MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17LD	A. BUILDING: _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DESOTO	3068 NAIL ROAD WEST HORN LAKE, MS 38637

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 10/28/24 through 10/30/24. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M 500, M 615, M 620, and M 705. The facility held a license for 60 beds at the time of survey, and the facility census was 53.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or	M 500		11/18/24

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M 500	Continued From page 1 nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial	M 500		

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M 500	Continued From page 2	M 500		

transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care,

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M 500	Continued From page 3 and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide privacy for a resident (Resident #17) and failed to ensure a resident	M 500	1. On 10/28/2024 the Licensed Practical Nurse covered resident #17 with his covers and then pulled the privacy curtain, to ensure his dignity was maintained.	

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M 500	Continued From page 4 was able to make independent healthcare decisions (Resident #58) for two (2) of 20 sampled residents. Findings Include: Review of the facility policy titled "Dignity and Respect" policy, revised on 7/22, revealed: "A facility must treat each resident with dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility shall protect and promote the rights of the resident... Residents will be examined and treated in a manner that maintains bodily privacy..." Also revealed under, "3. All residents should have autonomy of choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care." Review of the facility policy titled "Advance Directives" with a revision date of 7/15 revealed under, "Policy: The facility recognizes that all adults have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care." Also revealed under, "Procedure:... The resident will be encouraged to participate in all aspects of decision-making regarding care and treatment. Statements by a competent resident regarding his/her desire to accept or refuse treatment will be documented in the resident's clinical record." Resident #17 An observation from the hallway on 10/28/24 at 9:30 AM, revealed Resident #17's door was open and was lying in bed uncovered, with an adult	M 500	2. All 53 Residents have the potential to be affected by this deficient Practice regarding Resident Rights/ Exercise Right. 3. An In-Service on the facility policy and procedure for "Dignity" was completed by the Director of Nurses on 10/28/2024. The Director of Nurses visually checked all residents in the building to ensure all residents dignity was being maintained on 10/28/24. Upon hire staff will be educated on resident right's then annually and as needed. 4. The Director of Nurses will visualize residents starting 10/31/2024 five (5) times a week for four (4)weeks then one (1) time a week for two (2) weeks then monthly for two (2) months will continue longer if problems are identified. The Director of Nurses Will present findings in the Quarterly Improvement meeting. Quality Assurance Committee Meeting was conducted on 10/30/2024 a follow-up Quality Assurance Committee Meeting will be conducted again on 11/17/2024, and quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service/ and or disciplinary action could lead to termination. 1. On 10/29/2024, Resident #58 was provided with her right to make decision related to her medical treatments. Admissions Director revised and completed Advance Directive with Resident # 58.	

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M 500	Continued From page 5 incontinence brief on the resident, stomach exposed, with the Percutaneous Endoscopic Gastrostomy (PEG) tube visible. In a follow-up observation from the hallway on 10/28/24 at 9:55 AM, Resident #17 was still lying uncovered in bed, with an adult brief, stomach, and PEG tube exposed, and with the door open and privacy curtain pulled back. An observation and interview on 10/28/24 at 10:20 AM, with Licensed Practical Nurse (LPN) #1 confirmed that Resident #17's door and privacy curtain were open and that the resident was in bed uncovered, with their hospital gown partially up, revealing an adult brief. The LPN stated that the resident never stays covered but acknowledged that staff should be keeping the privacy curtain pulled so that the resident was not visible from the hallway. In an interview on 10/29/24 at 9:00 AM, the Director of Nursing (DON) confirmed that Resident #17 being uncovered, with the brief and PEG tube visible from the hallway, was a dignity concern. Record review of the Admission Record revealed the facility admitted Resident #17 on 7/27/22 with a diagnosis of Cerebral Infarction. Resident #58 Record review of the "Advanced Directive Consent" for Resident #58 revealed, the consent was initialed and signed by a family member dated 9/12/24 and that Resident #58 did not sign the consent. An interview with Resident #58 on 10/29/24 at	M 500	2. All 53 Residents have the potential to be affected by this deficient Practice regarding Request/Refuse/Advance Directive. 3. Administrator in-Serviced Admission coordinator on 10/30/2024 regarding facility policy and procedures on Advance Directives. The Admission Coordinator initiated a facility audit on 10/31/2024, on all residents to ensure residents exercises their right to healthcare decisions. On all admissions and care plan reviews the Admission coordinator will ensure the resident rights to healthcare decisions. 4. The Administrator will monitor all new admission two time (2x) a week for four (4) weeks, then monthly for three (3) months to ensure residents exercise their right to Advance Directive. A Quality Assurance Committee Meeting was conducted on 10/30/2024, A follow-up Quality Assurance Committee Meeting will be conducted again on 11/17/2024, and quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service/ and or disciplinary action could lead to termination.	

