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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY HEALTH & REHAB LLC	230 RIVER OAKS DRIVE CANTON, MS 39046

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M 000	Initial Comments The State Agency (SA) conducted two (2) Complaint Investigations (CI) at the facility on 1/14/25 for CI MS #25730, and CI MS #26510. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements for CI MS#26510 regarding Quality of Care/Treatment, Medications,and Misappropriation of property and deficiencies were cited at M 500 and M 705. The facility was found to be in compliance for CI MS #25730 regarding pressure sores,incontinent care,and dignity with no deficiencies cited. At the time of survey the facility had a census of 78 residents and was licensed for 87 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;	M 500		2/7/25

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M 500	Continued From page 1 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 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,	M 500		

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M 500	Continued From page 2	M 500		

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 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;

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M 500	Continued From page 3 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, 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:	M 500		

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M 500	Continued From page 4 Level II Based on observation, staff interview, record review, and facility policy, the facility failed to ensure a resident's right to be free from misappropriation of property when a bottle of Morphine Sulfate was found altered in color composition and not properly accounted for on the medication administration record for (1) one of (3) residents reviewed for misappropriation. (Resident #1) Findings include: Review of the facility policy titled, "Abuse Prevention Program," with no revision date revealed, "Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation ..." Review of the facility policy titled, "Controlled Substances, "with no revision date revealed under the "Policy Statement :The facility complies with the laws, regulations and other requirements related to handling, storage, disposal, and documentation of controlled substances ..." An interview on 1/14/25 at 8:00 AM, with the Director of Nursing (DON) confirmed there had been a narcotic diversion investigation back in September 2024 regarding Resident #1. During a continued interview with the DON and record review of the facility investigation/video surveillance on 1/14/25 at 9:10 AM, she revealed that on the morning of Monday 9/16/24 the day shift nurse Licensed Practical Nurse (LPN) #1 reported to her that after drawing up Resident #1's morphine from her only vial that was dated	M 500	*On 1/14/25, the Director of Nursing(DON), in-serviced Licensed Practical Nurse (LPN) #1 and began an in-service with all staff to include the facility policy, titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating. This included but not limited to resident medications and the definition of misappropriation. LPN #2, responsible for the misappropriation, was terminated from facility on 9/17/24. The DON and the Administrator were in-serviced by the Regional Director of Operations on 1/14/25. The said in-service covered Resident Rights and Misappropriation of Property. *100% of the resident population could have been affected without a strong audit system *The DON did a 100% audit of the prn narcotics; this audit ensured that all narcotics not signed out on either the medication administration record (MAR) or on the narcotic sheet were identified. Said audit was started on 1/14/25 and ended on 1/17/25. *The DON will be responsible to audit a minimum of 10 narcotic records per week for 4 weeks to ensure they are signed out on both the MAR and the narcotic log and then monthly on an ongoing basis. This audit began on 1/14/25. The results of the audit will be presented to Quality Assurance Committee(QA) to ensure full compliance following the policy and procedures at the scheduled QA meeting on 2-6-25. The QA committee will monitor	

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M 500	Continued From page 5 9/6/24, he discovered that the medicine was not the color it was supposed to be. She stated that he immediately brought it to her, and she confirmed that the liquid inside the vial was clear and was supposed to be a light blue. She reported that the Hospice nurse was notified and that they brought a new bottle of morphine, and the medicine was blue in color. The DON stated she immediately contacted all nurses who had access to the morphine on the 100-hall cart and requested that they meet at the clinic on 9/16/24 for a random drug screen related to a narcotic concern. She revealed that all the nurses complied with the random drug screen except for LPN #2. She stated that after LPN #2 did not comply with a drug screen, the Administrator reviewed the video footage of the 100 hallways for the weekend and found on 9/14/24 at approximately 3:00 PM, LPN #2 was observed to position her medication cart in front of room 109 with the medication drawers facing the inside of the room. LPN #2 was observed to reach into the narcotic box, pull out the Morphine box, insert the syringe into the morphine bottle, pull back on the syringe, remove the syringe and go into the bathroom of room 109. She then returned to the medication cart, inserted the syringe into the morphine again, pulled back on the syringe, then went back into the bathroom of room 109. The DON also confirmed based on the investigation, the video, and the failure of LPN #2 to submit to a drug screen, the undeniable change in the color of the liquid morphine, the allegation of diversion was substantiated by the facility. An observation and interview on 1/14/25 at 9:20 AM of the Morphine vial dated 9/6/24 compared to the vial dated 9/16/24 with the DON confirmed that the morphine dated 9/6/24 was notably a few shades lighter blue than the one dated 9/16/24.	M 500	all medication errors on a quarterly basis.	

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The DON confirmed there were no other bottles of morphine in the 100-hall medication cart at the time of the incident.

Record review of the Termination Report for LPN #2 revealed the facility terminated her on 9/17/24 for failure to comply with narcotic investigation. LPN #2's last day to work was 9/15/24.

Record review of Resident #2's September 2024 Order Summary Report revealed this residents' location was room 109 and there were no orders for any narcotics for this resident.

Record review of the "Admission Record" revealed Resident #2 was admitted by the facility on 6/05/24 and discharged on 9/21/24.

An interview with LPN #1 on 1/14/25 at 10:10 AM, revealed that on the morning of 9/16/24 he went in to give Resident #1 some morphine and did not see anything in the syringe. He then revealed he shook the medicine up and attempted to withdraw the morphine again and realized the liquid in the syringe was clear. He stated that he had administered the morphine to Resident #1 on Friday 9/13/24 and the medication was blue at that time. He confirmed that there were no other bottles of morphine on the medication cart at the time that the morphine was found to be a different color. LPN #1 stated he notified the DON, the Administrator, and called hospice to have a new bottle of morphine delivered. LPN #1 stated the new bottle of morphine that was delivered was a much brighter blue color.

