

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46FM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/07/2019
NAME OF PROVIDER OR SUPPLIER COLUMBIA REHABILITATION AND HEALTHCA		STREET ADDRESS, CITY, STATE, ZIP CODE 1506 NORTH MAIN STREET COLUMBIA, MS 39429		
(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) determined during an annual recertification survey, conducted from 6/4/19 to 6/7/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm; and extended the survey, related to an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) related to unsecured medications. The SA identified an IJ and SQC on 6/5/19, which began on 4/26/19, when the A-wing medication "Cart 1" drawer was identified by facility staff as not locking properly, which contained significant medications accessible to residents. The facility was aware the drawer would not lock, on 4/26/19, and failed to remove/secure the medications and/or replace the cart until 6/5/19. The facility also failed to supervise cognitively impaired residents to ensure they did not have access to the unsecured medications that were in the A-Wing medication drawer, which did not lock. Resident #41, a severely cognitively impaired resident, was observed on 6/4/19 at 6:45 PM, to open the unlocked drawer of A-Wing medication "Cart 1", which contained Nitroglycerin, Insulin and other medications. The cart was in the middle of the hallway, with the drawers facing toward the center of the hallway, and the Medication Nurse was not present. Resident #41 demonstrated the ability to easily open the bottle, which contained the Nitroglycerin tablets. The failure of the facility to secure the medication cart, and to supervise cognitively impaired residents to prevent access to significant medications, from 4/26/19 until 6/5/19, placed Resident #41 and other residents, with severely impaired cognition, in a situation that was likely to cause serious injury, harm, impairment, or death.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/08/19

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M 000	Continued From page 1 The facility's Administrator was notified of the IJ and SQC on 6/5/19 at 6:50 PM. The IJ and SQC existed at: 45.31.8 - Accidents -M640 IJ existed at: 45.24.2-Policies and Procedures (Pharmacy)-M705 The facility provided a credible Removal Plan on 6/6/19, in which the facility alleged all corrective actions were completed as of 6/5/19, and the IJ removed as of 6/6/19. The SA validated the Removal Plan 6/7/19, and determined the IJ was removed prior to exit. Therefore, the scope and severity for M640 and M705 were lowered to a "Level II" level, while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The SA also cited deficiencies at M500, M610, M700, M840, M855, and M970. The facility census was 86, and the facility was licensed for 119 beds at the time of survey.	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	M 500		7/12/19

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STREET ADDRESS, CITY, STATE, ZIP CODE

COLUMBIA REHABILITATION AND HEALTHCA

**1506 NORTH MAIN STREET
COLUMBIA, MS 39429**

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M 500	Continued From page 2 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 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	M 500		

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M 500	Continued From page 3 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 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	M 500		

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M 500	Continued From page 4 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, 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);	M 500		

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M 500	Continued From page 5 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: Level II Based on record review, Grievance Log review, resident interview, staff interview, Resident Council meeting interviews, and facility policy review, the facility failed to resolve food grievances voiced by six (6) residents in the Resident Council meeting, of 86 residents in the facility, Residents #1, #4, #23, #65, #70, and #83. Findings Include: Record Review of the facility policy, titled "Grievances", undated, revealed the facility will assist residents, their representatives, other family members, or advocates, in filing grievances or complaints when such requests are made. Any resident, his or her representative, family member, or advocate may file a grievance concerning his or her treatment, medical care, behavior of other residents, staff members, theft of property without fear of discrimination, threat or reprisal of any kind. Grievances or complaints may be made orally or in writing to the Social Worker, and may be filled anonymously. Upon	M 500	M500 1. Resident #1 interviewed by Dietary Manager on 7/2/19 regarding specific food related complaints. Interview recorded on facility grievance form. Resident #4 interviewed by Dietary Manager on 7/2/19 regarding specific food related complaints. Interview recorded on facility grievance form. Resident #23 interviewed by Dietary Manager on 7/2/19 regarding specific food related complaints. Interview recorded on facility grievance form. Resident #83 interviewed by Dietary Manager on 7/2/19 regarding specific food related complaints. Interview recorded on facility grievance form. Resident #70 interviewed by Dietary Manager on 7/2/19 regarding specific food related complaints. Interview recorded on facility grievance form. Resident #65 no longer resides in the facility as of 6/19/19. Concerns identified were addressed/corrected by Dietary Manager on 7/2/19. 2. Current residents in the facility who	

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M 500	Continued From page 6 receipt of written grievance, the social worker or relevant department head will investigate the allegation and report the findings to the Administrator within 72 hrs to determine what corrective actions, if any, need to be taken. The resident, or the person filing the grievance on behalf of the resident, will be informed verbally and in writing (if requested) of the findings of the investigation and the actions that will be taken to correct any identified problems. Record Review of the facility's "Resident Rights" procedure, undated, revealed the resident 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 rights of action for damages or other said relief for deprivations or infringements of rights to adequate and proper treatment and care established by applicable statute, rule regulation, or contract, and to recommend changes in policies and services to facility staff and/or outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal. Record Review of the resident Council minutes from December 2018 through June 2019, revealed the resident's talked to The Dietary Manager on 12/8/2018, about the chicken that was hard, uncooked and/or burnt. They discussed the menu and residents not asked about food preference on 1/22/2019. Record Review of the Facility's Grievance log from August 2018 through June 2019, revealed residents complained of dietary concerns on 8/9/2018, 10/8/2018, 11/9/2018, 11/12/2018, 11/13/2018, 12/28/2018, and 4/29/2019. There was no documented evidence that the facility	M 500	receive meals from the dietary department are at risk of being affected by deficient practice. Cognitive residents with Brief Interview for Mental Status (BIMS) score of twelve (12) or higher were interviewed by Dietary Manager regarding their level of satisfaction with Dietary Services on 7/2/19; concerns noted were addressed/corrected by 7/3/19. 3. Dietary Manager in-serviced dietary department staff on food palatability on 7/2/19. Administrator in-serviced management staff on proper grievance procedures and accurately recording council minutes pertaining to concerns voiced in resident council on 7/2/19. Dietary Manager was invited, by the Resident Council President, and will attend Resident Council and address dietary concerns on a monthly basis. Dietary Manager will also interview five (5) residents on food satisfaction on a monthly basis, beginning 7/12/19 and on-going. Administrator in-serviced Dietary Manager on following up on food related grievance issues in a timely manner on 7/2/19. Meal monitoring program initiated on 6/12/2019 and completed daily by Registered Nurse (RN) Supervisor or Licensed Practical Nurse (LPN) Charge Nurse. 4. Beginning on 7/12/19, the Administrator will interview five (5) residents in regards to food satisfaction weekly for four (4) weeks, then monthly for two (2) months and quarterly thereafter. Administrator will review concerns/grievances and log in daily stand-up meeting for discussion,	

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M 500	Continued From page 7 resolved the grievances. During an observation on 06/04/19 at 6:20 PM, of the dinner meal, Resident #65 complained that the sandwich bread was really hard and had no meat. Resident #65 complained of the taste and said he would not give this to a dog. During interview on 06/05/19 at 2:15 PM, the six (6) Resident Council members revealed they had complained about the food every month for a year. The Council Members also said the Dietary Manager was present for all Resident Council meetings. The Council Members said the Activity Director and the Assistant takes the minutes during the council meeting. During an interview on 06/05/19 at 2:22 PM, Resident #1, the Council President, revealed the Council had complained every month about the food being cold, burnt, and/or the meat is always hard. Resident #1 stated the complaints were not always documented in the minutes. During an interview on 06/06/19 at 3:00 PM, the Activity Director confirmed the residents have complained about the food every month. The Activity Director said she don't know why the residents' complaints about the food was not always put in the minutes. The Activity Director also stated that she has observed cold and burnt food served during meal times. During an interview on 06/06/19 at 9:18 AM, the Dietary Manager revealed she attended all of the Resident Council meetings. The Dietary Manager stated that the resident's had complained about the food being burnt, or cold, and does not taste good. The Dietary Manager said she was working on correcting the issues.	M 500	follow up and resolution. Concerns identified will be acted upon immediately. The Administrator will report findings of the food satisfaction interviews and grievances/log to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Administrator will be responsible for on-going monitoring and compliance.	

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M 500	Continued From page 8 During an interview on 06/6/19 at 10:13 AM, the Social Worker confirmed the residents had complained about the food not tasting good and/or cold for several months. The Social Worker stated the Dietary Manager reported the complaints were resolved. The Social Worker said she had not been talking to the residents to see if the complaints were resolved. The Social Worker said she will follow up with the residents as of today to make sure the complaints were addressed and/or resolved. Record Review of the most recent Minimum Data Set (MDS) of the Resident Council members that were present during interview, revealed the following Brief Interview for Mental Status (BIMS) scores: Resident #1 (BIMS=15), Resident #4 (BIMS=13), Resident #23 (BIMS=15), Resident #65 (BIMS=15), Resident #70 (BIMS=13), Resident #83 (BIMS=13). BIMS 0-6 indicates severe cognitive impairment, BIMS 7-12 indicates moderate cognitive impairment, and BIMS of 13-15 indicates no cognitive impairment.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting.	M 610		7/12/19

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M 610	Continued From page 9 This Statute is not met as evidenced by: Level II Based on observation, resident interview, facility staff interview, and record review, the facility failed to provide nail care for one (1) of 18 residents reviewed, Resident #11. Findings include: Review of the facility policy, "Fingernails/Toenails, Care of", dated February 2018, revealed: The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infection. Nail care includes daily cleaning and regular trimming. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his/her skin. In an observation and interview on 06/04/19 at 7:19 PM, Resident #11's fingernails were dirty and uneven in length. Resident #11 stated, "My nails need to be done. It is an issue for me when I play the piano. It bothers me when I try and play the piano". Resident #11's right pinky, right ring finger, and right middle fingernails were long; approximately 3/4 inches in length. The forefinger nail was approximately 1/2 inch long. The left hand had several nails broken and uneven in length. Nails were jagged on both hands. The resident stated, "I like my nails longer, but they need to be done closer to same size on both hands". An interview with Resident #11, on 06/06/19 at 10:27 AM, with Registered Nurse (RN) #1 present, revealed her nails hurt. She stated her pinky was long, and had broken off, and it hurt. She stated she didn't want the nails cut off short,	M 610	M610 1. Resident #11's nail care was performed on 6/6/19 by Licensed Practical Nurse (LPN). 2. Current residents in the facility who are dependent on staff for nail care are at risk for the deficient practice. An audit was conducted of the condition of fingernails of active residents on 6/6/19 by Licensed Practical Nurse (LPN) and Registered Nurse (RN) Supervisor. Any adverse findings were corrected during the audit by Licensed Practical Nurse (LPN) and Registered Nurse (RN) Supervisor. 3. Beginning on 6/20/19, nursing staff were in-serviced by Licensed Practical Nurse (LPN) Staff Development Coordinator in regards to requirement of providing nail care for residents. 4. Beginning on 7/12/19, Registered Nurse (RN) Supervisor will complete an audit on ten (10) residents for nail care weekly for four (4) weeks, then monthly for two (2) months and quarterly thereafter. The RN Supervisor will report findings to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Director of Nursing is responsible for on-going monitoring and compliance.	

