

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Lady of the Oaks Retirement Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 Eraste Landry Road Lafayette, LA 70506	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784</p> <p>Based on record review and interview, the facility failed to ensure the resident's Minimum Data Set (MDS) was completed accurately for 1 (#77) out of 33 sampled residents.</p> <p>Findings:</p> <p>Review of Resident #77's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses that included but not limited to, Cerebral Infarction, Hemiplegia affecting left non dominant site, Restlessness and agitation, Generalized Anxiety Disorder, Other lack of Coordination, Cognitive communication deficit, Muscle Weakness.</p> <p>Review of Resident #77's electronic health record revealed on 02/18/2023, a physician order to Maintain bed alarm q (every) shift.</p> <p>Review of Resident #77's Quarterly MDS assessment with an ARD (Assessment Reference Date) of 01/17/2024 revealed in Section P - Restraints- Bed alarm was coded as 0 that indicated Resident #77 had no bed alarm in use.</p> <p>On 04/11/2024 at 10:45 a.m., an interview and record review was conducted with S8MDS (Minimum Data Set) Lead Coordinator She reviewed Resident #77's Quarterly MDS with an ARD of 01/17/2024 and confirmed that it was inaccurately coded for the use of a bed alarm.</p>

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: 195633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Lady of the Oaks Retirement Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 Eraste Landry Road Lafayette, LA 70506	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49784</p> <p>Based on observations, interviews and record reviews, the facility failed to develop and/or implement a person centered care plan by failing to:</p> <ol style="list-style-type: none"> 1. Ensure staff repositioned Resident #47 every 2 hours. 2. Develop a plan of care for the use of hand rolls for Resident #72. 3. Ensure Resident #77's bed alarm was in proper working condition. <p>This deficient practice had the potential to affect all the residents who reside in the nursing home.</p> <p>Findings:</p> <p>1. Resident#47 was admitted to the facility on [DATE] with a diagnoses including Muscle Weakness, Unspecified osteoarthritis, Pain, Other malaise, Dementia, unspecified severity, without behavior/psychosis/mood/anxiety.</p> <p>Review of the resident's care plan with a start date of 08/29/2021 revealed that she was high risk for skin breakdown r/t (related to) DM2 (Diabetes Mellitus II), Occasional Incontinence. Interventions included in part . Place me on the turn q (every) 2hr (hours) turn program. Further review of the resident's care plan revealed she required staff assistance with bed mobility.</p> <p>On 04/09/2024 at 08:45 a.m., Resident #47 was observed in bed lying on her back. A second observation was conducted at 10:45a.m. and the resident observed in bed lying on her back. A third observation was made at 1:00p.m. and Resident #47 was observed still lying in bed on her back. She stated that no one had turned her.</p> <p>An interview was conducted on 04/09/2024 at 1:15p.m.n with S6CNA. She stated that she, along with S7CNA were responsible for Resident #47's care. She stated she was familiar with the resident. She stated that staff do not have to turn the resident because she turns herself.</p> <p>A phone interview was conducted on 04/09/2024 at 2:10 p.m. with S7CNA. She stated that she was assigned the side of the hall Resident #47 was located from 6 a.m. to 12 p.m. because the regular scheduled CNA (Certified Nursing Assistant) called in. She stated she gave the resident a bed bath this morning between 8:30 a.m. and 9:00 a.m. After the bed bath, she positioned the resident on her back. She stated that she was aware that the resident needed to be turned every two hours. She confirmed that she had not turned/repositioned the resident during her shift.</p> <p>An interview was conducted on 04/11/2024 AM with S1DON (Director of Nursing). After reviewing the resident's care plan, she verified that the resident needs assistance with turning and repositioning. She confirmed that the staff should have been turned/repositioned the resident at least every two hours.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Lady of the Oaks Retirement Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 Eraste Landry Road Lafayette, LA 70506	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49176</p> <p>2. Review of Resident #72's electronic health record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Dementia, Acute Kidney Failure, Epilepsy, Muscle Weakness, and Lack of Coordination.</p> <p>Review of Resident #72's April 2024 physician's orders revealed an order dated 08/30/2022 for Right Hand: Maintain hand roll as tolerated, may remove for ADLs (Activities of Daily Living) and/or split use.</p> <p>Review of Resident #72's care plan read in part ADLs .I require staff assistance for ADLs r/t (related to) Dementia, Epilepsy . I am mobile via staff propelled geri chair, I prefer to stay in bed. I have contractures to arms and legs. Further review of Resident #72's care plan revealed no interventions to include Right Hand: Maintain hand roll as tolerated.</p> <p>On 04/11/2024 at 11:47 a.m., an interview was conducted with S4MDS (Minimum Data Set Nurse) who stated that she was responsible for completing and updating the care plan for Resident #72. A review of the resident's care plan was conducted with S4MDS. S4MDS confirmed that Resident #72's care plan did not include that the resident had an order for right hand roll as tolerated. S4MDS confirmed the care plan should have been developed to include the intervention for right hand roll.</p> <p>39319</p> <p>3. Resident #77 was admitted on [DATE]. Her diagnoses included in part, Cerebral Infarction (Stroke), Hemiplegia following cerebral infarct affecting left non-dominant site, Restlessness and agitation, Aphasia, Generalized anxiety disorder and Muscle weakness (generalized).</p> <p>Review of the resident's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 01/17/2024 revealed the resident's BIMS (Brief Interview Mental Status) score was 15, cognitively intact.</p> <p>Review of the resident's April 2024 physician orders revealed an order dated 02/18/2023 that read, bed alarm q shift.</p> <p>Review of the resident's care plan addressed the resident's risk for falls and risk for injury/immobility. A bed alarm was used as an intervention that read, Check my device daily to make sure it is in good working condition .</p> <p>On 04/08/24 at 12:12 p.m., Resident #77 was observed lying in bed. Her bed alarm was observed hanging from the bed's right upper side rail. The wire connected to the alarm box was freely hanging and frayed on one end. Resident #77 communicated by nodding her head up and down that her bed alarm was not working.</p> <p>On 04/08/24 at 1:06 p.m., an interview with S5CNA (Certified Nursing Assistant). She verified that the resident should have a bed alarm. She observed the resident's bed alarm and confirmed that the wire had been cut. She stated the bed alarm wire should be connected to a bed alarm mat. S5CNA turned the resident on her right side and confirmed that there was no bed alarm mat under the resident. She confirmed that the bed alarm was not functioning correctly.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Lady of the Oaks Retirement Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 Eraste Landry Road Lafayette, LA 70506	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/08/24 at 1:14 p.m., an interview and observation with S1DON (Director of Nursing) was conducted. S1DON observed the bed alarm with the frayed wire on the resident's bed side rail. She verified that the bed alarm should be connected to a bed alarm mat under the resident. S1DON and another staff member turned the resident on her left side and then on her right side. S1DON confirmed that there was no bed alarm mat present under the resident. She stated that the bed alarm should be monitored by the nurses every shift to ensure it was working properly. She confirmed that the resident's bed alarm was not functioning properly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Lady of the Oaks Retirement Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 Eraste Landry Road Lafayette, LA 70506	

