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
	15CL	A. BUILDING: _____ B. WING _____	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPIAH LIVING CENTER	806 WEST GEORGETOWN STREET CRYSTAL SPRINGS, MS 39059

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M 000	Initial Comments The State Survey Agency (SSA) conducted a recertification survey and complaint investigation MS# 18014 from 11/07/2021 to 11/10/2021. During the survey the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm. The SSA cited M500 and M710 State Regulatory statutes. The SSA did substantiate MS #18014 related to incontinent care not being provided in a manner to prevent the possible spread of infection. The census at the time of the survey entrance was 56, and the facility was licensed for 60 beds.	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 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	M 500		12/29/21

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M 500	Continued From page 1 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 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;	M 500		

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M 500	Continued From page 2 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 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	M 500		

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M 500	Continued From page 3 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); 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	M 500	M 500	

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M 500	Continued From page 4 Based on observation, staff and resident interview, record review and facility policy review the facility failed to ensure residents were free from neglect by failing to administer medications ordered by the physician on dialysis days for two (2) of two (2) residents reviewed for dialysis. Resident # 12 and Resident #51. Findings include: Record review of the facility's policy, "Seven Components to Reduce, Detect, and Prevent Abuse and Neglect" with an origination date of 06/19 revealed "The facility has a comprehensive program to reduce, detect and prevent neglect of the residents ....Prevent-The facility has policies and procedures in place ...to detect and prevent ...neglect ...IDENTIFY-The facility ...maintains a proactive approach for identifying events ...that may constitute ...neglect ...The objective ...is to address ...neglect at critical points ..." Record review of the "Employee Corporate Compliance Code of Conduct" date (05/18) revealed " ...4. Quality of Care: All ...residents ...are to be provided care in compliance with all federal and state laws, regulations and guidelines ...No ...neglect will be tolerated ...relevant terms as defined ...Neglect: A failure to provide goods and services necessary ..." Resident #51 On 11/10/21 at 10:51 AM, in an interview with Licensed Practical Nurse #2 (LPN), stated Resident #51 does not get his 9 :00 AM medication on the days he goes to dialysis. She stated she did not notify the physician the	M 500	a. Licensed Practical Nurse (LPN) #2 was in-serviced on 11/10/21 by the Staff Development Nurse related to the following policies: Seven components of abuse including abuse, neglect and exploitation, Drug Administration and Documentation, Medication Errors and to provide proper notification to the physician when medication is unable to be administered as ordered. Licensed Practical Nurse (LPN) #3 was in-serviced on 11/10/21 by the Staff Development Nurse related to the following policies: Seven components of abuse including abuse, neglect and exploitation, Drug Administration and Documentation, Medication Errors and to provide proper notification to the physician when medication is unable to be administered as ordered. Pharmacy Consultant was in-serviced on 12/10/2021 by the Facility Administrator regarding Medication Errors and Pharmacy Consultant Responsibilities which include reviewing of orders and comparing orders to the Electronic Medication Administration Record. Resident #51 was observed on 11/10/21 by a Licensed Practical Nurse for any adverse effects related to not receiving the ordered medication on the dialysis days as ordered. There were no adverse effects noted. Resident #51 was assessed on 12/15/21 by the Director of Nurses for any adverse effects related to not receiving the ordered medication on the dialysis days as	

