MSDH - Health Facilities Licensure and Certification

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| RIVERVIEW NURSING & REHABILITATION CEI | 1600 WEST CLAIBORNE AVENUE EXTENDED GREENWOOD, MS 38930 |

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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted a licensure survey from 1/12/2020 to 1/15/2020. During the survey the SA determined the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statutes at M500, M625, M640, M655 and M715.<br><br>The census at the time of entrance was 68, and the facility was certified for 91 beds. | M 000 | | |
| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;<br><br>2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his | M 500 | | 2/14/20 |

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| M 500 | Continued From page 1<br>medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;<br><br>4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;<br><br>5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;<br><br>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the | M 500 | | |

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| M 500 | Continued From page 2<br>facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;<br><br>7. is free from mental and physical abuse;<br>8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;<br>9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;<br><br>10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail | M 500 | | |

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| M 500 | Continued From page 3<br>unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, staff interview and facility policy review, the facility failed to ensure Resident #52's right for privacy during the administration of | M 500 | 1. Licensed Practical Nurse (LPN) #4 was one on one in-serviced on Resident Rights by the Director of Nursing on 1/12/2020, to ensure the privacy and dignity is given to the residents. Resident #2 is unable to be interviewed due to cognitive deficits. | |

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| M 500 | Continued From page 4<br>medications through a Percutaneous Endoscopic Gastrostomy (PEG) Tube, for one (1) of nine (9) residents observed for medication administration.<br><br>Findings include:<br><br>Record review of the facility's "Quality of Life - Dignity" policy, revised August 2009, revealed: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Policy Interpretation and Implementation: 1. Residents shall be treated with dignity and respect at all times; 2. Treated with Dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth; 10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.<br><br>On 1/12/2020, at 3:17 PM, during an observation of Percutaneous Endoscopic Gastrostomy (PEG) tube medication administration, Licensed Practical Nurse (LPN) #4, did not pull the privacy curtain between Resident #2 and her roommate. Resident #2's roommate was sitting up in her wheelchair facing Resident #2's bed. Resident #2's abdomen and PEG tube medication administration was exposed to her roommate during the procedure.<br><br>On 1/13/2020, at 4:32 PM, an interview with the Interim Director of Nursing (IDON), revealed she stated that would be a privacy issue and a dignity issue for sure and that staff should always pull the curtain when performing care.<br><br>On 1/15/2020, at 1:29 PM, during an interview with LPN #4 she stated she should have pulled | M 500 | 2. Residents receiving medication by Percutaneous Endoscopic Gastrostomy tube and have a roommate have the potential to be affected.<br>Nursing staff was in-serviced on 1/15/2020, on Resident Rights by the Director of Nursing to ensure privacy and dignity of residents.<br><br>3. Beginning 1/17/2020, the Director of Nursing will monitor nurses providing Percutaneous Endoscopic Gastrostomy (PEG) tube medication administration three (3) times a week for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure services are being given per the care plans.<br><br>4. The Administrator is responsible for on-going monitoring and compliance. Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing for three (3) months for review and recommendations. | |

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| M 500 | Continued From page 5<br>the curtain between the residents to ensure Resident #2's privacy.<br><br>Record review of Resident #2's Quarterly Minimum Data Set Assessment, with an Assessment Reference Date of 9/26/19, revealed in Section C, Item C1000, Cognitive Skills for Daily Decision Making was coded a 3, which indicated severe cognitive impairment-never/rarely made decisions. | M 500 | | |
| M 625 | 45.21.5 Range of motion<br><br>Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on staff interview, resident interview, facility policy review and record review, the facility failed to ensure Resident #45's Passive Range of Motion (PROM) exercises were performed correctly to prevent the potential decline in range of motion for one of three (1 of 3) residents reviewed receiving restorative services.<br><br>Findings include:<br><br>Review of the facility's "Restorative Nursing Services" policy, revised July 2017, revealed, "Policy Statement: Residents will receive restorative nursing care as needed to help promote optimal safety and independence".<br><br>On 1/12/19, at 3:40 PM, during an interview with Resident #45, he stated he was supposed to | M 625 | 1. Certified Nursing Assistant (C.N.A.) #2 was one on one in-serviced on 1/17/2020 by Occupational Therapist on performing the restorative exercise according to the care plan for Resident #45. Resident #45 assessed by the Director of Nursing on 1/17/2020, with no negative affects due to the alleged deficient practice.<br><br>2. Four (4) residents receiving restorative services have the potential to be affected.<br><br>3. The nursing staff was in-serviced on 1/17/2020, by the Director of Nursing on following the orders for restorative services. Beginning 1/17/2020, the Restorative Nurse will monitor Certified Nursing Assistants providing restorative services three (3) times a week for four (4) weeks, then weekly for four (4) weeks and | 2/14/20 |

