

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Lauderdale Community Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Lackey Lane Ripley, TN 38063	

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** 50408</p> <p>Based on policy review, medical record review, observation and interview, the facility failed to accurately assess residents with wandering for 1 of 12 residents (Resident #32) reviewed for accuracy of assessments.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility's policy titled, Elopement/Unsafe Wandering Plan dated 2/7/2012 revealed, . Wandering is a random or repetitive locomotion. This movement may be goal directed or may be non goal directed or aimless .residents shall be evaluated for unsafe wandering or elopement potential during each care planning review . Review of the medical record revealed Resident #32 was admitted to the facility on [DATE], with diagnoses including Cognitive, Social, or Emotional Deficit following Cerebrovascular Disease, Vascular Dementia Severe with Agitation, Diabetes, Chronic Kidney Disease, and Alzheimer's Disease. <p>Review of the Care Plan dated 5/1/2024, revealed Resident #32 was an Elopement risk/wanderer and wandered aimlessly.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed .Section E- Behavior .E0900 . Wandering .Behavior not exhibited .</p> <p>Review of the quarterly MDS dated [DATE], revealed .Section E- Behavior .E0900 .Wandering .Behavior not exhibited .</p> <p>During observations on 6/10/2024 at 10:09 AM and 12:06 PM, on 6/11/2024 at 8:21 AM, 9:49 AM, and 4:07 PM, and on 6/12/2024 at 3:00 PM, Resident #32 was wandering aimlessly in the facility.</p> <p>During an interview on 6/12/2024 at 8:30 AM, the Director of Nursing (DON) was asked if Resident #32 was a wanderer. The DON stated, Yes .</p> <p>During an interview on 6/12/2024 at 8:40 AM, The MDS Coordinator was asked if Resident #32 was a wanderer. The MDS Coordinator stated, Yes. The MDS Coordinator was asked if Resident #32 should have been coded on the MDS for wandering behavior. The MDS Coordinator stated, Yes .he has wandered since he was admitted here.</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
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38909</p> <p>Based on policy review, observation, and interview, the facility failed to ensure medications were properly and securely stored when medications were left in residents' rooms for 4 of 34 (Resident #9, #19, #28, and #30) sampled residents, and 1 of 4 medication storage areas were left unlocked and unattended by (Licensed Practical Nurse (LPN) B), and when opened, undated, and expired medications were noted in 1 of 1 medication storage rooms.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, Self-Administration of Medications dated 11/18/2016 revealed . self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be clinically appropriate for the resident .Prescription medication of the residents permitted to self-administer are stored in central medication cart or medication room .The nurse then records such self-administration on the MAR [Medication Administration Record] .</p> <p>Review of the facility's policy titled, Administering Medications dated 4/2019, revealed .During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse . Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary team, has determined that they have the decision-making capacity to do so safely .</p> <p>Review of the facility's policy titled, Storage of Medications dated of 11/2020, revealed .Drugs and biologicals used in the facility are stored in locked compartments .Only persons authorized to prepare and administer medications have access to locked medications .The nursing staff is responsible for maintaining medication storage .Drug containers that have missing, incomplete, improper, incorrect labels are returned to the pharmacy for proper labeling before storing .Compartments containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended .</p> <p>2. During an observation of medication administration on 6/12/2024 at 8:49 AM, revealed LPN D gathered medications for administration to Resident #9's room. LPN D placed medication cup of 13 meds and 2 eye drop medications on the resident's over the bed table. LPN D then exited resident's room to perform hand hygiene, leaving the medications unattended and out of sight on the over the bed table.</p> <p>3. During a random observation in Resident #19's room on 6/10/2024 at 9:05 AM, revealed Resident #19 was lying in bed with a medication cup on the over the bed table with approximately 15 pills in it. Resident #19 sat up on side of bed and self-administered the medication.</p> <p>During an interview on 6/11/2024 at 3:21 PM, the DON confirmed that medications should not be left at residents' bedside. The DON was asked if a resident should have an order and an assessment completed to self-administer medications. The DON stated, Yes. The DON confirmed that the facility does have wanderers in the building.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During a random observation in Resident #28's room on 6/10/2024 at 2:22 PM, revealed approximately 10 medications in a medication cup on the resident's over the bed table. Resident #28 confirmed that the medications were brought into his room and left at bedside after breakfast.</p> <p>During an observation and interview in Resident #28's room [ROOM NUMBER]/10/2024 at 2:27 PM, LPN E was asked if the medication cup should be left at the resident's bedside. LPN E confirmed that medications should not be left at bedside and removed the medications from Resident #28's room.</p> <p>5. During a random observation in Resident #30's room on 6/10/2024 at 9:37 AM, revealed Silver Sulfadiazine Cream (cream used to prevent wound infections) and wound cleanser on Resident #30's nightstand.</p> <p>During an interview on 6/10/2024 at 10:19 AM, LPN F was asked if the Silver Sulfadiazine Cream and wound cleanser should be left at the bedside. LPN F confirmed that it should not be left at the bedside.</p> <p>6. During an observation of medication administration on 6/11/2024 at 10:53 AM, revealed LPN B gathered medications, placed the medications in a medication cup, knocked and entered Resident #24's room, leaving the medication cart unlocked and out of sight on the 100 Hall.