| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445140 | A. Building<br>B. Wing | 03/03/2026 |

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| Signature Healthcare of Primacy | 6025 Primacy Parkway<br>Memphis, TN 38119 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, hospital record review, observation, and interview, the facility failed to ensureˆresidents receivedˆtreatment and services to promote healing, provide skin assessments, initiate wound treatments, and administer wound treatments for 5 of 96 (Residents #4, #10, #74, #79, and #90) sampled residents for pressure injuries/ulcers. The findings include: 1. Review of the facility policy titled, Skin Integrity, dated 1/2025, revealed .The facility will ensure that based on the comprehensive assessment of a resident.A resident receives care, consistent with professional standards of practice, to prevent avoidable skin integrity issues .unless the individual's clinical condition demonstrates that they were unavoidable.A resident with impaired skin integrity receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent avoidable skin integrity issues from developing.Upon admission, the licensed nurse shall complete the initial skin check and obtain orders from the physician/practitioner for any areas of impaired skin integrity that may not have orders in place when the resident is admitted to the facility from other healthcare settings or home.It is recommended that a nursing leader does a follow-up visualization of skin integrity concerns that were present upon admission.Recommend ongoing observation of skin integrity by licensed nursing staff.The licensed nurse shall initiate applicable Skin Integrity documentation if a new area of impairment is identified.The Nurse Leader/Wound Nurse shall document all impaired skin integrity areas such as.pressure.in the EMR [Electronic Medical Record] on an ongoing basis or until closed or the resident has been discharged .In addition, to ongoing observations of skin integrity impairments mentioned above, nursing stakeholders shall observe the skin for areas of impairment during bathing, dressing, and peri care. Nursing stakeholders will notify the nurse if a new area is identified. 2. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Rectal Abscess, Rectal Fistula, Urinary Tract Infection, and Chronic Kidney Disease. Review of the undated comprehensive care plan revealed .Start Date .1/12/2026 .Provide me with a weekly skin assessment via [by way of] a licensed nurse . Review of the hospital's After Visit Summary from (Named Hospital) dated 1/22/2026, revealed .The instructions below are accurate as of the time you leave [Named Hospital] .Discharge to Outside Facility Orders .For wound vac [a medical device that uses suction to promote healing in chronic, acute, or deep wounds] .Cleanser .wound cleanser .Periwound [skin area, typically extending up to, immediately surrounding a wound bed] tx [treatment] .skin prep, transparent drape, ostomy ring [moldable, adhesive, hydrocolloid seals used between the stoma and appliance to prevent leakage, protect skin from output, and fill uneven skin contours] at the bottom of the wound near the rectum to aide in seal .Foam/Sponges applied: 2 piece of black foam applied to wound, 1 piece of black foam bridged up left hip .Settings: [named wound vac] @ [at] 125mm/hg [millimeters of mercury a standard pressure setting for a wound vac] with 16ml [milliliter] install and 10 min [minute] soak .Discharge order . Review of the facility's admission Observation dated 1/22/2026 at 11:08 PM, revealed .Skin Impairment upon admission.No. Review of the Daily Skilled Notes revealed .Skin Integrity.N/A [not applicable]. on the following dates: a. 1/24/2026 at 12:55 AM b. 1/27/2026 at 1:08 (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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | AM c. 1/28/2026 at 9:16 AM d. 1/29/2026 at 7:57 AM e. 1/29/2026 at 7:39 PM f. 2/1/2026 at 3:57 AM The facility failed to complete an accurate admission assessment, failed to provide a follow up assessment from the Nurse Leader/Wound Nurse (per the facility policy), failed to identify and obtain measurements for a sacral wound, failed to implement the orders for a wound vac, and failed to obtain orders for wound care when Resident #4 was readmitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #4 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was cognitively intact.