

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

PRINTED: 03/24/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255294	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/26/2025
NAME OF PROVIDER OR SUPPLIER GREENBOUGH HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 340 DESOTO AVE EXTENDED CLARKSDALE, MS 38614		
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F 000	INITIAL COMMENTS The State Agency (SA) conducted two (2) Complaint Investigation (CI MS# 27969 and CI MS# 28068) at the facility on 2/26/25. During the investigation, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F 760 for CI MS# 28068 for failure to prevent significant medication errors. There were no deficiencies cited for CI MS# 27969.	F 000			
F 760 SS=D	The census at the time of the survey was 56 with a bed capacity of 60 beds. Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review the facility failed to ensure residents were free from significant medication errors for seven (7) of 30 residents reviewed. Resident #1, #2, #3, #4, #5, #6, and #7. Findings Include: Record review of the facility policy, titled "Administering Medications" with a revision date of 04/2019 revealed "Policy Statement, Medications are administered in a safe and timely manner and as prescribed..." Record review of a facility investigation revealed that on 2/20/25 Registered Nurse (RN) #1 notified	F 760	1. The Director of Nursing called the physician on 2/20/25 at 4:00 pm and notified her that residents #1,2,3,4,5,6,7, did not receive their medications from 7 am until 4 pm. The Director of Nursing followed a verbal physician order to begin the evening medications ordered for the 3-11 pm shift. The residents that were identified were placed on acute charting for monitoring for any adverse effects from omission of medications. On 2/21/25 the Director of Nursing notified the resident's resident representatives of the omission of their medications. The state department of health and the attorney general's office, the board of	3/20/25	

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

TITLE

(X6) DATE

Electronically Signed

03/11/2025

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 760	Continued From page 1 the Director of Nursing (DON) that she had not given medication to seven (7) of the residents she was assigned to for the 7:00 AM to 3:00 PM shift. The DON conducted an audit and verified that seven (7) out of 30 residents RN #1 was assigned to for the 7:00 AM to 3:00 PM shift had not received their scheduled medications. Record review of Resident #1 and Resident #7's written statement dated 2/21/25 confirmed the resident did not receive their scheduled medicines on time on 2/20/25. Record review of the "Medication Administration Audit Report, Documentation Type: Missed" dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/25 for all residents in the facility revealed that Residents #1, #2, #3, #4, #5, #6 and #7 had no documentation of administration of medications scheduled between 7:00 AM and 3:00 PM on 2/20/25. Resident #1 Record review of the "Medication Administration Audit Report, Documentation Type: Missed" dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #1 had active orders that included Metoprolol Succinate ER Oral Tablet Extended Release 24-hour 25 milligram (mg) give one (1) tablet by mouth one time a day with missed dose at 9:00 AM, Eliquis Oral Tablet 5 mg give 1 tablet by mouth two (2) times a day with missed dose at 9:00 AM, Cozaar Oral Tablet 50 mg give one (1) tablet by mouth one time a day with missed dose at 9:00 AM, and Dilantin Oral Capsule 100 mg 2 capsules three (3) times a day, with a missed dose at 9:00 AM and 1:00 PM.	F 760	nursing and the local police were notified by the executive director on 2/21/25. Statements were obtained from the staff that offered to help the nurse pass medications and included that she had refused assistance. 2. 30 residents out of 56 had the potential to be affected by RN #1 not providing the medications that were ordered by the physician. 3. Education was started by the Director of Nursing on 2/21/25 with the nurses that were present on medication administration including the six rights of medications and the importance of following the physician orders. This was completed on 3/10/2025. Nurses will not be allowed to work until they have been educated. The education will be completed by new nurses upon hire during orientation. The staff development nurse educated all staff that were present on abuse and neglect. This Inservice was completed on 3/10/2025. Newly hired staff will be educated on abuse and neglect upon hire during orientation. ON 3/6/25 The facility nurses Began completeing a medication administration omission audit and will review before the end of their shift. The nurse will sign the audit, and it will be provided to the director of nursing each shift. 4. The director of nursing or the RN house supervisor will review the audits daily times four weeks which started on 3/6/25, then monthly times three months to ensure that medications are not omitted. The risk management quality improvement checklist will be completed		

