STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255273	A. BUILDING _____ B. WING _____	C 01/14/2025

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

(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 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 requirements for participation in Medicare and Medicaid for CI MS #26510 regarding Quality of Care/Treatment, Medications,and Misappropriation of property and cited F602, F609,and F842. 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.	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 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	F 602	*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-	2/7/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/30/2025

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F 602	Continued From page 1 the medication administration record for (1) one of three (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 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	F 602	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 all medication errors on a quarterly basis and with any significant medication errors.	

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F 602	Continued From page 2	F 602		

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. 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

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F 602	Continued From page 3	F 602		

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 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.

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F 602	Continued From page 4 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.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		2/7/25

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F 609	Continued From page 5 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to report an allegation of narcotic diversion/misappropriation of property to the State Agency (SA) for one (1) of three (3) residents reviewed for narcotic diversion/misappropriation of property. (Resident #1) Cross Reference F602 Findings include: Review of the facility policy titled," Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating," with a revision date of 09/2022 revealed under the "Policy Interpretation and Implementation ...1. If resident ...misappropriation of property ...is suspected, the suspicion must be reported immediately to... 2. a. The state licensing/certification agency	F 609	*On 1/14/25, the Director of Nursing (DON) reviewed the Abuse Critical Element Pathway and the F609 guidance in The Long Term Care Survey Manual, to ensure complete understanding and ensure no other incidents need to be reported that have not been. On 9/16/24, incident was reported to the hospice provider, Attorney General, Board of Pharmacy and to the family. The morphine was replaced and paid for by the facility. The resident was discharged from the facility on 10/2/24. On 1/14/25, the Regional Director of Operations, in-serviced the DON and the Administrator on policy titled, Facility Responsibilities for Reporting Allegations. *It was determined by the DON and	

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F 609	Continued From page 6 responsible for surveying/licensing the facility..." Upon entrance to the facility on 1/14/25 at 8:00 AM, the Director of Nursing (DON) confirmed that they had one reportable incident that was a narcotic diversion investigation involving Resident #1 in 09/2024. Record review of the facility investigation, dated 9/19/24 involving Resident #1, revealed there was no notification of the narcotic diversion investigation to the State Agency. In an interview with the DON regarding the narcotic diversion investigation on 1/14/25 at 9:10 AM, she revealed on the morning of Monday 9/16/24 the day shift nurse Licensed Practical Nurse (LPN) #1 came to her and let her know that the liquid narcotic for Resident #1 was not the color it should be. She stated the liquid morphine the facility receives is a clear blue color. The DON and LPN #1 together assessed the morphine to be clear once again when pulled in the syringe. The Hospice nurse was called and brought a new bottle of morphine to the facility for Resident #1. The DON revealed the bottle of morphine delivered on 9/6/24 and the new bottle of morphine was delivered on 9/16/24 for Resident #1 were compared, and the bottle dated 9/6/24 was a lighter clear blue color than the new bottle recently delivered. She stated the Morphine in question was removed from the narcotic count and locked up securely. The DON stated she immediately contacted all nurses who had access to the morphine on the 100-hall cart to meet at the clinic at 1:00 PM on 9/16/24 for a random drug screen related to a narcotic concern. She revealed all the nurses complied with doing the random drug screen with no positive results for	F 609	Administrator that all residents with a reportable event related to medication discrepancy could have been affected. *The DON started in-service on 1-14-25 on the policy titled, Facility Responsibilities for Reporting Allegations; including but not limited to medication misappropriation to Licensed Practical Nurse (LPN) #1 and to all staff members. The DON reviewed incidents for the last 12 months with none being found to need further reporting. The audit process will be changed by including the QA committee to determine proper reporting to all entities for any medication discrepencies. *The DON will follow the Critical Element Pathway on Abuse and the guidance from the Long Term Care Survey manual to ensure all reportable events, including but not limited to medication misappropriation is reported to appropriate entities fully and timely. Medication discrepancies will be brought to the Quality Assurance Committee for review and determination of whether policies have been followed at the scheduled QA meeting on 2/6/25. Monitoring of all medication discrepancies by the QA committee will continue weekly for 4 weeks then monthly for 2 months and then quarterly on an ongoing basis.	

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F 609	Continued From page 7	F 609		

narcotics, 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.

Review of the Order Summary Report for Resident #1 revealed an order for 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.

In an interview with the DON on 1/14/25 at 9:00 AM, she revealed she thought she had reported it to the SA, but she was unable to find any documentation that she had reported the incident and confirmed that she should have reported it. She then confirmed the allegation of narcotic diversion should have been immediately reported as part of the investigation process to ensure thorough investigation and follow-up is completed for the investigation.

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

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F 609	Continued From page 8 Failure with Hypoxia.	F 609		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		2/7/25

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F 842	Continued From page 9 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: 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	F 842	*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	

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F 842	Continued From page 10 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. 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.	F 842	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 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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(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
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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 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.