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| F 000 | INITIAL COMMENTS<br><br>The State Survey Agency (SSA) conducted an annual recertification along with a Complaint Investigation (CI), MS #18014 from 11/07/2021 thru 11/10/2021. During the survey, the SSA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SSA cited F580, F600, F623, F641, F656, F698, F756, F760, and F880 during the survey. The SSA did substantiate MS #18014 related to incontinent care not being provided in a manner to prevent the possible spread of infection.<br><br>The census at the time of the survey was 56 with a bed capacity of 60. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in | F 580 | | 12/29/21 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/10/2021

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| F 580 | Continued From page 1<br>§483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff and resident? interviews record review and facility policy review the facility failed to notify the physician that dialysis Residents were not receiving their morning medications as prescribed on dialysis days for two (2) of two (2) sampled residents reviewed. Resident #12 and Resident #51.<br><br>Findings include: | F 580 | F 580<br><br>a. Licensed Practical Nurse (LPN) #2 was in-serviced on 11/10/21 by the Staff Development Nurse related to the following policies: Drug Administration and Documentation, Medication Errors and to provide proper notification to the physician when medication is unable to be | |

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| F 580 | Continued From page 2<br>A record review of the facility's "Change in Resident Medical Status" policy revealed a revision date of 09/17 stated, "facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with the resident representative when there is ... 3. A need to alter treatment significantly ...or change an existing treatment due to adverse consequences ...).<br><br>Resident #51<br><br>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 resident's medication was not 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) for the resident being out of the building. She stated they have never sent medications with the resident. She stated she has not given the resident 9:00 AM medications after dialysis. She stated she did not follow physician orders and that could cause a significant medication error. She stated the resident leaves around 5:00-5:30 AM for dialysis and returns to the facility at 10:30 AM. She stated it is important that the resident gets all his medications.<br><br>On 11/10/21 at 11:55 AM, in an interview with Physician #1 he explained he was not aware Resident #51 was not getting medication on dialysis days. He stated he makes rounds monthly at the facility and reviews the orders but does not review the EMAR. He stated he has not | F 580 | administered as ordered.<br><br>Licensed Practical Nurse (LPN) #3 was in-serviced on 11/10/21 by the Staff Development Nurse related to the following policies: Drug Administration and Documentation, Medication Errors and to provide proper notification to the physician when medication is unable to be administered as ordered.<br><br>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.<br><br>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 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<br><br>Resident #12 was observed on 11/10/21 | |

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| F 580 | Continued From page 3 | F 580 | | |

seen a change in Resident #51's behavior. He stated he has not been contacted to ask about dialysis resident medication and he assumed medications were given. He stated they could give Resident #51's medication at 10:30 AM when the resident returns from dialysis. He explained he expects medications to be given as ordered and it is very important for the resident to receive all medications daily.

On 11/10/21 at 3:30 PM, interview with LPN #3, she explained she has worked with Resident #51 on the days the resident went to dialysis. When asked what "N" meant on the EMAR, she explained it means "not given". When asked why she did not report that medications were not given on dialysis days, she explained when she started at the facility, she noticed meds not being given and she thought it was the normal way to do at the facility. She stated they have never sent medications with residents to dialysis and morning medications were not given to resident after dialysis. She stated she did not follow physician orders and missing medications could cause a significant medication error. She stated it is important that Resident #51 gets medications as ordered.

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

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 11/10/21 with a completion date of 11/15/21. 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 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

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| F 580 | Continued From page 4<br>esophagitis (GERD), Dependence on renal dialysis and Cardiomyopathy.<br><br>Record review of the quarterly 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 which indicated Resident # 51 had moderate cognitive impairment.<br><br>Record review of Resident #51's Physician's Orders revealed an order dated 10/16/20 for "Levemir 100 units/ML (milliliter) vial-give 18 units subcutaneous every morning related to DM".<br><br>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 Levemir 100 units/ML vial-give 18 units subcutaneous.<br><br>Record review of Resident #51's Physician's Orders revealed an order dated 9/29/17 GERD Famotidine 20 MG (milligram) tablet give one tablet by mouth daily for GERD.<br><br>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.<br><br>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). | F 580 | 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 Pharmacy Consultant duties and drug regimen reviews, Medication Administration and Physician Notification when medication not received with no recommend changes to facility policy.<br><br>d. Medical Records will monitor dialysis residents Medication Administration Records for medication administration and physician notification if medication not received 3 x per week x 2 months until substantial compliance is attained. Medical Record audits of Medication Administration Records began on 12/01/21. Director of Nursing 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 | |

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| F 580 | Continued From page 5<br>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 Lexapro 5MG by mouth at 9:00 AM.<br><br>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)<br><br>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 by mouth at 9:00 AM.<br><br>Record review of Resident #51's Physician's Orders revealed an order dated 8/9/21 Aspirin 81 MG chewable tablet-give 4 tablets to equal 325 MG by mouth daily related to circulation. (Acute or chronic systolic CHF)<br><br>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 by mouth daily related to circulation. (Acute or chronic systolic CHF) 9:00 AM.<br><br>Record review of Resident #51's Physician's Orders revealed an order dated 11/8/17 Ferrous Sulfate 325 MG tablet give one tablet by mouth twice daily related to Anemia iron supplement.<br><br>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 | F 580 | Meeting shall be held monthly until substantial compliance is attained. Quality Assurance Committee Meetings began reviews on 12/16/21. | |

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AM dose of Ferrous Sulfate 325 MG tablet give one tablet by mouth twice daily related to Anemia iron supplement.

Record review of Resident #51's Physician's Orders revealed an order dated 9/30/21, house liquid protein supplement 30 CC (cubic centimeters) by mouth twice daily related to End Stage Renal Disease (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 house liquid protein supplement 30 CC by mouth twice daily related to End Stage Renal Disease (ESRD).

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 9 :00 AM dose of Midodrine HCL 2.5 MG tablet one tablet by mouth three times a day related to Hypotension.

Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/1/17, and a Goal and Target Date of 1/11/21 of "Has a diagnosis of Hypo and Hypertension Heart Failure/CHF "Goal" will not have any complications through next review 1/11/22." Interventions included "Administer Medications as ordered."

Resident #12

A record review of Resident #12's Face Sheet

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revealed the facility admitted Resident #12 on 08/13/20 with diagnoses of Chronic Systolic Congestive Heart Failure, End Stage Renal Disease, Type 2 Diabetes Mellitus, Alzheimer's Disease, Dementia, Essential Hypertension, Generalized Anxiety, Major Depressive Disorder, and Dependence of renal dialysis.

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 (3) 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.

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 N of the MDS revealed Resident #12 received four (4) days of antipsychotic, antianxiety, and antidepressant medications. Section O of the MDS revealed Resident #12 received dialysis while a resident at the facility.

A record review of Resident #12's EMAR for November 2021 revealed on dialysis days (Monday, Wednesday, and Friday) 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21,

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Resident #12 did not receive the following morning medications as ordered: 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 11:00 AM, during a phone interview with Registered Nurse (RN)#2 from the local dialysis treatment center, she explained Resident #12 does attend the dialysis clinic three (3) times a week. She explained the dialysis clinic only gives the resident the medications listed on the communication forms sent back to the facility and the facility is responsible for all other medications.

On 11/10/21 at 10:45 AM during interview with LPN #2, she reviewed the current EMAR and explained the "N" represented medication not given. She explained none of the medications are given for the morning medication pass. When asked if meds are given when resident returns to the facility, she explained no, the morning medications are not given at all on the day the resident goes to dialysis. She further explained the nurse does not send any medications with the residents. She stated she did not notify the physician the resident's medication was not given. She stated if a resident refuses medication for three days, she contacts the physician. State Survey Agency (SSA) asked her if she should have notified the physician, since the resident did not get medication on dialysis days and missed medications three (3) times a week, she explained she never thought about it like that. She stated she has not given the resident's morning medications after dialysis. She stated she did not follow physician orders and it could

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cause a significant medication error. She stated it is important that the resident gets medications as ordered.