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M 500	Continued From page 5 resident's medication was not being given. She stated the resident goes to dialysis on Monday, Wednesday, and Friday. She stated the resident is out of the building, so she charts in the Electronic Medication Administration Record (EMAR) that the resident is out of the building. She stated she did not follow physician orders and confirmed it is important that the resident gets all his medications. On 11/10/21 at 11:06 AM, in an interview with Interim Director of Nursing (DON), stated a nurse should get an order on the days the resident goes to dialysis to give medication when they return. He stated it is important that residents get their medications. On 11/10/21 at 11:41 AM, an phone interview with Physician #1 stated, he was not aware that Resident #51 was not getting his 9:00 AM medications on dialysis days. He stated the resident needs their medications. On 11/10/21 at 3:40 PM, in an interview with LPN #2 stated Resident #51 can have stomach and Acid Reflux issues if he does not get his Gastroesophageal Reflux Disease (GERD) medication. She stated resident missing Clopidogrel (Plavix) and Aspirin could cause the resident to have circulatory issues and Congestive Heart Failure. She stated Levemir not given can cause high blood sugar and affect his eyesight. She stated Lexapro can cause the resident to have behavioral issues. On 11/10/21 at 4:00 PM, in an interview with Registered Nurse #1 (RN) Nurse Supervisor/Wound Care Nurse, she stated she was not aware that Resident #51 did not get his 9:00 AM medication on dialysis days. She stated	M 500	ordered. There were no adverse effects noted. Physician #1 was notified on 11/10/21 with a change in medication administration time related to receiving dialysis for Resident #51. A drug regimen review was conducted by the Pharmacy Consultant for Resident #51 on 11/30/21 Resident #12 was observed on 11/10/21 by a Licensed Practical Nurse for any adverse effects related to not receiving the ordered medication on the dialysis days as ordered. There were no adverse effects noted. Resident #12 was assessed on 12/15/21 by the Director of Nurses for any adverse effects related to not receiving the ordered medication on the dialysis days as ordered. There were no adverse effects noted. Physician #2 was notified on 11/10/21 with a change in medication administration time related to receiving dialysis for Resident #12. A drug regimen review was conducted by the Pharmacy Consultant for Resident #12 on 11/20/21 through 12/14/21. b. All dialysis residents with physician orders for medication to be administered have the potential be affected by this deficient practice. c. All licensed Nurses In-serviced by the Staff Development Nurse beginning 11/10/2021 with a completion date of 11/15/2021. A Directed In-service was provided for all licensed nurses to include Licensed Practical Nurses and Registered Nurses (RN□s) by a Registered Nurse not affiliated with Copiah Living Center on	

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M 500	Continued From page 6 their policy is to notify the Physician. She stated the resident not getting medication can have major effects. She stated that by not receiving the medication for Hypertension and Diabetes could cause the resident's blood pressure and blood sugar to rise and depression medication would not be as effective. She stated it can cause change in behavior and mood and not getting blood thinner medications could cause the resident's dialysis shunt to clot. She stated it is very important that residents get their prescribed medication. On 11/10/21 at 4:17 PM, in an interview the Interim Administrator, she stated nobody bought it her attention, that the resident was not getting his 9:00 AM medications on dialysis days. She stated the resident's medications is a care or service that should be provided. She stated the nurse should have given the medication to the resident when they came back from dialysis. On 11/10/21 at 4:26 PM, in an interview with Resident #51 stated he go to dialysis on Monday, Wednesday, and Friday. He stated he takes one pill before he goes to dialysis. Record review of the Face Sheet revealed Resident #51 was admitted to the facility on 6/14/2017 with current diagnoses of Cerebral Infarction due to embolism of left post Cerebral Artery, Acute on Chronic systolic Congestive Heart Failure (CHF), Chronic Pulmonary Disease (CPD), Type II Diabetes Mellitus (DM), Chronic Kidney Disease (CKD), Hypotension, Anxiety Disorder (AD), Recurrent Depression Disorder (RDD), Essential (primary) Hypertension, Gastroesophageal reflux disease without esophagitis (GERD), Dependence on renal dialysis and Cardiomyopathy.	M 500	12/14/21 with completion of training on 12/15/21 on the following: Seven components of abuse including Abuse, Neglect and Exploitation, Drug Administration and Documentation and notification of physician when medication is not given as ordered. Newly hired Licensed Practical Nurses and Registered Nurses will be in-serviced on upon hire on the following: Seven components of abuse including Abuse, Neglect and Exploitation, Drug Administration and Documentation and notification of physician when medication is not given as ordered by Staff Development Nurse and/or Director of Nursing. A Quality Assurance Committee Meeting was held on 11/10/21 members consisting of Director of Nursing, Staff Development Nurse/Infection Preventionist, Accounts Manager, Administrator, Regional Administrator, Medical Records, Social Services, Medical Director on call. Quality Assurance Committee Meeting reviewed Seven Components of Abuse including abuse, neglect and exploitation, Pharmacy Consultant duties and drug regimen reviews, Medication Administration and Physician Notification when medication not received with no recommend changes to facility policy. d. Director of Nursing and/or Staff Development Nurse will monitor two medication administration to ensure resident needs are met related to abuse/neglect 3 x per week x 2 months until substantial compliance is attained. Medication Administration monitoring began on 12/01/21. Director of Nursing	