ˆResident #4 had 1 unhealed pressure ulcer that was Unstageable and present upon admission.ˆ Review of the Physician Order dated 2/1/2026, revealed .1/28/2026.SACRAL.CLEANSE SACRALWOUND [sacral wound] WITH WOUND CLEANSER, PAT DRY, APPLY MEDIHONEY [medical grade honey for healing], CALCIUM ALGINATE [dressing used for heavily exudating, infected, or bleeding wounds] AND COVER WITH FOAM TUES-THURS-SAT [on Tuesday, Thursday, and Saturday] UNTIL RESOLVED. and .2/17/2026.(sacrum) monitoring every shift. The facility failed to obtain a Physician's Order for wound care to Resident #4's sacral wound from the readmission date of 1/22/2026 until 1/28/2026. Review of the Treatment Administration Record (TAR) dated 1/2026, revealed staff failed to provide wound care to Resident #4's sacral wound from 1/22/2026 to 1/31/2026. Review of the Wound Administration History dated 2/1/2026 through 2/26/2026, revealed there was no documentation wound care was performed to the sacral wound until Sunday 2/1/2026, 10 days after Resident #4 was readmitted to the facility with the wound. Review of the TAR dated 2/2026, revealed staff failed to provide wound care to Resident #4's sacral wound as ordered on 2/3, 2/5, 2/10, 2/14, and 2/17. Review of the Wound Management Detail Report revealed the first documented wound measurements for Resident #4's sacral wound was not obtained until 2/6/2026, 15 days after Resident #4 was readmitted to the facility. The documented measurements were (length- head to toe direction) 14 cm, (width- side to side direction) 15.2 cm, and (depth- deepest part of visible wound) 3 cm. Review of the undated comprehensive care plan revealed .Start Date .2/17/2026.Resident has pressure ulcer(s) r/t [related to] Sacrum .Resident has potential for alterations in skin integrity . The facility failed to include the sacral wound in the comprehensive care plan until 2/17/2026, 26 days after Resident #4 was readmitted to the facility. During an interview on 2/25/2026 at 11:32 AM, Licensed Practical Nurse (LPN) B was asked what her position at the facility was. LPN B stated, Weekend wound care.11 years. LPN B was asked if she recalled Resident #4. LPN B stated, .she wouldn't have been one I treated. LPN B was asked if Resident #4 had any wound orders. LPN B stated, I think she had one when she initially came in. LPN B was asked how she knows what treatments are due on the weekends. LPN B stated, .we have a cheat sheet.that we write on during the week if anyone comes in. LPN B was asked how staff ensures that wound treatments don't get missed. LPN B stated, We've never missed anyone that I can recollect on. LPN B read the order for Resident #4's sacral wound care and was asked if she completed the wound treatment ordered for Saturdays. LPN B stated, No, I did not. During an interview on 2/25/2026 at 4:48 PM, the Director of Nursing (DON) was asked about the process for skin assessments when a resident was newly admitted or returned from the hospital. The DON stated, .the charge nurse or supervisor would do the skin assessment.and then the next day the wound nurse does her assessment, and the wound nurse will put in the orders. The DON was asked who was responsible for making sure staff completed skin assessments. The DON stated, I am. The DON was asked about Resident #4's sacral wound after readmission on [DATE]. The DON stated, .I do not see a wound care leader assessment. The DON was asked what date an assessment was done on Resident #4's sacral wound. I see the 1/10 [1/10/2026] when she was first admitted and I don't see any other assessments for January. The DON was asked if Resident #4 should have been assessed for wounds when she was readmitted to the facility on [DATE]. The DON stated Yes. The DON was asked when Resident #4's sacral wound measurements were recorded. The DON stated, February 6th [2/6/2026]. The DON stated Resident #4's sacral wound was not measured until 2/6/2026. The DON was asked<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | what the order for Resident #4's sacral wound was upon readmission to the facility on 1/22/2026. The DON stated, Looks like her order started on 1/28 [1/28/2026]. The DON was asked if Resident #4 returned the facility on 1/22/2026 and an order was not placed until 1/28/2026. The DON stated, Correct. The DON admitted a wound