| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325067 | A. Building<br>B. Wing | 09/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Las Cruces Village Nursing & Rehabilitation LLC | 3025 Terrace Drive<br>Las Cruces, NM 88011 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to keep the resident free from neglect for 1 (R #8) of 3 (R #8, R #9, and R #10) residents reviewed for neglect when staff failed to conduct rounds (check on) on a resident and was left on the floor after a fall for 3 hours and 10 mins. This deficient practice could likely result in the resident suffering from lack of care, having anger, fear, and anxiety as a result of their neglect, and not getting the help she needs in a timely manner. The findings are: A. Record review of R #8's admission record, no date, revealed the following: 1. R #8 was admitted to the facility on [DATE]. 2. R #8 has the following diagnosis: a. Parkinson's disease with dyskinesia, with fluctuations (a condition where a person experiences the typical symptoms of Parkinson's disease, such as tremors, rigidity, and slow movements, along with involuntary, writhing movements). b. Repeated falls. c. Muscle weakness (generalized). d. Need for assistance with personal care. e. Dependence on a wheelchair. f. Disorientation (the condition of having lost one's sense of direction), unspecified. g. Unspecified abnormalities of gait and mobility (difficulty walking or moving that has no clearly identified cause or specific type). B. Record review of a video from the motion activated camera in R #8's room, revealed the following: 1. On 06/15/25 at 12:50 AM, R #8 was on the floor beside her bed. 2. On 06/15/25 at 3:59 AM, R #8 was heard shrieking and moaning. 3. On 06/15/25 at 4:01 AM, CNA #8 was seen entering R #8's room and finds R #8 on the floor. C. Record review of a video from the facility's camera revealed the following: 1. Staff entered R #8's room on 09/14/25 at 9:46 PM. 2. Staff did not reenter R #8's room again until 09/15/25 at 4:01 AM. D. On 09/08/25 at 2:31 PM, during an interview, R #8's daughter stated the facility called her and told her R #8 had fallen out of bed on the morning of 09/15/25. R #8's daughter stated she called her brother and asked him to review the video from R #8's room. R #8's daughter stated that is when they saw R #8 had fallen out of bed and been on the floor for 3 hours. R #8's daughter stated R #8 is not able to use the call light. R #8's daughter stated R #8 is nonverbal and not able to call out for help because she has Parkinson's disease. R #8's daughter stated R #8 is not able to ambulate (walk; move about) on her own. E. On 09/09/25 at 9:40 AM, during an interview, the Administrator stated that she had viewed the facility's video and confirmed staff did not go into R #8's room from 06/14/25 at 11:00 pm until 06/15/25 at 4:00 AM. The Administrator stated her expectation and the standard practice are for staff to conduct rounds on residents every two hours and more often if the resident is not able to call for help on their own. The Administrator confirmed R #8 could have been on the floor for 5 hours and that R #8 is not able to push the call light, call out for help, or get up on her own. |

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 |
|---|---|---|---|
| | 325067 | A. Building<br>B. Wing | 09/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Las Cruces Village Nursing & Rehabilitation LLC | 3025 Terrace Drive<br>Las Cruces, NM 88011 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide evidence for the alleged violations of neglect and exploitation were thoroughly investigated for 2 (R #8 and R #16) of 6 (R #8, R #9, R #10, R #16, R #17, and R #18) residents reviewed for allegations of neglect and misappropriation of property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent). If the facility does not keep evidence of investigations, then the state agency is unable to determine if a thorough investigation was completed and determine if the facility implemented appropriate actions to protect residents. The findings are:<br><br>R #8<br><br>A. Record review of R #8's admission record, no date, revealed R #8 was admitted to the facility on [DATE].<br><br>B. Record review of R #8's quarterly MDS assessment, dated 07/10/25, revealed he had a Brief Interview for Mental Status (BIMS a number between 0 and 15 that indicates a person's cognitive functioning) score of 0 (Severe Impairment 0-7).<br><br>C. Record review of the state agency's complaint intake dated 07/29/25 revealed R #8 had fallen out of bed and was left on the floor for approximately three hours without staff rounding (intentionally and regularly visit patients to assess their needs, discuss their care, and address potential issues proactively).<br><br>D. Record review of the facility's incident report dated 06/15/25, revealed the Administrator did not document that she interviewed all staff that worked the night of 06/14/25 and 06/15/25 when R #8 fell and was on the floor. The Administrator did not document that she spoke with R #8's family. The incident report did not contain any documentation that the facility's video was reviewed or the findings of the video.