STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675592	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C C Young Memorial Home	4849 W. Lawther Dr. Dallas, TX 75214

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments inaccessible to unauthorized staff, visitors, and residents for 1 (Resident #63) of 40 residents reviewed for medication storage. The facility failed to ensure Resident #63 did not have medications stored at the bedside. This failure could place residents at risk of ingesting unprescribed medications resulting in adverse health consequences. Findings included: Review of Resident #63's face sheet revealed a [AGE] year-old woman admitted on [DATE] with diagnoses of hypertension, muscle weakness, abnormalities of gait and mobility, lack of coordination, need assistance with activities of daily living, and chronic diastolic (congestive) heart failure. Review of Resident #63's annual MDS dated [DATE] reflected she had a brief interview of mental status score of 14, indicating no cognitive impairment. Resident # 63 required supervision or moderate assistance with activities of daily living. Review of Resident #63's physician orders dated 10/02/24 reflected the following medications were not ordered for the resident; Tums Ultra 400 mg calcium (1,000 mg) chewable tablet, Nasal Spray 12 Hour 0.05 % (Oxymetazoline), Cortizone-10 1 % topical gel (Hydrocortisone), Debrox 6.5 % ear drops (Carbamide peroxide), and fiber gummies (chewable). Review of Resident #63's care plan dated 10/03/24 revealed, (Resident #63) wishes to administer some of her own medication. Resident's cognition level BIMS score of 14. Goal, (Resident #63) will successfully name medication and reason for administration within next 90 days.Obtain order for self-medication administration, .Ensure medications can be safely secured from other resident's access within room. Ensure (Resident #63) is able to demonstrate safe handling and storage. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/02/24 at 11:45 AM revealed Resident #63 was in bed, awake, and alert. The following medications were noted on the bedside table; bottle of Xylident dry mouth, 1 tube of Hydrocortisone cream which was about half used, 1 bottle of ear wax removal, and 2 bottles of nasal spray. On the shelf wall there was a bottle of fiber chewable gummies. In an interview on 10/02/24 at 11:52 AM with Resident #63, she stated she had been in the facility for about 1 year and reported no concerns. Resident #63 stated she ordered the medications from store and self-administered the medications and at times being assisted by the staff, but she was not able to identify the staff who assisted her. Resident #63 stated she had been using the medication for a while and she did not give a specific timeline she had used the medications. She stated she always stored the medications on the bedside table and the shelf. Resident #63 stated she had not been educated on self-administration of medications. In an interview on 10/02/24 at 01:51 PM with LVN A she stated she was the charge nurse of Resident #63. LVN A stated she was not aware of the medications in the resident's room, but again stated the resident had been assessed for self-medication administration and she was looking for the record in the resident's clinical record. LVN A then stated she was going to get the document from a printer, and she did return. Later, LVN A was noted in Resident #63's room, and she stated she had gone to help the staff who was getting Resident #63 in the wheelchair. LVN A then stated she was not able to find the self-administration assessment or the orders to indicate the resident could administer her own medications. LVN A stated Resident #63 was supposed to have the orders of all the medications she was taking. LVN A stated she saw the medications in the resident's room on the bedside table and on the shelf. LVN A stated the resident was supposed to have orders of the medications and complete a self-medication administration assessment on the resident. The medications were not supposed to be in the resident's room on the bedside table or shelf, they were supposed to be stored in a safe place. Resident #63 self-administering medications without the knowledge of the facility could lead to medication interaction with the ones the resident was prescribed which could lead to side effects. In an interview on 10/02/24 at 03:53 PM with the ADON she stated she was made aware of Resident #63 having medications in her room. The ADON stated the staff were supposed to report to the charge nurse any medications noted in any resident's room. The ADON stated Resident #63 was not supposed to have medications in the room without the physician's order. The ADON stated Resident #63 had not been assessed for self-medication administration prior to the medications being noted in the room. The ADON stated she called the resident's primary care provider and obtained the orders for the medication, and she will complete the self-medication administration assessment. Resident's self-administering medications could lead to medication interactions and even overdose. In an interview on 10/02/24 at 04:20 PM with the DON he stated he had just been notified that the resident had medications in the room. The DON stated the self-medication administration assessment was being completed today and the orders for the medications would be obtained from the primary care provider. The DON stated the resident was not supposed to have medications in the room and use without the doctor's orders and staff assessment for self-medication administration. The DON stated the staff were supposed to report if there were any mediations in the resident's room to prevent medication interactions, overdose, or side effects. The facility was supposed to be aware of all the medications the resident was taking. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy undated and titled, Medication Storage reflected, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. Review of the facility policy revised February 2021 and titled Self - Administration of Medication reflected, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.7. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them. 8. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.