care order should have been obtained prior to 1/28/2026. The DON was asked while looking at Resident #4's TAR if she could see that Resident #4 received any wound treatments between 1/22/2026 and 1/31/2026. The DON stated, Looking at this screen, I do not. The DON was asked if staff should document Stage 4 pressure ulcers. The DON stated, Of course. The DON was asked how do you know if the wound was improving or declining if no measurements of Resident #4's sacral wounds were obtained until 2/6/2026. The DON stated, I wouldn't know. The DON was asked if wound measurements should have been obtained when Resident #4 returned to the facility on 1/22/2026. The DON stated, Yes. The DON was asked, while looking at the 2/2026 TAR, if wound treatments were provided as ordered by the physician in February. The DON stated, It's not signed off for 3 [2/3/2026], 5 [2/5/2026], 10 [2/10/2026], 17 [2/17/2026]. 3. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Encephalopathy, Urinary Retention, Cerebral Infarction, Urinary Tract Infection, Hypotension. Review of the quarterly MDS assessment dated [DATE], revealed Resident #10 scored a 3 on the BIMS assessment, which indicated she was moderately cognitively cognitive impaired. Resident #10 had no pressure ulcer, was at risk for developing a pressure ulcer/injury, and required a pressure reducing device for her chair and bed. Observation in Resident #10's room on 2/26/2026 during a skin sweep (facility wide skin assessments) revealed Resident #10 had reddened area to her buttocks and the nurse was unable to stage. The wound nurse was asked to go back and stage the wounds and identified an unstageable wound to the Left buttock. The facility was unable to provide documentation of physician's orders for wound care when the wound was identified on 2/26/2026. Review of the Care Plan dated 2/27/2026, revealed .Pressure Injury(s): STAGE 2-Left Medial Thigh.Notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during cares.Pressure Injury(s): UNSTAGEBLE-RIGHT MEDICAL BUTTOCK. Review of the Progress Notes dated 2/27/2026 at 9:40 PM, revealed .has a new area that has been identified .Wound Care-Physician Assistant has completed a head- to- toe skin assessment (2/27/2026). [Named Resident #10] has an Unstageable to the right medial buttock. The measurements are as follows: 4 x 2.9 x UTD [Unable to determine] cm [centimeters]. [Named Resident #10] has a Stage 2 to the left medial thigh. The measurements are as follows 0.2 x 0.2 x 0.1[cm]. Order decision has been made by Physician Assistant and placed in the system to reflect care . Review of the Physician Orders dated 2/27/2026, revealed .zinc sulfate tablet; 50 mg [milligrams] zinc (220 mg); multivitamin tablet; ascorbic acid (vitamin C) tablet; 500 mg; amt [amount] 1 tablet; oral Twice A Day. During an interview on 2/27/2026 at 10:15 AM, the Regional Nurse Consultant acknowledged there were no orders for wound care to the stage 2 pressure ulcer on Resident #10's left thigh or the unstageable pressure ulcer on her left buttock identified on 2/26/2026. Review of the Physician Orders dated 2/28/2026, revealed .Santyl (collagenase clostridium .) ointment [topical ointment used to remove dead tissue]; 250 unit/gram; amt: Nickel thick; topical Special Instructions: Unstageable (Right Medial Buttock): Cleanse with NS [normal saline], pat dry, apply nickel thick Santyl, cover with dry/foam dressing every 3 days. Review of the Physician Orders dated 2/28/2026, revealed Stage 2 (Left Medial Thigh) Special Instructions: Cleanse with soap and water. Pat dry. Apply skin barrier cream.twice a day until resolved. Twice A Day. 4. Review of the medical record revealed Resident #74 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Coronary Artery Disease, Dementia, and Pressure Ulcer of Sacral Region. Review of the annual MDS assessment dated [DATE], revealed Resident #74 scored a 3 on the BIMS assessment which indicated she was severely cognitively impaired. Review of the Care Plan for Resident #74 revised on 1/27/2026, revealed .Potential for alteration in skin integrity, breakdown, pressure ulcer r/t [related to] incontinence . Review of the Physician Orders (continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dated 2/16/2026, revealed, Weekly Skin Assessment .Open appropriate event for newly identified skin issues. Once A Day on Tue [Tuesday]. Review of