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M 610	Continued From page 10 but did want them clean and shaped the same length. She stated she played the piano and it bothered her that her nails were in that shape. An interview on 06/06/19 at 10:35 AM, with RN #1, revealed the nurses are supposed to cut the resident's nails on the weekend. She stated she could see that Resident #11's nails were uneven, jagged, and somewhat unclear. An interview on 06/06/19 on 12:31 PM, with RN #4, revealed the facility was implementing a new schedule, where the diabetic residents nail care will be placed on the Electric Medical Record (EMAR) for the nurses to do, and the nail care the CNA can do will be placed on the "point of care" for them to check off that nail care was completed. RN #4 stated this was schedule at some of the facilities, but not at this one yet. An interview on 06/07/19 at 10:35 AM, with the DON, revealed Resident #11's sisters do her nails sometimes and she had supplies in her room for when they visited. The DON stated that Resident #11 liked her nails long, and she guessed it just fell through the crack and they weren't done. The DON stated the Activity Department does nails monthly and she didn't know how it fell through the crack for the nails not being done, including trimmed or cleaned.	M 610			
M 640	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	M 640		7/12/19	

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M 640	Continued From page 11 appropriate state agencies. This Statute is not met as evidenced by: Level IV Based on observation, facility staff and consulting staff interviews, record review, and facility policy review, the facility failed to provide adequate supervision for a severely cognitively impaired resident, to ensure the resident did not have access to medication from an unsecured medication cart, for one (1) of five (5) residents reviewed for accidents and hazards, Resident #41. On 6/4/19 at 6:45 PM, Resident #41 was observed opening the drawer of the A Wing medication cart (Cart #1), which contained the significant medications Insulin and Nitroglycerin tablets, along with other medications. The failure to provide adequate supervision, to ensure Resident #41 and the other five (5) residents identified with severe cognitive impairment, did not have access to remove medications from an unsecured medication cart, placed these residents in a situation that was likely to cause serious injury, harm, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 4/26/19, when facility staff became aware that the medication cart had a drawer that would not lock and did not correct the situation. Resident #41, a resident with severe cognitive impairment, was observed to open the unsecured medication cart drawer, with accessible medications, on 6/4/19. On 6/5/19 at 6:50 PM, the State Agency (SA) notified the facility's Administrator of the IJ and	M 640	M640 1. On 6/4/19, Resident #41 was immediately redirected from malfunctioning medication cart by Registered Nurse (RN) #3. Medication cart was locked in the medication room once medication pass was completed. Contracted pharmacy service provider replace malfunctioning cart on 6/5/19. 2. Current residents in the facility have the potential to be affected by the deficient practice. Staff was in-serviced beginning on 6/5/19 by Licensed Practical Nurse (LPN) Staff Development Coordinator regarding requirement of facility to provide a safe environment for residents. No staff permitted to work until in-serviced. 3. Licensed nurses were educated by Licensed Practical Nurse (LPN) Staff Development Coordinator on 6/5/19 to notify Administrator/Director of Nursing immediately if a medication cart or other unsafe condition exists. In-service was conducted by contracted pharmacy services representative to educate licensed nursing staff on accuracy of ordering medication and correct medication administration on 6/13/19. 4. Beginning 7/12/19, medication carts will be checked on a weekly basis for four (4) weeks, then monthly for two (2) months and quarterly thereafter - by the Administrator/Director of	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46FM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/07/2019
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M 640	Continued From page 12 SQC. The facility submitted an acceptable Removal Plan on 6/6/19, in which the facility alleged that all corrective actions were completed as of 6/5/19, and the IJ removed as of 6/6/19. The SA validated the Removal Plan on 6/7/19, and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CRF(s) 483.25 (d)(2)-Supervision, F689, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility's policy titled "Security of Medication Cart", revised 4/2007, revealed the nurse must secure the medication cart during the medication pass to prevent unauthorized entry. A review of the facility's policy titled, "Safety and Supervision of Residents", with a revision date of July 2017, revealed: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Observation on 6/4/19 at 6:45 PM, revealed Resident #41 opened the uppermost right top medication cart drawer as the surveyor was walking down A-wing 100 hallway. The primary medication nurse was not present, or in sight of, the medication cart at this time. Registered Nurse (RN) #3 was walking down the hallway and met the resident at the medication cart and redirected his right hand away from the cart. Shortly after, the primary medication nurse and	M 640	Nursing/Maintenance Director to ensure they are locking without issue. Any cart identified as not locking will be placed in the medication room and medications will be walked to the resident until cart can be replaced. Administrator will report findings of audits to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Administrator is responsible for on-going monitoring and compliance.		

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M 640	Continued From page 13 the Director of Nursing (DON) came to the cart. The primary medication nurse verified that the drawer contained the following medications: three (3) insulin pens, one (1) Scopolamine patch, one (1) tube of Glucagon, one (1) 2.5 milliliter (ML) bottle of Latanoprost eye drops, one (1) bottle of Prednisone eye drops, one (1) bottle of Original eye drops, one (1) bottle of Nitroglycerin 0.4 milligram (MG) tablets (which contained 25 tablets), six (6) 2 ML vials of Zofran, one (1) 20 ML bottle of 1 percent (%) Lidocaine with approximately 15 ML remaining in the bottle, and one (1) tube of oral pain relief medication. On 6/4/19 at 8:30 PM, an interview with the DON revealed, "We have been trying to get that medication cart fixed for the past month or so." On 6/4/19 at 8:40 PM, an interview with Licensed Practical Nurse (LPN) #10 revealed the facility had been having trouble with this medication cart drawer since she started to work at this facility, in April 2019. Review of the Electronic Medication Administration Records (MARs) revealed LPN #10 first documented medication administration on 4/26/19 for the 100 hall. On 6/5/19 at 8:50 AM, an interview with the Director of Nursing (DON) revealed, RN #3 moved the resident's hand away from the medication cart. The DON also stated the medication cart lock had been broken for at least the past two (2) weeks. She stated the medication carts are usually kept in the medication room or in the hallway with the lock turned towards the wall. She also stated Resident #41 could have gotten an alcohol pad from the medication cart, because he is cognitively impaired. The DON stated there was some Insulin in the drawer, but it was in a bag,	M 640		

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M 640	Continued From page 14 and the eye drops were in a box. She stated the resident could have taken the Nitroglycerin from the drawer and could have been sent to the hospital. Observation and interview on 6/5/19 at 9:00 AM, revealed Resident #41 lying in bed awake and getting ready to receive Activities of Daily Living (ADL) care. This Surveyor asked Resident #41 to make a fist and he stated, "Do you mean make a fist like this" and proceeded to open and close both of his hands demonstrating a fist five (5) times very quickly. He demonstrated the ability to follow a command. Observation on 6/5/19 at 9:30 AM, revealed LPN #9 pulled on each medication drawer of the A-wing medication cart, while it was in the locked position. Only the uppermost top right drawer would open. The same medications, including Insulin and Nitroglycerin tablets, remained in the unsecured medication drawer at this time. During observation, on 6/5/19 at 9:35 AM, LPN #9 emptied the Nitroglycerin tablets from the bottle (from the unsecured medication cart) into a plastic 30 Cubic Centimeter (CC) medication cup. LPN #9 approached Resident #41 and asked the resident to open the empty Nitroglycerin bottle. The resident twisted the cap off of the Nitroglycerin bottle easily. This was demonstrated in the presence of two (2) surveyors. Observation on 6/5/19 at 10:05 AM, revealed LPN #9 counted the Nitroglycerin tablets that were in the bottle from the top right drawer of A-wing medication cart. There were a total of 25 0.4 MG tablets in the bottle. Interview on 6/5/19 at 10:55 AM, revealed LPN #9	M 640		

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M 640	Continued From page 15 had not redirected any resident away from the medication cart before. She denied any problems with residents getting into the medication cart. LPN #9 stated no resident has been harmed from any medications and she has not seen any medications in any resident hands. She also stated, she was just made aware of the medication cart not locking as of last week. She stated she had called the pharmacy this past weekend and told them the top right medication cart drawer had problems with locking and the response was they would have to give her a call back. LPN #9 stated the pharmacy had not called her back as of today (6/5/19). She stated she had told her Charge Nurse, LPN #4 or LPN #5 about the medication cart drawer not locking; she was not sure which one of those Charge Nurses she had told. LPN #9 stated she never had gotten a chance to report the drawer not locking to the DON, because she had just discovered it over the weekend. On 6/5/19 at 11:05 AM, an interview with RN #6 revealed she had not had any residents attempting to open her medication cart. She stated she tried to anticipate what the residents need to help prevent the residents from trying to get a medication themselves. On 6/5/19 at 11:15 AM, an interview with the DON revealed she had not had any problems with residents trying to get into medication carts. She stated she was about to intervene when she had seen Resident #41 open the medication cart drawer. The DON stated that if the medication cart would have been turned around towards the room, the resident would not have been able to open the drawer. On 6/5/19 at 11:28 AM, an interview with RN #5	M 640			

