MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) at the facility for CI MS #23578 from 12/17/23 through 12/18/23. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements. The SA investigated CI MS #23578 for misappropriation of property and cited M 500. At the time of survey, the facility had a census of 53 and was licensed for 60 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically	M 500		1/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 1 contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 2	M 500		

given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 3 facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on interviews, record/video surveillance review, personnel record review, and facility policy review, the facility failed to prevent	M 500	The facility failed to prevent Misappropriation of property when an LPN #1 was seen on video taking a blue liquid from our narcotic box, identified as liquid	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 4 diversion of controlled substances by a nurse for one (1) of four (4) residents reviewed, Resident #1. Findings include: Policy/procedure review of the facility's "Abuse, Neglect and Exploitation" policy dated 10/24/2022 revealed, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property." The definition of Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. Interview with the Administrator on 12/18/23 at 11:00 AM revealed that administrative staff was notified on 12/6/23 on the 3-11 shift by Resident #4 about Licensed Practical Nurse (LPN) #1 acting "tired". LPN #1 was sent home. The Administrator stated that he, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) watched the surveillance video on 12/7/23 prior to the next 3-11 shift. When LPN #1 came in to work 3-11 PM shift on 12/7/23, LPN #1 was taken immediately into a room, told of the suspicions, and agreed to take a drug test. LPN #1 denied taking medications. He was suspended after submitting the drug test. His drug test was positive for Marijuana, Opiates/Morphine, Amphetamines, and Benzodiazapine. The Administrator stated their investigation started on 12/7/23 and was reported in the appropriate time frames. The allegations were reported to the Board of Nursing, Licensing	M 500	morphine, belonging to resident #1. On 12/6/23, LPN #1 was noted to be acting "tired", so we releived him of his duties for the night to go rest. On 12/7/23, Administrator and DON reviewed the facility cameras prior to LPN #1 reporting to work for his scheduled shift. Seen on camera was LPN #1 pushing med cart to the end of the hall, backing the med cart up near the exit door. LPN#1 then lifted the lid to the narcotics box, were blue liquid was then noted in a cup in which was then spilt on the med cart top surface. LPN #1 then removed a drinking straw from a can on the med cart and proceeded to drink the blue liquid from the med cart surface top. Not hall of the blue liquid was drank, so LPN #1 wiped the remaining blue liquid up with a towel. An investigation ensued. After reviewing Narc count sheets & EMAR, it was noted there was missing pain pills. Upon these findings, residents were interviewed regarding receiving their medication. No residents reported being in pain due to this alleged act. When LPN#1 reported for his scheduled 12/7/23 shift, he was immediately taken to our Director of Nursing office, told of our review of hall cameras. LPN#1 denied taking meds for his personal use. LPN#1 agreed to a drug screen conducted at out facility. Drug screen test positive for marijuana, opiates morphine, amphetamines and benzothiazines. LPN#1 was suspended after submitting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 5 State Agency, local police, the Attorney General office, and the Board of Pharmacy. He stated that LPN #1 was arrested by the local police department. LPN #1 was hired recently and that on 12/6/23 3-11 PM shift was the first shift that LPN #1 had worked by himself. His pre-hire drug test was negative for any drugs. He stated that all of Resident #1's liquid Morphine and Ativan were discarded, and new bottles of both medications were reordered. Record/video surveillance review by the State Agency (SA) on 12/18/23 of facility video surveillance dated 12/6/23 of LPN #1 during medication pass on the 3-11 shift. Video surveillance review revealed that the recording starts at 5:25:42 PM dated 12/6/23. It was noted that at 5:25:42 PM, LPN #1 backs his medication cart to the exit door of that hall and facing the nursing desk/station. There is a video camera above his head over his right shoulder. At 5:27:30, LPN #1 opened the narcotic box. The video shows the top of the narcotic box of the medication cart is open. There is not a view of the inside of the narcotic box. At 5:27:35, it is noted LPN #1 pours a clear liquid from the water pitcher into one (1) of the 30 milliliter (ml) medication cups the facility uses for medication pass. Beginning at 5:27:37, LPN #1 takes an empty medication cup towards the open narcotic box. LPN #1 then took the full cup of clear liquid towards the open narcotic box. LPN #1 knelt down behind the medication cart and then at 5:28:54 PM LPN #1 put a medication cup with a blue colored liquid onto the top of the medication cart. Beginning at 5:29:12 PM, the blue liquid in the medication cup is spilled onto the top of the medication cart. LPN #1 then takes a straw out of a soda can that was located on top of the medication cart and drank the blue liquid with the	M 500	drug screen. LPN#1was reported to our local police, Attorney General office, Board of Nursing, MS Dept. of Health and MS Board of Pharmacy. LPN#1 was arrested by our local police department. On 12/7/23 Resident #1, remaining liquid morphine and Ativan was discarded, and new replacement meds were ordered. Steps taken to identify other residents having the potential to be affected by the same alleged deficient practice. All residents of the facility are at risk for the alleged deficient practice. Residents that LPN#1 was responsible for, were interviewed regarding receiving their medications. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? On 12/7/23 In-service held by Assistant Director of Nursing, with all nursing staff, about signs of alcohol drug abuse. On 12/7/23 In-service by ADON with all nursing staff regarding abuse and neglect. On 12/7/23 QA team recommended increasing the frequency of in-service on abuse & Neglect to monthly and to not only include lecture but also role play on what alcohol drug abuse could look like. All applicants that facility desires to hire must first obtain approval from Director of Operations. ADON and administrator will ensure the in-service on abuse & neglect are held on a monthly basis starting 1/15/24 and both lectured with role play.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 6 straw. Beginning at 5:29:20 PM, LPN #1, looked toward the nursing station and then wiped up the blue liquid left on the top of the medication cart that he didn't drink. At 5:30:00 PM, LPN #1 is noted taking the medication cup with a small amount of blue liquid remaining and went back to the open narcotic box. The medication cart has not moved so the SA was unable to see inside the narcotic box. At 5:30:23 PM, LPN #1 poured clear liquid from the water pitcher into another empty medication cup and went back towards the open narcotic box. At 5:30:29 PM, it is noted there is blue liquid in an eight (8) ounce (oz) cup noted on top of the medication cart. He then poured clear liquid from the water pitcher into the 8 oz cup with the blue liquid. At 5:30:43 PM LPN #1 puts an empty medication cup onto the top of the medication cart moving from the direction of the open narcotic box. At 5:30:59 PM, LPN #1 put a medication cup with blue liquid in it on top of the medication cart. The medication cup appears to be full of the blue liquid. Between 5:31:30 PM and 5:31:53, LPN #1 is noted taking a pill from a medication card from the medication cart and a pill from the open narcotic box and putting these into a medication cup. At 5:32:00 PM, LPN #1 poured the blue liquid from a medication cup into the 8 oz cup of now light blue liquid and then pours the light blue liquid from the 8 oz cup into the soda can on top of the medication cart. At 5:32:14 PM, LPN #1 is noted putting the pills from the medication cup into his mouth and drank the liquid from the soda can. At 5:32:35 PM, LPN #1 is observed drinking blue liquid from an 8 oz cup as he looks towards the nurses station. At 5:32:46 PM, LPN #1 is noted pouring the remaining blue liquid from the 8 oz cup into the soda can. The narcotic box lid is no longer seen at 5:31:51 PM. At 5:34:03 PM, LPN #1 pours liquid from the soda can into a small brown bottle	M 500	Monitoring the corrective action QA program to ensure that the alleged deficient practice does not recur. Beginning - the QAPI Committee will direct the staff In-service on abuse and neglect at their monthly meetings for a period of 6 months ending when compliance is achieved. Beginning - On 12/7/23 our ADON started reviewing our Narcotic control sheets and med count compared to the EMAR to audit for any signs of diversion weekly X 8 weeks, monthly X 3 months. Our QA will review our monitoring findings on 1/15/24 and continuing to monitoring for three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 7 and at 5:34:07 PM he drank the liquid from the brown bottle. LPN #1 continues to drink from the soda can beginning at 5:34:22 PM. He is noted to move the medication cart up the hall towards the nurses station and parks it between resident rooms. He took the soda can towards the nurses station and out of view at 5:36:32 PM. He returned to the medication cart with the soda can at 5:38:25 PM. He is noted drinking from the soda can at 5:40:47 PM. Interview with the ADON on 12/18/23 at 11:48 AM, revealed that Resident #4 called the receptionist desk and said she was concerned about the male nurse and that he seemed tired. Interview with Resident #4 on 12/18/23 at 1:20 PM, revealed that she saw a "male nurse" recently standing at the medication cart near the door of her room on the 100 hall making "strange hand movements" and "not paying attention to what he was doing". She confirmed that she called the "front office" and told the person answering the phone that the male nurse seemed "tired". Resident #4 stated she talked to the male nurse and tried to get him to sit down for a moment. "I thought he was sick". She stated that the male nurse "was just standing at the med cart moving his computer mouse back and forth for what seemed like an hour". She stated someone came up to the male nurse and asked if was "feeling ok". She said that soon another nurse came and started passing medications from that medication cart and she has not seen that male nurse in the facility again. Record review of Resident #4 on 12/18/23 revealed she has a Brief Interview for Mental Status (BIMS) of 15 with the Assessment Reference Date (ARD) being 11/24/23.	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 8 Interview with the DON on 12/18/23 at 11:30 AM, revealed that the only resident that takes a blue liquid medication is Resident #1. Resident #1 is on palliative care and has Morphine Sulfate 20 mg (milligrams)/5 ml (millimeters) solution prescribed as needed (PRN). Resident #1 is the only resident on the 100 hall that has that prescribed. She stated that at that time, the Morphine solution was colored blue. Interview with the ADON on 12/18/23 at 10:50 AM revealed that she was the nurse that counted the narcotic medications with LPN #1 when he was told to go home and get some rest. She stated the narcotic count had no issues. She stated that the Morphine sulfate prescribed to Resident #1 and the liquid Ativan for Resident #1 was correct. The narcotic count was correct. She stated that administration thought LPN #1 was tired and that is why he was sent home on 12/6/23 early in the shift. She said that when she asked LPN #1 which residents had been given their medications and he stated he had given all the residents on the left side of the hall their medications. He asked if he could administer medications to another resident on that hall and she told him no. She stated that during count, she noted the narcotic medications for that other resident was off and LPN #1 said he had given those medications and just forgot to sign the narcotic book. She said she noticed a liquid spill on top of the medication cart and LPN #1 said he had spilled his energy drink. She stated a hand towel on top of the medication cart had some blue liquid on it. She noted the morphine sulfate for Resident #1 was blue, but the count was correct. Record review of the Face Sheet revealed the facility admitted Resident #1 on 2/24/21 with	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 9	M 500		

