STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255191	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attala County Nursing Center	326 Highway 12 West Kosciusko, MS 39090

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, staff and resident interviews, record review and facility policy review, the facility failed to provide a homelike environment for four (4) of 103 residents residing in the facility. Resident #11, Resident #20, Resident #38, and Resident #99. Resident #11 On 8/18/25 at 8:37 AM, an observation and interview revealed Resident #11's door was dragging the floor when opening and closing. Resident #11 stated his door is hard to open and close and that it has been this way for a while.During an interview on 8/19/25 at 11:00 AM, the Maintenance Supervisor stated he was aware of the issue with Resident #11's door and explained the door frame was bent. He said the door would have to be replaced and acknowledged there were other environmental concerns in the facility that he was working on repairing them.Record review of Resident #11's admission Record revealed the facility admitted the resident on 6/16/25 with medical diagnoses that included Diabetes Mellitus.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/08/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #11 is cognitively intact.Resident #20 An interview and observation with Resident #20 and Licensed Practical Nurse (LPN #4) on 8/19/25 at 1:00 PM revealed her room door was difficult to open. She stated her door had been hard to shut for two years and staff members were aware of the problem. LPN #4 entered the room briefly during this interview and observation confirmed the resident's room door was difficult to open.During an interview on 8/19/25 at 1:40 PM, the Administrator acknowledged being aware of a couple of doors that were difficult to open and close. She confirmed this could present a safety hazard if the residents needed to evacuate the room in an emergency.Record review of Resident #20's admission Record revealed the facility admitted the resident on 4/24/25 with medical diagnoses that included Chronic Obstructive Pulmonary Disease.Record review of the MDS with an ARD of 7/10/25 revealed a BIMS score of 15, indicating Resident #20 is cognitively intact.Resident #38An initial tour on 8/18/25 at 11:30 AM revealed Resident #38's overbed table with a thick black substance scattered over the base of the table. An observation and interview on 8/19/2025 at 9:00 AM, revealed Resident #38 sitting on the side of her bed with her bed overbed table in front of her. The metal base of the overbed table had a thick black substance scattered over ninety percent (90%) of the base. Resident #38 admitted this table looks pretty bad and needs cleaning.An observation and interview on 8/19/2025 at 2:50 PM, the Director of Nurses (DON) and the Administrator (ADM) confirmed that Resident #38's overbed table was corroded with a rust-like substance and needed to be replaced. The ADM stated that with her furniture being in this shape, it doesn't represent a home-like environment. Record review of Resident #38's admission Record revealed the facility admitted the resident on 4/11/22 with medical diagnoses that included Congestive Heart Failure.Record review of Resident #38's MDS with an ARD of 6/24/25 revealed in Section C a BIMS score of 12, which indicates the resident has moderate cognitive impairment. Resident #99During an observation on 8/18/25 at 10:49 AM, and again on 8/19/2025 at 9:28 AM, it was noted that Resident #99's intravenous (IV) pole had a scattered thick substance on the base of the pole.During an interview and observation on 8/19/25 at 2:05 PM, Certified Nurse Aide (CNA) #2 revealed if we see any equipment that needs to be cleaned, we can clean it ourselves, but if it needs (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be disinfected, we let the housekeepers know. She confirmed that Resident #99's IV pole needed to be cleaned, and that Resident #38 needed a new overbed table since it looked rusty. She stated she thought housekeeping was responsible for cleaning the IV poles. She revealed that if any furniture or anything needs to be repaired or replaced, we fill out the sheet on the wall at the nurses' station for maintenance to address. In an interview and observation on 8/19/25 2:40 PM, with LPN #1 and the facility ADM, LPN #1 revealed that nursing is supposed to clean the IV poles that are used for the Percutaneous Endoscopic Gastrostomy (PEG) tube feedings, especially when the milk drips down and splatters on the base. LPN #1 and the ADM confirmed that the IV pole base for Resident #99 was dirty with a thick substance. In an interview on 8/19/25 at 3:10 PM, the DON confirmed that it is the responsibility of all nursing staff that find any equipment that is dirty or needs to be replaced to either clean it themselves or notify maintenance for a replacement. During an interview on 8/19/2025 at 3:37 PM, the Housekeeping Supervisor revealed that he tells his housekeeping staff that any IV poles that need cleaning should be done by the nursing staff. He stated that we don't want to get any chemicals around their feedings or medicines. He revealed there is a maintenance log that the nurses or CNA's fill out regarding any issues that need to be addressed, and we look at them daily. He revealed he was unaware of any overbed tables needing to be replaced before the ADM asked me to replace some today.Record review of Resident #99's admission Record revealed the facility admitted the resident on 12/28/23 with medical diagnosis that included Cerebral Infarction due to Thrombosis of Right Middle Cerebral Artery.