<br><br>E. On 09/09/25 at 12:18 PM, during an interview, the Administrator stated she did not have documentation of the interviews she did with the other staff and family of R #8. The Administrator stated she did view the facility's video, but she does not have documentation of the findings.<br><br>R #16<br><br>F. Record review of R #16's admission documents, no date, revealed resident was admitted to the facility on [DATE].<br><br>G. Record review of R #16's quarterly MDS, dated [DATE], revealed he had a BIMS score of 15.<br><br>H. Record review of R #16's grievance report, dated 07/31/25, revealed the following:<br><br>1. R #16 and the transportation worker met with SSD after returning from the bank.<br><br>2. R #16 reported there were many unauthorized transactions on his bank statement.<br><br>3. R #16 reported that $60 cash was missing from his wallet.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325067 | A. Building<br>B. Wing | 09/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Las Cruces Village Nursing & Rehabilitation LLC | 3025 Terrace Drive<br>Las Cruces, NM 88011 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4. R #16 kept his wallet wrapped in towels and Velcro.<br><br>5. The document had half a sentence and an arrow to turn the page over, however, there was no documentation on the back of the page or any other pages attached.<br><br>I. On 09/09/25 at 12:58 PM, during an interview, the Administrator stated the following:<br><br>1. She completed the investigation of R #16's allegation of misappropriation of property and was unable to determine who took R #16's money and the purchases with his card were not within the United States.<br><br>2. She did not have evidence to prove that the allegation of misappropriation of property was thoroughly investigated.<br><br>J. On 09/10/25 at 11:47 AM, during an interview, the corporate nurse confirmed the following:<br><br>1. Administrators are expected to document interviews that are conducted regarding investigations.<br><br>2. Administrators are expected to keep all documents related to an investigation. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325067 | A. Building<br>B. Wing | 09/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Las Cruces Village Nursing & Rehabilitation LLC | 3025 Terrace Drive<br>Las Cruces, NM 88011 |

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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to create an accurate baseline care plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) within 48 hours of admission for 1 (R #24) of 3 (R #24, R #26 and R #27) residents reviewed for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care and may place residents at risk of an adverse event (undesirable experience, preventable or non-preventable, that caused harm to a resident because of medical care or lack of medical care) or worsening of current condition after admission. The findings are: A. On 09/15/25 at 9:04 AM, during an interview with R #24's family member, she stated R #24 did not have a plan of care in place. B. Record review of R #24's admission Record, no date revealed R #24 was admitted into the facility on [DATE]. C. Record review of R #24's physician orders dated 08/25/25, revealed wound care to the sacrum (a large triangular-shaped bone located at the base of the vertebral column) area cleanse with wound cleanser and pat dry apply Collagen powder (a type of protein that forms the connective tissues in our bodies), and Barrier cream (a cream used to protect the skin from damage or infection) and cover with silicone dressing (a type of wound care product made from silicone gel or silicone-based materials) daily and PRN (as needed). D. Record review of R #24's progress notes dated 08/22/25 revealed staff documented R #24 had a small shallow sacral ulcer that was present on admission. E. Record review of R #24's admission MDS dated [DATE], revealed the following: 1. Staff documented R #24 had one-stage 2 pressure ulcer/injury (stage 2 pressure ulcers are characterized by partial-thickness skin loss into but no deeper than the dermis) that was present upon admission. 2. Staff documented R #24's need for pressure ulcer/injury care. F. Record review of R #24's baseline care plan, dated 08/22/25, revealed the following: 1. Staff did not document R #24's pressure ulcer. 2. Staff did not document R #24 need for wound care. G. On 09/16/25 at 1:31 PM during an interview with the DON, he confirmed R #24's baseline care plan did not indicate R #24 had a pressure ulcer. The DON also confirmed R #24's baseline care plan did not include the need for wound care. The DON stated his expectation is that the nurses should care plan the needs of residents within the first 48 hours of admission. