| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 45CM | A. BUILDING: _____ B. WING _____ | C 05/12/2025 |

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| MADISON CO NH | 1421-A EAST PEACE STREET CANTON, MS 39046 |

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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted Complaint Investigations (CI) at the facility on 5/12/25 for two (2) complaints, CI MS #28101 for diversion of narcotics and CI MS #28721 for Significant Medication error. During the survey, the SA determined the facility was found to not be in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and a deficiency was cited at M 500 for both CIs.<br><br>At the time of survey, the facility had a census of 94 residents and was licensed for 96 beds. | M 000 | | |
| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>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;<br><br>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;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his | M 500 | | 6/2/25 |

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|---|---|---|---|---|
| M 500 | Continued From page 1<br>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;<br><br>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;<br><br>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; | M 500 | | |

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|---|---|---|---|---|
| M 500 | Continued From page 2<br>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;<br><br>7. is free from mental and physical abuse;<br>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;<br>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;<br><br>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;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>12. may associate and communicate privately with persons of his choice, may join with other | M 500 | | |

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|---|---|---|---|---|
| M 500 | Continued From page 3<br>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);<br><br>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);<br><br>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);<br><br>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<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Level III<br>Based on staff interview, record review, and facility policy review the facility failed to ensure | M 500 | A. 1. LPN #1 was terminated on 02/28/25 following an internal investigation. The missing medication was replaced at facility | |

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|---|---|---|---|---|
| M 500 | Continued From page 4<br>residents' rights were honored when a resident was a victim of narcotic diversion (Resident #1) and when a significant medication error resulted in the harm of a resident (Resident #2) for two (2) of six (6) residents narcotics reviewed.<br><br>Findings include:<br><br>Resident #1<br><br>Review of the facility policy titled, "Abuse Policy & Procedure," with no revision date, revealed that each resident of the facility has the right to be free from misappropriation of property. The policy further defines "misappropriation of resident property" as the deliberate misplacement, exploitation, or wrongful use of a resident's belongings without the resident's consent.<br><br>During an interview on 5/12/25 at 11:30 AM with the Director of Nursing (DON) related to a facility reported incident of drug diversion, she confirmed that narcotic drug diversion occurred involving Resident #1. The DON reported that on the morning of 2/13/25, staff notified her that a card of oxycodone 10 mg, delivered on 2/3/25, was missing from the medication cart. Staff indicated that it was unlikely the resident had taken 60 pills in a week's time. Upon investigation, it was discovered that 120 pills of oxycodone were delivered for Resident #1 on 2/3/25. On 2/12/25, a card of oxycodone was deducted from the Controlled Drug Record for Resident #1. However, upon reviewing the Medication Administration Record for Resident #1, it was noted that only 24 oxycodone pills had been signed out as administered between the time the Oxycodone card was added and removed from the medication cart. The DON revealed she questioned Licensed Practical Nurse (LPN) #1, | M 500 | expense on 02/24/25.<br>2. Once the medication error was noted at the beginning of the 11:00pm-7:00am shift on 04/23/25, Resident #2 was monitored throughout the night. Hospice was notified and visited on 04/24/25. The attending physician was notified of decline in condition on 04/24/25 and narcan was ordered and given. The resident's condition improved to her base line before the medication error with no other problems noted throughout the day. After an investigation, LPN #3 was suspended on 04/24/25 pending investigation and terminated on 04/29/25.<br>B. All residents have the potential to be affected by the deficient practice.<br>C. Nursing staff were assigned an inservice on Resident and Patient Rights on 03/01/25 and on 05/21/25 they were assigned inservices on the Facility Abuse Policy, Abuse and Neglect - Clinical Protocol as well as Residents' Rights. The Quality Assurance Nurse will monitor to ensure all nursing staff have completed the training.<br>D. The Director of Nursing will complete a weekly inspection of the MAR and narcotic count sheets for accuracy for a minimum of two residents per medication cart for four months beginning 03/01/25. The Director of Nursing will also inspect all liquid narcotics for hospice residents weekly beginning the week of 05/19/25 for three months for accurate dosage and documentation. The RN Supervisor and/or Director of Nursing will conduct medication administration observations in addition to a medication administration competency skills check list beginning the | |