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M 640	Continued From page 16 revealed the nurses try to keep the medication cart within eye's view. She stated the nurses started calling last week to let the pharmacy know that the lock was broken on the A wing medication cart. On 6/5/19 at 11:40 AM, an interview with the DON revealed the facility should receive a new medication cart tonight from Omnicare. (Medications still remained in the cart at this time). On 6/5/19 at 3:04 PM, an interview with LPN #10, via telephone, revealed the medication cart drawer had been broken for a couple of weeks. She stated she told the pharmacy people about the medication cart being broken. She also stated she had gone to the DON. LPN #10 stated the DON told her to call the pharmacy initially, and she had started calling them last week. She also stated Maintenance attempted to fix the medication cart the day before (referring to 6/4/19). LPN #10 stated she was on the hallway and had just came out of room 102. She stated the medication cart was parked between room 101 and room 102. She also stated she was able to see the resident in room 102 and the medication cart at the same time. On 6/5/19 at 3:15 PM, LPN #10 disconnected the telephone call. On 6/5/19 at 3:18 PM, LPN #10 called back to continue the interview. During this interview LPN #10 stated, "Yes, I said it had been broken, and I think I told you since April 25th" (referring to how long the A-wing medication cart 1 had been broken). LPN #10 stated the cart was broken when she first started working (verified by the initials on the Electronic Medication Administration record as 4/26/19). She stated when she first identified the lock was broken, she asked Maintenance if they could fix the lock. She	M 640		

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M 640	Continued From page 17 stated Maintenance said they do not look at medication carts; she would have to call the people they (referring to the medication carts) had come from. She also stated the DON told her to call the pharmacy. LPN #10 stated she would keep the medication cart in view and/or turn it around. She stated when the surveyors had come to the facility, she was just finishing her medication pass. She then stated, she was able to see the medication cart, but could not see the resident. She also stated she had seen RN #3 intervene, but she (LPN #10) did not. LPN #10 then stated, the lock was facing her and she could see the lock. She stated the medication cart was close to rooms 101 and 102 and it was facing towards the middle of the hallway. She stated the resident could have side effects if he had taken some of the medications. She also stated the resident could have heart problems and could have died. LPN #10 stated if she was giving medications to a resident and had the privacy curtain pulled, she would pull the medication cart to the door and she could hear if someone opened the drawer to the cart. She stated they would have to totally move the cart. She also stated, "We have to keep the medications separated", so she could not have moved the medications to another drawer. She stated sometimes the other drawers would not lock and it's possible the resident could have gotten into another unlocked drawer. LPN #10 stated she tried several times to get the medication cart drawer fixed. On 6/5/19 at 4:08 PM, an interview with the DON revealed the staff reports to maintenance or puts the problem in the maintenance book for any broken equipment. She stated the Maintenance Supervisor or Maintenance Staff #2, are always on call even for equipment that need to be	M 640			

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M 640	Continued From page 18 reported immediately. On 6/5/19 at 4:35 PM, an interview with Maintenance Staff #2 revealed he first became aware of the medication cart lock being broken on 6/4/19. He stated as he was walking down the hallway, he was flagged down by RN #1 to talk to the pharmacy. Maintenance Staff #2 stated Omnicare staff asked him to check out the lock on the medication cart. He stated he and the Maintenance Supervisor were unable to fix the medication cart lock. He stated he called back and the lady on the phone stated she would send a technician out to the facility. He stated he had gotten the lady's first name but he was unable to get her last name. He also stated he does not know if the pharmacy sent the technician out to the facility or not. On 6/5/19 at 4:40 PM, an interview with the Maintenance Supervisor, revealed, Maintenance Staff #2, told her about the medication cart not being able to be locked on 6/4/19. She stated, they (referring to her and her assistant) tried to work on it (referring to A-wing medication cart 1 lock) and could not get it fixed. She stated Maintenance Staff #2 called Omnicare. She stated the top right drawer would not lock. During an interview on 6/5/19 at 4:45 PM, Maintenance Staff #2 revealed the A-wing medication cart (Cart #1) measured 40 and 1/4 inches in height. This was observed to be easily accessible to any resident, even a resident who used a wheelchair. On 6/5/19 at 5:47 PM, an interview with Consultant Pharmacist #2, revealed Omnicare (pharmacy) was first notified on Monday (6/3/19), of the facility having a medication cart that would	M 640		

MSDH - Health Facilities Licensure and Certification

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M 640	Continued From page 19 not lock. She stated the facility emailed Pharmacy Staff #1 on Monday, 6/3/19, at 5:08 PM. She also stated she was not aware that the medication cart had been broken for two (2) weeks. She stated she called the facility Tuesday 6/4/19, to see if the maintenance man could fix the cart. She also stated if a resident took 25 0.4 MG Nitroglycerin tablets, she believed they would have a headache and Hypotension. She also stated that 25 Nitroglycerin tablets would be a higher than indicated dose. She stated it is not an indicated dose, and could lead to Hypotension, Headache, and falls. On 6/5/19 at 5:57 PM, an interview with the Medical Director revealed she was made aware of this incident (A-wing medication "Cart 1" drawer lock being broken) today when she walked through the door at 2:00 PM. She stated there was a plan of correction in place. She also stated the Pharmacist is a major issue here at the facility. She stated if a resident had taken 25 of the 0.4 Mg Nitroglycerin tablets that could cause death. On 6/6/19 at 12:04 PM, an interview with RN #3 revealed she was making rounds and when she headed back, that's when she took the resident's hand and said, "No, no, no, we can't do that" (referring to Resident #41 opening the medication cart drawer). She stated Resident #41 said all he wanted was a pencil. RN #3 also stated she was headed back from the end of A-wing hallway to the nursing station. She stated the DON was coming from the opposite direction. RN #3 stated she had not had to redirect a resident away from a medication cart before. She also stated she does not remember any other resident opening the medication cart before. She stated she does not have a clue as to how long the medication	M 640		

MSDH - Health Facilities Licensure and Certification

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M 640	Continued From page 20 cart lock had been broken. On 6/6/19 at 12:15 PM, observation revealed LPN #7 moved a Medication cart, just like the cart that had the broken drawer, to the middle of A-wing hallway between rooms 101 and 102. The medication drawers faced the center of the hallway, just as positioned on 6/4/19, when the resident was observed opening the medication cart drawer. The surveyor sat at the nursing desk on A-wing and the medication cart drawers were not visible from the nursing station with the medication cart being in this position. On 6/6/19 at 3:22 PM, an interview with Consultant Pharmacist #1 revealed there is some form of medication audit done monthly. He stated carts are checked basically once a quarter. He stated he was not aware and cannot recall the A-wing medication cart drawer being unable to be locked. On 6/7/19 at 11:32 AM, an interview with RN #3 revealed the staff could have supervised and redirected the resident to prevent this incident from occurring. On 6/7/19 at 1:28 PM, an interview with the Administrator revealed the DON notified him of the incident (A Wing top right medication cart drawer not locking) on 6/4/19. He stated the expectation is not that the staff wait to report these types of issues. He stated he must be made aware for the safety and well-being of the residents. The facility identified five (5) residents, who had severe cognitive impairment and who were mobile in the facility.	M 640		

MSDH - Health Facilities Licensure and Certification

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M 640	Continued From page 21 The facility provided the following Removal Plan: Brief Summary: At approximately 6:50 PM on June 5, 2019, the facility was notified by the annual survey team that the facility was being placed in Immediate Jeopardy, due to the Facility on June 4, 2019 at approximately 6:45 PM, failed to adequately supervise to prevent a severely cognitively-impaired resident from opening a medication cart drawer where multiple medications, including 25 Nitroglycerin 0.4 milligram (mg) tablets were located. The facility failed to store medications safely to prevent a cognitively impaired resident from having access to the medication cart, and the medication cart drawer would not lock. Licensed Practical Nurse (LPN) #10 stated the cart did not lock properly and has malfunctioned since she started to work in the Facility on April 26, 2019, at approximately 7:00 AM. On the evening of June 4, 2019, Resident #41 was witnessed by a surveyor opening the malfunctioning drawer where medication was located. The cart was locked in the medication room once medication pass was completed. (The name of the Pharmacy Vendor) was contacted on June 3, 2019 and a new cart was requested. The replacement cart arrived at the Facility on June 5, 2019, and medications were transferred from the malfunctioning cart to the properly locking replacement cart. Corrective actions included: 1. On June 4, 2019 at approximately 6:45 PM, Resident #41 was observed opening the malfunctioning drawer. This incident was witnessed by RN #3 and LPN #7. RN #3 immediately redirected resident. This incident was also witnessed by the annual survey team. The primary LPN #10 assigned to the cart was	M 640		

MSDH - Health Facilities Licensure and Certification

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M 640	Continued From page 22 not present. 2. On June 5, 2019 at approximately 1:00 PM, a new medication cart was delivered to the Facility. Medications were exchanged from the old cart into the new properly locking cart. 3. On June 5, 2019 at approximately 2:00 PM, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the RN Supervisor (RN) #1, and the Minimum Data Set (MDS) RN #2, audited medication carts regarding proper locking and storage. No issues were identified. 4. On June 5, 2019 at approximately 2:30 PM, the Administrator held a Quality Assurance Performance Improvement (QAPI) meeting to discuss action plan and resolution steps. The members of the committee discussed the medication cart malfunction, proper storage of medication, necessary steps in reporting issues and an audit tool developed as a tracking mechanism to ensure medication carts are in proper working order. The Members in attendance were the Administrator, DON, ADON, Medical Director, Social Services Director, Dietary Manager, Activities Director, Director of Therapy, Staff Development Coordinator LPN #7, Maintenance Director, Business Office Manager, Human Resources Generalist, Housekeeping Manager, MDS RN #2, LPN #4, LPN #5, Risk Manager RN, and the RN Supervisor (RN #1). 5. On June 5, 2019 at approximately 3:00 PM, the Staff Development Coordinator LPN #7 in-serviced Licensed Nursing Staff on the daily audit tool used to validate that all medication carts are in proper-working order, proper storage of medication to maintain a safe environment, and proper procedure for unavailable	M 640			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46FM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/07/2019
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M 640	Continued From page 23 medications. 6. No nursing staff will be permitted to work until in-serviced. 7. The facility alleges that all corrective actions to remove the immediate jeopardy was completed as of June 5, 2019, and the immediate jeopardy removed as of June 6, 2019. The SA validated the facility's Removal Plan and determined the facility had taken the following actions to correct the IJ: 1. Based on observations record review and staff interviews the State Agency (SA) validated Resident #41 had severe cognitive impairment and was observed opening the drawer of an unsecured medication cart. The SA validated the resident was redirected by RN #3. 2. The SA validated by interview with the Director of Nurses (DON) and observation on 6/6/19, that a new cart had been delivered and medications were exchanged from the old cart into the new cart on 6/5/19, and the cart properly locked. 3. The SA validated by interview with the DON that an audit was completed on 6/5/19, that all carts locked appropriately. The SA found no other carts that malfunctioned. 4. The SA validated through review of the sign-in sheet and interview with the Administrator, that a QAPI meeting was held on 6/5/19, with all stated members, in regards to the malfunctioning medication cart, storage of medications, reporting requirements if there's a malfunction, and a tracking/audit tool for ensuring medication carts were in proper working order.	M 640			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46FM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/07/2019
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M 640	Continued From page 24 5. The SA validated through random interviews with nursing staff and review of in-service sign in sheets, that the Staff Development Coordinator, LPN #7, initiated in-services regarding use of the audit tool, proper storage of medication to maintain a safe environment for residents, and procedures for medications not available. 6. The SA validated through interview with random nursing staff that no staff was allowed to work until they were in-serviced. 7. The SA validated that all corrective actions to remove the Immediate Jeopardy were completed on 6/5/19, and the Immediate Jeopardy removed as of 6/6/19.	M 640		
M 700	45.24.1 General General. The facility shall provide routine drugs, emergency drugs and biologicals to its residents or obtain them by agreement. This Statute is not met as evidenced by: Level II Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to ensure medications were not borrowed from other residents and that medications were available for administration for one (1) of five (5), Residents, Resident #1. Medications not available included Insulin and Flonase; medication borrowed included Insulin. Findings include: Record Review of a facility document on	M 700	M700 1. Resident #1 s physician orders were reconciled against Medication Administration Record (MAR)s on 6/4/19 by Registered Nurse (RN) Supervisor. Physician was notified of results, which included various missing medications a hold order was obtained from Medical Doctor (MD) on 6/4/19 by Registered Nurse (RN) Supervisor. An incident report was completed, by Risk Manager Registered Nurse (RN) on 6/5/19, due to borrowing of medication from another resident. Nurses identified as failing to	7/12/19