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M 500	Continued From page 7 Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/11/21, revealed in Section C, a Brief Interview for Mental Status (BIMS) score of 09 which indicated Resident # 51 had moderate cognitive impairment. Record review of Resident #51's Physician's Orders revealed an order dated 10/16/20 for "Levemir 100 units/ML vial-give 18 units subcutaneous every morning related to DM". Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on, 11/1/21, 11/3/21, 11/5/21, 11/8/21 and 11/10/21 the facility failed to administer the 9:00 AM dose of Levemir 100 units/ML vial-give 18 units subcutaneous. Record review of Resident #51's Physician's Orders revealed an order dated 9/29/17 for Famotidine 20 MG tablet give one tablet by mouth daily for GERD. Record review of the Resident 51's EMAR revealed on, 11/1/21, 11/3/21, 11/5/21, 11/8/21 and 11/10/21 the facility failed to administer the 9:00 AM dose of Famotidine 20 MG tablet gives one tablet by mouth. Record review of Resident #51's Physician's Orders revealed an order dated 1/20/21 for "Lexapro 5 MG tablet one tablet by mouth daily related to depression (target behavior, tearful, anger, withdrawal)." Record review of the Resident 51's EMAR revealed on 11/1/21, 11/3/21, 11/5/21, 11/8/21 and 11/10/21, the facility failed to administer the	M 500	shall monitor Pharmacy Consultant reviews for physician order and medication administration record comparison and drug regimen reviews monthly x 3 months until substantial compliance is attained. Director of Nursing began pharmacy consultant reviews on 12/17/21. Areas in need of correction will be reviewed by the Quality Assurance Committee Meeting for corrective action to include in-service training, and/or disciplinary action. The facility Quality Assurance Committee Meeting shall be held monthly until substantial compliance is attained. Quality Assurance Committee Meetings began reviews on 12/16/21.	

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M 500	Continued From page 8 9:00 AM dose of Lexapro 5 MG. Record review of Resident #51's Physician's Orders revealed an order dated 8/5/21 for "Clopidogrel 75 MG tablet one tablet by mouth daily related to circulation. (Acute or chronic systolic CHF)." Record review of the Resident 51's EMAR revealed on 11/1/21,11/3/21, 11/5/21, 11/8/21 and 11/10/21, the facility failed to administer the 9:00 AM dose of Clopidogrel 75 MG. Record review of Resident #51's Physician's Orders revealed an order dated 8/9/21 for Aspirin 81 MG chewable tablet-give 4 tablets to equal 325 MG by mouth daily related to circulation. (Acute or chronic systolic CHF) Record review of the Resident 51's EMAR revealed on 11/1/21,11/3/21, 11/5/21, 11/8/21 and 11/10/21, the facility failed to administer the 9:00 AM dose of Aspirin 81 MG chewable tablet-give 4 tablets to equal 325 MG. Record review of Resident #51's Physician's Orders revealed an order dated 11/8/17 for Ferrous Sulfate 325 MG tablet give one tablet by mouth twice daily related to Anemia iron supplement. Record review of the Resident 51's EMAR revealed on 11/1/21, 11/3/21, 11/5/21, 11/8/21 and 11/10/21, the facility failed to administer the 9:00 AM dose of Ferrous Sulfate 325 MG. Record review of Resident #51's Physician's Orders revealed an order dated 9/30/21 for house liquid protein supplement 30 CC by mouth twice daily related to End Stage Renal Disease	M 500		

