STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255216	A. BUILDING _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW NURSING & REHABILITATION CENTER	**1600 WEST CLAIBORNE AVENUE EXTENDED GREENWOOD, MS 38930**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigations survey at the facility for two (2) complaint investigations (CI MS #23248 and CI MS #23236) on 11/8/23 and 11/9/23. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated CI MS #23236 for Environment Services and Environment/other and did not cite any deficiencies. The SA investigated CI MS #23248 for Nursing Services and Resident Rights and cited F656, F658 and F760. The facility held a license for 91 beds, with a census of 53.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		12/22/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/04/2023

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.

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F 656	Continued From page 1 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility policy/procedure review, and record review, the facility failed to implement the interventions of a care plan for a resident related to medication administration for one (1) of six (6) residents care plans reviewed. Resident #1 Findings include: Review of the facility's policy/procedure "Using the Care Plan" last revised "August 2006" revealed the "Policy Statement: The care plan	F 656	LPN 1 was in-serviced and counselled by the Director of Nursing on 10/18/2023 on Medication Administration. Resident #1□s 8:00am narcotic was ordered by the Medical Director to be held and monitor for 24 hours for adverse reactions. Facility conducted an Emergency QA on 10/18/2023 in regards to the medication error and the Medical Director was in attendance. The Assistant Director of Nursing assessed Resident #1 on 10/18/2023 with no adverse reactions	

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F 656	Continued From page 2 shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident." Record review of Resident #1's care plan revealed, "Pain risk r/t (related to) diagnosis Breast Cancer and impaired mobility ...Start date 10/06/2023 ...Roxicodone 30 mg (milligrams) tablet: take one tablet by mouth Q (every) 4 (four) hours 12A/4A ...Dilaudid 4 mg tablet: take three tables (12 mg) by mouth q 4 hours PRN (as needed) ..." Record review of Resident #1's Physician Orders List revealed orders dated 10/6/23 for Roxicodone 30 MG (milligrams) 1 tablet every (q) four (4) hours (hr) and Dilaudid 4 MG tablet three (3) tablets q 4 hrs PRN. All medications are taken by mouth (PO). Record review of the Report of Investigation signed by the Administrator and Director of Nursing (DON) on 11/10/23 revealed, "Date of occurrence: 10-18-23 Time of occurrence 7:00 AM ...9. Unusual occurrence ...Medication Error ...Injury: NO ...Details of investigation ...On 10/18/2023 at approximately 6:25am while conducting a medication count with the oncoming nurse, (Proper Name Licensed Practical Nurse (LPN)#1) noticed she performed a medication error on resident (Proper Name Resident #1). Resident #1's order was for 3 (three) dilaudid and 1 (one) roxicodone to be administered and (LPN#1) administered 1 dilaudid and 3 roxicodone. The medication error occurred two times, once at 12:00am and again at 4:00am on 10/18/2023. (LPN#1) then notified the on-call nurse who in turned notified the Director of	F 656	noted. On 10/18/2023 the facility Care Plan nurse reviewed Resident #1□s care plan on Pain Risk with no negative findings noted. All residents have the potential to be affected. Nursing staff was in-serviced on 11/9/2023 on by the Director of Nursing on Medication Administration to ensure the residents care plans were being followed and residents received the medication as ordered. Facility held monthly Quality Assurance meeting on 11/22/2023 and discussed the potential findings of the alleged deficient practice and steps on how to prevent from further occurrences. Beginning 11/09/2023 the Director of Nursing will observe medication administration with one nurse per shift one (1) time a week covering all three shifts for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure care plans in regards to medication administration are being followed. Findings will be reported to the Quality Assurance Performance Improvement Committee by the Assistant Director of Nursing for three (3) months for review and recommendations. The next Quality Assurance meeting is scheduled 12/20/2023 to review the facility findings. The Administrator is responsible for on-going monitoring and compliance.	

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F 656	Continued From page 3	F 656		

Nursing. The facility MD (Medical Doctor) was notified and gave the order to hold (Resident #1's) 8:00am narcotics and monitor for 24 hours for any adverse reactions. The Director of Nursing notified the Pharmacy of the medication error and conducted a narcotic count on all carts with no discrepancies noted with the exception of the medication error. Based on resident interview by the Assistant Director of Nursing, (Resident #1) stated she did not notice the difference in appearance of the medication given but consumed them anyway ..."

Interview with the facility Care Plan Nurse, on 11/9/23 at 1:15 PM revealed, pain medications are listed on the pain care plan interventions. The pain care plan also has why the resident is taking the pain medication. Resident #1's care plan was not followed.

Interview with the facility's DON on 11/8/23 at 1:20 PM, revealed that nurses are supposed to follow the care plans and that care plans have the medications listed.