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| M 625 | Continued From page 6<br>have Restorative Nursing for exercises to his shoulders but "they don't do it".<br><br>Record review of the January 2020 Physician's Orders revealed an order, dated 11/14/19, to admit Resident #45 to the Restorative Nursing Program for 1) Active Range of Motion (AROM) right shoulder flexion exercises four (4) sets 15 repetitions (reps) 2) Passive Range of Motion (PROM) left (L) Shoulder Flexion/Abduction 4 sets 15 second holds six (6) days weekly.<br><br>On 1/14/2020 at 10:25 AM, an interview revealed Restorative Certified Nursing Assistant (CNA) #1, stated, the CNA who gets him up does it for me and they just tell me. Other than that, he gets done. He has AROM to the left and PROM to the right shoulder. CNA #1 stated CNA #2 has him four (4) days and she usually does it for me. CNA #1 said normally by the time I get down there she will have already done his exercises, dressed him and got him up. This morning he got up at 8:15 because he had to be at the dentist at 9:00. CNA #2 did it this morning. CNA #1 stated therapy explains and tells her about new orders for each individual. CNA #1 said she did not know if the CNAs on the floor got the instructions when she got them or when they are discharged to the floor CNAs. CNA #1 states a man from therapy did go over a lot of things with all the CNAs recently.<br><br>Record review of the Therapy to Restorative Form for Resident #45 revealed the resident was discharged from Occupational Therapy on 11/11/19 with "Goals for Restorative Program: 1. Resident will perform RUE shoulder flexion exercises 4 sets of 15 reps pain free range. 2. Perform PROM to LUE in shoulder flexion and shoulder abduction 4 sets of 15 second holds. Pain free range." Restorative CNA #1 signed the | M 625 | monthly for three (3) months to ensure services are being provided according to the orders.<br><br>4. The Administrator is responsible for on-going monitoring and compliance. Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by the Assistant Director of Nursing for three (3) months for review and recommendations. | |

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| M 625 | Continued From page 7<br>form on 11/14/19.<br><br>On 1/14/2020, at 10:46 AM, an interview with CNA #2 revealed she stated, she does Resident #45's exercises because sometimes CNA #1 has a section and I don't know if she has a section or not. CNA #2 said Resident #45 does look for CNA #1 because he knows she's the restorative aide. CNA #2 said she did ROM with his shoulders and arms. Just a little exercise up and down with his shoulders, the left is passive. CNA #2 said she did PROM 15 times to the left shoulder and arm, and one set of 15 or sometimes 10. CNA #2 said they had an in-service a good while ago where they took us in there (therapy room) and showed us dressing, ROM and stuff. No one goes over exercises for individual residents with us when they are discharged to restorative from therapy. We are responsible for making sure Restorative exercises get done if Restorative CNA #1 is assigned to a section. CNA #2 stated that CNA #1 has a lot of different assignments from working on the floor to transportation. CNA #2 stated she does have access to Restorative Nursing Program (RNP) Care Task in the Kiosk as she demonstrated by opening it in the Kiosk and this surveyor observed that the exercises for Resident #45 were documented as completed for January 2020. CNA #2 stated sometimes she charts it's done and sometimes she just tells CNA #1 that it's done and she charts it. CNA #2 reviewed the order at this time for PROM to the left shoulder from the Kiosk and she stated she does it 10 sometimes 15 times, and she thought it meant to hold it a couple of seconds and let it go rest on the bed".<br><br>On 1/14/2020, at 11:00 AM, an interview with the Occupational Therapist (OT), revealed PROM to the left shoulder for 4 sets of 15 second holds, | M 625 | | |