At 11/10/21 at 11:05 AM, during a phone interview with the pharmacy consultant, she explained she has not had access to the resident's EMAR and therefor has not reviewed the resident's EMAR. She reported she was not aware of resident not receiving medications on dialysis days. She explained she was under the impression medications were given when the resident returned to facility from dialysis but has not looked at the EMARs.

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 medication on dialysis days. He stated he makes rounds monthly at the facility and reviews the orders but does not review the EMARs. He stated he has not been contacted to ask about dialysis resident's medications and assumed medications were given as ordered. He stated they could give Resident #12's medication when resident returns from dialysis. He explained he expects medications to be given as ordered and it is very important for resident to receive all medications daily.

On 11/10/21 at 3:30 PM, interview with LPN #3, when asked what "N" meant on the EMAR, she explained it means "not given". When asked why she did not report to anyone medications not given on all of dialysis days, she explained when she started at the facility, she noticed meds not being given she explained she thought it was the normal way to do at the facility. She stated the nurses have never sent medications with resident

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and morning medications were not given to resident after dialysis. She stated she did not follow physician orders. She stated Resident #12 missing medications could cause a significant medication error. She stated it is important that Resident #12 gets medications as ordered.

On 11/10/21 at 5:00 PM, interview with Resident #12, she explained the staff has not reported to her of missing any medication.

On 11/10/21 at 11:30 AM, during an interview with 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. He explained the physician should be notified if a resident is not receiving their medications.

On 11/10/21 at 4:00 PM, during an interview with RN #1 supervisor, she reported she was not aware that residents were not getting medication on dialysis days. She explained if residents are not getting medications as ordered, residents could have major effects of missing medications. She reported if the medication is for blood pressure the resident's blood pressure can go up, and if the medication is for diabetes, blood sugars can go up. If residents miss depression medication, the medication will not be as effective and can cause changes in behaviors and moods. Medications for depression would not be therapeutic. She explained if a resident is not receiving blood thinning medication such as Plavix or any anticoagulant, missing this kind of medications can cause shunt to clot off and

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| F 580 | Continued From page 11<br>resident can get a blood clot.<br><br>At 5:10 PM on 11/10/21 interview with the DON, he explained the pharmacy consultant was at the facility on 11/04/21 and he is not sure if she looks at resident's MAR. He explained he seen her follow a nurse with medication pass and done a random cart check. When ask if the MAR was part of the medical records, he explained it is. | F 580 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings include: | F 600 | F 600<br><br>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 | 12/29/21 |

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| F 600 | Continued From page 12<br><br>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 ..."<br><br>Record review of the "Employee Corporate Compliance Code of Conduct" date (05/18) revealed<br>" ...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 ..."<br><br>Resident #51<br><br>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 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 | F 600 | provide proper notification to the physician when medication is unable to be administered as ordered.<br><br>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.<br><br>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.<br><br>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 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 | |

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| F 600 | Continued From page 13<br>gets all his medications.<br><br>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.<br><br>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.<br><br>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.<br><br>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 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 | F 600 | Pharmacy Consultant for Resident #51 on 11/30/21<br><br>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.<br><br>b. All dialysis residents with physician orders for medication to be administered have the potential be affected by this deficient practice.<br><br>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 12/14/21 with completion of training on 12/15/21 on the following: Seven components of abuse including Abuse, Neglect and Exploitation, Drug | |

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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.

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

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 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 shall monitor Pharmacy Consultant reviews for physician order and medication administration record

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| F 600 | Continued From page 15<br>cognitive impairment.<br><br>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".<br><br>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.<br><br>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.<br><br>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.<br><br>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)."<br><br>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 Lexapro 5 MG.<br><br>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 | F 600 | 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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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 (ESRD).

Record review of the Resident 51's EMAR revealed on 11/1/21, 11/3/21, 11/5/21, and

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| F 600 | Continued From page 17<br>11/8/21 the facility failed to give the 10:00 AM house liquid protein supplement 30 CC).<br><br>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.<br><br>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.<br><br>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.<br><br>Resident #12<br><br>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.<br><br>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.<br><br>Record review of Resident #12's "Physician Orders" for November 2021 revealed orders for | F 600 | | |

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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. She explained the nurses have never sent medications with the resident and she has not given the resident morning medications after

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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.

On 11/10/21 at 3:30 PM interview with LPN #3,

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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 neglect, dated 11/2/21.

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| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or | F 623 | | 12/29/21 |

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| F 623 | Continued From page 22<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice. | F 623 | | |

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| F 623 | Continued From page 23<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and resident interviews, record review, and facility policy review, the facility failed to ensure two (2) of two (2) sampled residents received written notice of transfer following a transfer to the hospital. Resident # 51 and Resident # 57.<br><br>Findings Include:<br><br>Review of the facility's policy, "Notice of Hospital Transfer/Therapeutic Leave", revised 8/21, revealed "... 2. When a resident is transferred to the hospital, or goes out on therapeutic leave, a copy of the completed form (notice) is provided to the resident, specifying the duration of the bed-hold according to the state plan, and the facility's policy regarding bed-hold periods. In case of emergency transfer, notice "at the time of transfer" means that the family or resident representative are provided with written notification within 24 hours of the transfer. The | F 623 | F 623<br><br>a. A telephone call was placed to the Resident Representative for Resident #57 on 8/13/21 and within 24 hours of transfer to the hospital to discuss the transfer for Resident #57.<br><br>Resident #51 Resident Representative was notified on 12/20/21 of residents 8/2/21 hospital transfer<br><br>b. Any resident being discharged from the facility or transferred to the hospital has the potential to be affected by this deficient practice.<br><br>c. The Accounts Manager, Social Service Director/Admissions were in-serviced on 11/11/21 on Notice of | |

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| F 623 | Continued From page 24<br>requirement is met if the resident's copy of the notice is sent with other papers accompanying resident to the hospital. The staff member completing the transfer paperwork ...should also be forwarded to the Accounts Manager. The Accounts Manager will contact the Resident representative and complete the verification of telephone notice within 24 hours. The Accounts Manager will also mail a copy of the Notice of Hospital Transfer/therapeutic leave form for signature by the Resident Representative if the Resident Representative is not available to sign on the day they are contacted. A copy of the completed form should be retained in the residents Administrative folder ...."<br><br>Resident #57<br><br>Review of the facility's, "Departmental Notes", dated 8/13/21 at 2:14 PM, revealed "Late entry for 415 PM 8/12/2021...Resident received CXR (chest x-ray)...results for CXR received noting extensive pneumonia in both lungs. Resident with a Dx (diagnosis) of COVID...New order to transfer...to (name of local hospital)..."<br><br>During an interview on 11/09/21 at 03:44 PM, with License Practical Nurse (LPN) #1 revealed Resident #57 was at the facility short term. Resident #57 developed COVID-19 and was sent to the hospital.<br><br>Record review of the Face Sheet revealed Resident #57 was admitted to the facility on 7/09/21with diagnoses that included Dementia, Benign Prostatic Hyperplasia (BPH), and Hypertension.<br><br>Record review of the discharge Minimum Data | F 623 | Hospital Transfer/Therapeutic Leave by Staff Development Nurse. A Directed In-service was provided for all licensed nurses to include Licensed Practical Nurses (LPN□s), Registered Nurses (RN□s), Accounts Manager and Social Service Director/Admissions Coordinator by a Registered Nurse not affiliated with Copiah Living Center on 12/14/21 with a completion of training on 12/15/21 regarding Notice of Hospital Transfer/Therapeutic Leave. Newly hired Licensed Practical Nurses, Registered Nurses, Social Service/Admissions, Accounts Manager will be in-serviced on Notice of Hospital Transfer/Therapeutic Leave by the Facility Staff Development Nurse 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, Hospital Transfer Notifications, 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 recommended changes to facility policy.<br><br>d. The Nursing Facility Administrator will monitor Resident Representative notification of Hospital | |