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M 500	Continued From page 6 8:10 AM, revealed the facility had not gone over the advanced directives consent or code status with her. She revealed she would like to make her own healthcare decisions because she was still able. She confirmed she did not have a medical Power of Attorney (POA) established and explained she wanted everything done to save her life, should something happen. An interview with the Admission Coordinator on 10/29/24 at 8:24 AM, confirmed she did not go over the advanced directives and code status with Resident #58 on admission. She explained that she allowed a family member to sign the consent because the family member was the Resident Representative (RR). The Admission Coordinator confirmed she should have spoken with the resident regarding her wishes. She revealed Resident #58 was cognitive and able to make her own healthcare decisions, and she did not have a medical POA to make decisions for her. An interview with the Administrator on 10/29/24 at 8:56 AM, confirmed Resident #58 was cognitive and should have been allowed to sign her consent related to code status on admission. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/10/24 revealed under, section C, a Brief Interview for Mental Status (BIMS) summary score of 12, which indicated Resident #58 was moderately cognitively impaired. Record review of the "Admission Record" revealed the facility admitted Resident #58 on 9/12/24.	M 500		

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Resident #58

Record review of the "Advanced Directive Consent" for Resident #58 revealed, the consent was initialed and signed by a family member dated 9/12/24 and that Resident #58 did not sign the consent.

An interview with Resident #58 on 10/29/24 at 8:10 AM, revealed the facility had not gone over the advanced directives consent or code status with her. She revealed she would like to make her own healthcare decisions because she was still able. She confirmed she did not have a medical Power of Attorney (POA) established and explained she wanted everything done to save her life, should something happen.

An interview with the Admission Coordinator on 10/29/24 at 8:24 AM, confirmed she did not go over the advanced directives and code status with Resident #58 on admission. She explained that she allowed a family member to sign the consent because the family member was the Resident Representative (RR). The Admission Coordinator confirmed she should have spoken with the resident regarding her wishes. She revealed Resident #58 was cognitive and able to make her own healthcare decisions, and she did not have a medical POA to make decisions for her.

An interview with the Administrator on 10/29/24 at 8:56 AM, confirmed Resident #58 was cognitive and should have been allowed to sign her

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M 500	Continued From page 8 consent related to code status on admission. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/10/24 revealed under, section C, a Brief Interview for Mental Status (BIMS) summary score of 12, which indicated Resident #58 was moderately cognitively impaired. Record review of the "Admission Record" revealed the facility admitted Resident #58 on 9/12/24.	M 500		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level III Based on observation, record review, resident and staff interview the facility failed to provide treatment and services to prevent pressure ulcers for two (2) of five (5) residents observed with pressure ulcers. Resident #28 and Resident # 209 Findings Included: Record review of facility policy Pressure Ulcer Prevention and Treatment Intervention Guidelines, revised 10/22, revealed "C. Protection from Fiction or Shear...4. Provide padding for	M 615	Facility failed to provide treatment and services to prevent pressure ulcers for (2) of 5 Residents observed with pressure ulcers. (Resident # 28 and Resident # 209). 1 . On 10/29/2024 Physician orders were clarified for resident #209 regarding brace Resident # 28 were revised. One on One education completed with Treatment Nurse by the Director of Nursing on 10/30/2024 on obtaining physicians orders as needed and pressure ulcer staging. Resident # 28 and Resident # 209 was assessed for any adverse effects of failing	11/18/24