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| M 625 | Continued From page 8<br>that's for contracture management. and pain management. The PT stated he goes over the exercises with the Restorative Aide, have them return demonstrations and sign the competency sheet. The OT stated we try to word it so that if another aide comes in he/she will know what to do as well. If they have any questions about it they can consult with us. It should be the 4 sets of 15 second hold with the passive, key word is pain free with the hold. The CNA should be holding the extremity in the pain free position for 15 seconds 4 times. I think sometimes it gets confusing with the wording. Active ROM should be 4 sets of 15. Probably there are communication issues with that. The important part is the hold for 15 seconds. Reps and holds get a little confusing. We have in-serviced the CNAs on different exercises, AROM, PROM, a list of things that they would be doing actually in the restorative program".<br><br>On 1/14/20, at 2:26 PM, an interview with the OT revealed he stated he just evaluated Resident #45 and there were no changes found with ROM of bilateral shoulders since discharge from therapy.<br><br>An interview with Licensed Practical Nurse (LPN) #3/Restorative Nurse, on 1/15/2020, at 9:06 AM, revealed LPN #3 stated all Certified Nursing Assistants (CNA) staff are aware of how to do the restorative. They were in-serviced by a therapist because when CNA #1 is not here, the floor CNA picks it up, We do six (6) days a week, Monday-Saturday. CNA #1 wears many hats, she drives the van, works a section and when she works a section the CNAs are required to do their people. LPN #3 stated she was not aware that CAN #2 was not aware of how to interpret the PROM order of 4 sets of 15 second holds. | M 625 | | |

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| M 625 | Continued From page 9<br><br>On 1/15/2020 at 9:40 AM, an interview with the Interim Director of Nursing (IDON), revealed a consequence of not getting the correct restorative exercises could be a regression of the resident's ability to move instead of a progression toward his goals. The IDON stated she believed that CNA #2 truly did not understand the order. She said she felt that the RCNA should be the one to do the restorative exercises because she is the one who was trained to do them. The IDON stated she did not know that the floor CNAs were doing the exercises on a regular basis. She stated there were three (3) residents on the Restorative Nursing Program at this time and even though the RCNA has other duties, she should be able to cover those residents She stated the facility just hired a new RCNA and that she felt like having a backup RCNA would be a good idea.<br><br>Record review of the Face Sheet for Resident #45 revealed the resident was admitted by the facility, on 8/28/19, with diagnoses including but not limited to Other Seizures, Muscle Wasting and Atrophy, not elsewhere classified (NEC), left upper arm, Hemiplegia following Cerebral Infarction Affecting Left Non-dominant Side.<br><br>Record review of the Quarterly Minimum Date Set, with an Assessment Reference Date of 12/2/19, revealed in Section C, Resident #45 had a Brief Interview for Mental Status score of 15, indicating intact cognition.<br><br>Record review of the Occupational Therapy Plan of Care (Evaluation Only) performed by the Occupational Therapist, on 1/14/2020, revealed no decline in function since discharge from OT on 11/11/19. | M 625 | | |

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| M 640 | 45.21.8 Accidents<br><br>Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, staff interview, and record review, the facility failed to ensure Resident #40's Care Plan was updated/revised after a fall to prevent the potential for another fall. Resident #40 was assessed a high risk for falls by the facility, on 11/15/2019, and experienced another fall on 12/9/2019. This concern was identified for one of two (1 of 2) residents reviewed for falls.<br><br>Findings include:<br><br>Review of Resident #40's Resident Incident Report, dated 12/09/2019 at 2:30 PM, revealed Resident #40 had a fall, in which she entered another resident's room, threw the covers back on the bed and attempted to crawl in bed. She was found laying on the floor next to the bed with her knees bent and asking for a pillow so she could put it under her head.<br><br>Review of Resident #40's Care Plan, with the reviewed/update of 11/20/19, revealed the Problem/Need for risk for fall related to (r/t) a history (HX) of falls, and impaired mobility. The Approaches included: call light within reach, bed in lowest position and wheels are locked, | M 640 | 1. Resident #40□s fall care plan was updated on 1/13/2020, by the Care Plan Nurse with a new fall intervention for staff to monitor resident when up in wheelchair.<br><br>2. Residents at risk for falls have the potential to be affected.<br><br>3. The Interdisciplinary Team was in-serviced on 1/17/2020, by the Administrator to ensure interventions are put in to place for residents with falls. A 100% care plan audit was conducted by the Minimum Data Set Coordinator beginning 1/17/2020, and concluding 1/21/2020, with no additional issues found. Beginning 1/17/2020, the Director of Nursing will audit fall incidents three (3) times a week for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure interventions are put in to place to help prevent to potential another fall.<br><br>4. The Administrator is responsible for on-going monitoring and compliance. Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by | 2/14/20 |

