MSDH - Health Facilities Licensure and Certification

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 57ME | A. BUILDING: _____ B. WING _____ | C 10/24/2019 |

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| COURTYARD REHABILITATION AND HEALTHC | 501 SOUTH LOCUST STREET MCCOMB, MS 39648 |

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| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;<br><br>2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his 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; | M 500 | | 12/3/19 |

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| M 500 | Continued From page 1<br><br>4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;<br><br>5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;<br><br>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;<br><br>7. is free from mental and physical abuse;<br>8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have | M 500 | | |

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| M 500 | Continued From page 2<br>policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;<br>9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;<br><br>10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>14. may retain and use his personal clothing and | M 500 | | |

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| M 500 | Continued From page 3<br>possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>MS #16272<br>Based on staff interview, record review, facility policy, and resident interview, the facility failed to obtain and provide Resident #61's pain medication, as ordered, in a timely manner for one (1) of four (4) residents reviewed for pain. Resident #61 did not have Norco available for pain, as ordered by the physician, for nine (9) scheduled doses.<br><br>Findings Include:<br><br>A review of the facility's, "LTC Receiving Pharmacy Products and Services from Pharmacy", revised 10/31/16, revealed new orders for Schedule II controlled substances required a written prescription prior to dispensing, | M 500 | 1. Root Cause Analysis (RCA) was conducted by the Inter Disciplinary Team 10-28-19 and based on results.<br><br>2. Quality review of current residents with physician orders for pain medications was completed 10-23-19 by Director of Nursing to ensure current residents pain medications ordered by physician are available for administration. Resident #61 received her pain medication on 9-26-19 as ordered by the physician.<br><br>3. Education with licensed nurses 11-8-19 by Divisional Director of Clinical Services (DDCS)on this Federal regulation F755 with emphasis on ordering medications and ensuring medication is available for administration. Policy for providing pain | |

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| M 500 | Continued From page 4<br>unless there is an emergency situation. An emergency situation is one in which the prescribing Practioner determines that immediate administration of the Schedule II controlled substance is necessary for proper treatment of the intended ultimate user. If the medication is needed before the next scheduled delivery, facility staff should indicate the exact time by which the medication is needed.<br><br>Review of the Physician's Orders, for Resident #61, revealed Norco 10-325 milligram (mg) one (1) tab every eight (8) hours for pain.<br><br>Record review of the Medication Administration Record (MAR) for Resident #61 revealed no documentation for Norco 10-325 milligram (mg) on 9/23/19 at 2:00 PM and 10:00 PM; 9/24/19 at 6:00 AM, 2:00 PM, and 10:00 PM; and 9/25/19 at 6:00 AM.<br><br>Record review of Resident #61's Controlled Narcotic Log for Norco 10-325 mg revealed the Norco 10-325 mg was last signed out 9/22/19 at 10:00 PM. The Log also shows Norco 10-325 mg #30 signed in for Resident #61 on 9/25/19, with the first dose signed out on 9/26/19 at 6:00 AM. This indicated the resident didn't receive Norco on 9/23/24 for three (3) doses, 9/24/19 for three (3) doses, and 9/25/19 for three (3) doses. (Total of nine (9) doses).<br><br>During an interview on 10/21/19 at 11:25 AM, Resident #61 stated she ran out of her pain medication for about three (3) days. She stated the nurses told her the pharmacy needed a signed script for the medication, so they had to wait to get a doctor to sign a new script. She stated she was upset because she was hurting so bad. Resident #61 stated since the issue was | M 500 | medication in a timely manner review began on 11-8-19 with Licensed Nurses by the DDCS.<br><br>New hires will be educated in orientation. Facility will provide routine emergency drugs and biologicals to its residents and provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident.<br><br>4. Quality monitoring began 11-11-19 and is to be conducted three times a week for four weeks, then two times a week for four weeks, then monthly by Director of Nursing, Charge Nurse, or Unit Manager of medication availability to ensure physician ordered medications are available for administration. The findings of the Quality Review will be reported in the monthly Committee meeting and reviewed by the IDT. RCA will be used by the committee and updates made to the performance improvement plan as indicated by findings. | |