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F 760	Continued From page 2 Record review of the "Admission Record" revealed that the facility admitted Resident #1 on 2/13/25 with diagnoses that included Cerebral Infarction, Hyperlipidemia, Occlusion and Stenosis of Bilateral Carotid Arteries, and Hypertension. Resident #2 Record review of "Medication Administration Audit Report, Documentation Type: Missed" dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #2 had active orders that included Rivaroxaban Tablet 20 mg give 1 tablet by mouth one time a day, with a missed dose at 9:00 AM. Record review of the "Admission Record" revealed that the facility admitted Resident #2 on 10/29/21 with diagnoses that included Acute Kidney Failure, Protein-Calorie Malnutrition, Peripheral Vascular Disease and Hypertension. Resident #3 Record review of "Medication Administration Audit Report, Documentation Type: Missed" dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #3 had active orders that included Hydralazine Hydrochloride (HCL) Tablet 100 mg give 1 tablet by mouth 3 times a day, with a missed dose at 9:00 AM and 1:00 PM. Keppra Tablet 500 mg give 1 tablet by mouth 2 times a day, with a missed dose at 9:00 AM. Amlodipine Besylate Tablet 10 mg give 1 tablet by mouth one time a day, with a missed dose at 9:00 AM. Carvedilol Tablet 12.5 mg give 1 tablet by mouth 2 times a	F 760	by the director of nursing or RN house supervisor weekly times three weeks then monthly times three months. The Quality assurance performance improvement committee met on 2/21/25 and will review the results of the auditing and the risk management quality improvement checklists on 3/19/25 then monthly times two months. Changes to the plan will be made by the committee as it is found necessary to maintain substantial compliance. Completion Date : 3/19/2025		

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F 760	Continued From page 3 day, with a missed dose at 9:00 AM. Spironolactone Oral Tablet 25 mg give 12.5 mg by mouth one time a day, with a missed dose at 9:00 AM. Record review of the "Admission Record" revealed that the facility admitted Resident #3 on 12/8/18 with diagnoses that included Cerebral Infarction, Hypertension, Congestive Heart Failure, Other Seizures, and Cardiomyopathy. Resident #4 Record review of "Medication Administration Audit Report, Documentation Type: Missed" dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #4 had active orders that included Hydralazine Hydrochloride (HCL) Tablet 25 mg give 1 tablet by mouth 1 time a day, with a missed dose at 9:00 AM. Keppra Tablet 500 mg give 1 tablet by mouth 2 times a day, with a missed dose at 9:00 AM. Coreg Tablet 3.125 mg give 1 tablet by mouth 2 times a day, with a missed dose at 9:00 AM. Record review of the "Admission Record" revealed that the facility admitted Resident #4 on 2/1/25 with diagnoses that included Diabetes Mellitus, Hypertension, Chronic Venous Hypertension, Gastro-Esophagel Reflux Disease, and Atherosclerotic Heard Disease. Resident #5 Record review of "Medication Administration Audit Report, Documentation Type: Missed" dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #5 had	F 760			