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46FM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/07/2019
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M 700	Continued From page 25 letterhead, signed by the Administrator and dated 6/5/19, revealed the facility did not have a designated policy on borrowing medications amongst residents. However, a policy "5.2 Receipt of Interim/Stat/Emergency Deliveries", dated 2013, revealed: "4. Facility should not borrow medication from another resident". Review of a documented procedure, signed by the Administrator and dated 6/5/19, and placed on company letter head, revealed, "It is the policy of the facility to do the following when medication is unavailable: 1. the nurse shall check the omniceil for the appropriate medication in need 2. If the medication is not available, the nurse shall call Medical Director for a hold order, or alternate medication order 3. If Medical Director is unavailable, the nurse shall contact the Nurse Practitioner for appropriate orders." An observation on 06/04/19 at 7:30 PM, revealed Licensed Practical Nurse (LPN) #3 pulled Resident #1's medications for the 8:00 PM medication pass. LPN #3 stated Resident #1 does not have any Levemir Insulin or Flonase to administer. An interview on 06/04/19 at 8:33 PM, with Resident #1 revealed, "I missed my Levemir Insulin, Flonase, and Symbicort medication since I've been back from pass. I haven't gotten those medications since five (5) days ago. I left them with my family in North Mississippi and they are six (6) hours away and cannot bring them back". Further interview with Resident #1 on 06/07/19 at 06:15 PM, revealed "I am seriously concerned about the Insulin issue. I always run out of Insulin". Review of the medical record revealed Resident	M 700	follow proper protocols were disciplined according to facility policy by Director of Nursing on 6/5/19. Medications were ordered by Licensed Practical Nurse (LPN), and were received on 6/5/19. 2. Current residents in the facility are at risk for the deficient practice. On 6/10/19, LPN Staff Development Coordinator completed a Medication Administration Record (MAR) to medication cart review to ensure medications were available for administration per physician orders. Medications were obtained from contracted pharmacy for MARs found to have discrepancies to facilitate compliance with appropriate medication pass. On 6/14/19, contracted pharmacy services Registered Nurse (RN) completed internal MAR to cart review to ensure medications are available for administration. Medications noted not available as a result of the audit were ordered and received on 6/14/19 by Licensed Practical Nurse. 3. In-service was held by contracted pharmacy representative to educate licensed nursing staff on ordering medication procedures and medication administration on 6/13/19. 4. Director of Nursing/Assistant Director of Nursing will complete MAR to cart reviews on (10) residents per week with findings recorded on MAR to cart check form beginning 7/8/19 for four (4) weeks, then monthly for two (2) months and quarterly thereafter to ensure that medications are available for administration. Director of	

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M 700	Continued From page 26 #1 was on leave with family and returned to the facility on 6/1/19. Review of the current physician's orders revealed Resident #1's orders included Levemir Sol 100 units/milliliter (ml) 50 units Subcutaneously (SQ) at bedtime (scheduled for 9:00 PM) and 15 units SQ in the mornings (scheduled for 6:00 AM), initiated 2/13/19; and Flonase Suspension 50 microgram (mcg) ACT one (1) spray in each nostril every 12 hours (scheduled for 2100), initiated 2/22/18. A review of facility electronic physician's order, dated 6/5/19 at 12:01 PM, revealed: Hold Levemir and Flonase until available from pharmacy. Use sliding scale and monitor for signs/symptoms of hyperglycemia, effective 6/4/19, one (1) time only for one (1) day. (This order did not cover 6/1/19-6/3/19.) Review of the Electronic Medication Record (EMAR), dated 6/4/19, revealed Levemir Insulin and Flonase Nasal Spray was not signed as administered for Resident #1 for the 9:00 PM dose. Review of the EMAR for June 2019, revealed Resident #1's blood glucose (BG) levels were checked three (3) times daily. The BG level for 6/5/19 at 6:30 AM, after non-receipt of Insulin on 6/4/19 at 9:00 PM, read 239 with six (6) units of sliding scale insulin administered. The other BG levels ranged from 108 to 318. There were no documented adverse effects for Resident #1, related to BG levels. Review of a document, provided by the facility, titled "Refill Reorder Form", revealed Levemir was reordered on 6/2/19, and Flonase was	M 700	Nursing will report findings of audits to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Director of Nursing is responsible for on-going monitoring and compliance.		

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M 700	Continued From page 27 reordered on 6/3/19, for Resident #1. Review of a facility document titled "Delivery Receipt", revealed Levemir's ship date as 6/4/19, and not delivered to facility until 6/5/19 at 12:30 PM; and Flonase's ship date as 6/5/19, and not delivered to facility until 6/5/19 at 12:30 PM. A review of a facility document titled "24 hour report", revealed Resident #1's medication was not identified as needing ordered on the 24 hour communication sheet (from 6/1/19-6/4/19). In an interview on 06/04/19 at 7:30 PM, LPN #3 revealed, "Resident #1 went out on pass for a couple weeks with family and she did not bring her Levemir Insulin or Flonase back from pass". LPN #3 stated, "I borrowed Levemir Insulin on Monday night (6/3/19) to give Resident #1 from another resident. I gave it to Resident #1 on Monday night. I did not give the Flonase because I did not have it in the facility. However, I guess I just got busy and signed the Electronic Medication Record Administration (EMAR) by mistake that I gave it". Further interview with LPN #3 on 06/04/19 at 8:25 PM, revealed, "As I stated earlier, Resident #1's Levemir Insulin and Flonase was not here tonight for me to give, but I borrowed Levemir Insulin and gave it to Resident #1 on Monday night. I know I'm not supposed to borrow Insulin, but she has high blood sugars. I was probably going too fast and marked the EMAR by mistake for giving the Flonase". An interview on 06/04/19 at 8:13 PM, with LPN #4/ Charge Nurse (7 AM-7 PM), regarding the Levemir Insulin being borrowed and the Flonase not being in the facility revealed, "This is the first time I've been told the medications are missing. They usually make me a list of the medications	M 700			

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M 700	Continued From page 28 that they need and I order it". LPN #4 verified Resident #1 returned from pass on 6/1/19. LPN #4 stated that prior to 6/5/19, the last time the Flonase was ordered was 3/4/19, and the last time the Levemir Insulin was ordered was 5/2/19". During an interview on 06/04/19 at 8:26 PM, LPN #4 revealed she pulled the fax sheets that were sent to Omnicare Pharmacy to be filled, and it revealed Flonase was ordered from the pharmacy on 6/3/19, and Levemir Sol Insulin was ordered on 6/2/19. Further interview on 06/05/19 at 9:10 AM, with LPN #4, revealed she was told by the ADON that if a medication is ordered, and it is not available in the Omnicell machine, they are supposed to send the resident out to the hospital for the medication. LPN #4 revealed that there is no physician's order for Resident #1 to be sent out for Flonase or Levemir Insulin after missing her medication from 6/1/19 through 6/4/19. An interview on 06/04/19 at 8:29 PM, with LPN #5 revealed, "It takes two (2) days for medications to come in to the facility once they are ordered, if they are ordered after a certain time of day". LPN #4 was present during the interview, and stated, "That is correct, it does take two (2) - three (3) days to get our meds sometimes. The process for checking in medications is the 7 PM-7 AM nurse checks the medications in and they are to tell the charge nurse on days, or the nurse they count off with, that a medication is missing or needing to be ordered. They are also to tell them if the medication did not come in after it was ordered". An interview on 06/04/19 at 8:30 PM, with LPN #3, revealed she reported to LPN #2, the 7 AM-7 PM nurse, that the Levemir Insulin and Flonase was not at the facility. In a further interview, on	M 700			

MSDH - Health Facilities Licensure and Certification

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M 700	Continued From page 29 06/04/19 at 8:35 PM, LPN #3 stated, "Resident #1 did not miss her Levemir Insulin last night. I borrowed it from another resident and gave it to her". An interview on 06/05/19 at 9:40 AM, with LPN #4, revealed, "Resident #1 receives Levemir Insulin from a multi dose vial. She stated that LPN #3 did state to her last night that she borrowed Levemir Insulin from another resident and administered it to Resident #1. An observation of the Medication Cart on 06/04/19 at 8:34 PM, revealed Symbicort was on the medication cart and available for administration to Resident #1, but Levemir and Flonase were not on the cart. An interview on 06/04/19 at 8:45 PM, with the Director of Nursing (DON) revealed they couldn't use the local pharmacy as an after hours pharmacy. She stated they had been told by the pharmacy that the facility had to use the pharmacy that they used. The DON stated she didn't know why they couldn't use the local pharmacies that were open 24 hours per day. An observation on 06/05/19 at 2:32 PM, of the medication cart, revealed that Resident #1's Levemir Insulin and Flonase had arrived from pharmacy, and was located on the mediation cart at this time. In an interview on 06/05/19 at 12:10 PM, LPN #4 revealed, "As of now, we do not have a policy as to what to do when the medications are not in the facility to give the residents. Administration is working on a policy now with pharmacy and corporate about creating a policy".	M 700		

