STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26LM	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON MANOR SENIOR CARE, LLC	56 ROCKPORT ROAD LEXINGTON, MS 39095

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 8/08/23 through 8/10/23. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M610 and M640 The facility held a license for 60 beds at the time of the survey and the facility census was 59.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review and facility policy review the facility failed to provide nail care for a resident dependent on staff for Activities of Daily Living (ADL's) as evidenced by brown substance under the resident's nails for one (1) of five (5) residents reviewed for ADL's. Resident # 48 Findings Include:	M 610	1. On 8/8/2023, the Infection Control Nurse assessed resident #48 for nail care needs. On 8/8/2023, the infection Control Nurse filed and cleaned Resident #46 fingernails. 2. On 8/08/23 the Director of Nurses and Minimum Data Set Coordinator determined that all residents who require extensive to maximum assistance with activities of daily living (nail Care) have the	9/13/23

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M 610	Continued From page 1 A review of the policy titled, "Care of Fingernails for the Certified Nursing Assistant," dated 5/2019, revealed "Policy: It is the purpose of this procedure to provide appropriate care according to current standards of practice. Care of fingernails will be provided by the Certified Nursing Assistant..." An observation of Resident #48 on 8/08/23 at 1:00 PM, revealed the resident's fingernails to be approximately 1/4 inch long with an unknown dark brown substance under the nail beds. During an observation and interview of Resident #48's nails on 8/09/23 at 8:30 AM, with Licensed Practical Nurse (LPN) #1 and Certified Nursing Assistant (CNA)#1 revealed both CNA #1 and LPN #1 confirmed Resident #48's nails were approximately 1/4 inch long and had a brown substance under the fingernails. LPN #1 confirmed the nails were dirty and needed to cleaned and trimmed. LPN #1 then revealed a possible concern from not cleaning and trimming Resident #48's nails is the resident could scratch herself and would be at risk for infections. A review of the Progress Notes related to behavior monitoring, for the last 30 days for Resident #48, revealed no documentation of refusal of ADL care. A record review and interview with the Director of Nursing (DON) on 8/09/23 at 8:55 AM, revealed a possible concern from Resident #48's nails being long and having an unknown brown substance under them could place her at risk for an infection. A continued review of the last 30 days of Progress Notes and the daily CNA Behavior Monitoring for Resident #48 with the DON confirmed there was no documented refusals of	M 610	potential to be affected. On 8/8/2023, the Director of Nurses, Charge Nurse, Treatment nurse and Infection Control Nurse completed an assessment of all Fifty-eight (58) remaining Residents for long nails and any substance underneath the nails. No other Residents were identified that required nail care. 3. On 8/9/2023, the Infection Control Nurse did a one-on-one in-service (education) program with the Certified Nursing Assistant assigned to Whirlpool on providing nail care for Residents focusing on substances underneath the nails and ensuring nails are not long. 8/9/2023 through 8/14/2023, the Infection Control Nurse did an in-service (education) program with all direct care staff on providing nail care for Residents focusing on substances underneath the nails and ensuring nails are not long. The infection Control Nurse and Director of Nurses will perform competency check-offs on all care partners regarding nail care starting on 8/18/2023 through 8/31/2023. On 8/14/2023, the Quality Assurance Committee reviewed the “Nail Care” policy with no recommended change to the procedure. 4. The Infection Control Nurse or Director of Nurses will assess three (3) Residents per day, three (3) days a week for five (5) weeks beginning on 8/14/2023. After five (5) weeks, the Infection Control Nurse or Director of Nurses will monitor monthly for three (3) months (Beginning 9/18/2023) to ensure that nail care is provided per policy and procedure. On	

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M 610	Continued From page 2 care. An interview with the Infection Control Nurse on 8/09/23 at 2:51 PM, revealed failing to perform proper nail care could lead to accidents such as tears to the skin and and possible infections "especially if the resident scratches or is a digger". A review of the Admission Record revealed that the facility admitted Resident #48 to the facility on 7/19/22 with diagnoses that included Bilateral Primary Osteoarthritis of Hip and Benign Neoplasm of the Pituitary Gland. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) on 6/27/23, revealed that Resident #48 had a Brief Interview for Mental Status (BIMS) score of 4 which indicated that he was severely cognitively impaired. Section G revealed Resident #48 was extensive assistance of one staff for personal hygiene.	M 610	9/07/23, the monitoring results will be taken to the Quality Assurance Committee for three (3) months to evaluate the process and effectiveness and make changes as found necessary to ensure substantial compliance.	
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review and facility policy review the facility failed	M 640	• On 8/09/23, the Director of Nurses removed the bottle of Hibiclens, bottle of hydrogen peroxide, an open storage carry case filled with different size unopened	9/13/23