diagnoses including Unspecified Dementia, Anxiety disorder, Unspecified protein-calorie malnutrition, and Dysphagia.

Record review of the Minimum Data Set with an Assessment Reference Date of 11/28/23 revealed a Brief Interview for Mental Status (BIMS) score of 4 which indicated that she was severely cognitively impaired.

Record review of Resident #1's "Physician Orders" for December 2023 revealed an order dated 11/16/23 for Morphine Sulfate 20 mg/5 ml solution dissolve ½ ml under the tongue every two (2) hours as needed for pain and respirations greater than 27, an order dated 11/13/23 for Norco 5-325 mg give 1 tablet per G-tube twice a day, an order dated 11/09/23 for Norco 5-325 mg tablet give 1 tab per PEG (percutaneous endoscopic gastrostomy tube) every six (6) hours as needed for pain, and an order dated 11/13/23 for Lorazepam 2 mg/ml oral concentrate dissolve ½ ml under the tongue every 2 hours as needed for restlessness.

Record review of Resident #1's Medication Administration Record (MAR) on 12/18/23 revealed that as of 12/17/23, Resident #1 has not received a dose of Morphine Sulfate or Lorazepam for the month of December 2023.

Record review of the Drug Test Record Form dated 12/7/23 revealed LPN #1 tested positive for Marijuana, Opiates/Morphine, Amphetamines, and Benzodiazapine.

Record review of the Personnel Termination Notice revealed LPN #1 was terminated on 12/7/23 for "consuming narcotics out of our resident med cart ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 10	M 500		

Based on interviews, record/video surveillance review, personnel record review, and facility policy review, the facility failed to prevent diversion of controlled substances by a nurse for one (1) of four (4) residents reviewed, Resident #1.

Findings include:

Policy/procedure review of the facility's "Abuse, Neglect and Exploitation" policy dated 10/24/2022 revealed, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property." The definition of Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.