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M 500	Continued From page 9 (ESRD). Record review of the Resident 51's EMAR revealed on 11/1/21, 11/3/21, 11/5/21, and 11/8/21 the facility failed to give the 10:00 AM house liquid protein supplement 30 CC). Record review of Resident #51's Physician's Orders revealed an order dated 8/5/21, Midodrine HCL 2.5 MG tablet one tablet by mouth three times a day. Record review of the Resident 51's EMAR revealed on 11/1/21, 11/3/21, 11/5/21, and 11/8/21 the facility failed to give the 9 :00 AM dose of Midodrine HCL 2.5 MG. Record review of LPN #2's Employee Corporate Compliance Code Of Conduct revealed her signature for training on Quality of Care and neglect, dated 11/2/21. Resident #12 Record review of Resident #12's Face Sheet revealed the facility admitted Resident #12 on 08/13/20 with the diagnoses of Chronic Systolic Congestive Heart Failure, End Stage Renal Disease, Type 2 Diabetes Mellitus, Dementia, Hypertension, Anxiety, Major Depressive Disorder, and Dependence of renal dialysis. Record review of Resident #12's yearly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/02/2021 section C revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated	M 500		

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M 500	Continued From page 10 Resident #12 had severe cognitive impairment. Record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Renvela 800 milligram (mg) one (1) tablet by mouth with meals three times daily, Abilify 2 mg one (1) tablet by mouth every day, Aspirin 81 mg chewable tablet one (1) tablet by mouth every day, Metoprolol Succinate extended release (ER) 25 mg one (1) tablet by mouth every day, Memantine 10 mg one (1) tablet by mouth twice a day, Brilinta 90 mg one (1) tablet by mouth twice a day, Hydralazine 25 mg one (1) tablet by mouth three times a day, Klonopin 0.5 mg one (1) tablet by mouth every day, and Venlafaxine 75 mg one (1) tablet by mouth daily. A record review of Resident #12's EMAR for November 2021 revealed on the Mondays, Wednesdays, and Friday dates: 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 Resident #12 did not receive the following morning medications as orders: Klonopin 0.5 mg, Venlafaxine 75 mg, Renvela 800 mg, Abilify 2 mg, Aspirin 81 mg, Metoprolol Succinate ER 25 mg, Memantine 10mg, Brilinta 90 mg, and Hydralazine 25 mg. On 11/10/21 at 10:51 AM in an interview with LPN #2, reviewed the current EMAR and explained the "N" represented medication not given and further explained Resident #12 does not get her morning medications on the days she goes to dialysis. She stated she did not notify the physician the resident medication was not given. She stated the resident goes to dialysis on Monday, Wednesday, and Friday. State Survey Agency asked her if she should have notified the physician, since the resident did not get medication on dialysis days, she reported she never thought about it like that.	M 500		

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M 500	Continued From page 11 She explained the nurses have never sent medications with the resident and she has not given the resident morning medications after dialysis. She stated she did not follow physician orders. She stated it could cause a significant medication error. She stated it is important that the resident gets medications as ordered. On 11/10/21 at 11:00 AM, during a phone interview RN #2 from local dialysis center, she explained Resident #12 does attend the dialysis clinic three (3) times a week. She explained the dialysis center only gives the resident the medications listed on the communication forms and the facility is responsible for all other medications. On 11/10/21 at 11:30 AM, during an interview with the interim Director of Nursing (DON), he explained he is not aware of medications not being given on dialysis days. He explained as a Corporate Nurse Consultant, he understood medications were to be given when residents returned to the facility from dialysis unless the physician had ordered something else. On 11/10/21 at 11:55 AM, in an interview with Physician #2 he explained he was not aware Resident #12 was not getting his medication on dialysis days. He stated he thought the facility set times for dialysis residents to get medications on dialysis days. He stated he has not been contacted to ask about dialysis residents medications. He stated he assumed medications were given as ordered. He stated they could give Resident #12's medication at 10:30 AM when the resident returns. He explained he expects medications to be given as ordered and it is very important for resident to receive all medications daily.	M 500		