Physician Orders dated 2/17/2026, revealed, Encourage float heels while in bed as resident [Resident #74] allows. Review of Physician Orders dated 2/20/2026, revealed, Pressure Pressure/Relieving/Redistribution mattress. Review of the Wound Management Detail Report dated 2/24/2026, revealed left and right planter 5th metatarsophalangeal (MTP) joint MTP, right heel and left 5th digit dorsal aspect were identified as Deep Tissue Injuries (DTI's). The wounds were discovered on 2/24/2026 but not documented until 2/26/2026. The facility was unable to provide documentation of Physician's orders for wound care when the wounds were identified on 2/24/2026. Review of the (Named Wound Care company) document dated 2/27/2026 at 3:15 PM, revealed the following: a. A Stage 4 sacral Pressure Ulcer that was present on admission. b. A left plantar 5th MTP Deep Tissue Pressure Injury (DTPI) that was present on admission. c. A right plantar 5th MTP DTPI that was present on admission. d. A right heel facility acquired DTI that measured 5 cm x 6 cm x UTD cm that was identified 2/24/2026, during the survey. e. A left 5th digit dorsal aspect facility acquired DTI that measured 1.4 cm x 1 cm x UTD cm that was identified 2/24/2026, during the survey. 5. Review of the medical record revealed Resident #79 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Encephalopathy, Atrial Fibrillation, Congestive Heart Failure, and Dementia. The quarterly MDS assessment dated [DATE], revealed Resident #79 scored a 00 on the BIMS assessment which indicated she was severely cognitively impaired. Resident #79 had no pressure injuries, was at risk for pressure injuries and had a pressure reducing device for her chair and bed. Review of Progress Note dated 2/24/2026 at 10:11 PM, revealed .quarter sized skin opening on right elbow . Review of Progress Note dated 2/25/2026 at 5:33 AM, revealed .cont [continues] to have skin open but dry without drainage to right elbow .covered with dry drsg [dressing] plan of care ongoing . Observation in Resident #79's room on 2/26/2026 at 11:25 AM, during a skin sweep with LPN F, revealed Resident #79 had an open area to her Right elbow measuring 2.2 cm x 1.3 cm. Review of the Physician orders dated 2/26/2026 at 12:27 PM revealed, apply barrier cream as needed. The facility was unable to provide documentation of physician's orders for wound care when the wound was identified on 2/24/2026. The Wound Nurse provided documentation on 2/27/2026 that Resident #79's wound was a Stage 2 to the right elbow. Review of Progress Note dated 2/27/2026 at 22:56 PM, revealed, .new area that has been identified .Wound Care-Physician Assistant has completed a head- to- toe skin assessment [2/27/2026] .a Stage 2 to right elbow 1 [cm] x 0.9 [cm] x 0.1 [cm]. Order decision has been made by Physician Assistant and placed in the system to reflect care. 6. Review of the medical record revealed Resident #90 was admitted to the facility on [DATE], with diagnoses including Peripheral Vascular Disease, Diabetes, Chronic Kidney Disease, and Dementia. Review of the annual MDS assessment dated [DATE], revealed Resident #90 scored an 8 on the BIMS assessment, which indicated that she was moderately cognitively impaired. Resident #90 was at risk for developing pressure ulcer/injuries, no pressure ulcer/injuries were documented, and she was coded for a pressure relieving device for her bed and chair. Review of the Care Plan dated 2/24/2026, revealed .Skin Integrity Resident has potential for alterations in skin integrity r/t [related to] decreased mobility, episodes of incontinence, non pressure ulcer to left great toe . Review of the Physician Orders dated 2/26/2026, revealed .apply barrier cream as needed . Observation in Resident #90's room during a skin sweep on 2/26/2026 at 9:40 AM, revealed a sacral wound measuring 6.2 cm x 13 cm identified as a Stage 3 pressure ulcer. This wound was not listed on the wound report provided to the surveyors on entrance to the facility. Review of the progress note dated 2/27/2026 at 10:50 PM, revealed, .new area that has been identified .Wound Care-Physician Assistant has completed a head to toe skin assessment (2/27/26) .a stage 2 sacrum 4.2 x 4.0 x 0.2 [cm] .purple area around sacrum .Order decision has been made by Physician Assistant and placed in the system to reflect care . Review of Progress Note dated 3/1/2026 at 3:23 AM, revealed, .Sacral wound noted .Area clean and dried. Barrier cream applied. Dressing applied . Review of the Physician's Orders dated 3/1/2026, (continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | revealed .