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M 615	Continued From page 9 casts, braces, splints, oxygen tubing, shoes etc. as needed to prevent friction. 5. Remove orthotics on a regular basis for skin inspection...Therapy Department Interventions...3. Explore possible therapy interventions for...c. Splinting/orthotic modifications... 1. Provide pressure ulcer topical treatments as ordered" Resident #28 A review of the "Skin & Wound Evaluation" dated 9/19/24, revealed that Resident #28 acquired an unstageable pressure ulcer on the right fourth (4th) ring finger on 9/19/24. Record review revealed measurements of 1.4 centimeters (cm) area, 1.4 cm length, 1.3 cm width and depth not applicable (n/a). The quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/16/24 Section GG revealed revealed Resident #28 had a functional limitation in the range of motion in the upper extremity on one side. A record review of Order Listing Report for September and October 2024 revealed no orders for pressure relief devices for Resident # 28. During an observation and interview with Licensed Practical Nurse (LPN) #2 on 10/29/24 at 8:00 AM, Resident #28 was observed with a palm shield in place on the right hand. LPN #2 confirmed that Resident #28 had a contracture in the right hand and stated that the palm shield was applied only after the pressure ulcer developed on the right 4th ring finger. She verified that no splinting or other pressure relief interventions were in place before the pressure ulcer developed.	M 615	to provide treatment and services to prevent pressure ulcers on 10/29/2024 by the Director of Nursing with negative findings noted. An 100% audit was completed on 10/31/2024 on all residents with assisted devices to ensue no other negative findings. 2. All 53 Residents have the potential to be affected by the deficient practice regarding Treatment/Service to prevent/Heal Pressure Ulcer. 3. The Director of Nurses initiated an in-service on 10/31/2024 with all licensed nursing staff on policy titled "Pressure Ulcer Prevention and Treatment Interventions Guidelines". The Director of Nurses and Treatment Nurse completed assessment audit on 10/31/24 on all residents with wounds to ensure proper staging and appropriate orders for treatment. 4. The Director of Nursing and Treatment Nurse will monitor residents starting 10/31/2024 at risk for skin breakdown, and residents with assistive devices by making rounds five (5) times a week for four (4) weeks then monthly for three (3) months then quarterly. Therapy to screen residents quarterly and as needed. The Director of Nursing will report findings to Quality Assurance meeting. A Quality Assurance Committee Meeting was conducted on 10/30/2024. A follow-up Quality Assurance Committee Meeting will	

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M 615	Continued From page 10 In an interview with the Wound Treatment Nurse on 10/29/24 at 8:30 AM, she explained that Resident #28 had developed a pressure ulcer on the right fourth ring finger due to pressure from the fingers being contracted in a fist. She stated that when she identified the pressure ulcer, she contacted therapy to request a pressure relief device. She acknowledged that pressure relief measures should have been in place to prevent pressure ulcers on Resident #28's fingers. She confirmed that there were no orders or documentation for the use of the palm shield. In an interview with the Rehabilitation Director on 10/30/24 at 9:00 AM, she verified that Resident #28 did not have a palm shield before developing the pressure ulcer on the right 4th finger and confirmed that she was consulted, and the shield was implemented after the ulcer appeared. Record review of the "Admission Record" revealed the facility admitted Resident # 28 on 5/31/21 with a diagnosis of Cerebral Infarction. Resident #209 An observation and interview with Resident #209 on 10/29/24 at 10:16 AM revealed, she was lying in bed with an immobilizer to the right leg. The resident verbalized she had an unrepaired femur fracture and revealed she had a new sore that developed under the brace since she admitted. She explained that she followed up with her orthopedic doctor last week, and he asked her to use foam under the brace, but the facility did not have any foam. An interview with the Wound Treatment Nurse on 10/29/24 at 11:20 AM revealed Resident #209 had a new pressure wound caused by the	M 615	be conducted again on 11/17/2024, and quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service/ and or disciplinary action could lead to termination.	

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immobilizer on the Achilles area. She explained that she was notified by the Therapy Rehab Director on 10/21/24 that the residents' immobilizer was sliding down and had caused a sore. She revealed she had been treating the wound since she was made aware, but the treatment order was not added to the Treatment Administration Record (TAR) until 10/26/24, and she had not staged the wound. The Wound Nurse confirmed Resident #209's skin had not been assessed under the immobilizer every day to determine if the resident had any skin breakdown.

Record review of the "Wound Evaluation" dated 10/22/24 revealed the wound to the right Achilles was not staged and measured 0.94 cm in length and 0.56 cm in width, with no determination on depth.

Review of the October 2024 "Treatment Administration Record" for Resident #209 revealed an order, dated 10/26/24, "Clean open area to right heel with NS (normal saline) and pat dry, apply Xeroform and cover with bandage every other day until resolved" with a discontinue date of 10/29/24. Also revealed an order, dated 10/29/24, "Clean open area to right Achilles with NS (normal saline) and pat dry, apply TAO (triple antibiotic ointment) and cover with bandage every other day until resolved."