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on staff interviews, record reviews, and facility policy review, the facility failed to accurately code a Medicare five (5) day and a Significant Change Minimum Data Set (MDS) assessment for one (1) of 25 MDS assessments reviewed. (Resident #41) Findings include:Review of the facility policy titled, Resident Assessment revised 9/19, revealed, .The completed assessment guide the staff in identifying key information about the resident and serves as a basis for identifying resident specific issues and objectives in order to develop a care plan. This process assists the resident in reaching the highest practicable physical, mental and psychosocial well-being .Any healthcare professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed .An observation and interview with Resident #41 on 8/18/25 at 11:02 AM revealed that Resident #41 did have an indwelling catheter and has had it since 5/1/25.Review of Resident #41's Medicare five (5) day and Significant Change MDS, with an Assessment Reference Date (ARD) of 6/6/25, noted that Section H - Bladder and Bowel, H0100 Appliances was coded that the resident did not have an indwelling catheter.Record review of the Order Summary Report with active orders as of 8/21/25 revealed an order dated 5/1/25 for an indwelling catheter.During an interview on 8/21/2025 at 10:04 AM with the MDS Coordinator, she acknowledged the incorrect coding, stating, I don't know how I missed that. That was my mistake. She further confirmed the purpose of accurate assessments is to provide a correct picture of the residents to deliver appropriate care. During an interview with the Director of Nursing (DON) on 8/21/2025 at 10:09 AM, she expressed her expectation that MDS assessments accurately reflect the resident's condition. She stated, It is very important for the assessment to be coded correctly for various reasons such as care planning, billing, look-backs, etc.Record review of the admission Record revealed that facility admitted Resident #41 originally on 4/23/25 with a readmission date of 5/31/25. Her medical diagnoses included Pressure Ulcer of Sacral Region, Stage 4 and Pressure Ulcer of Other Site, Stage 3.Record review of the Medicare five (5) day MDS with an ARD of 6/6/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 14, indicating that the resident was cognitively intact.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, resident and staff interviews, record reviews, and facility policy review, the facility failed to implement comprehensive care plans for two (2) of 25 sampled residents. (Resident #42 and #67) Findings Include:Review of the facility policy titled, Care Plan Process with a revision date of 12/24 revealed, .The facility shall develop and implement a Baseline Careplan . for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care .Resident #42Record review of the Activities of Daily Living (ADL) care plan revealed, .PERSONAL HYGIENE: The resident needs partial/moderate assistance with personal hygiene. Date Initiated: 06/06/2025.On 8/18/25 at 10:39 AM and again on 8/19/25 at 4:22 PM, observations and interviews with Resident # 42 revealed her fingernails were one-half inch in length, jagged, and had a brown substance underneath. Resident #42 expressed a desire to have her nails trimmed, stating she preferred them to be trimmed short. During an interview on 8/19/25 at 4:22 PM, Licensed Practical Nurse (LPN) #3 confirmed Resident #42's fingernails should have been trimmed by the nursing staff. During an interview on 8/20/2025 at 12:00 PM, with the Director of Nursing (DON), she confirmed that nursing staff should perform nail care on diabetic residents as needed.During an interview on 8/20/2025 at 12:27 PM with the Minimum Data Set (MDS) Coordinator, she confirmed that hand and nail care was listed on the task for the Certified Nurse Assistant (CNA) to perform daily as needed. She agreed the care plan was not being implemented as directed since the resident had long, dirty fingernails. She stated that the care plan was to be used as a guide for the staff to provide individualized care for the residents. Record review of the admission Record indicated that the facility admitted Resident #42 on 6/6/2025 with a medical diagnosis that included Type Two (2) Diabetes Mellitus with Diabetic Chronic Kidney Disease and Unspecified Dementia, Moderate, with Psychotic Disturbance. A record review of the MDS with an Assessment Reference Date (ARD) of 6/13/25 revealed under section C, a Brief Interview for Mental Status BIMS summary score of 15 which indicated Resident #42 was cognitively intact. Resident #67Record review of Resident #67's Care Plan Report revealed that he needs assistance with ADLs (Activities of Daily Living) with interventions that included, The resident needs substantial/moderate assistance with personal hygiene. Date