(sacrum) monitoring every shift .Special Instructions: Observe that dressing is dry and intact as applicable, if intact apply dressing, notify Director of Nursing or Wound Care Nurse . Review of the Care Plan dated 3/1/2026, revealed, .Skin Integrity Resident has pressure ulcer(s) STAGE 2-SACRUM . Review of the (Named Wound Care Company) Progress Note dated 3/2/2026 at 12:00 AM, revealed, .seen today for a follow up visit for wound care services .Location: Sacral, Wound Type: Stage 2 Pressure Ulcer, Depth Exposure: partial-thickness, Wound Size: 6 x 7.4 x 0.2 cm , clustered wound . Review of the Physician's Orders dated 3/2/2026, revealed, Sacrum (Stage 2) Special Instructions: Cleanse with wound cleanser. Pat dry. Apply collagen particles to the wound bed, cover with a dry/foam dressing, apply barrier cream to surrounding tissue on M, W, F until resolved. The facility failed to ensure Resident #90's sacral pressure ulcer/injury was accurately staged and assessed. 7. During an interview on 2/26/2026 at 8:37 AM, the DON stated that the facility staff completed skin sweeps of all residents the night of 2/25/2026. The DON was asked if there were any new skin injuries observed during the skin sweep. The DON stated, No. During an interview on 2/27/2026 at 12:33 PM, the DON was asked what date the staff did the skin sweeps on the residents. The DON stated, It was 2/25 and finished the morning of 2/26. She was then asked who participated in the skin sweep. The DON stated, DON, Unit Managers. In your interview yesterday, you stated, Nothing New related to the new skin sweep, the survey team found an additional 8 residents with pressure ulcers. Have you been notified by staff who these additional residents are. The DON stated, I heard partial of it yesterday evening and the remaining of it this morning. Administration generally gets those when discussed in the AM [morning] clinical meetings, but we have not had those [morning clinical meetings] this week. The DON was asked since finding out this new information, what interventions have been put in place, has the medical director been notified. The DON stated, .Orders have been put in, the Dietician and [named Medical Director], Nurse Practitioner, and Responsible Parties were notified. The DON was asked who was responsible for the wound process in the building. The DON stated, Myself, Wound Nurse and [named wound company] Physician Assistant if we need to change a process. During an interview on 2/27/2026 at 12:42 PM, the Administrator was asked if you are aware of the breakdown in the system for pressure ulcers. The Administrator stated, Towards the end of January we were having issues with the wound care nurse and in February the DON and I began digging into it. She was not doing what our expectations were and I suspended her. Then we completed our investigation and terminated her the week of 2/16/2026. The Administrator was asked if they had a Quality Assurance and Performance Improvement (QAPI) meeting about the wounds. The Administrator stated, No, our QAPI was scheduled for Tuesday of this week, but you all came in . No, we did not have one in January, since the ice storm. During a telephone interview on 3/2/2026 at 2:00 PM, the Medical Director was asked do you expect wound treatments to be completed as ordered. He stated, Yes, I ordered them for them to follow . |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to ensure the residents' environment was free from accident hazards for 2 of 3 (Resident #1 and #126) residents reviewed for accident hazards. The findings include: 1. Review of the facility policy titled, Oxygen Storage, dated 1/2025, revealed .The facility acknowledges the special hazards associated with the storage and use of compressed oxygen cylinders and the use of cryogenic (low temperature liquid) oxygen and has established procedures for the safe storage, use and transfer of oxygen in the facility.E-tanks [a 3-foot tall aluminum container filled with compressed medical-grade oxygen gas] will be stored in an approved O2 [oxygen] tank holding device or in an approved storage rack at all times. 