Record review of the "Order Listing Report" revealed there was not a physician order for Resident #209's leg immobilizer or to monitor the skin under the brace for skin breakdown.

An interview with the Director of Nursing (DON) on 10/29/24 at 12:50 PM confirmed, Resident #209 did not have an order for the right leg

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immobilizer. She revealed it was not clear to her why the staff would not have called and followed up on how the resident was supposed to wear it.

Record review of the "Physician Consultation Report" dated 10/24/24 revealed under, "Findings: ... Pressure sores where hinges are present." Also revealed under, "Recommendations: When pt is in bed open brace completely to relieve pressure; Apply thin layer of foam to posterior calf and thigh portion of brace."

An interview with the Wound Treatment Nurse on 10/29/24 at 2:30 PM confirmed she did not implement the orders recommended by the Orthopedic Physician. She revealed the foam would have been too thick under the brace and stated, "I don't think foam would work." She revealed Resident #209 had told her the hospital applied foam under the immobilizer, and it was too tight.

An interview with the Administrator (ADM) on 10/29/24 at 2:48 PM, confirmed the skin should be assessed underneath an immobilizer daily to ensure there was no skin breakdown caused by the device. She confirmed Resident #209's wound was avoidable, if the skin under the immobilizer had been assessed. She revealed the physician's recommendations should have been followed.

An interview with the Therapy Rehab Director on 10/30/24 at 9:10 AM revealed she usually had to take Resident #209's immobilizer off to reposition it correctly. She revealed she observed the area to the resident's leg and reported it to the nurse on duty on 10/20/24. She stated the nurse thought the brace had rubbed the area on the leg,

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M 615	Continued From page 13 and she needed something to pad the area for support. The therapist revealed they placed a towel under the brace that day for extra protection, and she told the Wound Treatment Nurse the following day. An interview with the Wound Treatment Nurse on 10/30/24 at 10:25 AM confirmed Resident #209's wound was avoidable if the proper monitoring under the brace had been done. Record review of the "Admission Record" revealed the facility admitted Resident #209 on 10/9/24 with a medical diagnosis of Displaced Fracture of the Lower Epiphysis of Right Femur. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/24 revealed under, section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #209 was cognitively intact.	M 615		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record	M 620	Facility failed to provide appropriate care services for (1) one of (5)residents Director of Nursing assessed resident #57	11/18/24

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M 620	Continued From page 14 review, and facility policy review, the facility failed to provide appropriate care services for (1) one of (5) resident care observations. (Resident # 57) Findings include: A review of the facility policy titled, "Perineal Care," latest revision date 01/24 revealed. ...Resident with Catheter:.. 4.) Using a clean washcloth or wash wipe, start at the meatus and wash the tubing in a circular motion away from the body... Rinse using the same method..." An observation of catheter care with Certified Nurse Assistants (CNA) #1 and CNA #2 for Resident #57 on 10/29/24 at 11:34 AM, revealed CNA #1 cleaned one side of the urinary catheter from the urinary meatus downward with a clean soapy wet washcloth, and then cleaned the other side with a clean area section of the washcloth. CNA #1 then placed the dirty washcloth into the clean water in the wash basin, rinsed it out and used the same dirty washcloth to rinse the urinary catheter tubing/urinary meatus all in the same swipe wearing the same gloves worn during cleaning process.. In an interview with CNA #2 on 10/29/24 at 11:56 AM, she revealed that she was in the room only to help CNA #1 if she needed any help. She confirmed that CNA #1 contaminated the clean water in the basin when she put the dirty washcloth in it. She then stated CNA #1 should also have used a clean washcloth to rinse the resident. In an interview with CNA #1 on 10/29/24 at 11:59 AM, she revealed she did not even realize she forgot to change her gloves as well as she used the same dirty washcloth to rinse Resident #57's	M 620	for any adverse effects no negative finding. 1. On 10/29/2024 all Certified Nursing Assistants were initiated an in-service to watch a required training video titled "Perineal care". 2. All 53 Residents have the potential to be affected by the deficient practice regarding Bowel and Bladder 3. A second in-service was initiated on the facility policy and procedure for "Perineal Care " completed by Director of Nursing on 10/30/2024. Director of Nursing initiated return demonstration on perineal care for all certified Nursing Assistants on perineal care starting 10/30/2024. Upon hire certified Nursing Assistants will be provided with a training and competency regarding perineal care annually and as needed. 4. The Director of Nursing will monitor five residents a week for perineal care starting 10/30/2024 for four (4) weeks then monthly for three (3) months then quarterly. The Director of Nursing will present findings to the Quarterly Quality Meeting. A Quality Assurance Committee Meeting was conducted on 10/30/2024. A follow-up Quality Assurance Committee Meeting will be conducted again on 11/17/2024, and quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will	