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| F 623 | Continued From page 25<br>Set (MDS) with an Assessment Reference Date (ARD) of 08/12/21 revealed Resident# 57 was discharged to the local hospital and had a Brief Interview for Mental Status (BIMS) score of 2 that indicted Resident # 57 had severe cognitive impairment.<br><br>Resident #51<br><br>On 11/8/21 at 3:49 PM, in an interview with Resident #51 stated he was hospitalized in August.<br><br>On 11/09/21 at 2:06 PM in an interview with Licensed Practical Nurse (LPN) #2 stated she sent Resident #51 to the emergency room(ER) due to a change in his level of consciousness.<br><br>On 11/9/21 at 4:00 PM, in an interview with the Interim Director of Nursing (DON) stated Social Services (SS) did not notify the family in writing of the hospitalization. He stated that SS did not know she had to do it.<br><br>On 11/09/21 at 4:13 PM, interview with the Business Office Manager (BOM) revealed she sends the hospital transfer letters to the Ombudsmen explaining why the resident was transferred to the hospital. The BOM said she did not know to send the letter to the family. The BOM said the nurses call the families explaining the reason for the hospital transfer. The families are also given bedhold letters upon admission.<br><br>On 11/10/21 at 9:10 AM, in an interview with Social Services stated she does not send any of the paperwork for discharge to the Resident Representative. She stated she was never trained to do it. | F 623 | Transfer/Therapeutic Leave weekly x 4 weeks then bi-monthly for one month until substantial compliance attained. The Notice of Hospital Transfer/Therapeutic Leave monitoring began on 11/19/21. The facility Quality Assurance Committee Meeting shall be held monthly until substantial compliance is attained. The Notice of Hospital Transfer/Therapeutic Leave process will be reviewed by the Quality Assurance Committee on 12/16/21 with the recommendation for any additional training and/or disciplinary action as warranted. Further monitoring will be reviewed for six months to allow for further evaluation. | |

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| F 623 | Continued From page 26<br><br>Record review of the discharge Minimum Data Ser (MDS) with an Assessment Reference Date of 8/2/21 revealed Resident # 51 was sent to the hospital 8/2/21. | F 623 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews, record review and facility policy review the facility failed to accurately code the Minimum Data Set (MDS) for three (3) of 16 resident MDS reviewed, Resident # 19, Resident #25, and Resident #50.<br><br>Findings Include:<br><br>A record review of a statement provided by the facility revealed the MDS assessment staff members of (Formal name of facility) uses the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual for researching and documenting information on the MDS 3.0 Assessment.<br><br>Record review of the "David Drug Guide for Rehabilitation Professionals" revealed "Aspirin ...Classification Therapeutic: antipyretic, nonopioid analgesics ... Pharmacologic: salicylates".<br><br>Record review of the "Resident Assessment Instrument (RAI) User's Manual for the MDS 3.0", dated October 2019, revealed "Section P: | F 641 | F 641<br><br>a. Resident #25□s Minimal Data Set was modified 12/10/21 and resubmitted to the Centers for Medicare and Medicaid (CMS) on 12/13/21.<br><br>Resident #19□s Minimal Data Set was modified on 12/10/21 and resubmitted to Centers for Medicare and Medicaid on 12/13/21.<br><br>Resident #50□s Minimal Data Set was modified on 12/10/21 and resubmitted to Centers for Medicare and Medicaid on 12/13/21.<br><br>b. All Minimal Data Set Assessments which are not accurately coded have the potential to be affected by this deficient practice.<br><br>c. A Directed In-service was provided to the Assessment Nurses on 12/14/21 with a completion date of 12/15/21 by a | 12/29/21 |

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| F 641 | Continued From page 27<br>Restraints and Alarms ... Assessors will evaluate whether or not a device meets the definition of a physical restraint.. and code only the devices that meet the definitions in the appropriate categories ...Definition Physical Restraints Any manual method or mechanical device, material or equipment attached to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body."<br><br>Resident #25<br><br>Record review of Resident #25's Five (5) day Medicare admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 09/08/2021, revealed Section N was coded for anticoagulant given for seven (7) days in the last seven (7) days or since admission.<br><br>Record review of Resident #25's Face Sheet revealed the facility admitted Resident #25 on 09/01/21 with the diagnoses of Pneumonia, Paroxysmal atrial fibrillation, Encounter for prophylactic measures, and other Seasonal Allergic Rhinitis.<br><br>Record review of Resident #25's "Physician Orders List" revealed an order dated 9/1/21 for Aspirin Enteric Coated (EC) 81 milligram tablet one by mouth daily related to circulation. There were no anticoagulant medications listed on the "Physician Orders List".<br><br>Record review of Resident #25's "Electronic Medication Administration Record" (EMAR) for September 2021 revealed Aspirin EC 81 mg was administered daily and there were no | F 641 | Registered Nurse not affiliated with Copiah Living Center regarding the Resident Assessment coding accuracy and completion.<br>A Quality Assurance Committee Meeting was held on 12/16/21 members consisting of Director of Nursing, Staff Development Nurse/Infection Preventionist, Assessment Nurse, Accounts Manager, Administrator, Medical Records, Social Services, Medical Director. Quality Assurance Committee Meeting reviewed MDS 3.0 coding accuracy with no recommend changes to facility policy.<br><br>d. The Director of Nursing and the Nursing Facility Administrator will review the Minimal Data Set for accuracy prior to submission weekly x 4 weeks until substantial compliance is attained. MDS coding review 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 monthly for six months to allow for further evaluation. | |

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| F 641 | Continued From page 28 | F 641 | | |

anticoagulant medications administered.

On 11/09/2021 at 1:30 PM, interview with the MDS nurse (LPN #4), explained she did not know aspirin was not considered an anticoagulant. She reviewed the MDS with an ARD of 09/09/21 and confirmed anticoagulant was selected and coded for the seven (7) days given.

On 11/09/2021 at 1:50 PM, interview with the interim Director of Nursing (DON), when asked if aspirin was an anticoagulant, he replied "no. He explained he expected all MDS assessments to be coded correctly.

Resident #19

On 11/07/21 at 02:25 PM, the State Survey Agency (SSA) observed Resident #19 in the bed with half bedrail noted to the bed.

In an interview with Resident #19 on 11/07/21 at 02:31 PM, she explained the bed rails help her move and turn over in bed. She denied having any restraints at any time.

Record review of Resident #19's "Face Sheet" revealed facility admitted Resident #19 on 06/11/21 with diagnosis of Acute Kidney Failure.

Record review of Resident #19's "Physician Orders" for August 2021 revealed no physician orders noted for restraints.

Record review of Resident #19's Quarterly MDS with an ARD of 08/18/2021 revealed Section P "restraints used in bed; bed rail used daily as physical restraints".

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On 11/09/2021 at 1:30 PM, during an interview with MDS nurse, LPN #4, she reviewed Resident #19's MDS with an ARD of 08/18/2021 and confirmed bed rail coded as used daily as physical restraints. She explained the MDS was coded in error. She explained prior to recent management changes the facility would do weekly meetings prior to submitting the MDS assessment but that has not been done regularly for months.

Resident #50

On 11/07/21 at 04:06 PM, the SSA observed a one-fourth bedrail on Resident #50's bed.

On 11/7/21 at 4:10 PM, Resident #50 explained she only has the two small bed rails on her bed and the rails help her with turning and moving in bed and getting up out of bed.

Record review of Resident #50's Face Sheet revealed the facility admitted the resident on 04/09/2021 with the diagnoses of Major Depressive Disorder, and Chronic Obstructive Pulmonary Disease.

Record review of Resident #50's "Quarterly MDS" with an ARD of 10/11/21, Section P revealed, "bed rail used daily as physical restraints."