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M 700	Continued From page 30 In an interview on 06/05/19 at 12:30 PM, the DON stated they were still having trouble with getting medications from the pharmacy. She stated she drove to a pharmacy in a nearby town to get Resident #1's medications, but they weren't ready. She stated the Pharmacist told her the medications would be there sometime today, because they had to come from the Pharmacy in (name of town). She stated the pharmacy said that they tried calling the facility last night to tell them the medication would not be ready, and no one answered the call. The DON stated, "I was at the facility until midnight last night, and nobody called the facility from the pharmacy. We have major issues in getting our medications for our residents". In an interview on 06/05/19 at 3:43 PM, LPN #6 revealed, "I borrowed the Levemir Insulin from another resident to give to Resident #1". She stated she borrowed it and gave it to the resident, because she knew how high the resident's sugars could be and she needed the medication. She stated she knew it was the weekend (6/1-6/2) and the pharmacy wouldn't have been able to deliver the Levemir Insulin. She stated they have trouble getting medication sometime, especially on the weekends. She stated she did not give the Flonase, but signed the EMAR as given, in error. She stated, "I was in a hurry I guess, and just checked it off that I gave the Flonase, but it wasn't there to give". In an interview on 06/06/19 at 2:30 PM, the Pharmacist with the contracted vendor revealed, "I do not know of any instances right off the bat where the facility didn't receive Resident #1's Levemir or Flonase, if it was ordered". The Pharmacist stated the facility should have a schedule posted at the nurse's desk with cutoff	M 700			

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46FM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/07/2019
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M 700	Continued From page 31 times for ordering medications. The Pharmacist stated the delivery contract with the facility did not guarantee delivery. He stated they try to have a four (4) hour turn-around time, but again, no guarantee. The Pharmacist stated the facility has a Pixel machine that contains 250 medications in it, but no Insulin, because a refrigerator is not linked to their Pixel. The Pharmacist stated, "We make one (1) delivery to the facility a day. If they miss the cut off time with ordering a medication, we have a system that if a medication is called or faxed into the pharmacy after hours, we call our on-call pharmacist and they will go in and fill the medication, if we have it in stock. The pharmacist will then try and catch a driver to deliver it to the facility. If we don't have the medication in stock, the on-call pharmacist will call it in to a 24 hour back up pharmacy, and someone from the facility will have to go pick it up. But, it is the facility's responsibility to call us and say they have faxed a medication they need immediately. If they don't call, then we will process the order the next day. He stated the back-up pharmacy is chosen by the contract vendor. The Director of Nursing and LPN #7 were present in the room for the call with Pharmacist and both the DON and Staff Development stated that the information given by the Pharmacist is not what they are experiencing at the facility, as far as getting medications to the facility in a timely manner. An interview on 06/06/19 at approximately 3:30 PM, with the Consultant Pharmacist for the facility, revealed the Pharmacist was not aware of the facility not getting medications timely, unless it was back-ordered. The Pharmacist stated he visited the facility monthly and checked carts, medication rooms, and followed med passes with nurses. The Pharmacist stated he had not come across any medication for a resident that was not	M 700		

MSDH - Health Facilities Licensure and Certification

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M 700	Continued From page 32 available at the facility for administration, to his knowledge, and no nurse had ever told him of any issues where they couldn't get medication in a timely manner. An interview on 06/06/19 at 5:45 PM, with the Medical Director revealed he wasn't called about Resident #1 not having Levemir or Flonase until late yesterday, he didn't recall the exact time, but knew it was late. The Medical Director stated he told the nurse to hold Flonase and Levemir and to cover with sliding scale if needed. He stated, "I don't know why they just didn't call me. If medications are not available, I expect a nurse to call me and I will give orders for a substitute medication or call a substitute pharmacy". The Medical Director stated he has had problems with this pharmacy on a couple of instances regarding getting medication, and had gone to administration about the issue. He stated he believed they were in the process of getting a new Pharmacy vendor. He stated borrowing the Insulin from another resident and giving it to Resident #1 and not giving the Flonase is unacceptable; it was definitely a medication error to not have the Flonase or Levemir to administer. He stated that nurses charting medications as given when they are not at the facility, is unacceptable also. An interview on 06/07/19 at 9:38 AM, with LPN #2 revealed, "I work 7a-7p and LPN #3 works 7p-7a. LPN #3 never reported off to me that the Levemir nor Flonase was not in the facility. Resident #1 actually told me that the Flonase was not here, because she had left it in her family's vehicle when they brought her back from pass. Resident #1 never said anything about the Levemir not being here. I know I was supposed to go call her daughter and see if we could get the Flonase	M 700			

MSDH - Health Facilities Licensure and Certification

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M 700	Continued From page 33 back, because I knew it had a lot in the bottle when she left, but I forgot and that's my fault". An interview on 06/07/19 at 10:46 AM, with the DON revealed, "You're not supposed to borrow medication from resident to resident. Borrowing would effect a resident's supply, especially with a multivital medication. It was a medication error with the resident not getting the Levemir Insulin on 6/4/19, and Flonase on other days. The nurses signing that they gave the Flonase is inaccurate documentation. A review of a facility document titled "Disciplinary Action Report", dated 6/5/19, revealed LPN #3 and LPN #6 received disciplinary action for borrowing medications. An interview on 06/07/19 at 1:12 PM, the Administrator stated, "I was made aware of the medication error on 6/4/19, after it was discovered. I understand what was done with the nurses borrowing the Levemir and I don't think the most appropriate decision was made however, the nurses borrowed the Insulin from another resident who had been discharged from the facility, so at least the resident did not go without her Insulin. It was a new flexpen of Insulin that the facility purchased (Medicare Part A) for the resident that had never been opened delivered on 5/29/19, because the resident discharged on 5/31/19". The Administrator stated that he/she was told that the nurses documented Resident #1 received Flonase from 6/1/19-6/ through 6/4/19, when the issue was identified that the Flonase was not available, and both nurses have voiced they accidentally documented that it was given, but it was not given. The Administrator stated that disciplinary actions were being taken with those nurses at this time.	M 700		

MSDH - Health Facilities Licensure and Certification

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M 700	Continued From page 34 In an interview on 06/07/19 at 1:45 PM, with the DON revealed, "I don't think we have a policy per say for borrowing medications from one resident to another or for medication errors and who they are supposed to report to".	M 700		
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; 3. Dispensing; 4. Storage; and 5. Administration of all drugs and biologicals. This Statute is not met as evidenced by: Level IV Based on observation, facility staff and consulting staff interviews, record review, and facility policy review, the facility failed to provide safe medication storage and security of medications in a manner to prevent resident access, as evidenced by a drawer of the medication cart would not lock. As a result, on 6/4/19 at 6:45 PM, Resident #41 was observed opening the drawer of the A Wing Medication "Cart 1," which contained significant medications including Insulin and Nitroglycerin tablets, as well as other medications. The facility was aware of the medication cart lock not functioning for approximately two (2) months prior to this	M 705	M705 1. On 6/4/19, Resident #41 was immediately redirected from malfunctioning medication cart by Registered Nurse (RN) #3. Medication cart was locked in the medication room once medication pass was completed. Contracted pharmacy service provider was contacted on the evening of 6/4/19 by the Administrator and Regional Vice President to expedite new medication cart delivery and a replacement cart was delivered on 6/5/19. 2. Current residents in the facility have the potential to be affected by the deficient	7/12/19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46FM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/07/2019
NAME OF PROVIDER OR SUPPLIER COLUMBIA REHABILITATION AND HEALTHCA		STREET ADDRESS, CITY, STATE, ZIP CODE 1506 NORTH MAIN STREET COLUMBIA, MS 39429		
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M 705	Continued From page 35 incident, as evidenced by an interview with Licensed Practical Nurse (LPN) #10, who stated the drawer would not lock when she started to work on 4/26/19. Resident #41 was observed opening the unsecured medication drawer on 6/4/19 at approximately 6:45 PM. The failure to provide adequate storage and locking of medications to ensure Resident #41 and the other five (5) mobile residents, identified with severe cognitive impairment, did not have access to remove medications from an unsecured medication cart, placed these residents in a situation that was likely to cause serious injury, harm, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 4/26/19, when facility staff identified the A-Wing medication "Cart 1" drawer, which contained Insulin and Nitroglycerin tablets, would not lock, allowing cognitively impaired residents to have access. On 6/5/19 at 6:50 PM, the State Agency (SA) notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Removal Plan on 6/6/19, in which the facility alleged that all corrective actions were completed as of 6/5/19, and the IJ removed as of 6/6/19. The SA validated the Removal Plan on 6/7/19, and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CFR(s) 483.45(h)(1) F761, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure	M 705	practice. Beginning on 6/5/19, medication carts will be monitored by facility managers throughout the day to ensure residents remain in a safe environment, free of accidents and hazards, and that carts are locked when not in use. Adverse findings will be address and reported to Administrator or Director of Nursing (DON) immediately. 3. Licensed nursing staff was in-serviced on 6/5/19, by LPN Staff Development Coordinator regarding requirement of medication carts being maintained in working order, and storage of medication to maintain a safe environment, which includes ensuring medication carts lock properly. Licensed nurses were educated to notify Administrator/Director of Nursing immediately if a medication cart or other unsafe condition exists. On 6/13/19 contracted pharmacy service provide in-serviced licensed nurses in regards to requirement of safe storage of medications/medication carts locking. Beginning on 6/5/19 facility staff were in-serviced LPN Staff Development Coordinator in regards to requirement of facility to provide a safe environment for residents, including freedom from accidents and hazards. 4. Beginning 6/10/19, medication carts were checked three (3) times weekly to ensure locking without issue and maintaining a safe environment for residents. Beginning 7/12/19, medication carts will be checked on a weekly basis for four (4) weeks, then monthly for two (2) months and quarterly thereafter, by the	

