablet by mouth 4 times per day stated that 6 tablets were supposed to be in the Oxycodone-Acetaminophen Tablet 7.5-325 mg medication card. Medication card reviewed with S10LPN for Resident #79's Oxycodone-Acetaminophen Tablet 7.5-325 mg which revealed 5 tablets. S10LPN stated she just administered Resident #79's Oxycodone-Acetaminophen Tablet 7.5-325 mg, and forgot to sign it off on the resident's Individual Patient's Narcotic Record, because she got busy doing other things. She confirmed that she should have documented on Resident #79's Individual Patient's Narcotic Record, before administering the medication and she did not. On 07/23/2025 at 1:30 p.m. a record review and interview was conducted with S3ADON (Assistant Director of Nursing). She stated in the EHR under administration details for Resident #79's Oxycodone-Acetaminophen Tablet 7.5-325 mg it was administered on 07/23/2025 at 12:09 p.m. by S10LPN. S10LPN reviewed Resident #79's Individual Patient's Narcotic Record for Oxycodone-Acetaminophen Tablet 7.5-325 mg and confirmed the 12:09 p.m. dose on 07/23/2025 was not documented and it should have been.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the medication error rate was less than 5%. A total of 33 opportunities were observed with 2 medication errors, which resulted in a medication error rate of 6.06%. FindingsA review of the facility's policy titled Medication Administration-General Guidelines which was last reviewed on 02/09/2025, read in part, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices. vi. Tablet Crushing/Capsule Opening: Crushing tablets may require a physician's order. 1. Long-acting or enteric-coated dosage forms should not be crushed; an alternative should be sought. 2. Administration: b. Medications are administered in accordance with written orders of the prescriber. Review of Pfizer Medical.com (Procardia XL Manufacture website), in part: Dosage and Administration. Procardia XL extended release tablets should be swallowed whole and should not ne bitten or divided.Resident #9Review of Resident #9's health record revealed she was admitted to the facility on [DATE] with a diagnosis which included, but were not limited to essential (primary) hypertension and hypertensive heart disease without heart failure.Review of Resident #9's physician orders revealed an order dated 04/30/2025 for Procardia XL oral table extended release 24 hour 90 mg (milligrams) (Nifedipine) Give 1 tablet by mouth one time a day. On 07/22/2025 at 7:46 a.m., an observation was made of S9LPN (Licensed Practical Nurse) administering medications to Resident #9. S9LPN was observed administering Nifedipine extended release to Resident #9 after crushing it. On 07/22/2025 at 1:51 p.m., an interview was conducted with S9LPN. She confirmed that she had administered Nifedipine extended release to Resident #9 crushed and should not have.On 07/22/2025 at 2:15 p.m., an interview was conducted with S2DON (Director of Nursing) and S1CN (Corporate Nurse). S1CN confirmed that Nifedipine Extended Release should not have been administered crushed to Resident #9.Resident #61 Review of Resident #61's health record revealed he was admitted to the facility on [DATE] with a diagnosis of allergic rhinitis. Review of Resident #61's physician orders revealed an order dated 09/03/2024, for Ipratropium Bromide Nasal Soln (Solution) 0.03% (21 mcg (micrograms)/spray) 1 spray in both nostrils two times a day related to Other allergic rhinitis. On 07/22/2025 at 8:22 a.m., an observation was made of S8LPN (Licensed Practical Nurse) administering medications to Resident #61. S8LPN handed Resident #61 his bottle of Ipratropium nasal spray. Resident #61 was observed spraying two sprays of Ipratropium in each nostril.On 7/22/2025 at 2:10 p.m., an interview was conducted with S8LPN. She confirmed that Resident #61 did administer Ipratropium two sprays which was not the correct dose. The facility failed to ensure the medication error rate was less than 5%. A total of 33 opportunities were observed with 2 medication errors, which resulted in a medication error rate of 6.06%.

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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. Based on observations and interviews, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles by failing to discard an expired medication in 1 (Med Cart C) of 2 (Med Cart B and Med Cart C) medication carts sampled for medication storage. Findings:On 07/23/2025 at 1:15 p.m., observation was conducted of Med Cart C with S10LPN (Licensed Practical Nurse) which revealed the following: 1 Aspirin 325 mg (milligram) bottle with an expiration date of 06/2025On 07/23/2025 at 1:21 p.m., an observation and interview was conducted with S10LPN who confirmed the expiration date on the Aspirin 325 mg bottle was 06/2025, and it should have been discarded and not in the med cart.On 07/23/2025 1:24 p.m., an interview was conducted with S3ADON (Assistant Director of Nursing). She confirmed that no expired medications should be in any med carts.