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M 620	Continued From page 15 meatus and catheter tubing. She stated that it was cross contamination and could lead to infections. In an interview with the Infection Control/Treatment Nurse on 10/29/24 at 12:12 PM, she revealed that the CNA should have performed hand hygiene and used a clean washcloth to rinse the perineal area after cleansing the resident to prevent cross contamination of bacteria. She stated that failing to do this could lead to urinary tract infections for the resident. Record review of the "Admission Record" revealed the facility admitted Resident # 57 on 9/16/24 with diagnoses including Neuromuscular dysfunction of the bladder. Record review of Resident #57's Section C of the Minimum Data Set (MDS) dated 9/23/24 revealed on a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. In Section H Bladder and Bowel item H0100 revealed the resident had an indwelling urinary catheter.	M 620	take necessary corrective action such as: Individual in-service/ and or disciplinary action could lead to termination.	
M 705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following: 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and	M 705		11/18/24

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M 705	Continued From page 16 5. Administration of all drugs and biologicals. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure a resident's environment was free from accident hazards as evidenced by medications left at bedside for one (1) of twenty sampled residents. Resident #58 Findings Include: Review of the facility policy titled "Medication Storage" with a revision date of 11/17 revealed under, "There shall be storage areas provided that assure adequate space, equipment and security for medications within the facility..." An observation and interview on 10/28/24 at 9:50 AM, revealed Resident #58 lying in bed and on the bedside table was a six (6) ounce bottle of red spray liquid with a label that read, "Sore Throat Spray" and a one (1) fluid ounce white bottle that read, "Lubricating Eye Drops". The resident revealed that she used the eye drops about six times a day for dry eyes and administered it herself. She revealed that she used the sore throat spray as needed for a sore throat. She explained the staff knew she had it because it had been on the table since she was admitted to the facility. An interview with Licensed Practical Nurse (LPN) #1 on 10/28/24 at 10:30 AM, confirmed Resident #58 had medications at her bedside. She revealed the resident did not have a physician order for the medication and the resident could be	M 705	Facility failed to ensure a Resident's environment was free from accident hazards as evidenced by medication left at bedside for one (1) of 20 Resident reviews. 1. On 10/28/2024 Resident #58 bedside medication was removed and resident was assessed for self-administration of medications by Registered Nurse. Resident performed a return demonstration by placing eye drop in eyes. Resident was assessed by Registered Nurse for any adverse effects no negative findings. Physician order was obtained on 10/28/2024 for self administration of medication education was provided to resident for usage and reporting. Medication will be available upon resident request at medication cart. 2. All 53 Residents have the potential to be affected by deficient practice regarding Storage of Drugs and Biologicals. 3. An in-service was initiated on 10/30/2024 with all nursing staff by Director of Nursing on medication storage and reporting any finding of medications in resident rooms. Director of Nurses and Treatment Nurse completed a visual audit on 10/30/2024 in all resident rooms to ensure no bedside medication.	

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M 705	Continued From page 17 using the medication too often without staff monitoring, or a confused resident could come along and take it. An interview with the Administrator (ADM) on 10/29/24 at 8:58 AM, revealed the residents were not supposed to have medications at bedside. She confirmed Resident #58 could take too much, or she could have a reaction to the medications, and that all medications should be secured and put away. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/10/24 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 12, which indicated Resident #58 was moderately cognitively impaired. Record review of the "Admission Record" revealed the facility admitted Resident #58 on 10/4/24 with a medical diagnosis of Cellulitis of the left lower leg.	M 705	4. The Director of Nursing and Administrator will monitor all residents rooms for medications at bedside starting 11/01/2024 five(5) times a week for four (4) weeks and then monthly for three (3) months and then quarterly. The Director of Nurses and Administrator will report findings to the Quality Assurance meeting. A Quality Assurance Committee Meeting was conducted on 10/30/2024. A follow-up Quality Assurance Committee Meeting will be conducted again on 11/17/2024, and quarterly thereafter after the follow-up. Administrator will report any recurring problems to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service/ and or disciplinary action could lead to termination.	