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M 500	Continued From page 12 On 11/10/21 at 3:30 PM interview with LPN #3, when ask what "N" meant on the EMAR, she explained it means "no" and the medication was not given. When asked why she medications were not given, she stated she has never sent medications with the resident and morning medications were not given to the resident after dialysis. She stated she did not follow physician orders. When asked if administering medications to residents was a service the facility provided to the resident, she stated "Yes". She explained the resident did not receive medications due to the resident being gone to dialysis. On 11/10/21 at 4:17 PM, during an interview the Interim Administrator, she explained nobody bought it her attention that dialysis residents were not receiving their morning medications due to the residents were gone to dialysis. She explained administering resident medication is a care and service that should be provided to all residents. On 11/10/21 at 6:00 PM, interview with the MDS nurse, LPN #4, she explained once a care plan is in place, she expects the staff to follow the plan of care. She explained if a medication is ordered, she expects the medications to be given unless there is an order in place to hold medication for any reason. She explained if a resident refuses or misses three (3) doses or more of medications, the physician should be notified of the reason for the resident not receiving medications. She explained administering medications is part of the resident's care at the facility. Record review of LPN #3's Employee Corporate Compliance Code Of Conduct revealed her signature for training on Quality of Care and	M 500		

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M 500	Continued From page 13 neglect, dated 11/2/21.	M 500		
M 710	45.24.3 Consultation Consultation. Each facility shall obtain the services of a licensed pharmacist who will be responsible for: 1. Establishing a system of records of receipt and disposition of all controlled drugs and to determine that drug records are in order and that an account of all controlled drugs are maintained and reconciled; 2. Provide drugs regimen review in the facility on each resident every thirty (30) days by a licensed pharmacist; 3. Report any irregularities to the attending physician or nurse practitioner/physician assistant and the director or nursing; and 4. Records must reflect that the consultation pharmacist monthly report is acted upon. This Statute is not met as evidenced by: Level II Based on staff interviews, record reviews, and facility policy review, the facility's pharmacy consultant failed to review Electronic Medication Administration Records (EMAR) and report irregular medication processes for two (2) of two (2) dialysis residents reviewed. Resident #51 and Resident #12. Findings include: A record review of the facility's "Pharmacist Services Policy" with latest revision date of 11/17 revealed "The facility shall have a written agreement for the provision of pharmaceutical	M 710	a. Pharmacy Consultant was in-serviced on 12/10/2021 by the Facility Administrator regarding Medication Errors and Pharmacy Consultant Responsibilities which include reviewing of orders and comparing orders to the Electronic Medication Administration Record. Resident #51 was observed on 11/10/21 by a Licensed Practical Nurse for any adverse effects related to not receiving the ordered medication on the dialysis days as ordered. There were no adverse effects noted. Resident #51 was assessed on 12/15/21 by the Director of Nurses for any adverse effects related to not receiving the	12/29/21