A post survey interview with LPN #1 on 11/17/23 at 12:10 PM, revealed that she gave Resident #1 the wrong pain medication twice in 1 night. She confirmed that nurses are trained on following the care plan and MD orders and med pass administration. She stated that the care plans do include the medications and that staff is supposed to follow the interventions and Resident # 1's care plan was not followed.

Record review on 11/8/23 of Resident #1's Face Sheet revealed she was admitted into the facility on 10/6/23 with diagnoses including Intraductal carcinoma in situ of right breast, Anxiety and

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F 656	Continued From page 4 Secondary malignant neoplasm of bone. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/23 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that Resident #1 is cognitively intact.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, facility policy/procedure review, and record review, the facility failed to ensure that one (1) of six (6) residents sampled received care and services that would meet the professional standards of quality as evidenced by Resident #1 not receiving medications as ordered. Findings include: Review of the facility's policy for "Administering Medications" last revised "December 2012" revealed "Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed." Review of the facility's policy for "Adverse Consequences and Medication Errors" last revised "April 2014" revealed the "...Policy Interpretation and Implementation... 5. A "medication error" is defined as the preparation or	F 658	LPN 1 was in-serviced and counselled by the Director of Nursing on 10/18/2023 on Medication Administration. Resident #1's 8:00am narcotic was ordered by the Medical Director to be held and monitor for 24 hours for adverse reactions. The Assistant Director of Nursing assessed Resident #1 on 10/18/2023 with no adverse reactions noted. Facility conducted an Emergency QA on 10/18/2023 in regards to the medication error and the Medical Director was in attendance. All residents have the potential to be affected. Nursing staff was in-serviced on 11/9/2023 on by the Director of Nursing on Medication Administration to ensure residents receive care and services that	12/22/23

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F 658	Continued From page 5 administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 6. Examples of medication errors include: c. Wrong dose..." Record review of the facility's "Charge Nurse-LPN (Licensed Practical Nurse)" job description dated "2003" revealed the "Duties and Responsibilities" and the section "Drug Administration Functions" are for the LPN (Licensed Practical Nurse) to "Prepare and administer medications as ordered by the physician." Record review of Resident #1's Physician Orders List revealed orders dated 10/6/23 for Roxicodone 30 MG (milligrams) 1 tablet every (q) four (4) hours (hr) and Dilaudid 4 MG tablet three (3) tablets q 4 hrs PRN. All medications are taken by mouth (PO). Record review of the Report of Investigation signed by the Administrator and Director of Nursing (DON) on 11/10/23 revealed, "Date of occurrence: 10-18-23 Time of occurrence 7:00 AM ...9. Unusual occurrence ...Medication Error ...Injury: NO ...Details of investigation ...On 10/18/2023 at approximately 6:25am while conducting a medication count with the oncoming nurse, (Proper Name Licensed Practical Nurse (LPN) #1 noticed she performed a medication error on resident (Proper Name Resident #1). Resident #1's order was for 3 (three) dilaudid and 1 (one) roxicodone to be administered and (LPN#1) administered 1 dilaudid and 3 roxicodone. The medication error occurred two times, once at 12:00am and again at 4:00am on 10/18/2023. (LPN#1) then notified the on-call	F 658	would meet the professional standards. The Pharmacy consultant conducts a Med Pass observation with one nurse each month and last conducted one on 11/21/2023 with no negative findings noted. On 11/18/2023 the Assistant Director of Nursing performed a Med Pass checkoff on LPN #1 with no negative findings noted. Checkoffs will begin on 11/18/2023 and will be performed on all nurses by the Director of Nursing and Assistant Director of Nursing until all nurses have been observed. Facility held monthly Quality Assurance meeting on 11/22/2023 and discussed the potential findings of the alleged deficient practice and steps on how to prevent from further occurrences. Beginning 11/09/2023 the Director of Nursing will observe medication administration with one nurse per shift one (1) time a week covering all three shifts for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure residents receive care and services that would meet the professional standards. Findings will be reported to the Quality Assurance Performance Improvement Committee by the Assistant Director of Nursing for three (3) months for review and recommendations. The next Quality Assurance meeting is scheduled 12/20/2023 to review the facility findings. The Administrator is responsible for on-going monitoring and compliance.	

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F 658	Continued From page 6	F 658		

nurse who in turned notified the Director of Nursing. The facility MD (Medical Doctor) was notified and gave the order to hold (Resident #1's) 8:00am narcotics and monitor for 24 hours for any adverse reactions. The Director of Nursing notified the Pharmacy of the medication error and conducted a narcotic count on all carts with no discrepancies noted with the exception of the medication error. Based on resident interview by the Assistant Director of Nursing, (Resident #1) stated she did not notice the difference in appearance of the medication given but consumed them anyway ..."

In an interview with the facility Administrator at 11:20 AM revealed there was a medication error with Resident #1.