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M 705	Continued From page 36 the facility sustains compliance with regulatory requirements. Findings include: A review of the facility's undated policy titled, "Security of Medication Cart", revealed the nurse must secure the medication cart during the medication pass to prevent unauthorized entry. A review of the facility's policy titled, "Safety and Supervision of Residents", with a revision date of July 2013, revealed: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. On 6/4/19 at 6:45 PM, an observation revealed Resident #41 opened the uppermost right top medication cart drawer of a medication cart as the surveyor was walking down A-wing 100 hallway. The primary medication nurse was not in sight of the medication cart at this time. Registered Nurse (RN) #3 was walking down the hallway and met the resident at the medication cart and redirected his right hand away from the cart. Shortly after, the primary Medication Nurse and the Director of Nursing (DON) came to the cart. The primary Medication Nurse verified that the drawer contained the following medications: three (3) Insulin pens, one (1) scopolomine patch, one (1) Glucagon tube, one (1) 2.5 milliliter (ML) bottle of Latanoprost eye drops, one (1) bottle of Prednisone eye drops, one (1) bottle of Original eye drops, one (1) bottle of Nitroglycerin 0.4 milligram (MG) tablets (which contained 25 tablets), six (6) 2 ML vials of Zofran, one (1) 20 ML bottle of 1 percent (%) Lidocaine with approximately 15 ML remaining in the bottle, and	M 705	Administrator/Director of Nursing/Maintenance Director to ensure they are locking without issue. Any cart identified as not locking will be placed in the medication room and medications will be walked to the resident until cart can be replaced. Administrator will report findings of audits to the Quality Assurance Performance Improvement committee monthly for three (3) months for further recommendations. The Administrator is responsible for on-going monitoring and compliance.	

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M 705	Continued From page 37 one (1) tube of oral pain relief medication. During an interview on 6/4/19 at 8:30 PM, the DON revealed, "We have been trying to get that medication cart fixed for the past month or so." In an interview on 6/4/19 at 8:40 PM, Licensed Practical Nurse (LPN) #10 revealed the facility had been having trouble with the "Cart I" medication cart not locking since she started to work at this facility, in April 2019. She verified the cart drawer would not lock her first day on the cart on 4/26/19, and contained medications, which included the Insulin and Nitroglycerin tablets. (Review of the Electronic Medical Records revealed LPN #10 began signing the Medication Administration Record for hall 100 on 4/26/19). In an interview on 6/5/19 at 8:30 AM, the DON stated that RN #3 moved the resident's hand away from the medication cart. The DON also stated, the medication cart lock had been broken for at least the past two (2) weeks. She stated the medication carts are usually kept in the medication room or in the hallway, with the lock turned towards the wall. She also stated Resident #41 could also have gotten alcohol pads from the medication cart, because he is cognitively impaired. The DON stated there was some Insulin in the medication cart, but it was in a bag, and the eye drops were in a box. She stated the resident could have taken the Nitroglycerin tablets and could have been sent to the hospital. On 6/5/19 at 9:00 AM, an observation revealed Resident #41 lying in bed awake and alert. This Surveyor asked Resident #41 if he could make a fist and he stated, "Do you mean make a fist like this" and proceeded to open and close both of his	M 705		

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M 705	Continued From page 38 hands demonstrating a fist five (5) times very quickly. Resident #41 was able to follow the command. On 6/5/19 at 9:30 AM, an observation revealed LPN #9 pulled on each medication drawer of the A-wing medication cart, while it was in the locked position, and only the uppermost top right drawer would open. The medications remained in the unsecured medication drawer. This was done in the presence of two (2) surveyors. Observation on 6/5/19 at 9:35 AM, revealed LPN #9 emptied the 0.4 MG tablets of Nitroglycerin from the bottle into a plastic 30 Cubic Centimeter (CC) medication cup. This nurse then approached Resident #41 and asked the resident to open the empty Nitroglycerin bottle. LPN #9 handed Resident #41 the empty Nitroglycerin bottle and the resident twisted the cap off of the bottle easily. He had no difficulty in removing the cap, therefore allowing access to medication in the bottle. This was done in the presence of two (2) surveyors. Observation on 6/5/19 at 10:05 AM, revealed LPN #9 counted the Nitroglycerin tablets that were in the Nitroglycerin bottle from the top right drawer of the A-wing medication cart, with a total of 25 tablets in the bottle. This was done in the presence of two (2) surveyors. On 6/5/19 at 10:55 AM, interview with LPN #9 revealed she has not had to redirect any resident away from the medication cart before. She stated she has not had any problems with any resident getting into the medication cart. LPN #9 stated she had not seen any medications in any resident hands. She also stated she was just made aware of the medication cart not locking, as of last	M 705			

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M 705	Continued From page 39 week. She stated she had called the pharmacy this past weekend and told them the top right medication cart drawer had problems with locking. LPN #9 stated the pharmacy had not called her back as of today (6/5/19). She stated she had told her Charge Nurse, LPN #4 or LPN #5, about the medication cart drawer not locking. LPN #9 stated she is not sure which of those Charge Nurses she had told. LPN #9 stated she never had gotten a chance to report the cart drawer not locking to the DON, because she had just discovered it over the weekend. On 6/5/19 at 11:05 AM, an interview with RN #6 revealed she had not had any residents attempting to open her medication cart. She stated she tries to anticipate what the residents need, to help prevent the resident from trying to get a medication themselves. RN #6 also stated she was not aware of any harm to residents from medications or any medications being in a resident's hands. On 6/5/19 at 11:15 AM, an interview with the DON revealed she had not had any problems with residents trying to get into medication carts. She stated she was about to intervene when she had seen Resident #41 open the medication cart drawer. The DON stated, if the medication cart would have been turned around towards the room, the resident would not have been able to open the drawer. On 6/5/19 at 11:28 AM, an interview with RN #5 revealed the nurses try to keep the medication carts within eye view. She stated the nurses started calling last week to let the pharmacy vendor know that the lock was broken on the A wing medication cart.	M 705		

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M 705	Continued From page 40 On 6/5/19 at 11:40 AM, an interview with the DON revealed the facility should receive a new medication cart tonight from the pharmacy vendor. On 6/5/19 at 3:04 PM, an interview with LPN #10, per telephone, revealed the medication cart drawer had been broken for a couple of weeks. She stated she told the pharmacy people about the medication cart being broken. She also stated she had gone to the DON. LPN #10 stated the DON told her to call the pharmacy vendor initially, and she had started calling them last week. She also stated Maintenance attempted to fix the medication cart yesterday (referring to 6/4/19). LPN #10 stated she was on the hallway and had just come out of room 102. She stated the medication cart was parked between room 101 and room 102. She also stated she was able to see the resident in room 102 and the medication cart at the same time. The call was disconnected at 3:15 PM, and LPN #10 called back to continue the interview. During this interview, LPN #10 stated, "Yes, I said it had been broken and I think I told you April 25th" (referring to how long the A-wind medication cart 1 had been broken). She stated when she first identified the lock was broken, she asked maintenance if they could fix the lock and Maintenance stated they do not look at medication carts; and she would have to call the people they (referring to the medication carts) had come from. She also stated she was told to call the pharmacy vendor by the DON. LPN #10 stated she would keep the medication cart in view and/or turn it around. She stated, when the surveyors had come to the facility, she was just finishing her medication pass. She then stated, she was able to see the medication cart, but could not see the resident. She also stated she	M 705		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COLUMBIA REHABILITATION AND HEALTHCA