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| M 640 | Continued From page 11<br>non-skid footwear, fall assessment quarterly and as needed (PRN), Physical Therapy (PT) to evaluate after each fall, body alarm when in bed, bilateral safety transfer bars on bed for turning and positioning. Resident # 40's Care Plan did not address fall interventions dated after the fall on 12/9/19.<br><br>During an interview with the Director of Nursing (DON), on 1/13/2020 at 4:30 PM, she revealed the staff had attempted another intervention after Resident #40's recent fall, she stated therapy had screened the resident, according to the Care Plan, and they recommended no therapy due to her cognitive impairment. When asked if any of the interventions currently listed on Resident #40's Care Plan would have helped to prevent the fall on 12/09/2019, in which resident #40 had wandered into another resident's room to try to get in their bed, the DON stated "no". When asked why the staff didn't attempt an additional intervention to address the cause of the fall, which was wandering into another resident's room in search of a place to lay down, the DON "We didn't put another intervention in place, when therapy didn't pick her up because she doesn't usually get up and move around a lot out of her chair. She is always on the move up and down the halls in her wheelchair, and she is hard to keep track of." When asked if another intervention to address the cause of the fall should have been put into place for Resident #40, she stated "yes".<br><br>Review of Resident #45's Fall Risk Evaluation revealed a score of "12". The assessment indicated "A score of 10 or GREATER indicates a potential FALL RISK".<br>Review of Resident #45's Assessment of Risk for Falls revealed a score of "8" on 11/15/19. This | M 640 | the Director of Nursing for three (3) months for review and recommendations. | |

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| M 640 | Continued From page 12<br>assessment indicated a score of "07-18 Resident is high risk".<br><br>Review of the Face Sheet revealed Resident #40 was admitted by the facility, on 3/16/18, with the included diagnoses of Unspecified Dementia without behavioral disturbance, Personal HX of TIA (Trans Ischemic Attack) and Cerebral Infarction without residual deficits and Major Depressive Disorder, single episode, unspecified.<br><br>Review of Resident #40's Quarterly Minimum Data Assessment, dated 11/15/19, revealed the resident's BIM score was 99 due to the resident was not interviewable. | M 640 | | |
| M 655 | 45.21.11 Special needs<br><br>Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, staff interview, resident interview, record review and facility policy review, the facility did not store and change oxygen (O2) tubing, and therefore failed to prevent the possibility of infection/cross contamination, for two (2) of 17 residents reviewed on oxygen therapy. Resident #50 and Resident #24 | M 655 | 1. Resident #24□s oxygen (O2) tubing was replaced, bagged and labeled by the Director of Nursing on 1/15/2020. Resident #50□s O2 tubing was replaced, bagged and labeled on 1/13/2020, by the Director of Nursing. Neither resident has had any adverse finding from this deficient practice.<br><br>2. Eighteen (18) residents with orders to receive oxygen have the potential to be | 2/14/20 |

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| M 655 | Continued From page 13<br>Findings include:<br><br>Review of the facility's "Changing of Oxygen Supplies" policy, dated September 2019, revealed: Policy Statement: Riverview Nursing and Rehabilitation Center incorporates procedures to maintain an environment as free of infection as possible for our residents. Policy Interpretation and Implementation: 1. Designated nursing staff will change oxygen tubing, mask, and cannulas at least every (7) days and PRN (as needed), 2. Designated nursing staff will label oxygen tubing, cannulas and oxygen humidifier water containers with date of change in a visible site. 3. Designated nursing staff will place opened oxygen tubing, mask and cannulas in labeled/dated container/covering while not in use.<br><br>An observation, on 1/12/2020 at 5:01 PM, in Resident #24's room, revealed the resident's O2 tubing was on the floor beside the bed, with the bed wheel on the tubing. The O2 tubing was dated 1/8/2020, and there was no storage bag or container for the O2 tubing.<br><br>On 1/13/2020 at 10:30 AM and 4:20 PM, an observation of Resident #24's room revealed the O2 tubing was still on the floor beside the bed, and there was no storage bag/container in the room.<br><br>Observations, on 1/14/2020 at 9:15 AM and 3:45 PM, of Resident #24's room, revealed the O2 tubing was on the floor beside the bed, and there was no storage bag/container in the room.<br><br>On 1/15/2020 at 9:15 AM, an observation of Resident #24's room revealed the O2 tubing was on the floor beside the bed, and these still was no storage bag/container in the room. | M 655 | affected.<br><br>3. The nursing staff was in-serviced on 1/17/2020, by the Director of Nursing to ensure oxygen tubing was labeled and stored according to policy. Beginning 1/17/2020, the Assistant Director of Nursing will inspect residents with orders to receive oxygen three (3) times a week for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure the tubing is labeled and stored according to the facility's policy and procedures.<br><br>4. The Administrator is responsible for on-going monitoring and compliance. Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by the Assistant Director of Nursing for three (3) months for review and recommendations. | |