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|---|---|---|---|---|
| M 500 | Continued From page 5<br>who had removed the card from the count. She stated that LPN #1 verbalized that she administered the last dose of oxycodone, deducted the card from the count, and placed the narcotic card in the shred box, with the completed narcotic sheet placed in the medical record's box. The DON confirmed that she holds the only key to the shred box and was unable to locate the medication card for Resident #1 in the box. Additionally, no narcotic sheet for the oxycodone was found in the medical record box. The DON confirmed that upon completing the investigation, she validated there was a narcotic diversion because 36 of the 120 oxycodone pills delivered on 2/3/25 for Resident #1 were unaccounted for.<br><br>Record review of the Physician's Order Report for Resident #1 from 2/1/25-2/28/25 revealed an order dated 12/30/24 for oxycodone 10 mg, one tablet by mouth every six (6) hours as needed for pain.<br><br>Record review of a written statement from LPN #2 revealed that on the morning of 2/13/25, she noticed that the first card of 120 oxycodone pills was missing from the medication cart. LPN #2 reported the missing medication to the DON because the medication was ordered every six hours, and the calculation did not add up.<br><br>Record review of a written statement from LPN #1 indicated that she worked on the medication cart from 7:00 AM to 3:00 PM, Monday through Friday, and dosed Resident #1 with oxycodone daily. On 2/12/25, she administered the last two pills from the card and placed the card in the shred box.<br><br>Record review of the pharmacy receipt dated 2/3/25 revealed Resident #1 had prescription | M 500 | week of 05/19/25 times three nurses weekly for two months. Any findings will be reported monthly to the Quality Assurance and Corporate Compliance Committee for resolution beginning 05/21/25 for three months. | |

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| M 500 | Continued From page 6<br>(RX) # N803917 two cards of oxycodone 10 mg with a total quantity of 120 pills delivered to the facility.<br><br>Record review of the "Controlled Drug Record" revealed that on 2/3/25, 120 pills (two cards of 60 pills) of oxycodone, RX #N8039713, were added to the narcotic count form on the dayshift. ... On 2/12/25, a card of oxycodone, RX #N8039713, was deducted from the narcotic count form on the dayshift.<br><br>Record review of the 'Medication Record' for Resident #1 with the DON on 5/12/25 at 12:10 PM revealed that, from 2/3/25-2/12/25, during the time oxycodone for Resident #1 was added and removed from the narcotic count, 24 pills were documented as administered.<br><br>Review of the "Face Sheet" revealed that Resident #1 was admitted to the facility on 9/20/24 with diagnoses that included Unspecified Pain.<br><br>Record review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/13/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.<br><br>Resident #2<br><br>A review of the facility policy titled, "Adverse Consequences and Medication Errors," revealed under Policy Interpretation and Implementation: 5.) A "Medication error" is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer specifications, | M 500 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| M 500 | Continued From page 7 | M 500 | | |

or accepted standards and principles of the professional providing services. Section 6 listed "wrong dose" as an example of a medication error.

During an interview with the Director of Nursing (DON) on 5/12/25 at 11:30 AM regarding a facility-reported significant medication error, she stated that on 4/23/25 at 10:00 PM, Resident #2 was administered the incorrect dosage of morphine sulfate. The DON reported receiving a call at approximately 11:00 PM when the end-of-shift narcotic count was found to be incorrect. She stated Licensed Practical Nurse (LPN) #3 reported that the morphine sulfate was delivered without a syringe, so she used a plastic medication cup to administer the dose. The DON stated the medication cup had the lowest measurable line of 2.5 ml (milliliter), while the prescribed dose was only 0.25 ml. She reported that LPN #3 was asked to mark on the cup where she had poured the dose, and the mark was at the 2.5 ml line. The DON confirmed the resident required Narcan (a medication primarily used to reverse opioid overdoses) due to a significant change in condition and respiratory status following the medication error. She stated the Narcan was effective, and the residents' vital signs began to recover. The DON reported that the day prior to receiving the morphine, Resident #2 had attended bingo activities twice.

An observation of the plastic medication cup with the DON on 5/12/25 at 11:45 AM confirmed a black line marked at the 2.5 ml level, which LPN #3 had indicated was the amount she administered.