initiated 5/23/25. An observation and interview on 08/19/2025 at 8:47 AM with Resident #67 revealed long, jagged fingernails approximately one-half inch long on both of his hands. Resident #67 stated that the staff had clipped his nails one time since he was admitted . He admitted that he would like his nails to be trimmed. An observation and interview on 08/19/25 at 4:17 PM with CNA #1 confirmed that Resident #67's fingernails were long and jagged and had a brown substance underneath his thumbnail and index fingernail of his right hand. CNA #1 confirmed that fingernail care was part of their daily care and that they should have been taken care of. During an observation and interview on 08/19/25 at 4:25 PM with LPN #1, she confirmed that Resident #67's fingernails were long and had a brown substance underneath. She also confirmed that cleaning fingernails was part of their daily care and should have been taken care of. On 08/19/25 at 4:30 PM, an interview with the DON revealed that the purpose of the comprehensive care plan was to identify specific needs of the residents that needed to be addressed so that all staff knew how to take care of them. She confirmed that Resident #67's nail care was included in his comprehensive care plan and that by leaving his nails long and dirty, it was not followed. Record review of Resident #67's admission Record revealed the facility admitted the resident on 05/23/25 with medical diagnoses that included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side and Type 2 Diabetes Mellitus. Record review of Resident #67's MDS with ARD of 06/04/25 under Section C revealed a BIMS score of 14 which indicated that he was cognitively intact.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, resident and staff interviews, record reviews, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care to maintain personal hygiene for two (2) of 25 sampled residents. (Resident #42 and #67) Findings IncludeReview of the facility policy titled, Nail Care with a revision date of 07/10 revealed under Purpose .to promote cleanliness, safety and a neat appearance; to observe skin condition on fingers and toes. Resident #42An observation and interview with Resident #42 on 8/18/25 at 10:39 AM and again on 8/19/25 at 4:22 PM revealed that the resident's fingernails were dirty with a brown substance underneath the nailbeds, they were approximately one-half inch past the fingertip and jagged. Resident #42 expressed a desire to have her nails trimmed, stating she preferred them to be trimmed short. An observation and interview on 8/19/25 at 4:22 PM with Licensed Practical Nurse (LPN) #3 confirmed that Resident #42's fingernails should have been cleaned and trimmed by the nursing staff. An interview on 8/20/2025 at 12:00 PM, with the Director of Nursing (DON) expressed her expectations that residents' nails should be kept clean and trimmed as necessary. She then confirmed that nursing staff should perform nail care on diabetic residents as needed. Record review of the admission Record indicated that the facility admitted Resident #42 on 6/6/2025 with a medical diagnosis that included Type Two (2) Diabetes Mellitus with Diabetic Chronic Kidney Disease and Unspecified Dementia, Moderate, with Psychotic Disturbance. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/13/25 revealed under section C, a Brief Interview for Mental Status BIMS summary score of 15 which indicated Resident #42 was cognitively intact. Resident #67 On 8/19/25 at 8:47 AM, an observation and interview with Resident #67 revealed the resident to have fingernails that were approximately one-half inch long past the fingertip with a brown substance under both the thumbnail and the index fingernail on the right hand. Resident #67 admitted that the staff had only clipped his fingernails one time since he had been there. He stated that he would like to have them trimmed. During an observation and interview on 08/19/25 at 4:17 PM with Certified Nursing Assistant (CNA) #1, she confirmed that Resident #67's fingernails were long, jagged and had brown substance underneath his right thumbnail and index fingernail on his right hand. CNA #1 revealed that fingernail care was part of their daily care and that his nails should have been taken care of. She also revealed that long, jagged dirty nails could cause a resident to scratch himself. An observation and interview with LPN #1 and Resident #67 confirmed that the resident's nails needed cleaning and trimming. She admitted that the resident's nails were long and had a brown substance underneath some of the nailbeds. She revealed that long dirty fingernails were a safety issue that could lead to inflammation of the skin. She stated that both CNA's and nurses could clean diabetic resident's fingernails and that the nurses were responsible for trimming. She acknowledged that the staff that see this should get their supplies and take care of them. Record review of Resident #67's admission Record revealed the facility admitted the resident on 05/23/25 with medical diagnoses that included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side and Type 2 Diabetes Mellitus. Record review of Resident #67's MDS with ARD of 06/04/25 under Section C revealed a BIMS Score of 14 which indicated that he was cognitively intact.