**1506 NORTH MAIN STREET
COLUMBIA, MS 39429**

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M 705	Continued From page 41 had seen RN #3 intervene, but she (LPN #10) did not. LPN #10 then stated, the lock was facing her and she could see the lock. LPN #10 stated the resident used his right hand and opened the medication cart drawer. She stated the medication cart was close to rooms 101 and 102 and it was facing towards the middle of the hallway. She stated the resident could have side effects if he had taken some of the medications. She also sated the resident could have heart problems and could have died. LPN #10 stated, if she was giving medications to a resident and had the privacy curtain pulled, she would pull the medication cart to the door and she could hear if someone opened the drawer to the cart. She stated they would have to totally move the cart. She also stated, "We have to keep the medications separated", so she could not have moved the medications to another drawer. She stated sometimes the other drawers would not lock and it's possible the resident could have gotten into another unlocked drawer. LPN #10 stated she tried several times to get the medication drawer fixed. On 6/5/19 at 4:08 PM, an interview with the DON revealed the staff reports to Maintenance or logs the problem in the maintenance book for any broken equipment. She stated the Maintenance Supervisor or Maintenance Staff #2 are always on call, even for equipment that need to be reported immediately. On 6/5/19 at 4:35 PM, an interview with Maintenance Staff #2 revealed he first became aware of the medication cart lock being broken on yesterday (referring to 6/4/19). He stated as he was walking down the hallway, he was flagged down by RN #1 to talk to the pharmacy vendor. Maintenance Staff #2 stated pharmacy staff	M 705		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46FM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/07/2019
NAME OF PROVIDER OR SUPPLIER COLUMBIA REHABILITATION AND HEALTHCA		STREET ADDRESS, CITY, STATE, ZIP CODE 1506 NORTH MAIN STREET COLUMBIA, MS 39429		
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M 705	Continued From page 42 asked him to check out the lock on the medication cart. He stated he and the Maintenance Supervisor were unable to fix the medication cart lock. He stated he called the pharmacy back and the lady on the phone stated she would send a technician out to the facility. He also stated he does not know if the pharmacy sent the technician to the facility or not. On 6/5/19 at 4:40 PM, an interview with the Maintenance Supervisor revealed Maintenance Staff #2 told her about the medication cart not locking on 6/4/19. She stated they (referring to her and her assistant) tried to work on it (referring to A-wing medication Cart 1's lock) and could not get it fixed. She stated Maintenance Staff #2 called the pharmacy vendor. She stated the top right drawer of the cart would not lock. On 6/5/19 at 4:45 PM, an interview with Maintenance Staff #2 revealed the A-wing medication cart "Cart 1", was 40 and 1/4 inches in height. This was observed to be easily accessible to any resident in a wheelchair. On 6/5/19 at 5:47 PM, an interview with Pharmacist #1, revealed the pharmacy vendor was first notified on Monday (6/3/19), of the facility having a medication cart that would not lock. She stated the facility emailed Pharmacy Staff #1 on Monday, 6/3/19 at 5:08 PM. She also stated she was not aware that the medication cart had been broken for two (2) weeks. She stated she called the facility Tuesday 6/4/19, to see if the maintenance man could fix the cart. She also stated if a resident took 25 Nitroglycerin tablets, she believed they would have a headache and Hypotension. She also stated that 25 Nitroglycerin tablets would be a higher than indicated. She stated it is not an indicated dose,	M 705		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46FM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/07/2019
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M 705	Continued From page 43 and could lead to Hypotension, Headache, and falls. On 6/5/19 at 5:57 PM, an interview with the Medical Director revealed she was made aware of this incident (the A-wing medication Cart 1 drawer lock being broken) today when she walked through the door at 2:00 PM. She stated there was a plan of correction in place. She also stated the Pharmacist is a major issue here at the facility. She stated if a resident had taken 25 of the 0.4 Mg Nitroglycerin tablets, that could cause death. On 6/6/19 at 12:04 PM, an interview with RN #3 revealed she was making rounds and when she headed back, that's when she took the resident's hand and said, "No, no, no, we can't do that" (referring to Resident #41 opening the medication cart drawer). She stated, the resident said, all he wanted was a pencil. She stated she was headed back from the end of A-wing hallway towards the nursing station. She stated the DON was coming from the opposite direction. RN #3 stated she had not had to redirect a resident away from a medication cart before. She also stated she does not remember any other resident opening the medication cart before. She stated she does not have a clue as to how long the medication cart lock had been broken. Observation on 6/6/19 at 12:15 PM, revealed LPN #7 moved a medication cart, just like the cart that had the broken drawer, to the middle of A-wing hallway between rooms 101 and 102 with the medication drawers facing the center of the hallway, just as positioned on 6/4/19, when the resident was observed opening the medication cart drawer. The surveyor sat at the nursing desk on A-wing and the medication cart drawers were	M 705		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46FM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/07/2019
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M 705	Continued From page 44 not visible from the nursing station, with the medication cart being in this position, indicating that the cart would have been unsecured without someone directly at the cart. On 6/6/19 at 3:22 PM, an interview with the Consultant Pharmacist revealed there is some form of medication audit done monthly. He stated carts are checked basically once a quarter. He stated he was not aware and cannot recall the A-wing medication cart drawer being unable to be locked. On 6/7/19 at 1:05 PM, an interview with the Administrator revealed the DON notified him of the incident (A Wing top right medication cart drawer not locking) on 6/4/19. He stated staff should not wait to report these types of issues. He stated he must be made aware for the safety and well-being of the residents. The facility provided the following Removal Plan: Brief Summary: At approximately 6:50 PM on June 5, 2019, the facility was notified by the annual survey team that the facility was being placed in Immediate Jeopardy, due to the Facility on June 4, 2019 at approximately 6:45 PM, failed to adequately supervise to prevent a severely cognitively-impaired resident from opening a medication cart drawer where multiple medications, including 25 Nitroglycerin 0.4 milligram (mg) tablets were located. The facility failed to store medications safely to prevent a cognitively impaired resident from having access to the medication cart, and the medication cart drawer would not lock. Licensed Practical Nurse (LPN) #10 stated the cart did not lock properly and has malfunctioned since she started to work	M 705		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46FM	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/07/2019
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M 705	Continued From page 45 in the Facility on April 26, 2019, at approximately 7:00 AM. On the evening of June 4, 2019, Resident #41 was witnessed by a surveyor opening the malfunctioning drawer where medication was located. The cart was locked in the medication room once medication pass was completed. (Name of Pharmacy Vendor) was contacted on June 3, 2019 and a new cart was requested. The replacement cart arrived at the Facility on June 5, 2019, and medications were transferred from the malfunctioning cart to the properly locking replacement cart. Corrective actions included: 1. On June 4, 2019 at approximately 6:45 PM, Resident #41 was observed opening the malfunctioning drawer. This incident was witnessed by RN #3 and LPN #7. RN #3 immediately redirected resident. This incident was also witnessed by the annual survey team. The primary LPN #10 assigned to the cart was not present. 2. On June 5, 2019 at approximately 1:00 PM, a new medication cart was delivered to the Facility. Medications were exchanged from the old cart into the new properly locking cart. 3. On June 5, 2019 at approximately 2:00 PM, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the RN Supervisor (RN) #1, and the Minimum Data Set (MDS) RN #2, audited medication carts regarding proper locking and storage. No issues were identified. 4. On June 5, 2019 at approximately 2:30 PM, the Administrator held a Quality Assurance Performance Improvement (QAPI) meeting to discuss action plan and resolution steps. The members of the committee discussed the	M 705		

MSDH - Health Facilities Licensure and Certification

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NAME OF PROVIDER OR SUPPLIER COLUMBIA REHABILITATION AND HEALTHCA		STREET ADDRESS, CITY, STATE, ZIP CODE 1506 NORTH MAIN STREET COLUMBIA, MS 39429		
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M 705	Continued From page 46 medication cart malfunction, proper storage of medication, necessary steps in reporting issues and an audit tool developed as a tracking mechanism to ensure medication carts are in proper working order. The Members in attendance were the Administrator, DON, ADON, Medical Director, Social Services Director, Dietary Manager, Activities Director, Director of Therapy, Staff Development Coordinator LPN #7, Maintenance Director, Business Office Manager, Human Resources Generalist, Housekeeping Manager, MDS RN #2, LPN #4, LPN #5, Risk Manager RN, and the RN Supervisor (RN #1). 5. On June 5, 2019 at approximately 3:00 PM, the Staff Development Coordinator LPN #7 in-serviced Licensed Nursing Staff on the daily audit tool used to validate that all medication carts are in proper-working order, proper storage of medication to maintain a safe environment, and proper procedure for unavailable medications. 6. No nursing staff will be permitted to work until in-serviced. 7. The facility alleges that all corrective actions to remove the immediate jeopardy was completed as of June 5, 2019, and the immediate jeopardy removed as of June 6, 2019. The SA validated the facility's Removal Plan and determined the facility had taken the following actions to correct the IJ: 1. Based on observations record review and staff interviews the State Agency (SA) validated Resident #41 had server cognitive impairment and was observed opening the drawer of an unsecured medication cart. The SA validated the	M 705		

MSDH - Health Facilities Licensure and Certification

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COLUMBIA REHABILITATION AND HEALTHCARE

**1506 NORTH MAIN STREET
COLUMBIA, MS 39429**

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M 705	Continued From page 47 resident was redirected by RN #3. 2. The SA validated by interview with the Director of Nurses (DON) and observation on 6/6/19, that a new cart had been delivered and medications were exchanged from the old cart into the new cart on 6/5/19, and the cart properly locked. 3. The SA validated by interview with the DON that an audit was completed on 6/5/19, that all carts locked appropriately. The SA found no other carts that malfunctioned. 4. The SA validated through review of the sign-in sheet and interview with the Administrator, that a QAPI meeting was held on 6/5/19, with all stated members, in regards to the malfunctioning medication cart, storage of medications, reporting requirements if there's a malfunction, and a tracking/audit tool for ensuring medication carts were in proper working order. 5. The SA validated through random interviews with nursing staff and review of in-service sign in sheets, that the Staff Development Coordinator, LPN #7, initiated in-services regarding use of the audit tool, proper storage of medication to maintain a safe environment for residents, and procedures for medications not available. 6. The SA validated through interview with random nursing staff that no staff was allowed to work until they were in-serviced. 7. The SA validated that all corrective actions to remove the Immediate Jeopardy were completed on 6/5/19, and the Immediate Jeopardy removed as of 6/6/19.	M 705		

MSDH - Health Facilities Licensure and Certification

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M 840	Continued From page 48	M 840			
M 840	45.30.4 Menu Menu. The menu shall be planned and written at least one week in advance. The current week's menu shall be approved by the dietitian, dated, posted in the kitchen and followed as planned. Substitutions and changes on all diets shall be documented in writing. Copies of menus and substitutions shall be kept on file for at least thirty (30) days. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to follow the meal menu for Resident #65 and Resident #36, for two (2) of 18 meal observations. Findings include: The facility policy "Menus", revised 9/2017, noted that menus will be served as written, unless a substitution is provided. This policy stated menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guide. In a review of the facility menu for week one, on Tuesday evening for dinner listed: Grilled Ham and Cheese Sandwich, Tossed Salad with Dressing, Tater Tots, Summer Fresh Fruit Cup and Tomato Soup. Resident #65 On 06/04/19 at 6:15 PM, during observation of the dinner meal, Resident #65 stated, "I can't eat	M 840	M840 1. Resident #36 offered the alternate meal or other foods available by Dietary Cook on 6/4/19, but declined. Resident #65 offered the alternate meal or other foods by Dietary Cook available on 6/4/19, but declined. Dietary staff member was terminated on 6/7/19 by Dietary Manager for failure to follow menu on 6/4/19. 2. Current residents who receive meals from the dietary department are at risk of being affected by deficient practice. Residents with Brief Interview for Mental Status (BIMS) of twelve (12) or greater were interviewed by Dietary Manager regarding their level of satisfaction with Dietary Services on 7/2/19; concerns noted were addressed/corrected by 7/3/19. 3. On 6/6/19, Dietary Manager was in-serviced by Administrator in regards to ensuring menu is followed and residents are notified when changes are made. Dietary department was in-serviced by Dietary Manager on 6/6/19 in regards to following menu. Dietary Manager was	7/12/19	