Interview with the Administrator on 12/18/23 at 11:00 AM revealed that administrative staff was notified on 12/6/23 on the 3-11 shift by Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 11 #4 about Licensed Practical Nurse (LPN) #1 acting "tired". LPN #1 was sent home. The Administrator stated that he, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) watched the surveillance video on 12/7/23 prior to the next 3-11 shift. When LPN #1 came in to work 3-11 PM shift on 12/7/23, LPN #1 was taken immediately into a room, told of the suspicions, and agreed to take a drug test. LPN #1 denied taking medications. He was suspended after submitting the drug test. His drug test was positive for Marijuana, Opiates/Morphine, Amphetamines, and Benzodiazapine. The Administrator stated their investigation started on 12/7/23 and was reported in the appropriate time frames. The allegations were reported to the Board of Nursing, Licensing State Agency, local police, the Attorney General office, and the Board of Pharmacy. He stated that LPN #1 was arrested by the local police department. LPN #1 was hired recently and that on 12/6/23 3-11 PM shift was the first shift that LPN #1 had worked by himself. His pre-hire drug test was negative for any drugs. He stated that all of Resident #1's liquid Morphine and Ativan were discarded, and new bottles of both medications were reordered. Record/video surveillance review by the State Agency (SA) on 12/18/23 of facility video surveillance dated 12/6/23 of LPN #1 during medication pass on the 3-11 shift. Video surveillance review revealed that the recording starts at 5:25:42 PM dated 12/6/23. It was noted that at 5:25:42 PM, LPN #1 backs his medication cart to the exit door of that hall and facing the nursing desk/station. There is a video camera above his head over his right shoulder. At 5:27:30, LPN #1 opened the narcotic box. The video shows the top of the narcotic box of the	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 12	M 500		

medication cart is open. There is not a view of the inside of the narcotic box. At 5:27:35, it is noted LPN #1 pours a clear liquid from the water pitcher into one (1) of the 30 milliliter (ml) medication cups the facility uses for medication pass. Beginning at 5:27:37, LPN #1 takes an empty medication cup towards the open narcotic box. LPN #1 then took the full cup of clear liquid towards the open narcotic box. LPN #1 knelt down behind the medication cart and then at 5:28:54 PM LPN #1 put a medication cup with a blue colored liquid onto the top of the medication cart. Beginning at 5:29:12 PM, the blue liquid in the medication cup is spilled onto the top of the medication cart. LPN #1 then takes a straw out of a soda can that was located on top of the medication cart and drank the blue liquid with the straw. Beginning at 5:29:20 PM, LPN #1, looked toward the nursing station and then wiped up the blue liquid left on the top of the medication cart that he didn't drink. At 5:30:00 PM, LPN #1 is noted taking the medication cup with a small amount of blue liquid remaining and went back to the open narcotic box. The medication cart has not moved so the SA was unable to see inside the narcotic box. At 5:30:23 PM, LPN #1 poured clear liquid from the water pitcher into another empty medication cup and went back towards the open narcotic box. At 5:30:29 PM, it is noted there is blue liquid in an eight (8) ounce (oz) cup noted on top of the medication cart. He then poured clear liquid from the water pitcher into the 8 oz cup with the blue liquid. At 5:30:43 PM LPN #1 puts an empty medication cup onto the top of the medication cart moving from the direction of the open narcotic box. At 5:30:59 PM, LPN #1 put a medication cup with blue liquid in it on top of the medication cart. The medication cup appears to be full of the blue liquid. Between 5:31:30 PM and 5:31:53, LPN #1 is noted taking a pill from a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 13	M 500		

medication card from the medication cart and a pill from the open narcotic box and putting these into a medication cup. At 5:32:00 PM, LPN #1 poured the blue liquid from a medication cup into the 8 oz cup of now light blue liquid and then pours the light blue liquid from the 8 oz cup into the soda can on top of the medication cart. At 5:32:14 PM, LPN #1 is noted putting the pills from the medication cup into his mouth and drank the liquid from the soda can. At 5:32:35 PM, LPN #1 is observed drinking blue liquid from an 8 oz cup as he looks towards the nurses station. At 5:32:46 PM, LPN #1 is noted pouring the remaining blue liquid from the 8 oz cup into the soda can. The narcotic box lid is no longer seen at 5:31:51 PM. At 5:34:03 PM, LPN #1 pours liquid from the soda can into a small brown bottle and at 5:34:07 PM he drank the liquid from the brown bottle. LPN #1 continues to drink from the soda can beginning at 5:34:22 PM. He is noted to move the medication cart up the hall towards the nurses station and parks it between resident rooms. He took the soda can towards the nurses station and out of view at 5:36:32 PM. He returned to the medication cart with the soda can at 5:38:25 PM. He is noted drinking from the soda can at 5:40:47 PM.

