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TISHOMINGO COMM LIVING CENTER	1410 WEST QUITMAN STREET IUKA, MS 38852

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 7/29/24 through 8/1/24. During the survey, the SA determined that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm and cited M500 for resident's rights and M640 for accidents. The census at the time of the survey was 65 with a bed capacity of 73.	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 contraindicated (as documented by a physician or	M 500		8/22/24

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M 500	Continued From page 1 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 given at least a quarterly accounting of financial	M 500		

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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 facility to work for improvements in resident care,

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M 500	Continued From page 3 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: Based on resident and staff interviews and record review, and the facility policy the facility failed to notify the provider of an increase in blood pressure for one (1) of three (3) residents reviewed for blood pressure monitoring. Resident	M 500	1. On 7/30/2024, the Director of Nurses reviewed Resident #55 blood pressures and sent blood pressure results to resident's physician. Resident's physician gave	

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M 500	Continued From page 4 #55 Findings include: Record review of facility policy titled, "Blood Pressure, Measuring" dated 8/25/24, revealed, "Hypertension is usually defined as blood pressure over 140/90 mm/Hg (although the elderly often have persistent systolic readings from 140 to 160 mm/Hg). Hypertension should be reported to the physician". Record review of facility policy titled, "Notification of Changes in a Resident's Condition or Status", undated, revealed, "It is the policy of this facility to inform the resident, consult with his or her physician, and notify, consistent with his/her authority, the resident's representative of changes in the resident's condition and/or status". The policy also revealed, "1. Nursing services shall be responsible for notifying the resident's attending physician when: ... b. There is a significant change in the resident's physical, mental, or psychosocial status ... f. Notification is deemed necessary or appropriate in the best interest of the resident." Record review of facility policy titled, "Change in a Resident's Condition or Status", dated 8/2023, revealed, "Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. ... 1. The nurse will notify the resident's attending physician or physician on call when there has been a ... d. significant change in the resident's physical/emotional mental condition". Record review of "Vital Signs In service" dated March 14, 2008, revealed, "Vital signs are	M 500	verbal orders via telephone to Director of Nurses for Lisinopril 10 mg daily for Hypertension. 2. All residents receiving hypertensive medication have the potential to be affected. 3. On 7/30/2024, the Administrator and Director of Nurses held an emergency Quality Assurance and Performance Improvement meeting with the facility's medical director and implemented standing vital sign notification parameters and hypertension protocol. This protocol guides nurses on when to notify physicians based on abnormal vital signs. Nursing staff was in serviced on 7/30/2024 on this protocol and notifying physician. 4. Beginning 8/1/2024, the Director of Nurses will review the vital signs exception report daily x 12 weeks during morning clinical meeting to identify abnormal vital signs. The Director of Nurses will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x three months starting 8/22/2024 and as needed for review and/or revision.	

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important indicators of how well the vital organs of the body such as the heart and lungs are functioning. Changes in vital signs are a good indicator of a person's health. ... Blood Pressure shows how well the heart is working. ... The normal range for the systolic is between 100 - 140 and 60 to 90 for the diastolic. ... Always report abnormal or changes in vital signs to the nurse".

During an interview on 7/30/24 at 8:50 AM, Resident #55 revealed he had hypertension and his blood pressure had been elevated several times recently and he wondered if his medications had been changed. He stated he had mentioned this to the nurses and had been told they would continue to monitor his blood pressure.

On 7/30/24 at 11:15 AM, an interview with the Director of Nursing (DON) revealed she had not been able to determine for certain how this resident's blood pressure readings were not reported, but it appeared the vital signs may have been entered by the Certified Nursing Assistants (CNA)'s and the nurses did not monitor these values closely enough. She confirmed the nurses should monitor the blood pressure values and should notify the provider if the blood pressure is not within the normal parameters and document this into the resident's record and there was a failure in this process. She stated the facility did not have a standing order on when to notify the physician, but they used the attached "Vital Signs In service" for acceptable parameters and anything outside those values should be reported. The DON confirmed the facility failed to notify the physician of changes of the resident's condition that could have indicated a clinical complication or led to devastating results such as a stroke.

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She stated notification to the provider should be done for each resident with a change of their clinical condition to ensure proper treatment was given.

During a phone interview on 7/31/24 at 9:30 AM, Resident #55's Medical Doctor revealed on admission, she was concerned that the resident had some hypotensive episodes and his blood pressure was within normal limits at that time and no blood pressure medications were ordered at the facility. She stated she was uncertain, but thought she had been notified of his increased blood pressure once and treatment was given, but she was not aware of any other times she was notified due to increased blood pressure. She stated if she had been notified of other times Resident #55 had increased blood pressure, she would have made changes, as needed.

