STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225110	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Massachusetts Veterans Home at Chelsea	100 Summit Street Chelsea, MA 02150

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on observation, interview, and record review for two Residents (#30, #264) out of 26 sampled residents, the facility failed to implement the plan of care. Specifically: 1. For Resident #30, the facility failed to follow the physician's order to apply heel protector booties. 2. For Resident #264, the facility failed to develop a plan of care for a pacemaker. Findings include: 1. Resident #30 was admitted to the facility in February 2024, and had diagnoses which included diabetes mellitus, hemiplegia, and peripheral vascular disease. Review of Resident #30's Minimum Data Set (MDS) assessment, dated 8/19/24, indicated he/she had a Brief Interview for Mental Status score of 15, signifying intact cognition, and was at-risk for the development of pressure ulcers. Review of Resident #30's most recent care plan indicated he/she was at risk for skin breakdown and required a pressure-relieving mattress. Review of Resident #30's physician order dated 9/30/24 indicated: - Please use heel protector booties while in bed. Review of Resident #30's Treatment Administration Record (TAR) dated October 2024 indicated the physician's order, dated 9/30/24 for heel protectors, was not transcribed onto the TAR. There was no documentation to indicate staff offered heel protectors to Resident #30. On 10/7/24 at 10:13 A.M. and on 10/8/24 at 8:47 A.M., the surveyor observed Resident #30 lying awake, in bed. Resident #30 was not wearing heel protector booties. The surveyor observed that booties were not visible in the bedroom or bathroom. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/8/24 at 8:50 A.M., Resident #30 said his/her ankle was sore, but that the skin was intact. Resident #30 said staff had discussed with him the use of protective booties while in bed to provide comfort to the ankle, but staff had not applied them. During an interview on 10/8/24 at 8:58 A.M., Certified Nurse Aide (CNA) #1 said she was assigned to Resident #30 on a regular basis. CNA #1 said Resident #30's left ankle was sore, but she was unaware that Resident #30 should wear heel protector booties while in bed. During an interview on 10/8/24 at 9:23 A.M., Nurse #5 said she was unaware there was a physician's order for Resident #30 to wear heel protector booties while in bed. 36797 2. Review of the facility policy titled Care Planning, revised 12/12/23 indicated the following: - it is the policy of the Veterans Home to develop and implement a comprehensive, person-centered care plan for each resident consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing and mental and psychological needs that are identified in the resident's comprehensive assessment. Review of the facility policy titled Pacemaker (Care of Patient with Permanent Cardiac) dated last reviewed 10/08. indicated the objective was to initiate and maintain the heartbeat when the normal pacemaker fails to do so in such conditions as AV block and in [NAME] arrhythmia's (slow heart rate). Further review indicated the following: 1. Assess patient's knowledge of his/her condition. 2. Attach identification bracelet stating type of pacemaker include physician's name, pacemaker rate and date of insertion. 3. explain condition to patient to allay fears and anxiety. 6. Observe and record vital signs at frequent intervals to determine effect of pacemaker. 8. Change of more than five impulses, missed beats, or failure of pacemaker to sense when rate drops below pre-set rate should be reported to physician. Resident #264 was admitted to the facility in February 2024 with diagnoses including dementia, diabetes and weight loss. Review of the hospital discharge report dated 9/26/24, indicated that Resident #264 has a single chamber medtronic pacemaker implanted on 1/12/17. Further review indicated the make, model, serial number and rate at which the pacemaker was set (45 beats per minute). Review of the current care plan dated 2/6/24, failed to indicate a care plan for the care of a pacemaker. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review Nursing Progress notes dated September 2024 and October 2024 failed to indicate Resident #264 had a pacemaker. Review of the physician's orders date October 2024 failed to indicate orders for the care of a pacemaker. Review of the Medication Administration Record dated October 2024 failed to indicate physician orders for the care of the pacemaker. Review of the Treatment Administration Record dated October 2024 failed to indicate physician orders for the care of the pacemaker. During an interview on 10/08/24 at 9:59 A.M., Nurse #1 said she was not aware Resident #264 had a pacemaker. Nurse #1 then said that she was not aware of a follow-up appointment scheduled for Resident #264 to check the pacemaker. Nurse #1 then said she would have to check with the clinic to see when a follow-up appointment would be needed.