Record review of the Order Summary Report for Resident #1 revealed an order to admit to Hospice on 9/05/24 related to Chronic Obstructive Pulmonary Disease (COPD) and

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M 500	Continued From page 7 Morphine Sulfate Oral Solution 20 mg (milligram) 5 (five) ml (milliliters): give 0.5 ml sublingual every 4 (four) hours as needed for pain and wheezing for 14 days, dated 9/05/24. Record review of the Individual Patient Narcotic-Controlled Drug form for Resident #1 for Morphine Sulfate 100 mg/5 ml was received on 9/6/24 by LPN #1 with 30 ml in the bottle. A record review of the Individual Patient Narcotic-Controlled Drug form for Resident #1 morphine sulfate revealed on 9/14/24 that five doses of morphine were signed out by LPN #2 at 8:30 AM, 11:00 AM, 2:00 PM, 6:00 PM, and 9:00 PM; on 9/15/24 a dose of morphine was signed out by LPN #2 at 2:00 PM. Record review of the "Admission Record" revealed Resident #1 was admitted by the facility on 10/14/22 with diagnoses of Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure with Hypoxia. Record review of Resident #1's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/16/24, revealed Section O: Special Treatments, Procedures, and Programs coded as receiving Hospice services while a resident.	M 500		
M 705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following: 1. Accurate acquiring; 2. Receiving;	M 705		2/7/25

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M 705	Continued From page 8 3. Dispensing; 4. Storage; and 5. Administration of all drugs and biologicals. This Statute is not met as evidenced by: Level II Based on staff interview, record review, and facility policy review, the facility failed to accurately document the administration of PRN (as needed) pain medication in the electronic medication system for one (1) of three (3) residents reviewed for narcotic administration. Resident #1 Findings include: Review of the facility policy titled, "Controlled Substances," with no revision date revealed, "Policy Statement: The facility complies with the laws, regulations and other requirements related to handling, storage, disposal, and documentation of controlled substances ..." Review of the facility policy titled, "Charting Documentation," with revision date 07/2017 revealed, "Policy Interpretation and Implementation: 2.) The following information is to be documented in the resident medical record...b. Medications administered ..." Record review of the Order Summary Report for Resident #1 revealed an order of Morphine Sulfate Oral Solution 20 mg (milligram)/5 (five) ml (milliliters): give 0.5 ml sublingual every 4 (four) hours as needed for pain and wheezing for 14 days dated 9/5/24.	M 705	*On 1/14/25, the Director of Nursing(DON), in-serviced Licensed Practical Nurse (LPN) #1 and began an in-service with all staff to include the facility policy, titled Charting Documentation. This included but not limited to resident medications. LPN #2, responsible for the misappropriation, was terminated from facility on 9/17/24. On 9/16/24, the bottle of Morphine was replaced by a new bottle purchased by the facility. Resident expired on 10/2/24; therefore, being discharged from facility *100% of the resident population could have been affected without a strong audit system *The DON did a 100% audit of the prn narcotics; this audit ensured that all narcotics not signed out on either the medication administration record (MAR) or on the narcotic sheet were identified. Said audit was started on 1/14/25 and ended on 1/17/25. The DON will implement the usage of the as needed medication administration report to audit comparison of the MAR and narcotic log. *The DON will be responsible to audit a minimum of 10 narcotic records per week for 4 weeks and then monthly on an	

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M 705	Continued From page 9 Record review of the individual Patient Narcotic -Controlled Drug form for Resident #1 morphine sulfate revealed on 9/13/24 a dose was signed out by LPN #1 at 9:30 PM; on 9/14/24 five doses of morphine were signed out by LPN #2 at 8:30 AM, 11:00 AM, 2:00 PM, 6:00 PM, and 9:00 PM and on 9/15/24 revealed a dose of morphine was signed out by LPN #2 at 2:00 PM. Record review of Resident #1's Medication Administration Record (MAR) dated 9/1/24-9/30/24 revealed there was no documentation of a dose of Morphine being given on 9/13/24 at 9:30 PM; on 9/14/24 at 8:30 AM, 11:00 AM 2:00 PM, 6:00 PM and 9:00 PM or on 9/15/24 at 2:00 PM. In an interview with LPN #1 on 1/14/25 at 10:10 AM, he confirmed that he did administer morphine to Resident #1 on 9/13/24 at 9:30 PM and failed to document the medication that was given. He stated that it is important to sign the MAR, to prove it was given, to let other staff know the time of the last medication, and if it was effective. He also stated it could be reflective of diversion of narcotics. In an interview with LPN #3 on 1/14/25 at 3:00 PM she revealed all narcotics should be signed out on the narcotic sheet and on the MAR. She stated if a narcotic is not documented given on the MAR, then it looks like staff did not administer the medication and provides an inaccurate record. In an interview with the Director of Nursing (DON) on 1/14/25 at 3:05 PM, she confirmed that narcotics should be signed out on the narcotic sheet and on the MAR, otherwise it could appear	M 705	ongoing basis. This audit began on 1/14/25. Any medication discrepancies will be brought to the Quality Assurance Committee for review and determination of whether policies have been followed at the already scheduled QA on 2/6/25. This monitoring will continue weekly for 4 weeks then monthly for 2 months and then quarterly on an ongoing basis.	

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M 705	Continued From page 10 as if staff were diverting narcotics, or they were missing. She revealed the purpose of documenting narcotic medications given on the medication record is to show staff gave it and are following physician's orders. Record review of the "Admission Record" revealed Resident #1 was admitted by the facility on 10/14/22 with diagnoses of Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure with Hypoxia.	M 705		