On 11/09/2021 at 1:30 PM, during an interview with MDS nurse, LPN #4, she reviewed Resident #19's MDS with an ARD of 08/18/2021, and Resident #50's MDS with an ARD of 10/11/21, and confirmed bed rails were coded as used daily as physical restraints. She explained the MDS was coded in error. She explained prior to recent management changes the facility would do

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| F 641 | Continued From page 30<br>weekly meetings prior to submitting the MDS assessment but that has not been done regularly for months.<br><br>On 11/09/2021 at 1:50 PM, interview with the interim DON, he reported the facility is a restraint free building and there are currently no restraints in use. He explained the facility uses the Long-term Facility Resident Assessment Instruction 3.0 User's Manual for researching and documenting information on the MDS 3.0 Assessment and expects the assessments to be completed accurately. | F 641 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will | F 656 | | 12/29/21 |

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| F 656 | Continued From page 31<br>provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews and facility policy review the facility failed to follow the comprehensive care plan for three (3) of (16) care plans reviewed. Resident #12, Resident #39 and Resident #51.<br><br>Findings include:<br><br>Record review of the facility's policy, "Care Plan Process" with a revision date of 08/17 revealed, "The care plan format includes the Problem Statement, the Goal, the Interventions, the staff responsible to carry out the interventions..."<br><br>Resident #39<br><br>Record review of Resident #39's care plan with a "Problem onset" date of 2/4/2020 revealed " ...Is | F 656 | F 656<br><br>a. Certified Nursing Assistant (C.N.A) #3 was provided an Employee Education and In-service training on 11/10/21 by the Staff Development Nurse related to the proper procedure to administer incontinent/perineal care and following the plan of care.<br><br>Resident #39 was assessed on 12/15/21 by the Director of Nurses for any signs/symptoms of infection. There were no sign/symptoms of infection noted.<br><br>Licensed Practical Nurse (LPN) #2 was in-serviced on 11/10/21 by the Staff Development Nurse related to the following policy: Care Plan Process | |

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| F 656 | Continued From page 32<br>at high risk for skin break down and is frequently incontinent of bowel and bladder ...Approaches ...Incontinent care every two (2) hours and PRN(as needed) ...Provide peri care following each incontinence episode."<br><br>During an incontinent care observation, on 11/09/21 at 10:00 AM, CNA # 3 failed to follow Resident #39's care plan by failure to provide care in a manner to prevent the possible spread of infection when she cleansed the residents peri area in a circular motion. CNA #3 wiped the peri area several times with the same side of the towel, then wiped down the middle of the vaginal area. CNA #3 turned the Resident over and cleansed the Resident's buttocks wiping from back to front with soap and water. CNA #3 also wiped the Resident from back to front with the rinse water.<br><br>In an interview on 11/9/21 at 10:30 AM, interview with CNA #3 confirmed she failed to change the position of the towel while providing incontinent care. CNA #3 also confirmed she wiped the Resident from back to front while cleansing her buttocks. CNA #3 confirmed this could cause the Resident to get infections by not wiping from front to back.<br><br>During an interview on 11/10/21 at 6:00 PM, with License Practical Nurse (LPN) #4, explained once a care plan is in place, she expects the staff to follow the plan of care. LPN #4 said CNA #3 should change positions with each wipe. LPN #4 said this could cause the resident to get Urinary Tract Infections if the CNA does not change the area of the towel when providing incontinent care.<br><br>Record review of the Face Sheet revealed the | F 656 | including following the plan of care.<br><br>Licensed Practical Nurse (LPN) #3 was in-serviced on 11/10/21 by the Staff Development Nurse related to the following policy: Care Plan Process including following the plan of care.<br><br>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 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. Resident # 51 care plan was updated on 11/10/21.<br><br>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. Resident #12 care plan was updated on 11/10/21. | |

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| F 656 | Continued From page 33<br>facility admitted Resident #39 on 2/04/20 with the diagnosis that included Hemiplegia, Convulsions, and Hypertension. The Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 09/30/21, revealed Resident# 39 had a Brief Interview for Mental Status (BIMS) score of 14 that indicted Resident #39 is cognitively intact.<br><br>Resident #51<br><br>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.<br><br>Record review of the quarterly 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 cognitive impairment.<br><br>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".<br><br>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 | F 656 | b. All residents have the potential to be affected by the deficient practice.<br><br>c. A Directed In-Service for all Certified Nurse Aides, Licensed Practical Nurses and Registered Nurses by a Registered Nurse not affiliated with Copiah Living Center on 12/14/21 with a completion of training on 12/15/21 on the following: Care Plan Process including following the plan of care. Newly hired Certified Nursing Assistants, Licensed Practical Nurses and Registered Nurses will be in-serviced on upon hire on the following: Care Plan Process to include following the plan of care. 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 Care Plan process including following the plan of care with no recommend changes to facility policy.<br><br>d. Director of Nursing and/or Staff Development Nurse will monitor care plan implementation via two medication administration observations and two care observations 3 x per week x 2 months until substantial compliance is attained. Care Plan implementation monitoring began on 12/01/21. Areas in need of correction will be reviewed by the Quality Assurance Committee Meeting for | |

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| F 656 | Continued From page 34<br>and 11/10/21 the facility failed to administer the 9:00 AM dose of Levemir 100 units/ML.<br><br>Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/01/2017, and a Goal and Target Date of 1/11/22 of "Diabetes Mellitus 2 "Goal" of resident will "have early detection of signs of hypo/hyperglycemia through next review date 1/11/22... Interventions...Administer medications as ordered..."<br><br>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.<br><br>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 Famotidine 20 MG.<br><br>Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/01/2017, and a Goal and Target Date of 1/11/22 of "Diabetes Mellitus 2". Approaches included..." Administer medications as ordered...."<br><br>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).<br><br>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 | F 656 | 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. | |

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11/10/21, the facility failed to administer the 9:00 AM dose of Lexapro 5MG by mouth at 9:00 AM.

Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 1/20/21, and a Goal and Target Date of 1/11/22 of "Potential for altered mood state related to depression. "Goal" will maintain on lowest effective dose of antidepressant medication to help control mood and behavior with minimal or no side effects through next review date of 1/11/22.". Approaches included... "Administer Medications as ordered."

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 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 Clopidogrel 75 MG by mouth at 9:00 AM.

Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/1/17, and a Goal and Target Date of 1/11/21 of "Has a diagnosis of Hypo and Hypertension HF/CHF "Goal" will not have any complications through next review 1/11/22.". Approaches included..." Administer Medications as ordered..."

Record review of Resident #51's Physician's Orders revealed an order dated 8/9/21Aspirin 81

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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 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 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 Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/1/17, and a Goal and Target Date of 1/11/21 of "Has a diagnosis of Hypo and Hypertension HF/CHF "Goal" will not have any complications through next review 1/11/22.". Approaches included..." Administer Medications as ordered..."

Record review of Resident #51's Physician's Orders revealed an order dated 11/8/17 Ferrous Sulfate 325 MG tablet give one tablet by mouth twice daily related to Anemia iron supplement.

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 Ferrous Sulfate 325 MG tablet give, one tablet by mouth twice daily related to Anemia iron supplement.

Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/1/17, and a Goal and Target Date of 1/11/22Have no complications through next review". Approaches included..." Administer

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Medications as ordered..."

Record review of Resident #51's Physician's Orders revealed an order dated 9/30/21, house liquid protein supplement 30 CC by mouth twice daily related to End Stage Renal Disease (ESRD).

Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on 11/1/21,11/3/21, 11/5/21, and 11/8/21 the facility failed to give house liquid protein supplement 30 CC by mouth twice daily related to End Stage Renal Disease (ESRD).

Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 6/15/17, and a Goal and Target Date of 1/12/21 Therapeutic diet no added salt/low concentrated sweets double large portion of meat/eggs at each meal/1000 ML fluid restrictions. Will attempt for resident to receive adequate nutrition daily through staff . Approaches included "...House liquid protein supplement 30 CC by mouth twice daily related to End Stage Renal Disease (ESRD)."

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 Electronic Medication Administration Record (EMAR) revealed on 11/1/21,11/3/21, 11/5/21, and 11/8/21 the facility failed to give 9 :00 AM dose of Midodrine HCL 2.5 MG tablet one tablet by mouth three times a day. Related to Hypotension

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Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/1/17, and a Goal and Target Date of 1/11/21 of "Has a diagnosis of Hypo and Hypertension HF/CHF "Goal" will not have any complications through next review 1/11/22.". Approaches included...."Administer Medications as ordered..."

Surveyor: Howard, Wendy

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 Resident #12 had severe cognitive impairment.