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 36797 Based on record review and interview the facility failed to ensure they followed standards of practice for 1 Resident (#264) out of a total sample of 26 residents. Specifically the facility failed to obtain lab results for a lab obtained during a hospitalization which was still pending upon discharge of the Resident from the hospital. Findings include: Resident #264 was admitted to the facility in February 2024 with diagnoses including dementia, diabetes and weight loss. Review of the medical record failed to indicate the facility had acquired the lab results. Review of the hospital document titled Hospital Course, dated 9/27/24 indicated that there were pending labs for Legionella. Review of the nursing progress notes failed to indicate that the facility called the hospital for the results of the pending labs. Review of the physician progress notes failed to indicate the physician was notified of the pending lab results. During an interview on 10/08/24 at 10:40 A.M., Nurse #1 said she was not aware that there was a pending lab result from Resident #264's 9/27/24 hospital discharge. During an interview on 10/08/24, at 10:57 A.M., the Superintendent of Operations said that it is the expectation that the nurse would call the hospital for the results of a pending lab on discharge from the hospital.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to ensure one Resident (#40) was safe from accidents/hazards out of a total sample of 26 residents. Specifically, the facility failed to appropriately assess the Resident for safety and ensure a safety care plan was developed to prevent an elopement. Findings include: Review of the facility policy titled Soldier's Home Policy Guide: Code Yellow: Missing Veteran, revised 9/22/23, indicated the following: -Policy: Veterans who are cognitively impaired have the right to a safe environment. Veterans who wander, exit seek, and/or elope their assigned unit will be identified and returned to their unit utilizing an expedited procedure for searching the Soldier's Home premises and surrounding communities. Resident #40 was admitted to the facility in February 2024 with diagnoses including psychiatric disorder and depression. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #40 scored an 8 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. Review of the MDS indicated Resident #40 is independent with wheelchair mobility. Review of the clinical record indicated that Resident #40 has an activated healthcare proxy as of 1/15/22 (when a person is designated to make decisions on the Resident's behalf when they are no longer able to). Review of the facility document titled Wander Data Collection Tool, dated 3/18/24 and 5/19/24, indicated that Resident #40 was not at risk of elopement, but that on 8/9/24, Resident #40 became a wander risk. Review of the Nurse Practitioner progress note, dated 7/19/24, indicated Resident #40 had left the campus in his/her wheelchair and was unable to return. Resident #40 stated that he/she cannot go uphill with his/her wheelchair and a good Samaritan called 9-1-1 to help Resident #40. Resident #40 had left the facility using his/her key card access. Review of the clinical record indicated that Resident #40's key card access was revoked after his/her elopement off campus. Review of the incident reports for Resident #40 indicated that on 9/28/24, Resident #40 had eloped off his/her locked unit and was found outside alone. Review of the incident report indicated that the employee entrance door on the unit was broken and Resident #40 was able to get off of the unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan for Resident #40 indicated that on 9/28/24, 2 months after the initial elopement, a care plan was developed for Resident #40's elopement risk. During an interview on 10/8/24 at 1:04 P.M., the Director of Nursing said the Resident agreed to only go out on the patio with his/her keycard access. The Director of Nursing said that physical therapy is the department who assesses resident's capability of being able to have access to the key cards. During an interview on 10/8/24 at 1:17 P.M., the Physical Therapist said he assesses a resident's physical capabilities and navigation abilities when determining key card access, but never assesses their cognitive ability to leave campus. The Physical Therapist said Resident #40's health care proxy was pushing for Resident #40 to have key card access since his/her freedom is tied to his/her mental health. The Physical Therapist said that Resident #40 was getting confused and lost during his/her assessment, but that the health care proxy was adamant. During an interview on 10/8/24 at 1:56 P.M., Social Worker #1 said that given Resident #40's mental health status, he would not have recommended giving the Resident a key card. Social Worker #1 said his involvement in the decision to grant key card access is minimal. During an interview with the Administrator and the Deputy Superintendent on 10/8/24 at 4:10 P.M., the Administrator said that she would expect that the Physical Therapist would document and communicate all concerns with the Resident's ability to safely navigate outside independently during the assessment. The Administrator said that the health care proxy cannot dictate care when it comes to safety and the Physical Therapist should not have considered the health care proxy's wishes when making the decision to sign off on the safety of the Resident's ability to safely navigate outside.