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and facility policy review, the facility failed to assess and identify potential triggers for a trauma survivor for one (1) of five (5) residents reviewed for post-traumatic stress disorder (PTSD). Resident #5. Findings Include:Review of the facility policy Social Documentation-Progress Notes with revision date of 10/23 under Purpose revealed, To record observations, outcomes and responses in relation to social services as well as interventions, including trauma informed care, as identified in the comprehensive care plan, and the delivery of direct social services . An observation and interview on 08/19/2025 at 8:50 AM with Resident #5, revealed him lying in bed in his room. He revealed that back in May of 1977 when he was a teenager, he witnessed his father shoot his mother with a gun and this led to her death. He revealed that he ran to a nearby neighbor's house because he feared for his life. Resident #5 revealed that loud noises often scared him, and people need to let me know ahead of time what is going on. He revealed that things like hammers, loud tools or anything that might sound like a gunshot gets his attention. He again stated that no one ever warned him or prepared him for anything loud about to take place in the facility, and he would appreciate it if they would. Resident #5 revealed that he had told staff at the facility about this past experience he had and stated, I didn't want them to be in the dark. He also confirmed that no one had talked to him about any possible triggers that he might have related to this. An interview on 08/19/25 at 3:07 PM with the Social Worker (SW) confirmed that a trauma informed care assessment had not been completed on Resident #5. She admitted that she was responsible for conducting the trauma-informed care assessments. She stated that she was not aware of Resident #5's traumatic past until today but admitted that they had a certified SW from an outside therapy group come to see him in February 2025 and he revealed this trauma to her. She stated that the Minimum Data Set (MDS) nurse found out about it and created a care plan regarding his past trauma. She admitted that despite that she should have completed a trauma informed assessment on the resident in order to inform staff about his past traumatic event and any potential triggers. An interview on 08/19/25 at 3:50 PM with the Director of Nursing (DON), revealed that she found out about Resident #5's traumatic event back in February of this year when he saw the social worker from an outside therapy group that came into the facility. The DON agreed that they should have evaluated him and completed a trauma informed care assessment on him to identify any trauma, possible triggers, and what might set him off. DON revealed that she didn't know how it was missed but would make sure they completed the assessment on him. An interview on 08/21/25 at 9:00 AM with MDS Coordinator revealed that in February of this year, 2025, Licensed Certified Social Worker (LCSW) from an outside therapy group, reported to her that Resident #5 told her (LCSW) in therapy about his history of trauma. MDS Coordinator revealed that Resident #5 had witnessed his father's attempt to kill his mother which resulted in her death. MDS Coordinator revealed that she marked trauma on the MDS assessment and generated a care plan. She confirmed that she did not report this to the facility SW and should have so the appropriate trauma-informed care assessment could have been completed.Record review revealed the facility did not complete a trauma-informed care assessment for Resident #5.Record review of Resident #5's Biopsychosocial Assessment Progress Note dated February 7, 2025, completed by provider Licensed Certified Social Worker (LCSW) from (Proper Name) therapy group revealed that he was experiencing depression and anxiety. This progress note also revealed, The patient has a significant history of trauma, including witnessing his father attempt to kill his mother when he was[AGE] years old, resulting in his mother's death . Record review of Resident #5's admission Record revealed an admission date of 11/21/24 with diagnoses that included Depression and Anxiety Disorder. Record review of Resident #5's MDS with Assessment Reference Date (ARD) of 06/13/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 14 which indicated that he was cognitively intact.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on staff interviews, record review, and facility policy review, the facility failed to provide adequate weekend staffing for one (1) of two (2) quarterly Payroll-Based Journal (PBJ) reviews. Quarter 2 2025 (January 1-March 31) Findings Include Record review of the facility policy titled, “Nursing Services – Staffing” with a revision date of 11/17 revealed, “Staffing – The facility will have sufficient nursing staff twenty-four hours every day to provide nursing and nursing related services to attain or help maintain the highest practicable physical, mental and psychosocial well-being of each resident as is determine in the comprehensive assessment and the resident care plan.” Record review of “PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 2 2025 (January 1 – March 