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M 710	Continued From page 14 services in order to meet the needs of the residents ... B) Consultant: The facility will provide Pharmacy Consultation on all aspects of the provision of Pharmacy Services in the facility; i.e., there will be a monthly audit of medication processes in the facility to ensure the correct procedures are being followed. The Consultant Pharmacist shall ...inspect medication processes ... ensure proper administration of medications ...". On 11/10/21 at 11:05 AM, during a phone interview with the Pharmacy Consultant, she explained she has been working from home and reviewing the resident's physician orders from home and has not been having access to the residents' EMAR. She was not aware of residents not receiving medications on dialysis days. She reported she was under the impression medications were given when resident returned to facility from dialysis. She explained she has not reviewed Resident #51's or Resident #12's EMARs. On 11/10/21 at 5:10 PM, interview with the Interim Director of Nursing (DON), he explained the Pharmacy Consultant was at the facility on 11/04/21. He explained he is not sure if she looks at resident's EMAR. He explained he saw her follow a nurse with medication pass and do a random cart check. When asked if the EMAR was part of the medical records, he explained it is and he has not been informed by the facility Pharmacy Consultant of any irregularities in administering medications or the medication processes for residents. On 11/10/21 at 11:30 AM interview with Interim DON, he explained he is not aware of medications not being given on dialysis days. He	M 710	ordered medication on the dialysis days as ordered. There were no adverse effects noted. Physician #1 was notified on 11/10/21 with a change in medication administration time related to receiving dialysis for Resident #51. Resident #12 was observed on 11/10/21 by a Licensed Practical Nurse for any adverse effects related to not receiving the ordered medication on the dialysis days as ordered. There were no adverse effects noted. Resident #12 was assessed on 12/15/21 by the Director of Nurses for any adverse effects related to not receiving the ordered medication on the dialysis days as ordered. There were no adverse effects noted. Physician #2 was notified on 11/10/21 with a change in medication administration time related to receiving dialysis for Resident #12. b. All dialysis residents with physician orders for medication to be administered have the potential be affected by this deficient practice. c. A Directed In-service was provided for all licensed nurses to include Licensed Practical Nurses and Registered Nurses (RNs) by a Registered Nurse not affiliated with Copiah Living Center on 12/14/21 with completion of training on 12/15/21 on the following: Drug Administration and Documentation and notification of physician when medication is not given as ordered. Newly hired Licensed Practical Nurses and Registered Nurses will be in-serviced on upon hire on the following: Drug Administration and Documentation	

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M 710	Continued From page 15 explained as a Corporate Nurse Consultant, he has not been informed from the Pharmacy Consultant of any irregularities in the medications. Resident #51 Record review of Resident 51's EMAR for November 2021 revealed an "N" for the following medications on 11/1/21, 11/3/21, 11/5/21, 11/8/21 and 11/10/21, which indicated the facility failed to administer the 9:00 AM doses of Levemir 100 units/ML(milliliters) 18 units, Famotidine 20 MG (milligram) tablet, Lexapro 5 MG tablet, Clopidogrel 75 MG tablet, Aspirin 81 mg 4 tablets to equal 325 MG, Ferrous Sulfate 325 MG tablet, Midodrine HCL 2.5 MG tablet, Multivitamins tablet, and the 10:00 AM house liquid protein supplement 30 CC (cubic centimeters). On 11/10/21 at 3:30 PM, interview with LPN #3, when ask what "N" meant on the MAR, she explained it means no and the medication was not given. When asked when why she did not report to anyone regarding medications not given on all of dialysis days, she explained when she started at the facility, she noticed medications not being given on dialysis days and thought it was the normal way to medications for dialysis residents at the facility. Record review of Resident #51's Physician's Orders dated November 2021 revealed orders for "Levemir 100 units/ML (milliliter) vial-give 18 units subcutaneous every morning related to Diabetes Mellitus (DM)". Famotidine 20 MG (milligram) tablet give one tablet by mouth daily, Lexapro 5 MG tablet one tablet by mouth daily related to depression, Clopidogrel 75 mg tablet 1 tablet by mouth daily related to circulation, Aspirin 81 MG	M 710	and notification of physician when medication is not given as ordered by Staff Development Nurse and/or Director of Nursing. A Quality Assurance Committee Meeting was held on 11/10/21 member consisting of Director of Nursing, Staff Development Nurse/Infection Preventionist, Accounts Manager, Administrator, Regional Administrator, Medical Records, Social Services, Medical Director on call. Quality Assurance Committee Meeting reviewed Medication Administration and physician notification when medication not received with no recommend changes to facility policy. d. Director of Nursing shall monitor Pharmacy Consultant reviews for physician order and medication administration record comparison and drug regimen reviews monthly x 3 months any negative findings will be reviewed with the facility Medical Director. Director of Nursing began pharmacy consultant reviews on 12/17/21. Medical Records will monitor all dialysis residents Medication Administration Records for medication administration 3 x per week x 2 months until substantial compliance is attained. Medical Record audits of Medication Administration Records began on 12/01/21. Areas in need of correction will be reviewed by the Quality Assurance Committee Meeting for corrective action to include in-service training, and/or disciplinary action. The facility Quality Assurance Committee Meeting shall be held for six months to ensure substantial compliance is attained. Quality Assurance Committee Meetings began reviews on	