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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** 41019 Based on record review and interview, the facility failed to develop a trauma informed plan of care for 2 Residents (#109 and 92) out of a total sample of 26 residents. Findings include: Review of the facility policy titled Trauma Informed Care, revised 9/22/23, indicates the following: - It is the policy of the Massachusetts Veterans Home at [NAME] to provide care and services to residents that meet professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. - The Veterans Home will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, and primary care clinician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions. 1. Resident #109 was admitted in 08/2024 with diagnoses including post traumatic stress disorder (PTSD). Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #109 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of Resident #109's history and physical assessment for long term care, dated 8/13/24, indicated Resident #109 has PTSD from physical abuse from his/her father. Review of the current care plan did not indicate that a trauma-informed plan of care was developed for Resident #109 or a PTSD assessment was completed. During an interview on 10/9/24 at 1:56 P.M., Social Worker #1 said that if a Resident has a diagnosis, then they should have a PTSD care plan. Social Worker #1 said that the care plan should include PTSD triggers and how to manage those triggers. Social Worker #1 said that the social worker who is responsible for the Resident should develop the care plan based on the PTSD assessment. 36797 2. For Resident #92 the facility failed to develop a resident centered comprehensive care plan that included triggers for PTSD. Resident #92 was admitted to the facility in March 2024 with diagnoses including PTSD, bipolar depression and kidney disease. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility document titled Behavioral Assessment/PTSD, not dated, indicated that Resident #92's triggers for an episode of PTSD are over stimulation and not understanding expectations. Further review indicated that early warning signs of distress are cursing, name calling, saying he/she does not feel well or feels hot. Further review indicated that his/her coping mechanisms are a change of activity, medication, warm shower, calling friends or family, watching TV and going outside. Review of the care plan dated 3/20/24, indicated a problem for PTSD and that Resident #92 was 100% disabled as a result of PTSD. Further review failed to indicate resident specific triggers for PTSD. During an interview on 10/08/24 at 1:56 P.M. Social Worker (SW) #1 said that the assigned social worker is responsible for assessing the residents for PTSD and then developing the care plan based on the results. SW #1 then said that he is the assigned SW for Resident #92 and did not follow through with including the individualized triggers that were found during the assessment, onto the care plan and should have.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 36797 Based on record review and interview the facility failed to ensure the physician was notified of a recommendation from a consulting dentist for one Resident (#79) out of a total sample of 26 residents. Findings include: Resident #79 was admitted to the facility February 2024 with diagnoses including dementia, diabetes and cancer. Review of the dental consult dated 7/15/24 indicated a recommendation for Peridex mouth rinse twice daily, swab with a toothette using 1/4 ounce of Peridex after breakfast and at bedtime. Review of the physician's orders dated July 2024, August 2024, September 2024 and October 2024 failed to indicate an order for Peridex mouth rinse. Review of the nursing progress notes dated after 7/14/24, failed to indicate acknowledgement or notification of the physician regarding the recommendation for the Peridex mouth rinse made by the dentist on 7/15/24. Review of the physician's progress notes failed to indicate a note written after 7/12/24. During an interview on 10/08/24 03:21 PM the Deputy Superintendent said that she would expect that nursing would inform the physician of the dentist's recommendation for Peridex and document the physician's response in the medical record. The Deputy Superintendent then said that she was not able to locate a policy and procedure regarding the notification of a consulting physician's recommendations to the primary care physician.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to provide appropriate behavioral health services for 1 Resident (#40) out of a total sample of 26 residents. Findings include: Review of the facility policy titled Behavioral Management, revised 9/23/23, indicates the following: - The Massachusetts Veterans Home will maintain an interdisciplinary Behavioral Management Committee (BMC) designed to identify, intervene, and monitor isolated and ongoing behavioral events occurring within the facility. - Committee members will intervene as described below when behavioral events occur and will document all assessments and changes in designated sections of resident's medical record. - If psychotherapy is indicated, LICSW (licensed social worker) assessing the resident to determine the type of therapy, frequency, and duration of services recommended. - Documenting intervention and outcome in psychosocial section of the medical record, care plan, and ensuring this is reflected in the Minimum Data Set (MDS). Resident #40 was admitted in February 2024 with diagnoses including psychiatric disorder and depression. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #40 scored an 8 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. Review of the current care plan for Resident #40, initiated 10/7/21, indicated the following: - Resident has a history of major depressive disorder and suicide ideation evidenced by self-report, discussion, chart review and reports from the interdisciplinary team. - When suicide ideation behavior witnessed, call clinician and/or social worker to evaluation for risk and subsequent interventions. - Keep close monitor for safety until cleared by clinician or nursing supervisor - Assess environment for safety - Complete event report - Refer to [contracted] Mental Health Services in plan of care - Behavior Committee to monitor for ongoing evaluation (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #40's hospital discharge paperwork, dated 3/19/24, indicated that Resident #40 was expressing suicidal ideation and wanted to end it all. Resident #40 was cleared the next day to come back to the facility. Review of the clinical record did not indicate that any behavioral health services were provided by the facility to manage the Resident's mood after re-admission. Review of the Nurse Practitioner note, dated 7/19/24, indicated Resident #40 was experiencing worsening depression with continued decline and a mental health visit and psych follow up was recommended. Review of the record did not indicate that psych services or a mental health visit took place after the Nurse Practitioner note. Review of the Nurse Practitioner note, dated 7/24/24, indicated that Resident #40 was sent out to the hospital for a psychiatric evaluation. Review of the medical record failed to indicate that any behavioral health services were implemented after the psychiatric admission in July 2024. Review of the Nurse Practitioner note, dated 9/26/24, indicated Resident #40 was having increased anxiety and behavioral disturbances with suicidal ideation. Resident #40 was sent to the emergency department for an evaluation. Review of the hospital discharge paperwork, dated 9/26/24, indicated the following: I spoke with PES (psychiatric emergency service), who states the patient has a bed assigned for voluntary inpatient admission at the VA (veteran's affairs). Pending transfer at time of shift change. Review of the emergency department note, dated 9/26/24, indicated the following: . refusing his/her meds for 4-5 days, plan to jump out the window (not possible at Soldiers Home) called in by Soldiers Home physician. Is a VA patient. They tried to transfer him/her there. EMS (emergency medical services) brought him/her here instead. Needs geri-psych admission. Resident #40 was admitted back to the facility. Review of the record failed to indicate that Resident #40 was provided with a geri-psych admission or reviewed/assessed by psych services. During an interview on 10/8/24 at 1:40 P.M., the Director of Nursing said that Resident #40 was supposed to be sent out to a different psych hospital to have a subsequent psychiatric inpatient stay, but the ambulance who picked the Resident up would not go to the location of the geri-psych hospital. The Director of Nursing said that by the time the Resident came back to the facility, his/her pending bed at the geri psychiatric hospital was no longer being held. Resident #40 had never gone for an inpatient psych stay. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/8/24 at 1:56 P.M., Social Worker #1 said Resident #40 has been a long term resident at the facility and was aware of his/her psych hospitalization in March 2024. Social Woker #1 said Resident #40 had a section 12 in July and two weeks ago had another one, but was sent back from the hospital after he/she was medically cleared. Social Worker #1 said that Resident #40 was sometimes receiving individual therapy at the VA, but said it wasn't consistent and there hasn't been an individual therapist since May or June. Social Worker #1 said the VA offers group therapy, but that is not the best for Resident #40. Social Worker #1 said the VA usually hires interns and he is unaware if they are licensed individuals. Social Worker #1 said that he does not have access to the therapy notes and hasn't called to receive them or communicate with the VA providing therapy. During an interview with the Administrator and the Deputy Superintendent on 10/8/24 at 4:10 P.M., The Administrator then said that she was not sure if the facility could obtain psychological therapy information from the Veterans Administration where the Resident goes outpatient for mental health therapy visits. The Deputy Superintendent said that it is the facilities responsibility to ensure that the residents in the facility are receiving the mental health they need and that based on the continued suicidal ideations with subsequent psychiatric hospitalization s the Resident was experiencing, it may be an issue that the facility should have looked into.