31)”, revealed “Excessively Low Weekend Staffing – Triggered. Triggered = Submitted Weekend Staffing data is excessively low.” During an interview on 8/20/2025 at 9:10 AM, the Staff Development nurse revealed she is responsible for compiling the nursing schedule to ensure they have sufficient staff to care for their residents. She revealed they had adequate staff on the schedule; however, during the 2nd quarter, January through March, they had many weekend call-ins and were trying to utilize Agency staff. She stated, “It was a really rough time for us”. Record review of the staffing grid for Quarter 2 2025 (weekends January 1-March 31) with the Staff Development nurse confirmed the facility had low weekend staffing for five days. In an interview on 8/21/2025 at 11:16 AM, the Administrator (ADM) revealed she wasn’t aware that the facility had triggered excessively low weekend staffing for the 2nd Quarter 2025 PBJ. She admitted that it was her expectation that they remain adequately staffed at all times to ensure the best care possible for their residents. During an interview on 8/21/2025 at 12:09 PM, the Director of Nurses (DON) revealed she was aware they were having staffing issues during January-March but wasn't aware that they triggered the PBJ for excessively low weekend staffing. She revealed they were having excessive call-ins and some no-call-no-shows. It was just a bad time. She stated that they were using agency and on-call staff to help cover shifts and admitted that their main issues were the Certified Nurse Assistants (CNA) calling in.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record reviews, and facility policy review, the facility failed to ensure that the physician was contacted for an order approval regarding psychotropic drug dosage recommendations for one (1) of four (4) residents reviewed for psychotropic drug dosage reduction. (Resident #10)Findings include:Review of the facility policy titled, Physician Orders review date 1/25 revealed, .When new or revised orders are requested due to consultant recommendations .the attending physician or nurse practitioner .shall be contacted for the order approval. The response of the attending physician or nurse practitioner .shall be documented in the resident clinical record. Additional follow-up may be needed until a response is received.Record review of the Behavioral Medicine Evaluation and Management Note dated 5/21/25 for Resident #10, revealed recommended dosage increase for Risperdal 1mg to three times a day (TID). The order was not implemented until 6/19/25.Record review of the Behavioral Medicine Evaluation and Management Note dated 6/24/25 for Resident #10, revealed recommended dosage increase for Risperdal 2mg twice a day (BID), which was never implemented.Record review of the Behavioral Medicine Evaluation and Management Note dated 7/28/25 for Resident #10, revealed recommended dosage decrease for Risperdal 1mg twice a day (BID), which was also never implemented.Record review of Resident #10's Clinical Physician Orders for active orders revealed that Risperdal 1mg three times a day (TID) was the only active order, with a start date of 6/19/2025.An interview with the Director of Nursing (DON) on 8/20/25 at 10:00 AM confirmed that the recommendation dated 5/21/25 was not implemented until 6/19/25, and the recommendations dated 6/24/25 and 7/28/25 were neither implemented nor documented in the medical record as having been reviewed by the physician. The DON confirmed that facility policy states the physician should review consultant recommendations timely and if necessary, the staff should make follow-up contact with the physician until the recommendation was addressed.Record review of the admission Record revealed Resident #10 was admitted to the facility on [DATE] with medical diagnoses that included Unspecified Dementia, Unspecified Severity, with Behavioral Disturbance.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/30/25 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident's cognition was moderately impaired.

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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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interviews, and facility policy review, the facility failed to ensure medications were stored in a properly secured refrigerator for (1) of (3) medication storage rooms. Findings include: Review of the facility’s policy titled “Medication Storage”, revised 11/17, states: “Medication storage shall meet all applicable federal, state and local guidelines.” An observation on 08/20/25 at 2:30 PM revealed the medication storage room on the second floor contained a narcotic lock box located inside the refrigerator door, locked, but not secured/affixed to the refrigerator. The lock box was easily removable and contained a bottle of Lorazepam. During an interview conducted on 08/20/25 at 2:35 PM with Registered Nurse (RN) #2, she confirmed that she thought the lock box was supposed to be secured to the refrigerator and not removable. During an interview conducted on 08/20/25 at 2:45 PM with the Director of Nursing (DON), she confirmed the narcotic lock box was not secured, explained that the refrigerator was new, and stated the box had not yet been properly installed.