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M 710	Continued From page 16 chewable tablet-give 4 tablets to equal 325 MG by mouth daily related to circulation, Ferrous Sulfate 325 MG tablet give one tablet by mouth twice daily related to Anemia/ iron supplement, house liquid protein supplement 30 CC (cubic centimeters) by mouth twice daily related to End Stage Renal Disease (ESRD), Midodrine HCL 2.5 MG tablet one tablet by mouth three times daily related to hypotension and Multivitamins tablet one by mouth. Record review of the Face Sheet revealed Resident #51 was admitted to the facility on 6/14/2017 with current diagnoses of Cerebral Infarction due to embolism of left post Cerebral Artery, Acute on Chronic systolic (Congestive Heart Failure (CHF), Chronic Pulmonary Disease (CPD), Type II Diabetes Mellitus (DM), Chronic Kidney Disease (CKD), Hypotension, Anxiety Disorder (AD), Recurrent Depression Disorder (RDD), Essential (primary) Hypertension, Gastro-esophageal reflux disease without esophagitis (GERD), Dependence on renal dialysis and Cardiomyopathy. Record review of the discharge Minimum Data Set (MDS) with an Assessment Reference Date of 10/11/21, revealed in Section C, a Brief Interview for Mental Status (BIMS) score of 09 out of 15 which indicated moderate impairment. Resident #12 A record review of Resident #12's "Face Sheet" revealed the facility admitted Resident #12 on 08/13/20 with the diagnoses of Chronic Systolic Congestive Heart Failure, End Stage Renal Disease, Type 2 Diabetes Mellitus, Dementia, Alzheimer's Disease, Essential Hypertension,	M 710	12/16/21.	

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M 710	Continued From page 17 Generalized Anxiety, Major Depressive Disorder, and Dependence of renal dialysis. A record review of Resident #12's Yearly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/02/2021, Section C revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #12 had severe cognitive impairment. Section O of the MDS revealed Resident #12 received dialysis treatment while a resident at the facility. A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Renvela 800 milligram (mg) one (1) tablet by mouth with meals three times daily, Abilify 2 mg one (1) tablet by mouth every day, Aspirin 81 mg chewable tablet one (1) tablet by mouth every day, Metoprolol Succinate extended release (ER) 25 mg one (1) tablet by mouth every day, Memantine 10 mg one (1) tablet by mouth twice a day, Brilinta 90 mg one (1) tablet by mouth twice a day, Hydralazine 25 mg one (1) tablet by mouth three times a day, Klonopin 0.5 mg one (1) tablet by mouth every day, and Venlafaxine 75 mg one (1) tablet by mouth daily. A record review of Resident #12's Electronic Medication Administration Record (EMAR) for November 2021 revealed the Monday, Wednesday, and Friday dialysis days of November 1st, 3rd, 5th, 8th, and 10th Resident #12 did not receive the following morning medications as ordered as indicated by an "N" for each dose: Klonopin 0.5 mg, Venlafaxine 75 mg, Renvela 800 mg, Abilify 2 mg, Aspirin 81 mg, Metoprolol Succinate ER 25 mg, Memantine 10mg, Brilinta 90 mg, and Hydralazine 25 mg.	M 710		