Interview with the ADON on 12/18/23 at 11:48 AM, revealed that Resident #4 called the receptionist desk and said she was concerned about the male nurse and that he seemed tired.

Interview with Resident #4 on 12/18/23 at 1:20 PM, revealed that she saw a "male nurse" recently standing at the medication cart near the door of her room on the 100 hall making "strange hand movements" and "not paying attention to what he was doing". She confirmed that she called the "front office" and told the person

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 14	M 500		

answering the phone that the male nurse seemed "tired". Resident #4 stated she talked to the male nurse and tried to get him to sit down for a moment. "I thought he was sick". She stated that the male nurse "was just standing at the med cart moving his computer mouse back and forth for what seemed like an hour". She stated someone came up to the male nurse and asked if was "feeling ok". She said that soon another nurse came and started passing medications from that medication cart and she has not seen that male nurse in the facility again.

Record review of Resident #4 on 12/18/23 revealed she has a Brief Interview for Mental Status (BIMS) of 15 with the Assessment Reference Date (ARD) being 11/24/23.

Interview with the DON on 12/18/23 at 11:30 AM, revealed that the only resident that takes a blue liquid medication is Resident #1. Resident #1 is on palliative care and has Morphine Sulfate 20 mg (milligrams)/5 ml (millimeters) solution prescribed as needed (PRN). Resident #1 is the only resident on the 100 hall that has that prescribed. She stated that at that time, the Morphine solution was colored blue.

Interview with the ADON on 12/18/23 at 10:50 AM revealed that she was the nurse that counted the narcotic medications with LPN #1 when he was told to go home and get some rest. She stated the narcotic count had no issues. She stated that the Morphine sulfate prescribed to Resident #1 and the liquid Ativan for Resident #1 was correct. The narcotic count was correct. She stated that administration thought LPN #1 was tired and that is why he was sent home on 12/6/23 early in the shift. She said that when she asked LPN #1 which residents had been given their medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 15	M 500		

and he stated he had given all the residents on the left side of the hall their medications. He asked if he could administer medications to another resident on that hall and she told him no. She stated that during count, she noted the narcotic medications for that other resident was off and LPN #1 said he had given those medications and just forgot to sign the narcotic book. She said she noticed a liquid spill on top of the medication cart and LPN #1 said he had spilled his energy drink. She stated a hand towel on top of the medication cart had some blue liquid on it. She noted the morphine sulfate for Resident #1 was blue, but the count was correct.

Record review of the Face Sheet revealed the facility admitted Resident #1 on 2/24/21 with diagnoses including Unspecified Dementia, Anxiety disorder, Unspecified protein-calorie malnutrition, and Dysphagia.

Record review of the Minimum Data Set with an Assessment Reference Date of 11/28/23 revealed a Brief Interview for Mental Status (BIMS) score of 4 which indicated that she was severely cognitively impaired.

Record review of Resident #1's "Physician Orders" for December 2023 revealed an order dated 11/16/23 for Morphine Sulfate 20 mg/5 ml solution dissolve ½ ml under the tongue every two (2) hours as needed for pain and respirations greater than 27, an order dated 11/13/23 for Norco 5-325 mg give 1 tablet per G-tube twice a day, an order dated 11/09/23 for Norco 5-325 mg tablet give 1 tab per PEG (percutaneous endoscopic gastrostomy tube) every six (6) hours as needed for pain, and an order dated 11/13/23 for Lorazepam 2 mg/ml oral concentrate dissolve ½ ml under the tongue every 2 hours as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45WB	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	1308 HIGHWAY 51 NORTH MADISON, MS 39110

(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) COMPLETE DATE
M 500	Continued From page 16 for restlessness. Record review of Resident #1's Medication Administration Record (MAR) on 12/18/23 revealed that as of 12/17/23, Resident #1 has not received a dose of Morphine Sulfate or Lorazepam for the month of December 2023. Record review of the Drug Test Record Form dated 12/7/23 revealed LPN #1 tested positive for Marijuana, Opiates/Morphine, Amphetamines, and Benzodiazapine. Record review of the Personnel Termination Notice revealed LPN #1 was terminated on 12/7/23 for "consuming narcotics out of our resident med cart ..."	M 500		