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325067 | A. Building<br>B. Wing | 09/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Las Cruces Village Nursing & Rehabilitation LLC | 3025 Terrace Drive<br>Las Cruces, NM 88011 |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on observation, record review and interview, the facility failed to revise the care plan for 2 (R #8, and R #10) of 3 (R #8, R #9, and R #10) residents reviewed for neglect when they failed to revise the care plan for the resident's need for the following: 1. R #8 and R #10's briefs and approaches (any action, treatment, or strategy intentionally undertaken to prevent, treat, or improve an individual's health, functioning, or well-being). 2. R #8 and R #10's beds in lowest position and fall mats in place for fall risk. 3. R #8 no longer being an elopement (the unauthorized departure of a resident from the facility without the knowledge or supervision of staff) risk. This deficient practice could likely result in staff being unaware of changes in care being provided and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are:R #8 A. On 09/08/25 at 3:17 PM, during an observation of R #8's room, revealed R #8's bed was in the lowest position and there was a fall mat by her bed. R #8 was wearing a brief. B. Record review of R #8's care plan, dated 12/24/24, revealed the following: 1. R #8 is a high risk for falls. 2. The care plan did not contain any documentation of the bed being in the lowest position and a fall mat or approaches for the bed positioning and mat. 3. R #8 is incontinent of bowel and bladder (experiencing a loss of control over when you urinate and defecate). 4. The care plan did not contain any documentation of R #8's briefs and approaches. C. Record review of R #8's care plan, dated 07/10/25, revealed R #8 is at risk for elopement. D. Record review of R #8's quarterly minimum data set (MDS a standardized collection of essential clinical and demographic information about an individual or service, designed to create a comprehensive understanding of their condition, needs, or performance) revealed R #8 is dependent (helper does all effort, resident does none of the effort) for activities of daily living care (ADL basic self-care tasks). E. On 09/09/25 at 3:21 PM, during an interview, the DON stated care plans should document if a resident needs the bed in the lowest position and if a fall mat is needed. The DON confirmed R #8's care plan did not contain any documentation that R #8 requires the bed to be in the lowest position, a fall mat and the interventions for them. The DON confirmed R #8's care plan documents that R #8 is an elopement risk. The DON said that the resident is not able to get out of bed on her own and is not able to elope. The DON stated R #8's care plan should be updated to document that R #8 is not at risk for elopement. R #10 F. On 09/09/25 at 3:13 PM, during an observation of R #10's room revealed R #10's bed was in the lowest position and that there was a fall mat in her room. G. On 09/09/25 at 3:15 PM, during an interview, CNA #9 confirmed R #10's bed is in the lowest position and when R #10 is in bed, they put the fall mat down. CNA #9 said R #10 has a history of falls. H. Record review of R #10's care plan dated 06/19/25, revealed the following. 1. R #10 is a high risk for falls. 2. The care plan did not contain any documentation of the bed being in the lowest position, a fall mat and interventions for the bed positioning and fall mat.3. R #10 is incontinent of bowel and bladder. 4. The care plan did not contain any documentation of R #10's briefs and interventions. I. On 09/09/25 at 3:21 PM, during an interview, the DON confirmed R #10's care plan did not contain any documentation that R #10's requires fall mat and bed to be in the lowest position. The DON stated the approaches should be documented. The DON confirmed R #10 is incontinent of bowel and bladder. The DON stated that if a resident uses briefs, they should be care planned. The DON confirmed R #10's care plan did not contain any documentation R #10 wears briefs and the approaches for the briefs. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325067 | A. Building<br>B. Wing | 09/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Las Cruces Village Nursing & Rehabilitation LLC | 3025 Terrace Drive<br>Las Cruces, NM 88011 |

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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on record review, and interview, the facility failed to meet professional standards of quality care for 11 of 19 residents on the 400 Unit (residents were identified by the resident matrix provided by the Administrator on 09/08/25) when staff failed to round on residents (regularly check on residents to assess needs, safety and comfort). This deficient practice could likely lead to the residents' needs and care not being met. The findings are: A. Record review of the state agency's complaint intake dated 07/29/25 revealed R #8 had fallen out of bed and was left on the floor for approximately three hours without staff rounding. B. Record review of a video from the facility's camera of the 400 unit on 06/14/25 at 11:00 PM until 06/15/25 at 3:23 AM revealed staff did not round on the following rooms: 1. 401 with 2 residents. 2. 402 with 2 residents. 3. 404 with 2 residents. 4. 405 with 2 residents. 5. 406 with 1 residents. 6. 