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Pneumonia. ˆ Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment, which indicated he was cognitively intact. Resident #1 received oxygen therapy and experienced shortness of breath with exertion and when lying flat. ˆ Review of the Physician's Order dated 2/1/2026, revealed .1/22/2026.Oxygen Therapy: Oxygen via [by way of] (NC) [Nasal Canula] @ [at] 4Liters per minute. 3. Review of the medical record revealed Resident #126 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Dementia, and Hypertension. ˆ The admission MDS was not completed at time of survey. Observation in Resident #1 and #126's shared room on 2/23/2026 at 12:48 PM, revealed an E-tank was sitting on the floor in front of Resident #1's bed, unsecured and uncontained, without any a holding device or approved storage rack, approximately 5-6 feet from the room entry way. During an observation and interview in Resident #1 and #126's shared room on 2/23/2026 at 12:56 PM, Registered Nurse (RN) A was asked if the portable oxygen cylinder should be sitting on the floor. RN A stated, No, not like that.ˆ During an interview on 2/25/2026 at 4:35 PM, the Director of Nursing (DON) was asked should portable oxygen cylinders be sitting on the floor without a proper tank holding device. The DON stated, .they can't be on the floor.no . |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview,ˆthe facilityˆ failed toˆensure that medications wereˆproperly storedˆfor self- administration when medications were found unsecured in 1 of 55 (Resident #40) resident rooms during initial tour. The findings include: 1. Review of the facility policy titled, Medication Storage Bedside Medication Storage, dated 1/2024, revealed .The manner of storage prevents access by other residents.ˆ Lockable drawers or cabinets are required .The nurse will oversee storage security and accountability of bedside medications . Review of the facility policy titled, Medication Storage .of Medication, dated 1/2025, revealed .medication supplies should remain locked when not in use or attended to by persons with authorized access . 2. Review of the medical record revealed, Resident #40 was admitted to the facility on [DATE], with diagnoses including Heart Failure, Atherosclerotic Heart Disease, Essential Hypertension, and Muscle Weakness. Review of the facility document titled, Self-Administration of Medications, dated 4/25/2025, revealed Licensed Practical Nurse (LPN) C completed an assessment for the medication Moxifloxacin (antibiotic) Eye drops.I agree to: Keep them stored in my room in a secure location . Review of the annual Minimum Data set (MDS) assessment dated [DATE], revealed Resident #40 scored a 15 on the Brief Interview Mental Status (BIMS) assessment, which indicated she was cognitively intact and was independent with all Activities of Daily Living skills. Review of the document titled, Self-Administration of Medications, dated 12/16/2025, revealed LPN C completed an assessment for the medication Sucralfate Oral Suspension (used to treat ulcers).I agree to: Keep them stored in my room in a secure location . Observation in Resident #40's room on 2/23/2026 at 10:15 AM, 11:26 AM, and 2:07 PM, revealed Sucralfate Oral Solution on the overbed table and Moxifloxacin drops unsecured on the nightstand. During an interview on 2/23/2026 at 2:10 PM, LPN D was asked, should Resident #40 have medications on the overbed table and nightstand. LPN D Stated, She does self-administer some of her medications. LPN D did not remove the medications from Resident #40's overbed table or nightstand and place them in a secure location at that time. ˆ Observation in Resident #40's room on 2/24/2026 at 7:45 AM, 10:20 AM, and 12:36 PM, revealed Sucralfate Oral Solution on the overbed table and Moxifloxacin drops unsecured on the nightstand. ˆ During an interview on 2/25/2026 at 10:41 AM, the Director of Nursing (DON) was asked when a resident is screened and approved for self-administration of medications, where would you expect those medications to be stored. TheˆDON stated, They would be stored at [the] residents' preference at [the] bedside or in [the] residents' bedside drawer.ˆThe DON was asked if self-administration medications should be kept in a lock box or cabinet. The DON stated, No we do not have lock boxes. The DON was asked where she thinks these medications should be kept. The DON stated, Should be kept in a drawer. |