During an interview with LPN #4 on 5/12/25 at 1:20 PM, she stated that at the start of her shift

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 45CM | A. BUILDING: _____ B. WING _____ | C 05/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| M 500 | Continued From page 8 | M 500 | | |

on 4/23/25 at 11:00 PM, she and LPN #3 completed the narcotic count and found the morphine sulfate count was incorrect. She stated that LPN #3 reported the pharmacy did not send a syringe, so she used a medication cup and indicated the 2.5 ml line as the amount given. LPN #4 confirmed the medication cup's lowest measurement line was 2.5 ml. She stated she immediately reported the error to the provider, Hospice, and the DON, and monitored the resident closely due to observed changes in respiratory status.

During a phone interview with LPN #3 on 5/12/25 at 3:33 PM, she confirmed she worked the 3:00 PM-11:00 PM shift on 4/23/25 and administered the first dose of morphine sulfate to Resident #2 from the new bottle. She confirmed the pharmacy did not send a syringe and she could not locate one, so she used a plastic medication cup. When asked how she measured the dose, she stated she poured to the lowest line on the cup. LPN #3 confirmed she again she did not locate a syringe or call for direction before administering the medication.

During an interview with the Pharmacy Consultant on 5/12/25 at 3:40 PM, he confirmed he was aware of the significant medication error involving Resident #2. He stated that morphine sulfate should never be administered without a calibrated measuring syringe and that the use of an inaccurate measuring device increases the risk for overdose, sedation, respiratory depression, and other complications.

Record review of the "Physician Order Report" dated 4/1/25 through 4/30/25 revealed an order dated 4/22/25 for morphine concentrate 100 mg (milligrams)/5 ml (20 mg/ml), to administer 0.25

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|---|---|
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|---|---|---|---|---|
| M 500 | Continued From page 9 | M 500 | | |

ml every hour as needed by mouth (PO) or sublingually (SL) for pain or air hunger. A subsequent order dated 4/24/25 directed Narcan (naloxone) nasal spray 2 mg to be administered one time "now."

Record review of the "Medication Administration Record" for Resident #2 revealed morphine concentrate was signed off as administered on 4/23/25 at 10:20 PM by Licensed Practical Nurse (LPN) #3.

Record review of the "Progress Notes" dated 4/23/25 at 3:33 PM for Resident #2 documented that the resident was alert, awake, and responsive to verbal and physical stimuli. On 4/24/25 at 2:01 AM, progress notes documented oxygen saturation at 81%, heart rate of 55, and respiratory rate of 12. Despite cueing to breathe deeply and continued oxygen use, the resident's saturation levels did not improve.

Record review of the "Progress Notes" for Resident #2 dated 4/24/25 at 10:14 AM documented that the resident had an altered mental status and was difficult to arouse. At 10:21 AM, the resident was noted to be unresponsive. The medical doctor was notified and gave a now order for Narcan. Vital signs at that time included a blood pressure of 131/78, heart rate of 33, respiratory rate of 11, and oxygen saturation of 68%. Emergency services were contacted, and Narcan was administered. Post-administration vital signs showed improvement: BP 131/78, HR 111, RR 16, O2 79%.

Review of a document from the Food and Drug Administration (FDA), last revised 12/2023, titled "Morphine Sulfate Oral Solution" under "Warnings and Precautions," stated: "Instruct caregivers to

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|---|---|---|---|
| | 45CM | A. BUILDING: _____ B. WING _____ | C 05/12/2025 |

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|---|---|---|---|---|
| M 500 | Continued From page 10 | M 500 | | |

always use the enclosed calibrated oral syringe when administering morphine oral concentrate to ensure the dose is measured and administered accurately." Under "Use in Specific Populations: Renal Impairment," the document stated that morphine pharmacokinetics are altered in patients with renal failure, with increased exposure and reduced clearance, and that metabolites may accumulate to higher plasma levels.

Review of a document from the FDA, last revised 11/2015, titled "NARCAN Nasal Spray" described Narcan as an opioid antagonist indicated for the emergency treatment of known or suspected opioid overdose, as manifested by respiratory and/or central nervous system depression.

Record review of the "Face Sheet" revealed that Resident #2 was admitted to the facility on 7/11/19 with medical diagnoses that included Chronic Kidney Disease, Stage 3.

Record review of Resident #2's Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 4/7/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #2 was cognitively intact.