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)
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49176</p> <p>Based on record review, observations and interview, the facility failed to ensure that a resident's enteral feeding was properly changed for 1 (#61) resident out of 1 (#61) sampled resident reviewed for tube feeding.</p> <p>Findings:</p> <p>Review of Resident #61's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Traumatic Subdural Hematoma, Alzheimer's Disease, Abnormal Weight Loss, Aphasia, Dysphagia, Other Epilepsy, Gastro-Esophageal Reflux Disease, and Gastrostomy status.</p> <p>Review of Resident #61's April 2024 physician's orders revealed an order dated 02/01/2024 that read in part, . Isosource 1.5 at 45 ml/hr (milliliter per hour) continuously .</p> <p>On 04/08/2024 at 9:35 a.m., an observation of Resident #61's tube feeding bag and administration set revealed the formula bag label listed a date of 04/07, and a time of 8:00 a.m.</p> <p>On 04/08/2024 at 12:35 p.m., a second observation of Resident #61's tube feeding bag and administration set revealed the formula bag label listed a date of 04/07, and a time of 8:00 a.m.</p> <p>On 04/08/2024 at 12:37 p.m., an interview was conducted with S3LPN (Licensed Practical Nurse). S3LPN stated that tube feeding bags are changed every 24 hours and should be labeled with the formula type and rate, the resident's name, date, time and nurse's initial. An observation was made with S3LPN of Resident #'s 61's tube feeding bag. S3LPN confirmed the resident's feeding bag was dated 04/07 and confirmed the bag was not changed every 24 hours. S3LPN called S1DON (Director of Nursing) on her personal cell, and S1DON confirmed that tube feeding bags are changed every 24 hours and the bag should have been changed before 8:00 a.m. on 04/08/2024.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Lady of the Oaks Retirement Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 Eraste Landry Road Lafayette, LA 70506	
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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20777</p> <p>Based on record review and interviews the facility failed assure the nursing staff were competent to ensure 1 (#3) of 33 sampled residents that was allergic to morphine did not receive this medication.</p> <p>Record review of Resident #3's face sheet (document that gives a resident's information at a quick glance) revealed she was admit to the facility on [DATE]. She was on Hospice care with diagnosis of End Stage Parkinson's disease. Her face sheet further revealed she was allergic to the medication, Morphine.</p> <p>Record review of Resident #3's care plan read in part, I am at risk for complications r/t (related to) my allergy. I am allergic to MORPHINE. I have no complications at this time r/t my allergy. My clinical record will be labeled to alert everyone to my allergies.</p> <p>Record review of Resident #3's physician orders revealed she was admitted to Hospice on 02/06/2024. On 03/04/2024, Morphine Sulfate 100 milligrams per 5 milliliter concentration to give 0.25 milliliters orally every 4 hours as needed for shortness of breath was ordered.</p> <p>Record review of Resident #3's MAR (Medication Administration Record) for February 2024, March 2024 and April 2024 revealed an order for Morphine Sulfate to administer 100 milligrams per 5 milliliter Concentrated to give 0.25 milliliters orally every 4 hours as needed for shortness of breath. Review of these MARs confirmed S12LPN, S13LPN, and S14LPN had administered Resident #3 Morphine Sulfate on various days during all three months.</p> <p>On 04/09/24 at 2:37 p.m., S12LPN stated the resident is on Hospice and is not cognizant and does not respond to verbal stimulation. She stated she gave the resident morphine for pain and discomfort at least once a day. S12LPN stated the hospice nurse told her to give her morphine to keep her comfortable as needed.</p> <p>On 04/11/2024 at 10:52 a.m., surveyor asked S12LPN how she would determine if Resident #3 was allergic to Morphine. She stated the resident's allergies were on the residents face sheet and on the MAR. At this time, S12LPN reviewed the MAR and stated Resident #3 was allergic to Morphine. S12LPN stated the nurses have gave Resident #3 morphine from February 2024 till present but has had no adverse effects to the Morphine.</p> <p>On 04/11/2024 at 11:02 a.m., S9MDS (Minimum Data Set) reviewed Resident #3's electronic record and confirmed the hospice physician wrote an order to administer Morphine as needed for shortness of breath on 03/04/2024. S9MDS reviewed the resident's electronic chart and confirmed the resident was allergic to Morphine. She stated the allergy to morphine was documented in the computer and on the Medication Administration Record. She also stated Resident #3's care plan listed that she was allergic to Morphine. She stated the nurses should have reviewed the allergies before giving the resident Morphine and notified the physician to get a clarification order prior to giving the medication.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Lady of the Oaks Retirement Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 Eraste Landry Road Lafayette, LA 70506	
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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/11/2024 at 2:02 p.m., S2DON (Director of Nursing) confirmed Resident #3 was allergic to Morphine and that nurses had administered it to the resident morphine despite the listed allergy. She stated the procedure for administering medications should have included reviewing the resident's allergies at the top of MAR to assure the resident was not allergic to the medications prior to administration. She also stated that nurse's should call the physician to get a clarification if the resident was ordered medication to which they were allergic.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Lady of the Oaks Retirement Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 Eraste Landry Road Lafayette, LA 70506	