MSDH - Health Facilities Licensure and Certification

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M 840	Continued From page 49 this mess, look at what they feed us." He stated, "This bread is hard as a rock." Resident #65's meal ticket listed for Grilled Ham and Cheese sandwich, Tossed Salad with Dressing, Tater Tots, Ketchup, Tomato Soup, Saltine Crackers and Summer Fresh Fruit Cup. Food was served on paper plates, with disposable cups, spoons and forks. Resident #65 confirmed he did not receive tomato soup or tater tots and did not have ham on his sandwich. Resident #65 stated he would have eaten the ham, tater tots and the tomato soup if they had given it to him. The bread on the sandwich was hard, dry (not like toast) and did not look presentable or edible. Resident #65 opened his sandwich and no ham was visible, but cheese was melted to both sides of the hard, dry bread. 06/04/19 at 6:18 AM, interview with Dietary Cook/Aide #3 revealed, "All of the sandwiches have ham and cheese and stated the tomato soup is a misprint for Resident #65's meal ticket and all residents that was to supposed to have (them) got tater tots". She confirmed other residents received tomato soup. She confirmed Resident #65 did not have Tomato Soup or Tater Tots on his supper meal tray. Review of the Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/14/19, reveled Resident #65 had a score of 15 on the Brief Interview for Mental Status (BIMS), which indicated he was cognitively intact. Resident #36 Review of Resident #36's current June 2016 physician orders revealed an order for a Regular diet.	M 840	invited by Resident Council President, and will attend resident council and address diet concerns on a monthly basis beginning July 2019. Beginning on 6/20/19, licensed nurses, certified nurses aides and department heads were in-serviced by Licensed Practical Nurse (LPN) Staff Development Coordinator in regards of requirement of facility to provide meals per requirement and follow posted menu or notify residents when changes are made. Beginning 6/12/19, the facility implemented a meal monitor program in which a meal monitor checklist, Meal Monitor, must be completed to ensure accuracy of meals served, completed by Registered Nurse (RN) Supervisor/licensed nurse/department head. 4. Beginning on 7/12/19, Administrator will interview five (5) residents on food satisfaction weekly for four (4) weeks, then monthly for two (2) months and quarterly thereafter. Dietary Manager will bring concerns/grievances to stand-up for daily discussion. Any concerns will be acted upon immediately. Administrator will report findings during monthly Quality Assurance and Performance Improvement committee monthly for three (3) months for further recommendations. RN Supervisor will bring concerns identified by the daily meal monitor to stand-up for daily discussion. Administrator will report findings during monthly Quality Assurance and Performance Improvement committee monthly for three (3) months for further recommendations. The Administrator is responsible for on-going monitoring and	

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M 840	Continued From page 50 An observation an interview on 06/04/19 at 6:39 PM, revealed Resident #36 had tomato soup six (6) ounces listed to be served on her tray card. The dinner tray did not have tomato soup on her plate. Resident #36 said she would try the soup if it was on her tray. In an interview on 06/5/19 at 2:25 PM, the Dietary Manager confirmed the menu was to include the tomato soup. She said she thought the meals were correct when they left the kitchen and alternates were available.	M 840	compliance.	
M 855	45.30.7 Food Preparation Food Preparation. Foods shall be prepared by methods that conserve optimum nutritive value, flavor, and appearance. Also, the food shall be acceptable to the individuals served. A file of tested recipes shall be maintained to assure uniform quantity and quality of products. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to provide Resident #65 with a meal that was palatable, attractive and acceptable in flavor, for one (1) of 18 meal observations; and six (6) Resident Council members, during interview, also complained of food being cold and not palatable. This affected seven (7) of 86 residents in the facility. Findings include: The facility policy "Food: Quality and Palatability", revised on 9/2017, noted the facility would	M 855	M855 1. Resident #65 was offered the alternate meal or other foods available on 6/4/19 by Dietary Cook, but declined. On 6/19/19, Dietary Manager and Ombudsman attended resident council meeting, as invited by the Resident Council President, to discuss food related complaints regarding palatability and temperature. 2. Current residents who receive meals from the dietary department in the facility are at risk of being affected by the deficient practice. Residents with Brief Interview for Mental Status (BIMS) assessments of twelve (12) or higher were	7/12/19

MSDH - Health Facilities Licensure and Certification

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M 855	Continued From page 51 prepare food by methods that conserve nutritive value, flavor and appearance and will be palatable, attractive, and served at a safe and appetizing temperature. This policy also noted foods and liquids are to be prepared and served in a manner, form, and texture to meet resident's needs. Resident #65 On 06/04/19 at 6:15 PM, during the dinner meal observation with Resident #65, he stated, "I can't eat this mess, look at what they feed us." The resident stated the bread was hard as a rock. The bread was hard with no meat. Resident #65 complained of the taste and said he would not give this to a dog. The food was served on paper plates and disposable cups, with disposable spoons and forks. The bread on the sandwich was hard, dry (not like toast). When Resident #65 opened his sandwich, cheese was melted to both sides of the hard, dry bread, without any meat. In an observation on 06/04/19 at 6:18 PM, with Dietary Cook/Aide #3 present, the ham and cheese sandwiches had a dry-looking appearance. Dietary Cook/Aide #3 confirmed that the sandwiches in the metal tray were the ones being served to the residents. Interview with the Dietary Manager, on 06/05/19 at 4:35 PM, revealed there were concerns with one (1) Cook during the evenings. Taste of test trays on 6/6/19 at 12:30 PM, by the State Agency (SA) was acceptable in temperature, but bland with little to no seasoning. No concern with this meal appearance. The Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 5/14/19,	M 855	interviewed by Dietary Manager regarding their level of satisfaction with Dietary Services related to temperature and palatability on 7/2/19; concerns noted were addressed by 7/3/19 by Dietary Manager. 3. On 6/6/19, Dietary Manager was in-serviced by Administrator in regards to ensuring menu is followed and residents are notified when changes are made. Dietary department was in-serviced by Dietary Manager on 6/6/19 in regards to following menu, presentation of food and adequate temperature. Dietary Manager was invited by Resident Council President and will attend resident council and address diet concerns on a monthly basis beginning July 2019. Beginning on 6/20/19, full-time facility-wide staff were in-serviced by Licensed Practical Nurse (LPN) Staff Development Coordinator in regards of requirement of facility to provide meals per requirement and follow posted menu or notify residents when changes are made including palatability, appearance and adequate temperature. Beginning 6/12/19 facility implemented a meal monitor program in which a meal monitor checklist, Meal Monitor, must be completed to ensure accuracy of meals served, completed by RN Supervisor/licensed nurse/department head. The meal monitor, as a part of the meal monitor check list, will sample a tray to test for accuracy according to the menu, palatability and temperature. 4. Beginning on 7/12/19, Administrator will interview five (5) residents on food	

MSDH - Health Facilities Licensure and Certification

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M 855	Continued From page 52 revealed Resident #65 had a score of 15 on the Brief Interview for Mental Status (BIMS), which indicated he was cognitively intact. Resident Council Members During interview on 06/05/19 at 2:15 PM, six (6) Resident Council members revealed they have complained about the food every month for a year. The council Members also said the Dietary Manager was present for all meetings. Resident #1, the Council President, revealed the Council had complained every month about the food being cold, burnt and the meat is always hard. During an interview on 06/06/19 at 3:00 PM, the Activity Director confirmed the residents have complained about the food every month. The Activity Director also stated that she had observed cold and burnt food served during meal times. During an interview on 06/06/19 at 9:18 AM, The Dietary Manager revealed she attended all of the Resident Council meetings and the resident's had complained about the food being burnt, cold, and not tasting good. The Dietary Manager said she was working on correcting the issues.	M 855	satisfaction weekly for four (4) weeks, then monthly for two (2) months and quarterly thereafter. Dietary Manager will bring concerns/grievances to stand-up for daily discussion. Any concerns will be acted upon immediately. Administrator will report findings during monthly Quality Assurance and Performance Improvement committee monthly for three (3) months for further recommendations. RN Supervisor will bring concerns identified by the daily meal monitor to stand-up for daily discussion. Administrator will report findings during monthly Quality Assurance and Performance Improvement committee monthly for three (3) months for further recommendations. The Administrator is responsible for on-going monitoring and compliance.	
M 970	45.33.4 Control of insects, rodents, etc. Control of insects, rodents, etc. The facility shall be kept free of ants, flies, roaches, rodents, and other insects and vermin. Proper methods for their eradication and control shall be utilized. This Statute is not met as evidenced by: Level II Based on observation, interviews, and record	M 970	M970 1. Administrator contacted contracted pest control provider on 6/25/2019 to have pest	7/12/19

MSDH - Health Facilities Licensure and Certification

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M 970	Continued From page 53 review, the facility failed to have an effective pest control, as evidenced by flies for three (3) of four (4) days of survey, to include two (2) of three (3) kitchen observations. All 86 residents have the potential to be affected. Findings include: The facility's policy, "Pest Control", revised May 2008, noted the facility shall maintain an effective pest control program to ensure the building is kept free of insects and rodents. On 06/04/19 at 6:20 PM, during an observation of the supper meal, Certified Nursing Assistant (CNA) #1 confirmed a fly seen on Resident #65's plate while eating. Resident #65 stated, "We can't eat our food for the flies, they are everywhere". On 06/04/19 at 6:38 PM, during the initial kitchen tour, Dietary Cook/Aide #4 confirmed a fly in the kitchen area. On 06/06/19 at 11:45 AM, during an observation with the Dietary Manager (DM), a fly was visible on the rim of a desert bowl. During an interview on 6/6/19 at 11:45 AM, the DM was asked why it was important not to have flies and pests in the kitchen. The DM stated, "It's unsanitary". The DM did not remove the dessert bowl from the tray line after identifying the fly on the rim of the bowl and continued to let the desert be served. On 06/07/19 at 2:09 PM, observation of a fly on an un-sampled resident's left sleeve of shirt was confirmed by Licensed Practical Nurse (LPN) #1.	M 970	control to begin to treat weekly for pests. Weekly pest control services began on 6/26/19 superseding monthly scheduled pest control services. Maintenance Director replaced fly stations at all egress exits on 6/6/19. 2. Current residents are at risk of being affected by the deficient practice. 3. On 7/2/19, facility staff were educated by Maintenance Director on requirement of facility being maintained in manner that controls pest. Fly swatters have been placed at the Nurse's stations for employee use beginning 7/2/19. Pest control services will come on a weekly basis for six (6) weeks. 4. Beginning 7/12/19, Maintenance Director will perform rounds weekly for twelve (12) weeks to observe for pests in the facility, and to ensure pest control service are working. Maintenance Director will report findings monthly to the Quality Assurance and Performance Improvement committee monthly for three (3) months for further recommendations. The Maintenance Director is responsible for on-going monitoring and compliance.	

MSDH - Health Facilities Licensure and Certification

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M 970	Continued From page 54 On 06/07/19 at 1:15 PM, the facility Administrator was asked how he knows he has an effective pest control program? The Administrator responded, "By the absence of pests". The Administrator confirmed that pest control was not effective with the evidence of flies in the kitchen and throughout the facility. Record review revealed Pest Control Invoices dated 12/19/18, 1/10/19, 2/15/19, 3/19/19, 4/25/19, and 5/30/19.	M 970			