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Renvela 800 milligram (mg) tablet, one (1) tablet by mouth with meals three times daily related to end stage renal disease.

A record review of Resident #12's Electronic Medication Administration Record (EMAR) revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21 and 11/10/21 the facility failed to administer the 7:30 AM dose of Renvela 800 mg.

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Record review of Resident #12's Care Plan revealed "Problem/Need" with "onset" date of 08/13/2021 and a Goal and Target Date of 1/26/22 revealed "Diagnosis of Renal Insufficiency/Renal Failure/End Stage Renal Disease" and "Receives Dialysis" ... with the "Goal" of resident will "have no complications through next review 1/26/22", and Approaches included " Administer medications as ordered ... Resident is prescribed Renvela."

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Abilify 2 mg tablet one (1) tablet by mouth every day related to Dementia.

A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 8:00 AM dose of Abilify 2 mg.

Record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Altered Thought Process related to Moderately Impaired Cognition related to Alzheimer's/Dementia" with the "Goal" of resident will "have needs met through next review 01/26/22", and "Approaches include ... Resident is prescribed Abilify.

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Memantine HCL 10 mg tablet one (1) tablet by mouth twice a day related to Dementia.

A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21,

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| F 656 | Continued From page 40<br>11/08/21, and 11/10/21 the facility failed to administer the 9:00 AM dose of Memantine HCL 10 mg.<br><br>Record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Altered Thought Process related to Moderately Impaired Cognition related to Alzheimer's/Dementia" with the "Goal" of resident will "have needs met through next review 01/26/22", and "Approaches" include " ... Resident is prescribed Memantine HCL."<br><br>A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Aspirin 81 mg chewable tablet one (1) tablet my mouth every day related to heart failure.<br><br>A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 8:00 AM dose of Aspirin 81 mg.<br><br>Record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Diagnosis of Heart Failure/Hypertension" with the "Goal" of resident will be of any complications through next review 01/26/22, and "Approaches" include ... " Administer medications as ordered ...Resident is prescribed Aspirin."<br><br>A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Metoprolol Succinate ER 25 mg tab take one (1) | F 656 | | |

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tablet by mouth every day related to hypertension.

A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 8:00 AM dose of Metoprolol Succinate ER 25 mg.

Record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Diagnosis of Heart Failure/Hypertension" with the "Goal" of resident will be of any complications through next review 01/26/22, and "Approaches" include " ...Administer medications as ordered ...Resident is prescribed Metoprolol Succinate."

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Brilinta 90 mg tablet take one (1) tablet by mouth twice a day related to heart failure.
A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 9:00 AM dose of Brilinta 90 mg.

A record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Diagnosis of Heart Failure/Hypertension" with the "Goal" of resident will be of any complications through next review 01/26/22, and "Approaches" include " ...Administer medications as ordered ...Resident is prescribed Brilinta."

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for

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Hydralazine HCL 25 mg tablet take one (1) tablet by mouth three times a day related to hypertension (hold if systolic blood pressure is below 110).

A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 9:00 AM dose of Hydralazine HCL 25 mg.

A record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Diagnosis of Heart Failure/Hypertension" with the "Goal" of resident will be of any complications through next review 01/26/22, and "Approaches" include... Administer medications as ordered...Resident is prescribed Hydralazine HCL."

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Klonopin 0.5 mg generic Clonazepam tablet take one (1) tablet by mouth everyday related to anxiety.

A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 8:00 AM dose of Klonopin 0.5 mg.

Record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Risk for Depression/Anxiety" with the "Goal" of resident will have no complications through next review and resident will not show an increase in

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depression mood through next review 01/26/22 and "Approaches" include ... " Administer medications as ordered ...Resident is prescribed Clonazepam."

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Venlafaxine HCL 75 mg tablet take one (1) tablet by mouth daily related to depression.

A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 9:00 AM dose of Venlafaxine HCL.

Record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Risk for Depression/Anxiety" with the "Goal" of resident will have no complications through next review and resident will not show an increase in depression mood through next review 01/26/22, and "Approaches" include ... Administer medications as ordered ... Resident is prescribed Venlafaxine HCL."

On 11/10/21 at 10:45 AM, during interview with LPN #2 reviewed the current EMAR and explained the "N" represented medication not given and further explained none of the medications are given for the morning medication pass. When asked if meds are given when resident returns to the facility, she explained no, the morning medications are not given at all on the day resident goes to the dialysis. She further explained the nurse does not send any medications with the residents. She stated she did not notify the physician the resident's

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medication was not given. She explained the nurses have never sent medications with Resident #12 to dialysis and she has not given Resident #12 any morning medications after dialysis. She stated she did not follow physician orders and that could cause a significant medication error. She stated it is important that the resident get medications as ordered.

On 11/10/21 at 11:00 AM, during a phone interview with RN#2 from the local dialysis treatment center, she explained the dialysis clinic only gives the resident the medications listed on the communication forms sent back to the facility 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 medication on dialysis days. He stated he thought the facility set times for dialysis resident 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 when resident returns. He explained he expects medications to be given as ordered and it is very important for resident to receive all medications daily.

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| F 656 | Continued From page 45<br><br>On 11/10/21 at 3:30 PM interview with LPN #3, when asked what "N" meant on the EMAR, she explained it means "no" and the medication was not given. She explained she has never sent medications with Resident #12 and morning medications were not given to resident after dialysis. She explained she did not follow physician orders and Resident #12 missing medications could cause a significant medication error. She stated it is important that Resident #12 gets medications.<br><br>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. | F 656 | | |
| F 698 SS=D | Dialysis<br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, records review, and facility policy review the facility failed to provide | F 698 | F 698 | 12/29/21 |

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| F 698 | Continued From page 46<br>care and services for residents receiving dialysis for two (2) of two (2) sampled residents. Resident #12 and Resident #51.<br><br>Finding include:<br><br>A record review of the facility's policy "Hemodialysis-Care of Resident" latest revision date 12/20, revealed "Goal:... Dialysis center shall provide to the facility information on all aspects of the management of the resident's care related to the provision of dialysis services ... Evaluation: 3. Notify physician immediately of problems... follow physician orders..."<br><br>Resident #51<br><br>On 11/10/21 at 10:45 AM, during interview with LPN #2, she explained none of Resident #51's morning medications are given for the morning medication pass on the days Resident #51 goes to dialysis due to Resident #51 is not in the building. When asked if meds are given when the resident returns to the facility, she explained no, the medications are not given at all on days Resident #51 goes to dialysis because Resident #51 is gone to dialysis. She further explained the nurse does not send any medications with the resident. When asked if administering medications was part of care for the residents, she explained yes.<br><br>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 | F 698 | a. Licensed Practical Nurse (LPN) #2 was in-serviced on 11/10/21 by the Staff Development Nurse related to the following policies: Drug Administration and Documentation, Medication Errors and to provide proper notification to the physician when medication is unable to be administered as ordered.<br><br>Licensed Practical Nurse (LPN) #3 was in-serviced on 11/10/21 by the Staff Development Nurse related to the following policies: Drug Administration and Documentation, Medication Errors and to provide proper notification to the physician when medication is unable to be administered as ordered.<br><br>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.<br><br>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 ordered. There were no adverse effects noted. Physician #1 was notified on 11/10/21 with a change in | |

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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 #51 was not getting 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 resident medication. 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.

On 11/10/21 at 3:30 PM, in an interview with LPN #3, she explained she had worked with Resident #51 on the days the resident went to dialysis. When asked what "N" meant on the Electronic Medication Administration Record (EMAR), she explained it means "no" and the medication was not given. When asked why the medications were not given, she explained she thought it was the normal way to do at the facility, residents do not get morning medication on dialysis days. She stated she has never sent medications with the resident and morning medications were not given to the resident after dialysis because the resident was not in the building. She stated she did not follow physician orders. When asked if administering medications to residents was a care and service the facility provided to the resident, she explained "yes".