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| M 500 | Continued From page 5<br>cleared up, she hasn't had any problems with getting the pain medication and she's okay.<br><br>During a telephone interview on 10/21/19 at 3:23 PM, a Pharmacy Representative stated that the pharmacy's records revealed that Resident #61's Norco 10-325 mg #90 was delivered to the facility on 8/19/19, and on 9/25/19 #45 was delivered to the facility. Review of a delivery receipt revealed Norco 10-325 mg was delivered to the facility for Resident #61 on 8/19/19, and 9/25/19.<br><br>During a phone interview on 10/21/19 at 5:08 PM, Licensed Practical Nurse (LPN) #2 stated Resident #61 did go without her pain medication for one (1) - two (2) days. She stated that it was on her weekend to work and she gave the 10:00 PM dose on Sunday night 9/22/19, but there were none for Monday morning. LPN #2 stated that she returned to work on Wednesday 9/25/19, and Resident #61 still did not have any Norco, so she obtained a hard script from the facility's Physician's Assistant (PA) for the Norco. LPN #2 stated that when she spoke to the PA to obtain the new prescription, he stated that nobody had called him over the weekend for a hard script or for a substitute.<br><br>During an interview on 10/22/19 at 8:58 AM, the Physician's Assistant revealed that he was never made aware of Resident #61 being without her Norco at any time.<br><br>During a phone interview on 10/22/19 at 10:00 AM, LPN #3 revealed Resident #61 did not have Norco in the building for her shift on 9/23/19 for the 10:00 PM, 9/24/19 - 6:00 AM, 9/24/19 - 10:00 PM, and 9/25/19 - 6:00 AM doses. LPN #3 stated she reported not having the medication to Registered Nurse (RN) #2 the first night, and then | M 500 | | |

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| M 500 | Continued From page 6<br><br>RN #3 the second night. LPN #3 stated to her understanding they do have an E-kit, but they have to contact the pharmacist and the pharmacist has to contact the physician to be able to get into the box. LPN #3 stated that RN #2 tried to call the Physician's Assistant, without an answer. LPN #3 stated after she reported it the first night, she thought the Norco would come in with the medication order around 11:00 PM, but it didn't, and when she returned to work the next day, she thought it would be there, but it wasn't, so that's when she reported to RN #3. She stated she also reported it the next morning to the oncoming nurse.<br><br>During an interview on 10/22/19 at 10:12 AM, LPN #1 stated she didn't remember if the medication (Norco) was in the building or not. She stated if she would have noticed the medication was not there, she would have called the pharmacy to see if Resident #61 had any on backup that could have been sent. She further stated if the medication was a narcotic, she would call the doctor for a hard script and get the medication into the facility. LPN #1 stated she worked 9/23/19 and 9/24/19, and she just didn't remember calling the pharmacy or the doctor to get a script. She stated she didn't remember the resident complaining about not getting pain medication. LPN #1 stated they have an E-kit and a code was needed to call the doctor and the pharmacist. LPN #1 stated they have an after-hour backup pharmacy, (name) and they will come out at night. LPN #1 stated she gave the resident Tylenol on 9/23/19 at 4:45 PM, 9/24/19 at 8:45 AM, and 9/24/19 at 6:15 PM.<br><br>During an interview on 10/22/19 at 10:20 AM, RN #2 revealed she remembered on 9/24 or 9/25, that Resident #61 did not have her pain | M 500 | | |

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

medication. RN #2 stated Resident #61 called her to come to her room and the resident reported she didn't have her pain medication. RN #2 stated she called the Medical Director and left him a message and even called him two (2) or three (3) times with no answer from him. She stated she even called his house phone. RN #2 stated that she didn't know the process of getting into the E-kit, but she just usually called the physician with what she needed. RN #2 stated they offered Resident #61 some Tylenol and she refused it. RN #2 stated if it had been reported to her earlier in the day, she would have gotten a script, because the PA was in the building earlier that day. RN #2 stated she remembered the PA came into the building on 9/25/19, and LPN #2 got a hard copy from him and got Resident #61's Norco. RN #2 stated that she knew Resident #61 well and she needed her pain medication.

During an interview on 10/22/19 at 10:44 AM, RN #3 stated all she could remember was that Resident #61 didn't have her medication on 9/23/19, and she reported it to the morning nurses on 9/24/19. She stated Resident #61 was complaining that she needed her pain medication. RN #3 stated they offered her Tylenol and she refused at first, but then took it. RN #3 stated she called the Medical Director, who is Resident #61's physician, on 9/24/19, and left a message that Resident #61 needed a hard script sent to pharmacy for her pain medication, that she was out, and the physician texted back the word "ok". RN #3 stated that she didn't work 9/24/19 or 9/25/19, but came back on 9/26/19, and Resident #61 had her medication at that point.

During an interview on 10/22/19 at 1:20 PM, the Administrator revealed getting the medication for Resident #61 just fell through the crack. The

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| M 500 | Continued From page 8<br><br>Administrator stated the nurses did not follow through with the process to obtain Resident #61's pain medication in a timely manner, but she was glad they gave her something until it was obtained.<br><br>During an interview on 10/22/19 at 3:14 PM, the Medical Director revealed he did not have a memory regarding Resident #61 running out of pain medication. The Medical Director stated the nurses should have been persistent in contacting someone to get a hard script, or to get a substitute pain medication, until they received the Norco in the facility. The Medical Director stated, "I think Resident #61 receiving Neurontin and Tylenol is what helped her maintain a decent pain level without the Norco". The Medical Director stated he thought there was a way the nurses could call the pharmacy and get an emergency supply of medication, but he wasn't sure what the facility's process was. | M 500 | | |