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F 760	Continued From page 4 active orders that included Metformin HCL Oral Tablet 500 mg give 1 tablet by mouth 2 times a day with a missed dose at 9:00 AM. Lisinopril Oral Tablet 2.5 mg give 1 tablet by mouth 1 time a day, with a missed dose at 9:00 AM. Record review of the "Admission Record" revealed that the facility admitted Resident #5 on 1/30/25 with diagnoses that included Diabetes Mellitus, Hypertension, and Dementia. Resident #6 Record review of "Medication Administration Audit Report, Documentation Type: Missed" dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #6 had active orders that included Amlodipine Besylate Oral Tablet 5 mg give 1 tablet by mouth 1 time a day with a missed dose at 9:00 AM. Lacosamide Oral Tablet 200 mg give 1 tablet 1 time a day with a missed dose at 9:00 AM. Levetiracetam Oral Tablet 750 mg give 1 tablet in the morning with a missed dose at 9:00 AM. Cephalexin Oral Tablet 500 mg give 500 mg by mouth 2 times a day with a missed dose at 9:00 AM. Hydralazine HCL Oral Tablet 50 mg give 1 tablet by mouth 2 times a day with a missed dose at 9:00 AM. Lasix Oral Tablet 40 mg give 1 tablet by mouth 2 times a day with a missed dose at 9:00 AM. Sinemet Oral Tablet 25-100 mg give 1 tablet by mouth 3 times a day with missed doses at 10:00 AM and 2:00 PM. Record review of the "Admission Record" revealed that the facility admitted Resident #6 on 2/28/24 with diagnoses that included Parkinsonism, Angina Pectoris, Congestive Heart Failure, Myoclonus, Visual Hallucinations, Tremor, and Unspecified Convulsions.	F 760			

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F 760	Continued From page 5 Resident # 7 Record review of "Medication Administration Audit Report, Documentation Type: Missed" dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #7 had active orders that included Enalapril Maleate Oral Tablet 10 mg give 1 tablet 1 time a day with a missed dose at 9:00 AM. Record review of the "Admission Record" revealed that the facility admitted Resident #7 on 2/21/24 with diagnoses that included Protein-Calorie Malnutrition and Hypertension. An interview with the Staff Development Nurse (SDN) on 2/26/25 at 10:00 AM, she confirmed that on 2/20/25 RN #1 was assigned to the medication cart for 7:00 AM to 7:00 PM due to a call in. She stated that if there is a call in then an on-call nurse or supervisor is pulled to the cart to cover. She stated that she offered to assist RN #1 but was told she did not need any help. She stated that she offered to assist RN #1 again by checking blood sugars and vital signs around lunch but was told that she did not need help. She stated later in the afternoon she overheard RN #1 complaining to other staff and she called her into the DON ' s office to talk with her. She stated at that time RN #1 became agitated and turned in her resignation. She stated at that time RN #1 informed the DON of a list of residents that she had not yet administered medications to. SDN stated she assisted the DON with the care of the residents in that section. An interview with RN #2 on 2/26/25 at 10:30 AM, she stated that the Supervisor may get pulled to	F 760			

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F 760	Continued From page 6 work the med cart once about every two (2) weeks. She stated that all staff is trained to administer medications and if they are not comfortable then they can notify the Supervisors or DON in order to get more training. She stated that she tries to watch staff to see if they need help and help them. An interview with Licensed Practical Nurse (LPN) #1 on 2/26/25 at 10:45 AM, she stated that she worked on 2/20/25 and was assigned the opposite hall from RN #1. She revealed that she did hear the SDN offer to assist RN #1 with med pass. LPN #1 revealed she did not have any trouble getting assistance if needed and that administrative staff was very helpful. A telephone interview with RN #1 on 2/26/25 at 11:16 AM, she revealed that she had worked at the facility for about a month and 2/20/25 was the first time she had worked independently on medication administration and no one offered her any assistance. She then admitted that she had previously followed a nurse on medication administration. She revealed that around 3:00 PM the SDN called her into the DON's office about her attitude and at that time she gave report, counted narcotics and gave the DON a list of residents that she had not given medications to yet. She stated she had just not gotten to those residents yet. A follow up interview with the SDN on 2/26/25 at 11:30 AM, she stated that RN #1 had never complained about working on the medication cart before and that she had previously worked on the med cart on 2/10/25, 2/14/25 and 2/19/25 with no issues noted.	F 760			

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F 760	Continued From page 7 An interview with the Administrator on 2/26/25 at 2:05 PM he verified that he was present and heard the SDN offer RN #1 assistance, but she declined it. He verified that it was his expectation that RN #1 would have administered the residents' medications timely as ordered.	F 760			