Record review of the Face Sheet revealed Resident #51 was admitted to the facility on

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. 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 12/14/21 with completion of training on 12/15/21 on the following: Drug Administration and Documentation and notification of physician when medication

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| F 698 | Continued From page 48<br>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.<br><br>Record review of the quarterly 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 cognitive impairment.<br><br>Record review of Resident #51's Physician's Orders revealed an order dated 10/16/20 for "Levemir 100 units/ML(milliliter) vial-give 18 units subcutaneous every morning related to DM".<br><br>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.<br><br>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".<br><br>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 (milligram) | F 698 | 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 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. The Director of Nursing (DON) and/or Staff Development Nurse (SDN) will provide training monthly beginning 12/1/21 for the next three months related to importance of providing medication to dialysis residents for facility licensed nurses.<br><br>d. Medical Records will monitor 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. Director of Nursing shall monitor Pharmacy Consultant reviews for physician order and medication administration record comparison and drug regimen reviews monthly x 3 months until substantial | |

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| F 698 | Continued From page 49<br>tablet gives one tablet by mouth.<br><br>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)".<br><br>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 Lexapro 5MG by mouth at 9:00 AM.<br><br>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)".<br><br>Record review of 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 by mouth at 9:00 AM.<br><br>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)".<br><br>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.<br><br>Record review of Resident #51's Physician's Orders revealed an order dated 11/8/17 for | F 698 | 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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"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, house liquid protein supplement 30 CC (cubic centimeters) by mouth twice daily related to End Stage Renal Disease (ESRD).

Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on 11/1/21,11/3/21, 11/5/21, and 11/8/21 the facility failed to give house liquid protein supplement 30 CC twice a day.

Record review of Resident #51's Physician's Orders revealed an order dated 8/5/21 for "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 the Employee Corporate Compliance Code Of Conduct revealed LPN #2 and LPN #3's signatures for training on Quality of Care and neglect, dated 11/2/21.

Resident #12

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A record review of Resident #12's "Face Sheet" revealed the facility admitted Resident #12 on 08/13/20 with diagnoses of Chronic Systolic Congestive Heart Failure, End Stage Renal Disease, Type 2 Diabetes Mellitus, Alzheimer's Disease, Dementia, Essential Hypertension, Generalized Anxiety, Major Depressive Disorder, and Dependence of renal dialysis.

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 on the Monday, Wednesday, and Friday dialysis days of 11/01/21, 11/04/21, 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 10 mg, Brilinta 90 mg, and Hydralazine 25 mg.

On 11/10/21 at 10:45 AM, during interview with LPN #2, she explained none of Resident #12's

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morning medications are given for the morning medication pass on the days Resident #12 goes to dialysis due to Resident #12 is not in the building. When asked if meds are given when resident returns to the facility, she explained no, the medications are not given at all on days Resident #12 goes to dialysis because Resident #12 is gone to dialysis. She further explained the nurse does not send any medications to dialysis with the residents. When asked if administering medications was part of the care and services the facility must provide for the residents, she explained "yes".

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 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 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 medication on dialysis days. He stated he thought the facility set times for dialysis resident to get medications on dialysis days. He stated he has not been contacted to ask about dialysis resident medication. He stated he assumed medications

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| F 698 | Continued From page 53 | F 698 | | |

were given as ordered. He stated they could give Resident #12's medication when resident returns from dialysis. He explained he expects medications to be given as ordered and it is very important for resident to receive all medications daily.

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 ask why she medications were not given, she explained thought it was the normal way to do at the facility, residents do not receive morning medication of dialysis days. She stated she has never sent medications with Resident #12 and morning medications were not given to the resident after dialysis because resident was not in the building. She stated she did not follow physician orders. When asked if administering medications to residents was a service the facility provided to the resident and if the resident did not receive medications due to the resident being gone to dialysis, she explained yes.

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.

On 11/10/21 at 11:00 AM, during a phone interview RN #2 from local dialysis center, she explained Resident #51 and Resident #12 do attend the dialysis clinic three (3) times a week. She explained the dialysis only gives the resident the medications listed on the communication forms and the facility is responsible for all other

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| F 698 | Continued From page 54<br>medications.<br><br>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. | F 698 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, | F 756 | | 12/29/21 |

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| F 756 | Continued From page 55<br>action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, record reviews, and facility policy review, the facility's pharmacy consultant failed to review Electronic Medication Administration Records (EMAR) to ensure the correct medication process was completed for two (2) of two (2) dialysis residents reviewed. Resident #51 and Resident #12.<br><br>Findings include:<br><br>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 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 ...". | F 756 | 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.<br><br>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 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.<br><br>Resident #12 was observed on 11/10/21 by a Licensed Practical Nurse for any | |

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| F 756 | Continued From page 56<br>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.<br><br>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.<br><br>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 explained as a Corporate Nurse Consultant, he has not been informed from the Pharmacy Consultant of any irregularities in the medications.<br><br>Resident #51<br><br>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 | F 756 | 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.<br><br>b. All dialysis residents with physician orders for medication to be administered have the potential be affected by this deficient practice.<br><br>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 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, | |

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| F 756 | Continued From page 57<br>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).<br><br>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.<br><br>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 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 | F 756 | 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.<br><br>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 12/16/21. | |

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| F 756 | Continued From page 58 | F 756 | | |

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, 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.

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| F 756 | Continued From page 59<br>Section O of the MDS revealed Resident #12 received dialysis treatment while a resident at the facility.<br><br>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.<br><br>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. | F 756 | | |
| F 760 SS=D | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by: | F 760 | | 12/29/21 |

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| F 760 | Continued From page 60<br>Based on observations, staff and resident interview, record review, and facility policy review the facility failed to administer significant medications as ordered for two (2) of two (2) dialysis residents. Resident #12 and Resident #51.<br><br>Findings include:<br><br>Record review of the facility's policy, "Drug Administration and Documentation", revision date 4/021, revealed " ...If a dose of regularly scheduled medication is refused, held or for some reason not given for more than two (2) doses in a row, notify the attending physician."<br><br>Record review of the facility's policy, "Medication Errors", revision date 03/2015, revealed " ...Note: a significant medication error is one that cause resident discomfort and or jeopardizes his/her health and or safety ..."<br><br>Resident #51<br><br>On 11/10/21 at 10:51 AM, in an interview with Licensed Practical Nurse #2 (LPN), she 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 resident's medication was not given. She stated the resident goes to dialysis on Monday, Wednesday, and Friday and is out of the building, so she charts in the Electronic Medication Administration Record (EMAR) for the resident being out of the building. She stated they have never sent medications with the resident. She stated she has not given Resident #51's 9:00 AM medications after dialysis. She stated she did not | F 760 | F 760 Residents Are Free of Significant Med Errors<br><br>a. Licensed Practical Nurse (LPN) #2 was in-serviced on 11/10/21 by the Staff Development Nurse related to the following policies: Drug Administration and Documentation, Medication Errors and to provide proper notification to the physician when medication is unable to be administered as ordered.<br><br>Licensed Practical Nurse (LPN) #3 was in-serviced on 11/10/21 by the Staff Development Nurse related to the following policies: Drug Administration and Documentation, Medication Errors and to provide proper notification to the physician when medication is unable to be administered as ordered.<br><br>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 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.<br><br>Resident #12 was observed on 11/10/21 by a Licensed Practical Nurse for any adverse effects related to not receiving | |

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| F 760 | Continued From page 61 | F 760 | | |

follow physician orders and it could cause a significant medication error. She stated the resident leaves around 5:00-5:30 AM for dialysis and returns to the facility at 10:30 AM. She stated it is important that the resident gets all medications.

On 11/10/21 at 11:06 AM, in an interview with the Interim Director of Nursing (DON), stated we are supposed to get an order to give medication when the resident is out of the building. He stated the resident is back by 10:30 AM so the nurse should get an order to give medication upon return to the facility. As a nurse we should obtain 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 medication.

On11/10/21 at 11:41 AM, a phone interview with Physician #1 revealed he was not aware that Resident #51 was not getting his 9:00 AM medications on dialysis days. He stated he has not been contacted about the resident not getting his medications. He stated he would have told them to give the resident his medication after he returns from dialysis. He stated he assumed that the facility gave the medication before or after dialysis. He stated the resident needs their medication.