In an interview with the facility's DON on 11/8/23 at 1:20 PM, revealed that nurses are supposed to follow the care plans and that care plans have the medications listed. The care plans are updated when there are changes in the resident's care. She stated that LPN #1 was counseled and re-inserviced on medication administration. She stated she did not in-service the other nurses on medication administration when this incident occurred. Nurses are observed during medication pass by her, the Assistant Director of Nursing (ADON) and pharmacy consultant frequently. She stated the pharmacy consultant will watch medication pass during most visits.

In an interview with the ADON on 11/8/23 at 12:40 PM, she revealed, "on 10/18/23 12:00 AM and 4:00 AM (Resident #1) received 3 Roxicodone tablets and 1 Dilaudid tablet at each of those medication passes. She was supposed to get 1 Roxicodone tablet and 3 dilaudid tablets. When I

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explained to her there was a medication error, she stated she did notice there were 3 blue pills instead of 3 white pills. She never said anything to anyone. This nurse did it twice that shift. The nurse discovered the error at the end of the shift narcotic count. She was counseled and in-serviced on medication errors. The resident's vital signs were monitored for 24 hours. There was no increase in pain and no harm. She said she didn't want the nurse fired. We held all the narcotic pain medication until the 12:00 PM doses.

Interview with Resident #1 on 11/8/23 at 2:25 PM, revealed, "What I got was 3, 30 MG Roxicodone and 1, 4 MG Dilaudid. I got it at 12 midnight and again at 4:00 AM on October 18th. I do not know the nurse's name. I did not need any emergency care. The nursing home staff told me about the medication error. They held my other pain meds until 11:00 AM. They wake me up for my pills and it is in the middle of the night. So, I felt 4 pills in my mouth, I didn't see them."

On 11/17/23 at 12:10 PM, a post survey interview with LPN #1 confirmed that she gave Resident #1 the wrong pain medication twice in 1 night. She was unable to recall the date. She said that Resident #1 always sleeps with the television on and she always turns the light on when she goes into the room to give Resident #1 her medications. She stated that Resident #1 will always ask where her Dilaudid is when you take her the Roxicodone. This was found at shift change when I was counting narcotics with the on-coming nurse. The medication count was off. I notified the ADON. Someone else told Resident #1. She confirmed she was counseled and re-inserviced on medication administration. She

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F 658	Continued From page 8 confirmed that nurses are trained on abuse, neglect, following the care plan and MD orders and med pass administration. She stated that the care plans do include the medications and that staff is supposed to follow the interventions. She stated "No, Ms. (Resident #1) did not act any differently that shift. There were no noted side effects of the medications being given wrong." Record review on 11/8/23 of Resident #1's Face Sheet revealed she was admitted into the facility on 10/6/23 with diagnoses including Intraductal carcinoma in situ of right breast, Anxiety and Secondary malignant neoplasm of bone. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/23 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that Resident #1 is cognitively intact.	F 658		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, facility policy/procedure review, and record review the facility failed to ensure that one (1) of six (6) residents sampled were free from any significant medication errors. Resident #1. Findings include: Review of the facility's policy for "Administering Medications" last revised "December 2012"	F 760	LPN 1 was in-serviced and counselled by the Director of Nursing on 10/18/2023 on Medication Administration. Resident #1's 8:00am narcotic was ordered by the Medical Director to be held 10/18/2023 with no adverse reactions noted. Resident #1 was assessed by the Assistant Director of Nursing on 10/18/2023 with no adverse reactions noted. Facility conducted an Emergency QA on 10/18/2023 in regards	12/22/23

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F 760	Continued From page 9 revealed "Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed..." Record review of the facility's policy for "Adverse Consequences and Medication Errors" last revised "April 2014" revealed, "...Policy Interpretation and Implementation...5. A "medication error" is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 6. Examples of medication errors include: ...c. Wrong dose..." Record review of the facility's "Charge Nurse-LPN(Licensed Practical Nurse)" job description dated "2003" revealed the "Duties and Responsibilities" and the section "Drug Administration Functions" are for the LPN to "Prepare and administer medications as ordered by the physician." Record review of the Report of Investigation signed by the Administrator and Director of Nursing on 11/10/23 revealed, "Date of occurrence: 10-18-23 Time of occurrence 7:00 AM ...9. Unusual occurrence ...Medication Error ...Injury: NO ...Details of investigation ...On 10/18/2023 at approximately 6:25am while conducting a medication count with the oncoming nurse, (Proper Name LPN#1) noticed she performed a medication error on resident (Proper Name Resident #1). Resident #1's order was for 3 (three) dilaudid and 1 (one) roxicodone to be administered and (LPN#1) administered 1 dilaudid and 3 roxicodone. The medication error occurred two times, once at 12:00am and again	F 760	to the medication error and the Medical Director was in attendance. All residents have the potential to be affected. Nursing staff was in-serviced on 11/9/2023 on by the Director of Nursing on Medication Administration to ensure residents are free from any significant Med Errors. The Pharmacy consultant conducts a Med Pass observation with one nurse each month and last conducted one on 11/21/2023 with no negative findings noted. On 11/18/2023 the Assistant Director of Nursing performed a Med Pass checkoff on LPN #1 with no negative findings noted. Checkoffs will begin on 11/18/2023 and will be performed on all nurses by the Director of Nursing and Assistant Director of Nursing until all nurses have been observed. Facility held monthly Quality Assurance meeting on 11/22/2023 and discussed the potential findings of the alleged deficient practice and steps on how to prevent from further occurrences. Beginning 11/09/2023 the Director of Nursing will observe medication administration with one nurse per shift one (1) time a week covering all three shifts for four (4) weeks and monthly for three (3) months to ensure residents receive the ordered medication and are free from any significant Med Error. Findings will be reported to the Quality Assurance Performance Improvement Committee by the Assistant Director of Nursing for three	