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| M 655 | Continued From page 14<br><br>On 1/12/2020 at 5:05 PM, an interview with Resident #24, on revealed she doesn't remember ever having a bag to put the O2 tubing, so she just throws it wherever.<br><br>Review of the Physician's Order List revealed an order, dated 10/3/19, for Oxygen at 2L/min (liters per minute) via nasal cannula as needed for shortness of breath, change oxygen tubing out weekly on Wednesday, Check O2 sat (saturation) every shift. Notify MD (Medical Doctor) if <90% for Shortness of Breath.<br><br>On 1/15/2020, at 9:30 AM, an interview with the Director of Nursing (DON), revealed the floor nurses on the day shift was responsible for changing the O2 tubing on Wednesdays and should be ensuring there is a bag in there to store the tubing.<br><br>Record review of the Face Sheet revealed Resident #24 was admitted by the facility, on 1/31/2019, with the included diagnoses of Rhabdomyolysis, Heart Failure, Insomnia, Shortness of Breath, Chronic Obstructive Pulmonary Disease, Essential Hypertension.<br><br>Resident #50<br><br>On 1/12/2020 at 4:40 PM, 1/13/2020 at 8:45 AM, 1/13/2020 at 10:42 AM and on 1/13/2020 at 2:10 PM, observations of Resident #50's room revealed the O2 tubing and nasal cannula was hanging over the O2 concentrator, uncovered and undated.<br><br>On 1/13/2020, at 2:15 PM, the Director of Nursing (DON) verified Resident #50's O2 tubing was not dated, and there was no container visible or in the | M 655 | | |

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| M 655 | Continued From page 15 | M 655 | | |

resident's night stand to place the nasal cannula in when it was not in use. The DON stated, "there should be a bag in each resident's nightstand drawer that is dated, with the resident's name on it to put the cannula in when it is not being used, and I don't see one in here anywhere".

Review of Resident #50's Electronic Treatment Administration Record (eTAR), revealed an order was noted to change O2 tubing weekly every Wednesday, however, there were no signatures on the eTAR for the entire months of October 2019, November 2019, December 2019, or on Wednesday, the 1st of January, 2020, nor Wednesday, the 8th of January, 2020.

An interview, on 1/13/2020 at 2:47 PM, revealed the Director of Nursing (DON), revealed when she was asked about no signatures being present on the eTAR for the months of October 2019 through January 2020, she pulled up the eTARs on her computer, and verified there were no signatures to document the resident's O2 tubing was changed weekly for the months of October 2019 through January 13th, 2020.

An interview, on 1/13/2020 at 2:55 PM, with the DON revealed, "the nurse that put in the admission order marked it as a PRN medication and should have assigned a day and time to the oxygen tubing change order for it to fire for the nurses to sign. The nurse that put in the order did not do the special requirements section correctly." When asked if there was any way she could verify the tubing was being changed according to the physician's order and care plan, from October 2019, through 1/13/2020, and she stated "no".