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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. 48990 Based on observation, interviews, and record review, the facility failed to ensure prescribed medications were secured in locked compartments or under proper supervision for two Residents (#31 and #7) out of 26 total sampled residents. Specifically: 1.) For Resident #31, the nurse left two pills at bedside without proper supervision. 2.) For Resident #7, the nurse left topical prescription medication at bedside without proper supervision. Findings include: Review of the facility policy titled Medication Storage and Security, revised 9/26/22, indicated: - It is the policy of the facility that medications be kept secure. - Medications being administered must be under constant surveillance. - Medications removed from a medication storage area must always remain with the individual and are not to be left unattended. Review of the facility policy titled Bedside Medication Storage and Self Administration of Meds, revised 10/24/23, indicated: - Bedside storage of medications is indicated on the resident medication administration record (MAR) and in the care plan for the appropriate medications. 1.) Resident #31 was admitted to the facility in June 2024 with diagnoses including legal blindness and osteoarthritis. Review of the most recent Minimum Data Set (MDS) assessment, dated 9/14/24, indicated Resident #31 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. Review of Resident #31's assessment titled Patient/Resident Assessment of Ability to Self-Medicate, dated 6/20/24, indicated Resident #31 was not safe to self-administer medications. Review of Resident #31's medical record, including MAR and care plan, failed to indicate Resident #31 could store any medications at bedside. On 10/7/24 at 10:20 A.M., the surveyor observed Resident #31 with two blue pills in a medication cup beside his/her breakfast tray. There was no nurse within view of the Resident. Resident #31 said he/she doesn't like to take them all at once, so the nurse sometimes leaves medication to take later. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225110	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Massachusetts Veterans Home at Chelsea	100 Summit Street Chelsea, MA 02150

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	During an interview on 10/7/24 at 10:29 A.M., Nurse #2 said he left Resident #31's pills before he/she took all of them. Nurse #2 said he should not have left the pills because Resident #31 required constant supervision until all his/her pills were taken. During an interview on 10/8/24 at 1:20 P.M., Nurse #3 said no medications should be left at bedside unless the Resident was assessed to be safe for the ability to self-administer the specific medication and had a physician's order to store the specific medication at bedside. During an interview on 10/9/24 at 9:59 A.M., the Director of Nursing (DON) said Nurse #2 should not have left pills unattended at bedside if he was out of view of the Resident. 2.) Resident #7 was admitted to the facility in October 2023 with diagnoses including hypertension and back pain. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/30/24, indicated Resident #7 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of Resident #7's physician's order, initiated 10/18/23, indicated: - Lidocaine 5% patch (a topical prescription medication), 1 patch, apply to right shoulder. - Lidocaine 5% patch, 1 patch, apply patch to lumbar spine. Review of Resident #7's medical record, including MAR and care plan, failed to indicate the Resident could self-administer medications or have any medications stored bedside. On 10/7/24 at 9:08 A.M. and 9:33 A.M., the surveyor observed two Lidocaine patches, which were opened and dated 10/7/24, with the plastic protector intact on the back on Resident #7's bedside table. During an interview on 10/9/24 at 8:50 A.M., Nurse #2 said he left the Lidocaine patches at bedside, but he should not have. During an interview on 10/8/24 at 1:14 P.M., Nurse #4 said he cares for Resident #7 frequently and there is no reason Lidocaine patches should have been left at his/her bedside. During an interview on 10/8/24 at 1:20 P.M., Nurse #3 said no medications should be left at bedside unless the Resident was assessed for the ability to self-administer the specific medication and had a physician's order to store the specific medication at bedside. During an interview on 10/9/24 at 9:59 A.M., the Director of Nursing (DON) said Lidocaine patches should never had been left at bedside.