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F 760	Continued From page 10 at 4:00am on 10/18/2023. (LPN#1) then notified the on-call nurse who in turned notified the Director of Nursing. The facility MD (Medical Doctor) was notified and gave the order to hold (Resident #1's) 8:00am narcotics and monitor for 24 hours for any adverse reactions. The Director of Nursing notified the Pharmacy of the medication error and conducted a narcotic count on all carts with no discrepancies noted with the exception of the medication error. Based on resident interview by the Assistant Director of Nursing (ADON), (Resident #1) stated she did not notice the difference in appearance of the medication given but consumed them anyway ...Notification of State Health Department ...11-09-23 ..." Record review of Resident #1's Physician Orders List revealed orders dated 10/6/23 for Roxicodone 30 MG (milligrams) 1 tablet every (q) four (4) hours (hr) and Dilaudid 4 MG tablet three (3) tablets q 4 hrs PRN. All medications are taken by mouth (PO). Interview with the facility Administrator at 11:20 AM, revealed there was a medication error with Resident #1. He stated there was no harm to the resident. Interview with the ADON on 11/8/23 at 12:40 PM revealed that on 10/18/23 at 12:00AM and 4:00 AM Resident #1 received 3 Roxicodone tablets and 1 Dilaudid tablet at each of those medication passes. She was supposed to get 1 roxicodone tablet and 3 dilaudid tablets. When I explained to to her (Resident #1) there was a medication error, she stated she did notice there were 3 blue pills instead of 3 white pills. She never said anything to anyone. This nurse did it twice that shift. The	F 760	(3) months for review and recommendations. The next Quality Assurance meeting is scheduled 12/20/2023 to review the facility findings. The Administrator is responsible for on-going monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255216	A. BUILDING _____ B. WING _____	C 11/09/2023

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F 760	Continued From page 11	F 760		

nurse discovered the error at the end of the shift narcotic count. She was counseled and in-serviced on medication errors. The resident's vital signs were monitored for 24 hours. There was no increase in pain and no harm. She said she didn't want the nurse fired. We held all the narcotic pain medication until the 12:00 PM doses.

In an interview with Resident #1 on 11/8/23 at 2:25 PM, revealed she is her own Responsible Party. She stated, "What I got was 3, 30 MG (milligram) Roxicodone and 1, 4 MG Dilaudid. I got it at 12 midnight and again at 4 AM on October 18th. I do not know the nurse's name. I did not need any emergency care. The nursing home staff told me about the medication error. They held my other pain meds until 11:00 AM. They wake me up for my pills and it is in the middle of the night. So, I felt 4 pills in my mouth, I didn't see them."

During a post survey interview with LPN #1 on 11/17/23 at 12:10 PM confirmed she gave Resident #1 the wrong pain medication twice in 1 night. She was unable to recall the date. She said that Resident #1 always sleeps with the television on and she always turns the light on when she goes into the room to give Resident #1 her medications. She stated that Resident #1 will always ask where her Dilaudid is when you take her the Roxicodone. This was found at shift change when I was counting narcotics with the on-coming nurse. The medication count was off. I notified the ADON. Someone else told Resident #1. She confirmed she was counseled and re-inserviced on medication administration. She confirmed that nurses are trained on abuse, neglect, following the care plan and MD orders

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F 760	Continued From page 12	F 760		

and med pass administration. She stated that the care plans do include the medications and that staff is supposed to follow the interventions. She stated "No, (Resident #1) did not act any differently that shift. There were no noted side effects of the medications being given wrong."

Record review on 11/8/23 of Resident #1's Face Sheet revealed she was admitted into the facility on 10/6/23 with diagnoses including Intraductal carcinoma in situ of right breast, Anxiety and Secondary malignant neoplasm of bone.

Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/23 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that Resident #1 is cognitively intact.