On 11/10/21 at 3:40 PM, in an interview with LPN #2, she stated that Resident #51 can have stomach and acid reflux issues if does not get his medication for Gastro-esophageal reflux disease (GERD). She stated the resident missing 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

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 (RN□s) 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 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

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| F 760 | Continued From page 62<br>missing Lexapro can cause the resident to have behavioral issues.<br><br>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. She stated their policy is to notify the Physician. She stated the resident not getting medication can have major effects. She stated missing hypertension and diabetes medication can cause resident blood pressure and blood sugar to rise. She stated a resident that misses his medication for depression could cause the medication to not be as effective. She stated it can cause changes in behavior and mood. Medication for depression would not be therapeutic. She stated it is very important that residents get their prescribed medication. She stated not getting blood thinner medications can cause the shunt to clot.<br><br>On 11/10/21 at 4;17 PM, in an interview with the Interim Administrator she stated nobody bought it her attention that Resident #51 was not getting his 9:00 AM medication. She stated the resident medication is a service that should be provided. She stated the nurse should gave the mediation to resident when they come back from dialysis.<br><br>On 11/10/21 at 4:26 PM in an interview with Resident #51, he stated he goes to dialysis on Monday, Wednesday and Friday. He stated he takes one pill before he goes to dialysis.<br><br>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 | F 760 | 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.<br><br>d. 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 monthly until substantial compliance is attained. Quality Assurance Committee Meetings began reviews on 12/16/21. | |

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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, GERD, Dependence on renal dialysis and Cardiomyopathy.

Record review of the quarterly 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 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.

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 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 Famotidine 20 MG.

Record review of Resident #51's Physician's Orders revealed an order dated 1/20/21 for

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"Lexapro 5 MG tablet one tablet by mouth daily related to depression (target behavior, tearful, anger, withdrawal)".

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 Lexapro 5MG.

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 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 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 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 Aspirin 81 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.

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| F 760 | Continued From page 65<br><br>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 Ferrous Sulfate 325 MG.<br><br>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 (ESRD).<br><br>Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on 11/1/21,11/3/21, 11/5/21, and 11/8/21 the facility failed to give house liquid protein supplement 30 CC.<br><br>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.<br><br>Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on 11/1/21,11/3/21, 11/5/21, and 11/8/21 the facility failed to give 9 :00 AM dose of Midodrine HCL 2.5 MG tablet one tablet by mouth three times a day. Related to Hypotension<br><br>Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/1/17, and a Goal and Target Date of 1/11/21 of "Has a diagnosis of Hypo and Hypertension HF/CHF "Goal" will not have any complications through next review 1/11/22.". Interventions Administer Medications as ordered. | F 760 | | |

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Record review of LPN #2 competency evaluation revealed her signature on the page dated 9/17/18. The Annual Licensed Skills Competency Evaluation form revealed training on administering medication.

Record review of LPN #2 Employee Corporate Compliance Code Of Conduct reveals signature for training on Quality of Care and neglect, dated 11/2/21.

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, Hypertension, Anxiety, Major Depressive Disorder, and Dependence of renal dialysis.

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Renvela 800 milli gram (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 Yearly

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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 N of the MDS revealed Resident #12 received four (4) days of antipsychotic, antianxiety, and antidepressant medications.

A record review of Resident #12's EMAR for November 2021 revealed on the Mondays, Wednesdays, and Friday dialysis days of November 1st, 3rd, 5th, 8th, and 10th, Resident #12 did not receive the following morning medications as ordered: 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 10:45 AM, during interview and record review of the current Electronic Medication Administration Record (EMAR) with LPN #2 for Resident #12, she explained the "N" represented medication not given. She explained none of Resident #12's medications are given for the morning medication pass. When asked if medications are given when Resident #12 returns to the facility, she explained no, the morning medications are not given at all on the day Resident #12 goes to the dialysis. She further explained the nurse does not send any medications with the resident. She stated Resident #12 is out of the building, so she charts as resident not being in the facility at medication pass time. She stated the nurses have never sent medications with Resident #12. She stated she has not given Resident #12's morning medications after dialysis. She stated she did not

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follow physician orders. She stated it could cause a significant medication error. She stated it is important that resident get medications.

On 11/10/21 at 11:00 AM during a phone interview with RN#2 from local dialysis treatment center, she explained Resident #12 and Resident #51 attend the dialysis clinic three (3) times a week. She explained the dialysis clinic only gives the resident the medications listed on the communication forms sent back to the facility and the facility is responsible for all other medications.

On 11/10/21 at 11:30 AM during an interview with 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 rom dialysis unless the physician had ordered something else. He explained the physician should be notified if a resident is not receiving their medications.

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 medication on dialysis days. He stated he makes rounds monthly at the facility and reviews the orders but does not review the EMARs. He stated he does not think it will make a difference if the resident takes medication when they return or take medications with her to dialysis. He stated he thought the facility set times for dialysis residents to get medications on dialysis days. He stated he has not seen a change in Resident #12's behavior. He stated he has not been contacted to ask about dialysis resident medication. He stated he assumed medications were given. He stated

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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.

On 11/10/21 at 3:30 PM, interview with LPN #3, when ask what "N" meant on the EMAR, she explained it means "not administered" and the medication was not given. She stated the nurses have 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. She stated Resident #12 missing medications could cause a significant medication error. She stated it is important that Resident #12 gets medications. When ask what missing medications could cause for the resident, she explained missing Abilify and Memantine could cause increase in Dementia episodes, missing Aspirin and Brilinta could increase chance of resident getting blood clots and cause the shunt to become clotted, missing Metoprolol and Hydralazine could cause increased blood pressure, missing Klonopin 0.5 mg could cause increased anxiety, and missing Venlafaxine could cause increased depression.

On 11/10/21 at 4:00 PM, during an interview with RN #1 supervisor, she reported she was not aware that residents were not getting medication on dialysis days. She stated no nurses ever came and told her. She explained if the nurses had told her so she would have been aware, and she could have figured something out. She stated if there is a pattern the nurse should have noticed. She explained if residents are not getting medications as ordered, residents could have major effects of missing medications. She

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| F 760 | Continued From page 70<br>reported if the medication is for blood pressure the resident's blood pressure can go up, and if the medication is for diabetes, blood sugars can go up. If residents miss depression medication, the medication will not be as effective and can cause changes in behaviors and moods. Medications for depression would not be therapeutic. She explained if a resident is not receiving blood thinning medication such as Plavix or any anticoagulant, missing this kind of medication can cause the shunt to clot off and the resident can get a blood clot. She reported she thought all medications were given to residents after returning from dialysis.<br><br>Record review of LPN #3 Employee Corporate Compliance Code Of Conduct reveals signature for training on Quality of Care and neglect, dated 11/2/21. | F 760 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections | F 880 | | 12/29/21 |

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and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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| F 880 | Continued From page 72<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, record review and facility policy review the facility failed to prevent the possible spread of infection for two (2) of five (5) resident care observations (peri care and wound care). Resident #5 and Resident #39.<br><br>Findings include:<br><br>Record review of the facility's policy, "Infection Prevention and Control Surveillance Policy", revision date 8/2021, it is policy of this facility to prevent infections whenever possible ...<br><br>Record review of the facility's policy, "Hand Hygiene", with a revision date of 10/2017, revealed, "Purpose... To cleanse hands to prevent transmission of infection or other conditions... Procedure ...4. Before and after applying gloves... After contact with inanimate objects (including medical equipment)."<br><br>Review of the facility's, " Perineal Care", policy revised 10/18 revealed " ... Female without a catheter ... 5. Wash genital area, moving from front to back, while using a clean portion of the washcloth or pre-moistened wash wipe for each stroke. 6. When soap is used, rinse genital area | F 880 | F 880<br><br>a. Resident #5 and Resident #39 were observed on 11/10/21 by a Licensed Practical Nurse with no adverse findings noted. Resident #39 was assessed on 12/15/21 by the Director of Nurses with no adverse findings noted.<br><br>Certified Nursing Assistant # 1 and # 2 were provided an Employee Education on 11/10/21 by the Staff Development Nurse related to Infection Control and perineal care.<br><br>Registered Nurse #1 was provided an Employee Education on 11/10/21 by the Staff Development Nurse on infection control and Wound Dressing Change Policy and Procedure.<br><br>Certified Nursing Assistant # 3 was provided an Employee Education on 11/10/21 by the Staff Development Nurse on Infection Control and perineal care.<br><br>b. All residents have the potential to be affected by this deficient practice. | |