Record review of Resident #55's "Weights and Vitals Summary" revealed multiple blood pressure values that exceeded the facility's policy's definition of hypertension of 140/90. Record review of increased values over the past eight days included: 7/21/24 - 177/125; 7/22/24 - 164/91; 7/22/24 - 170/55; 7/23/24 - 175/93; 7/23/24 - 187/98; 7/24/24 - 174/123; 7/25/24 - 170/116; 7/26/24 - 160/100; 7/29/24 - 160/90; 7/29/24 - 186/128; 7/30/24 - 152/95. Review of resident's record revealed none of these blood pressure values had been reported to the provider.

Record review of Resident #55's "Admission Record" revealed the facility admitted the resident on 4/9/24. Diagnosis included an admission diagnosis of Hypertension.

Record review of Resident #55's Minimum Data

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M 500	Continued From page 7 Set (MDS) with Assessment Reference Date (ARD) of 4/16/24 revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated this resident was cognitively intact.	M 500		
M 640 SS=D	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review, the facility failed to prevent the possibility of an accident while administering medications for one (1) of four (4) residents observed for medication administration. Resident #34 Findings Include: Review of the facility policy titled, "Medication Administration-General Guidelines" with a revision date of 8/25/14 revealed under "Procedure...#1. Preparation: e. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing...". An interview and observation on 07/29/24 at 10:44 AM with Resident #34 revealed that her only problem was a huge pill they give her, and she cannot swallow it. She stated it gets stuck in her throat and she just has to let it dissolve. She revealed she told the nurse this morning, but she	M 640	1. On 7/30/2024, the Director of Nurses observed Resident #34□s medication to ensure they were small enough for resident to swallow. 2. All residents have the potential to be affected. 3. On 7/31/2024, the Director of Nurses performed a 1 on 1 in-service with Licensed Practical Nurse # 1 regarding medication administration, medications that can be crushed, and potential choking hazards with large pills. Nursing staff in-serviced on 8/1/2024 on medication administration, medications that can be crushed and potential choking hazards with large pills. 4. Beginning 8/1/2024, the Director of Nurses will observe medication pass weekly x 12	8/22/24

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M 640	Continued From page 8 told her it would not be much longer, and she would not have to take them anymore. An interview on 7/30/24 at 8:00 AM with Licensed Practical Nurse (LPN) #1 confirmed that Resident #34 had complained in the past that the Amoxicillin tablet was big but had never asked to have it split or crushed. An observation on 7/30/24 at 8:05 AM revealed LPN #1 administered the following medications. 1.) Amlodipine Berate 5 mg (milligram) PO one time per day 2.) Metoprolol 50 mg PO one time per day 3.) Potassium 99 mg PO one time per day 4.) Cholecalciferol 1000 units =2 tabs (tablets) one time per day 5.) Amoxicillin 875/125 mg PO BID 6.) Phenytoin 100 mg PO BID 7.) Mira lax 1 scoop=17 gm (gram) with water one time per day An observation and interview on 7/30/24 at 8:05 AM revealed LPN #1 ask Resident #34 if she would like for her to break the Amoxicillin in half since it was so big. The resident stated yes please that thing gets stuck in my throat, and it just sits there all day. An interview on 7/30/24 at 8:20 AM with LPN #1 revealed when Resident #34 had complained of the pill being so big in the past, she had not offered to split the pill. She stated that she should have offered to split it or get an order to crush it. She stated that the residents last swallow test was good, but again that is a big pill, and she could have choked. An interview on 7/30/24 at 10:50 AM with the Director of Nurses (DON) admitted that if	M 640	weeks to observe for any potential choking hazards with large pills. The Director of Nursing will report the results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x three months starting 8/22/2024 and as needed for review and/or revision.	

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Resident #34 was complaining of the pill being too big then the nurse should have offered to have split the pill, because she could have choked.

An interview on 07/30/24 at 3:11 PM with the Consultant Pharmacist revealed there would have been no problem crushing that Amoxicillin.

An interview on 07/30/24 03:17 PM with the DON confirmed that the Amoxicillin could have been crushed or the nurse could have called and got an order for liquid.

An interview on 8/1/24 at 8:50 AM with LPN #1 confirmed that she attended the in-service about what medications were crushable, but she just did not think about crushing Resident #34's large antibiotic pill, because none of her other medications were getting crushed.

Record review of the facility in-services revealed an in-service on 6/4/24 that included crushable medications and was attended by LPN #1.

Record review of Resident #34's Physicians orders revealed an order dated 7/23/24 for Amoxicillin-Pot Clavulanate Tablet 875-125 MG (Milligrams).

Give 1 tablet by mouth two times a day for UTI (Urinary Tract Infection) related to Urinary Tract Infection, site not specified for 7 (seven) days.

Record review of Resident #34's "Admission Record" revealed the resident was admitted to the facility on 4/17/24 with medical diagnoses that included Wedge Compression Fracture of First Lumbar Vertebra, Subsequent encounter for fracture with routine healing.

MSDH - Health Facilities Licensure and Certification

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