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)
<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>17364</p> <p>Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) provided services for 8 consecutive hours a day, on a weekend for 2 days on the dates of 10/21/2023 and 10/22/2023.</p> <p>Findings:</p> <p>Review of the facility's PBJ (Payroll Based Journal) Data time sheet for the dates of 10/21/2023 and 10/22/2023 revealed that there were no staffing hours for the RN. There was no evidence the RN worked 8 consecutive hours on those dates.</p> <p>On 04/11/2024 at 1:40 p.m., an interview was conducted with S1DON (Director of Nursing). She reviewed the PBJ Data time sheets and confirmed that there were no staffing hours for the RN for the dates of 10/21/2023 and 10/22/2023. S1DON stated that she could not provide evidence that an RN worked on the dates of 10/21/2023 and 10/22/2023.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Lady of the Oaks Retirement Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 Eraste Landry Road Lafayette, LA 70506	
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)		
<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17364</p> <p>Based on record review and interview, the facility failed to coordinate care as evidenced by failing to obtain pertinent information from the hospice agency for 1 (#152) out of 2 (#3, #152) residents investigated for hospice.</p> <p>Findings:</p> <p>Resident #152. Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Cerebral Infarction and Pneumonitis due to Inhalation of Food and Vomit.</p> <p>Review of the resident's clinical record revealed that there was no evidence of a hospice election form, no hospice plan of care and no evidence of the physician's certification of the resident's terminal illness.</p> <p>On 04/11/2024 at 9:15 a.m., S2ADON (Assistant Director of Nursing) reviewed the resident's clinical record and confirmed that there was no evidence of a hospice election form, no hospice plan of care and no physician's certification of the resident's terminal illness available in the clinical record.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195633	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Lady of the Oaks Retirement Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1005 Eraste Landry Road Lafayette, LA 70506	

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)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>20777</p> <p>Based on observation and interview, the facility failed to maintain cleanliness of medication carts for 1 (MC#1) of 4 (MC1, MC2, MC3, MC4) medication carts observed.</p> <p>Findings:</p> <p>On 04/09/2024 at 9:59 a.m., an observation of MC1 (Medication Cart) with S7LPN (Licensed Practical Nurse) revealed the left 2 lower drawers of the medication cart contained bottles of medication in plastic bags. In the second to last drawer, there were 4 bottles of medication in plastic bags. The bags were stuck to the bottom of the drawer and around the bottles. The bottom of the drawer was covered with a reddish gold sticky substance. When the bottles and plastic bags were picked up, the thick, sticky liquid stuck to the surveyor's fingers. In the bottom drawer, there were 3 bottles of medication in plastic bags. The plastic bags were stuck to the bottles of medication and the bottom of the drawer was covered with a thick reddish sticky substance. S1DON was called to MC1 and she confirmed that the left two lower drawers of the medication cart were not clean and sanitary and needed to be cleaned.</p>