</p> <p>During an interview on 6/12/2024 at 3:42 PM, the DON was asked if medications should be left at the resident's bedside. The DON confirmed that medications should not be left at bedside. The DON was asked if the medication cart should be left unlocked during medication administration. The DON confirmed that the medication cart should not be left unlocked or unattended.</p> <p>7. During a random observation and interview in the Medication Storage Room on 6/12/2024 at 2:21 PM, revealed a vial of Tuberculin (A TB skin test solution) opened and undated, Osmolite 1.5 (nutritional liquid supplement) opened and dated on 5/31/2024 in the medication refrigerator, and Osmolite 1.5 opened and dated 6/1/2024 in the nourishment refrigerator. RN C was asked if the Tuberculin should be dated when opened, and if the Osmolite should be discarded within a certain timeframe. RN C confirmed that all opened medications should be dated when opened and that the Osmolite should have been discarded after 24 hours of being opened.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48285</p> <p>Based on policy review, observation, and interview, the facility failed to ensure that food was prepared, and served under sanitary conditions when the oven door had a brown dried liquid on the glass, on the top of the oven door, carbon build up on the frying pans, a rusted mesh skimmer, steam table pans wet nesting on top of other table pans, and top of the convection oven and doors had a shiny film. The facility had a census of 34 with 34 of those residents receiving a meal tray from the kitchen.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, CLEANING SCHEDULES, dated 8/31/2018, revealed .The Food and Nutrition services staff shall maintain the sanitation of the Food and Nutrition Services Department through compliance with written, comprehensive cleaning schedules developed for the community by the Director of Food and Nutrition Services or other clinically qualified nutrition professional .</p> <p>2. During an observation on 6/10/2024 at 8:35 AM, revealed the oven had dried brown liquid on the inside and top of the door.</p> <p>During an observation on 6/10/2024 at 8:40 AM, revealed 3 frying pans with dark thick carbon buildup.</p> <p>During an observation on 6/10/2024 at 8:45 AM, revealed a rusted mesh skimmer hanging with the frying pans.</p> <p>During an observation on 6/11/2024 at 8:46 AM, revealed a wet nesting of a steam table pan on top of another pans.</p> <p>During an interview on 6/10/2024 at 8:42 AM, the DM confirmed that there was a carbon build up on the frying pans. The DM stated, .they needed to be replaced . The DM also took the mesh skimmer down and threw it out and stated, I need to order a new one .</p> <p>During an interview on 6/10/2024 at 8:48 AM, the DM confirmed the brown dried liquid needed to be cleaned off oven.</p> <p>During an interview on 6/11/2024 at 8:50 AM, the DM confirmed the pans should not be stacked while wet.</p> <p>During an observation and interview on 6/11/2024 at 10:45 AM, revealed the convection oven had a shiny substance on the top. The DM stated, .It needed to be cleaned.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38909</p> <p>Based on policy review, observation and interview, revealed the facility failed to ensure infection control practices were followed for 2 of 6 sampled residents (Resident #9 and #27) during medication administration when 2 of 5 nurses Licensed Practical Nurse (LPN) D and Registered Nurse (RN) C failed to perform hand hygiene during administration of medications, and when RN C failed to sanitize reusable equipment after exiting a residents room with enhanced barrier precautions.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility's policy titled, Administering Medications dated 4/2019, revealed . Staff follows established infection control procedures for the administration of medication as applicable . Review of the facility's policy titled, Handwashing/Hand Hygiene dated 8/2019, revealed .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections .Wash hands .after contact with a resident .Use an alcohol based hand rub .before and after direct contact with residents .before preparing and handling medications .after contact with resident's intact skin .after contact with objects .after removing gloves .before and after entering isolation precaution settings .Washing hands .wet hands first with water, then apply an amount of product recommended . rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers .rinse hands with water and dry thoroughly with a disposable towel .Use a towel to turn the faucet off . Review of medical record revealed Resident #9 was admitted to the facility on [DATE], with diagnoses including Chronic Kidney Disease, Polyneuropathy, Anxiety, and Depression. <p>During observation of medication administration on 6/12/2024 at 8:49 AM, revealed LPN D entered Resident #9's room to administer medications and did not perform hand hygiene prior to donning gloves</p> <ol style="list-style-type: none"> Review of the medical record revealed Resident #27 admitted to the facility on [DATE], with the diagnoses including Stroke, Anemia, Coronary Artery Disease, Heart Failure, Hypertension, Diabetes, Hemiplegia, and Seizure. <p>Review of the Physician's Orders dated 6/11/24 revealed , .May cocktail medications together for medication administration via PEG tube .</p> <p>During observation and interview during medication administration on 6/11/2024 at 4:00 PM, revealed RN C failed to perform hand hygiene at the completion of medication administration via peg tube on Resident #27 and failed to clean the stethoscope after checking peg tube placement. RN C placed the stethoscope around her neck after use and exited Resident #27's room. When RN C was asked if she had completed all tasks related to care, RN C stated, Yes. RN C was asked about if she should clean the stethoscope. RN C confirmed that she should and proceeded to clean the stethoscope, then placed the stethoscope back around her neck after she cleaned it.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/12/2024 at 3:42 PM the Director of Nursing (DON) confirmed nurses should perform proper hand hygiene with medication administration. The DON was asked the process of cleaning of reusable equipment after each use. The DON confirmed that reusable equipment should be cleaned with a bleach wipe and allowed to dry on a clean surface.</p>		