410 with 2 resident. C. On 09/09/25 at 9:40 AM, during an interview, the Administrator stated staff did not round as is expected. The administrator said that standard practice is that residents are rounded on at least every 2 hours. The Administrator confirmed the facility video revealed staff did not round on rooms 401, 402, 404, 405, 406, and 410 between 11:00 PM and 3:23 PM. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325067 | A. Building<br>B. Wing | 09/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Las Cruces Village Nursing & Rehabilitation LLC | 3025 Terrace Drive<br>Las Cruces, NM 88011 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide treatment and services specialized in managing and healing wounds that do not heal properly for pressure ulcers (damage to an area of the skin caused by constant pressure on the area for a long time) for 1 (R #24) of 3 (R #8, R #24 and R #25) residents reviewed for pressure ulcers, when staff failed to: Obtain wound care orders for R #24's pressure ulcer until three days after admission, Perform wound care for one day of the six days R #24 was in the facility. These deficient practices could likely result in the provider being unaware of the resident's current condition, leading to inconsistent interventions and worsening of pressure ulcers. The findings are:A. On 09/15/25 at 9:04 AM, during an interview with R #24's family member, she stated R #24 had a wound when he got to the facility and did not receive wound care on 08/21/25 (day of admission). R #24 received wound care on 08/25/25. B. Record review of R #24's face sheet no date, revealed R #24 was admitted to the facility on [DATE]. C. Record review of R #24's MDS dated [DATE], revealed the following: 1. Staff documented R #24 had one-stage 2 ulcer/injury (stage 2 pressure ulcers are characterized by partial-thickness skin loss into but no deeper than the dermis) pressure ulcer/injury that was present upon admission. 2. Staff documented a clinical assessment (a formal assessment instrument/tool (e.g., Braden, [NAME], or other) was completed for the pressure ulcer. D. Record review of R #24's physician orders dated 08/25/25, revealed wound care to the sacrum (a large triangular-shaped bone located at the base of the vertebral column) area cleanse with wound cleanser and pat dry apply Collagen powder (a type of protein that forms the connective tissues in our bodies), and Barrier cream (a cream used to protect the skin from damage or infection) and cover with silicone dressing (a type of wound care product made from silicone gel or silicone-based materials) daily and PRN (as needed). E. Record review of R #24's Treatment Administration Record (TAR, electronic document where facility staff document wound care was completed) for August 2025 revealed staff did not document any wound care provided to R #24 upon admission to the facility on [DATE] for the following dates: 1. 08/21/25, 2. 08/22/25, 3. 08/23/25, 4. 08/25/25, 5. 08/26/25, 6. 08/27/25. F. Record review of R #24's progress notes for August 2025 revealed staff did not document that wound care was not completed for R #24. G. On 09/16/25 at 10:32 AM, during an interview with the Wound Care Nurse (WCN), he stated he was off when R #24 was admitted on [DATE]. He did a skin assessment on 08/24/25 when he returned. The WCN noted a stage 2 pressure ulcer/injury to R #24's sacrum (a triangular bone in the lower back formed from fused vertebrae and situated between the two hip bones of the pelvis). The WCN stated his expectation is that the floor nurses use their nursing education and obtain orders to perform treatment on residents. H. On 09/16/25 at 1:31 PM, during an interview with the DON, he confirmed his expectation for the nurses is within the first 48 hours of admission to do the following: 1. Obtain basic care orders with the in-house provider, 2. Provide wound care, and 3. Follow-up with Wound Care Nurse. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325067 | A. Building<br>B. Wing | 09/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Las Cruces Village Nursing & Rehabilitation LLC | 3025 Terrace Drive<br>Las Cruces, NM 88011 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>Based on observation and interview, the facility failed to secure a medication cart for all 25 residents on the 500 and 600 units (residents were identified by the census list provided by the Administrator on 09/16/25). This deficient practice could result in residents obtaining medication not prescribed to them resulting in adverse side effects. The findings are: A. On 09/16/25 at 8:45 AM, during an observation of the nurses' station on the 500/600 unit revealed a medication cart was in a central location near halls 500 and 600. Insulin pen needles (is an injection device that you can use to deliver preloaded insulin) and lancets (a single-use sharp pointed two-edged device that collects whole liquid blood sample) were on top of the medication cart that was left unattended. B. On 09/16/25 at 8:48 AM, during an interview LPN #28, confirmed that the insulin pens and lancets were on top of the medication cart. C. On 09/16/25 at 8:48 AM, during an interview with the ADON, she confirmed that medications and lancets should be locked inside the medication cart. |