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| F 880 | Continued From page 73<br>moving front to back using a clean portion of the washcloth or pre-moistened wash wipe for each stroke. 7. Dry genital area moving front to back with a towel."<br><br>Resident #5<br><br>On 11/9/21 at 9:15 AM, an observation of incontinent care by Certified Nursing Assistant #1 (CNA) and assisted by Lead CNA #2 revealed before CNA#1 began peri care she applied clean gloves and raised the bed by turning the bed crank at the foot of the bed. CNA #1 did not remove gloves and sanitize hands. She began peri care with the same gloves on. CNA #1 provided peri care to the front of the resident's vaginal area and stated to the State Agency that she was going to remove gloves and sanitize hands and apply clean gloves. CNA #1 did not sanitize hands or wash hands. She changed gloves and continued care. CNA #1 did not sanitize hands or wash hands throughout peri-care.<br><br>On 11/9/21 at 1:35 PM, in an interview with CNA #1, she stated she did not wash her hands. She stated her actions could cause cross contamination and make the resident sick. She stated she should have washed hands before applying clean gloves. She stated she should have changed gloves after using the bed crank to adjust the resident's bed.<br><br>On 11/9/21 at 1:40 PM, in an interview with CNA #2, she stated that CNA #1 should have washed her hands and changed gloves when she raised the bed and sanitized hands before putting on clean gloves during care. | F 880 | c. A Directed In-service was provided for all licensed nurses to include : Licensed Practical Nurse and Registered Nurses by a Registered Nurse not affiliated with Copiah Living Center on 12/14/21 with a completion of training on 12/15/21 on the following: Infection Control, Incontinent Care/Wound Care and Hand Hygiene. Newly hired Certified Nursing Assistants, Licensed Practical Nurses and Registered Nurses will be in-serviced on Infection Control, Incontinent Care/Wound Care and Hand Hygiene. 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 Infection Control, Incontinent Care/Wound Care and Hand Hygiene with no recommend changes to facility policy. The Director of Nursing (DON) and/or Staff Development Nurse (SDN) will provide training monthly beginning 12/1/21 for the next three months related to infection control and hand hygiene for facility licensed nurses and Certified Nursing Aides.<br><br>d. Director of Nursing and/or Staff Development Nurse will monitor infection control standards including six hand hygiene care observations weekly x 4 weeks and then monthly until substantial compliance is attained. Care observation | |

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| F 880 | Continued From page 74<br>On 11/10/21 at 9:21 AM, in an interview with Licensed Practical Nurse (LPN)/ Infection Control Nurse stated that CNA #1 should have removed gloves after using the bed crank. CNA#1 should have removed gloves, sanitized her hands and applied clean gloves. She stated CNA #1's actions could cause the resident to get Urinary Tract Infection, vaginal infection or wound infection.<br><br>On 11/10/21 at 12:34 PM, in an interview with Interim Director of Nursing (DON) stated CNA #1 should have changed gloves and sanitized hands after touching the bed crank. He stated she should have done this before starting care. He stated that is an infection control issue. He stated it could introduce infection to the resident. He stated the resident could get a urinary tract infection.<br><br>Record review of CNA #1's Performance and Skill Evaluation dated 10/4/21 for infection control revealed her signature.<br><br>On 11/9/21 at 10 :25 AM, an observation of wound care provided by Registered Nurse #1(RN) revealed she used her gloved hands to lower resident bed rail and then begin wound care. She did not change gloves, sanitize hands, or apply clean gloves after touching the bed rail.<br><br>On 11/9/21 at 10:55 AM, in an interview with RN #1 stated she should have taken the gloves off, sanitize her hands and put on clean gloves before beginning wound care.<br><br>On 11/10/21 at 9:25 AM, in an interview with LPN #1/ Infection Control Nurse stated RN #1 should have removed gloves when she touches | F 880 | monitoring began on 11/10/21. 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 for six months to ensure substantial compliance is attained. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255291 | 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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|---|---|---|---|---|
| F 880 | Continued From page 75 | F 880 | | |

anything. She stated RN #1 should have stopped and washed her hands and put on fresh gloves. She stated RN #1 spread germs by not changing gloves and she could spread germs to the wound. Whatever she touched she carried it to the wound. She stated this can lead to infection of the wound.

On 11/10/21 at 12:30 PM, in an interview with the Interim DON, he stated RN #1 should have removed gloves and sanitized hands after touching the bed rail and before beginning care. He stated that is an infection control issue. He stated it can cause the wound to get infected.

Record review of the Physician Orders dated 11/3/21, revealed clean sacral wound with normal saline and pack with kerlix moistened with Dakin's solution. Cover with ABD pad and secure with tape two times a day till healed.

Record review of Resident #5's Face Sheet revealed the resident was admitted to the facility on 2/13/20 with diagnoses of unspecified lack of coordination, pressure ulcer of sacral region, stage three (3), Dementia in other diseases classified elsewhere with behavioral disturbance, and muscle weakness.

Record review of the significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/18/21 revealed a Brief Interview of Mental Status (BIMS) score of 03, which indicated the resident had severely impaired cognition. Section G is coded total dependence for toileting and personal hygiene two-person physical assist. Section H is coded always incontinent of bowel and bladder. Section M is coded for stage 3 pressure wounds.

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|---|---|---|---|
| | 255291 | A. BUILDING _____ B. WING _____ | 11/10/2021 |

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| F 880 | Continued From page 76 | F 880 | | |

Record review of a In-service Sign In Sheet on Hand Hygiene dated 10/6/21, revealed signature of RN #1.

Record review of RN #1 Orientation Checklist revealed hand hygiene was checked off on 8/18/21.

`Resident #39

During an observation on 11/9/2021 at 10:00 AM, revealed Certified Nursing Assistant (CNA) #3 provide incontinent care to Resident #39. CNA #3 cleansed the residents peri area in a circular motion. CNA #3 wiped the peri area several times with the same side of the towel, then wiped down the middle of the vaginal area. CNA #3 turned Resident #39 over and cleansed the Resident's buttocks wiping from back to front with soap and water. CNA #39 also wiped the Resident from back to front with the rinse water.

During an interview on 11/9/21 at 10:30 AM, CNA #3 confirmed she failed to change the position of the towel while providing incontinent care. CNA #3 also confirmed she wiped Resident # 39 from back to front while cleansing her buttocks. CNA #3 confirmed this could cause Resident #39 to get infections by not wiping from front to back.

During an interview on 11/9/20 at 11:00 AM, with License Practical Nurse (LPN) #1 said CNA #3 should have changed the position on the towel after each swipe. LPN #1 also said CNA #3 was trained to wipe from front to back because this could cause the resident to get infections. LPN #1 said the staff watch incontinent care videos upon hire and quarterly. The staff is also checked off

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|---|---|---|---|
| | 255291 | A. BUILDING _____ B. WING _____ | 11/10/2021 |

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|---|---|
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| F 880 | Continued From page 77<br>periodically during the year.<br><br>Record review of CNA #3's "CNA Performance and Skills Evaluation" with a date of employment of 8/24/2021 revealed, Section A: Skills Evaluation for Perineal Care male/female was dated 9/8 (21) and checked "S" for satisfactory and was initialed by CNA #3.<br><br>An "Inservice Training" dated 10/6/21 on Resident Care revealed CNA #3's signature was on the sign in sheet as having attended the inservice.<br><br>Record review of the Face Sheet revealed Resident #39 was admitted to the facility on 2/04/20 with diagnoses that included Hemiplegia, Convulsions, and Hypertension.<br><br>The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/30/21 revealed Resident# 39 had a Brief Interview for Mental Status (BIMS) score of 14 that indicted Resident #39 is cognitively intact. | F 880 | | |