Review of the Face Sheet revealed Resident #50 was admitted by the facility, on 9/25/19, with the

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| M 655 | Continued From page 16<br>included diagnoses Congestive Heart Failure (CHF), Diabetes Type II, Shortness of Breath (SOB), Cough and Wheezing. | M 655 | | |
| M 715 | 45.24.4 Labeling of drugs<br><br>Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, staff interview and facility policy review, the facility failed to properly label medications for two of four (2 of 4) medication carts and one (1) of two (2) medication storage rooms.<br><br>Findings include:<br><br>Review of the facility's "Labeling of Medication Containers" policy, revised April 2007, revealed the Policy Statement: All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. Under a section titled Policy Interpretation and Implementation it stated: 2. Any medication packaging or containers that are inadequately or improperly labeled shall be returned to the issuing pharmacy. 3. Labels for individual drug containers shall include all necessary information, such as:<br>a. The resident's name;<br>b. The prescribing physician's name;<br>c. The name, address, and telephone number of the issuing pharmacy;<br>d. The name, strength, and quantity of the drug; | M 715 | 1. The bottle of Artificial Tears with no open date noted, the two bottles of Opsumit without pharmacy prescription label, four tablets of Imodium loose in the cart without a container or labeling were removed by the Director of Nursing on 1/14/2020. The one bottle of Dorzolomide Hydrochloride (HCL) two percent (2%) eye drops with no date on the bottle or the box it was stored in was removed from Licensed Practical Nurse (LPN) #2□s cart by the Director of Nursing on 1/14/2020. The one vial of multi-dose Tubersol five (5) units/0.1 milliliter, opened, with flip top removed, and no date opened on the vial or box it was stored in was removed from the medication storage room by the Director of Nursing on 1/14/2020. The Director of Nursing had one on one in-service by the Nurse Consultant on 1/17/2020, on labeling medication upon opening and maintaining the pharmacy prescription labels are maintained on the bottles.<br><br>2. All residents have the potential to be affected. | 2/14/20 |

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| M 715 | Continued From page 17<br>e. The prescription number (if applicable);<br>f. The date that the medication was dispensed;<br>g. Appropriate accessory and cautionary statements;<br>h. The expiration date when applicable; and<br>i. Directions for use.<br><br>Review of the facility policy titled, "Storage of Medications", revised April 2007, revealed under the section Policy Interpretation and Implementation: 1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing.<br><br>On 01/14/2020 at 4:00 PM, an observation of Registered Nurse (RN) #1's medication cart, revealed: The medication cart was unlocked and the following items observed: One bottle of Artificial Tears, opened, no open date on the bottle or box, and without a designated resident name. Two bottles of Opsumit, ( a medication used to treat pulmonary arterial hypertension), without a pharmacy prescription label of any kind. Four tablets of Imodium (an over the counter (OTC) medication), loose in the cart without a container, prescription label, or expiration date. An interview with RN #1 at this time revealed she did not know who these medications belonged to because there was no names on the bottles.<br><br>On 01/14/2020, at 4:30 PM, an observation of Licensed Practical Nurse (LPN) #2's medication cart revealed one bottle of Dorzolomide HCL 2% eye drops, opened, partially used, with no open date on the bottle or box it was stored in. An | M 715 | 3. The nursing staff was in-serviced on 1/17/2020, by the Director of Nursing to ensure all medication is labeled and stored according to facility's policy and procedures. A 100% audit was conducted of all medication storage areas on 1/16/2020, by the Director of Nursing with no other issues found. Beginning 1/17/2020, the Director of Nursing will inspect the nursing carts and medication storage rooms three (3) times a week for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure medication is labeled according to the facility's policy and procedures.<br><br>4. The Administrator is responsible for on-going monitoring and compliance. Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing for three (3) months for review and recommendations. | |

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| M 715 | Continued From page 18<br>interview at this time with LPN #2 revealed there was a lot of new nurses working at the facility now, and he keeps telling them they need to date the medications when they open them.<br><br>An observation, on 1/14/2020 at 4:45 PM, with the Director of Nurses (DON), revealed one vial of multi-dose Tubersol 5T units/0.1 milliliter (ml), opened, with flip top removed, and no date opened on the vial or the box it was stored in. An interview at this time with the DON revealed the findings from the two medication cart checks and the medication storage room. The DON stated, "That the Tubersol vial is 100 percent my fault, I opened it and didn't mark the date I opened it. That one is 100 percent on me." When asked about the storage and labeling of medications in the facility, the DON indicated they should all be labeled appropriately from the pharmacy, and the date opened should be written on the label or box it is stored in for eye drops, insulin and multiple use vials. | M 715 | | |