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M 640	Continued From page 3 to maintain an environment that is free from accident hazards as is possible when an office door behind the nursing desk was left open and unsecured with a gallon bottle of Hibiclens (chlorhexidine gluconate), a small bottle of Hydrogen peroxide, syringes with needles intact, two (2) boxes of butterfly needles, vacutainer's, and a bottle of covid testing solution sitting on a shelf visible from the doorway for one (1) of three (3) days of survey. Findings include: A review of the facility policy titled, "Storage of Medication," revealed, Policy: Medications and biological's are stored safely, securely, and properly, following manufactures recommendations or those of the supplier. The medication is accessible only to licensed personnel, pharmacy personnel, or staff members lawfully authorized to administer medications." ...Procedures: B.) "Medication rooms, carts and medication supplies are locked when not attended by persons with authorized access..." Record review of a typed document on facility letter head, undated and signed by the Administrator revealed "Lexington Manor Senior Care does not have a policy for the storage of new/unused needles." An observation of the room behind the open floor plan nursing desk that was centrally located between all three resident occupied hallways on 8/09/23 at 8:35 AM, revealed the door was open to the room. There was no staff present in the room. The State Agency (SA) observed a large metal shelf with a 1 gallon bottle of Hibiclens, 1 small bottle of hydrogen peroxide, an open	M 640	syringes, vacutainers, 2 boxes of butterfly needles, and a bottle of covid test solution from the charge nurses office. The Charge nurse's office was inspected by the Director of Nurses and Administrator on 8/09/23 to ensure there were no other potentially hazardous items. No other Items were found. • On 8/09/23, the Director of nurses and Administrator determined that all mobile residents with cognitive impairment have the potential to be affected. Any area of concern was corrected by the Director of nurses on 8/09/23. • On 8/09/23, the Director of Nursing did a one/one in-service with the Charge Nurse on properly storing potentially hazardous items. From 8/09/23 through 08/16/23, the Director of Nursing/ Staff Development Nurse in-serviced all staff on proper storage of potentially hazardous items. • On 8/14/23, the quality Assurance Performance improvement committee developed the Policy and procedures for Accidents and Hazards—the Medication storage in the facility Policy was reviewed with no recommendation for changes. • Starting 8/09/23, the Director of Nursing or Administrator will inspect the Charge Nurse's office three (3) Days a week for four (4) weeks for potentially hazardous items. After four (4) weeks, the Director of Nursing or Administrator will continue monitoring monthly (Beginning 9/07/23) to ensure the Accidents and Hazards Policy and Procedures are followed. On 9/07/23, the monitoring results will be taken to the Quality Assurance Committee for three (3)	

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M 640	Continued From page 4 storage carry case filled with different size unopened syringes with needles intact, vacutainers, 2 boxes of butterfly needles, and a bottle of covid test solution. All the named items were in view from the doorway entrance by the SA. The SA stood at the doorway entrance of the room and waited for staff to return. The SA observed several staff walk past the nursing desk, a resident and visitor sitting in the lobby on the couch, and residents sitting in the dayroom while waiting. An observation and interview with the Charge Nurse on 8/09/23 at 8:40 AM, confirmed the open room was her office. The Charge Nurse revealed the office door should have been shut and locked before leaving. She said there are confused residents in the facility and a resident or unauthorized person could possibly enter the room, accidentally ingest the Hibiclens or hydrogen peroxide, become sick, and get 1 of the needles and stick themselves with it. An interview with the Director of Nursing (DON) on 8/09/23 at 8:55 AM, confirmed the door to the charge nurse office should not be left open because a resident could have possibly ingested the Hibiclens and could have possibly stuck themselves with a needle. An interview with the Staffing Nurse on 8/09/23 at 3:00 PM, revealed any room that has sharps or medicine related items stored in it should always be locked when not occupied staff. A phone interview with the Pharmacy Consultant on 8/09/23 at 3:46 PM, he revealed that a room with medication and related items should always be locked when not occupied by authorized staff and revealed accidental ingestion of Hibiclens	M 640	months (including 9/07/23) to evaluate the process and effectiveness and make changes as found necessary to ensure substantial compliance.	

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M 640	Continued From page 5 and hydrogen peroxide cause nausea and vomiting and gastric distress and puts residents/unauthorized people at risk for possible needle sticks or cutaneous (skin) injury related to items not being secured in the room .	M 640		