

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/18/2023
NAME OF PROVIDER OR SUPPLIER THE NICHOLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE	
F 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 requirements for participation in Medicare and Medicaid. The SA investigated CI MS #23578 for misappropriation of property and cited F602. At the time of survey, the facility had a census of 53 and was licensed for 60 beds.	F 000			
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: 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	F 602	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 morphine, belonging to resident #1. On 12/6/23, LPN #1 was noted to be acting "tired", so we relieved 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	1/26/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/02/2024

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 602	Continued From page 1 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 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	F 602	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 drug screen. LPN#1 was 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.		

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F 602	Continued From page 2 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 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	F 602	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. 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		

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F 602	Continued From page 3 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 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	F 602	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.		

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F 602	Continued From page 4 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. 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	F 602			

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F 602	Continued From page 5 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 diagnoses including Unspecified Dementia, Anxiety disorder, Unspecified protein-calorie malnutrition, and Dysphagia. Record review of the Minimum Data Set with an	F 602			

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F 602	Continued From page 6 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 ..."	F 602			