STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255102	A. BUILDING _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF RIPLEY	101 CUNNINGHAM DR RIPLEY, MS 38663

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F 000	INITIAL COMMENTS ****Amended 2567**** A Recertification and Complaint survey, MS #15733, was conducted by Healthcare Management Solutions, LLC on behalf of Mississippi State Department of Health from 4/8/19 through 4/11/19. The complaint was substantiated for misappropriation of medication. After administrative review by the State Agency and the Regional office, additional information was received/reviewed from 5/9/19 through 5/10/19, during an onsite visit to the facility and the 2567 was amended. The facility was found not to be in substantial compliance with Medicare and Medicaid requirements of participation and cited deficiencies at F602, F623, and F921. The facility's census on 4/8/19 was 114 and the facility held a license for 140.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, document review, and policy review, the facility failed to ensure five (5) of fourteen (14) short-term residents, Resident #316, Resident #317,	F 602	F602 Free from Misappropriation/Exploitation Each Resident in the Center has the	6/20/19

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

Electronically Signed | 06/18/2019

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F 602	Continued From page 1 Resident #318, Resident #319, and Resident #323, were free from diversion and misappropriation of their controlled substance medications by facility staff. Specifically, the facility failed to ensure resident medications were not diverted by facility staff, which did not result in any negative outcomes to the residents. The facility's failure had the potential to affect 14 residents residing on E/F unit. Findings include: Review of the facility's policy titled, "Rights of Nursing Facility Residents," dated 5/1/12, documented, "Every resident has the right to be free from abuse, neglect and exploitation." Review of the facility's policy titled, "Abuse, Neglect, Misappropriation, Exploitation Policy," dated January 2019, documented, "Purpose: To prohibit and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigation of alleged violations (to include injuries of unknown source, mistreatment and involuntary seclusion) in accordance with Federal and State Laws ... Exploitation: Taking advantage of a resident for personal gain, through the use of manipulation." Review of the facility's policy titled, "Reporting Reasonable Suspicion of Crimes," dated 12/1/17, documented, "Reasonable Suspicion" means that there are sufficient identified and undisputed factual details to allow an ordinary person similarly situated and in the same circumstances to conclude that a crime had been committed. . . . Examples of situations that would likely be considered crimes in all subdivisions would include but are not limited to: Drug diversion for	F 602	potential to be effected by this deficient practice. On 2-20-19 NSRN#4 was placed on immediate suspension per the Director of Nursing Services pending investigation that began on 2-20-19 that resulted in termination and appropriate notification to the MS Board of Nursing, Ripley Police Dept, MS Dept of Health, Attorney General, and Consultant Pharmacist who notified the MS Board of Pharmacy. Missing medications noted post a 100% narcotic audit for Residents #316, #317, #318, #319, #323 were replaced. ¿ Inservicing immediately initiated on 2-20-19 by the Registered Nurse, Director of Clinical Education with all center staff regarding narcotic medication administration and documentation, center s drug free workplace policy including reporting suspicious behavior of peer to center management immediately. Door lock codes changed on 2-20-19 per the Maintenance Director. Additional in servicing per Attorney General on March 11, 2019 on the topic of Misappropriation/Exploitation. ¿ Continue shift to shift narcotic count by floor nurses at the change of each shift beginning on 2-20-19. Nurse management, Director of Nursing, Assistant Director of Nursing, RN Unit Managers, and Weekend Supervisor to complete twice weekly times eight weeks random narcotic counts to ensure no discrepancies.	

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F 602	Continued From page 2 personal use or gain." Review of the "Investigation Report, Investigation Template," dated 2/22/19, documented, On the morning of 2/20/19, when the off-going night shift nurse, Registered Nurse (RN) #4, and the oncoming day shift nurse, Licensed Practical Nurse (LPN) #6, performed a change-of-shift narcotic medication count on the E/F wing's medication cart, multiple medication discrepancies were identified. At approximately 7:40 AM, RN #1 notified the facility's Director of Nursing Services (DNS) by telephone of the incorrect narcotic count. While in route to the facility, the DNS notified the Administrator, who went immediately to the E/F wing to investigate. Upon arriving at the E/F unit, the Administrator found RN #4 leaned back in a desk chair with his fingers crossed on his abdomen and his eyes closed. When the Administrator asked RN #4 to explain the discrepancies found during the narcotic count, the report documented that RN #4, mumbled that, "it was a mistake." When directly questioned by the Administrator, RN #4 denied taking any of the medications, stating he had mistakenly popped them out of the blister pack, and then disposed of the pills in the sharp's container (a specially-made container used to dispose of needles, syringes, and other potentially hazardous medical waste). The report documented RN #4 had been noted to sign "error" on several of the narcotic sheets, without obtaining a witness to his destruction of the narcotic medications, or notifying anyone of the destruction of those medications. Per the report, the sharps container was removed from the medication cart, and upon inspection, revealed, "4 [four] - 5 [five] pills were visible inside it amongst several used needles and lancets." RN	F 602	¿ The results of these audits will be submitted to the Quality Assurance Performance Improvement committee monthly per the Director of Nursing Services and addressed as necessary. This Committee is comprised of the Medical Director, Administrator, Director of Nursing Services and three other department managers. This Committee will review the audits for additional monitoring and continued improvement. Compliance Date: June 20, 2019	

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F 602	Continued From page 3 #4 consented to a drug screen; however, due to dry mouth and a lack of saliva, the facility was unable to complete an oral drug screen. The DNS and the facility's Maintenance Director then escorted RN #4 directly the hospital laboratory department to have a drug screen conducted. Further review of the facility's "Investigation Report, Investigation Template" indicated that upon RN #4's departure from the unit, the Administrator and the Director of Clinical Education and Infection Control (DCE) immediately removed RN #4's lunchbox from the refrigerator in the medication room on the E/F wing. Upon opening RN #4's lunchbox, a small pill bottle labeled, "DG health brand 24-hour Lansoprazole" was noted inside. Per the report, the pill bottle contained 21 and 1/2 various tablets. The facility's DCE and Administrator identified each individual pill, which included: 1. Seven (7), 5 milligrams (mg)/325 mg Norco tablets (an opioid pain medication); 2. Six (6), 10 mg Norco tablets; 3. Two (2) and a half (1/2) oxycodone tablets (an opioid pain medication) (with no dose strength noted); 4. Three (3), 10 mg Percocet tablets (an opioid pain medication); 5. Two (2) Neurontin (gabapentin) tablets (a medication used to treat nerve-related pain) (with no dose strength noted); and 6. One (1) Tramadol tablet, (a non-opioid pain medication) (with no dose strength noted).	F 602		

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F 602	Continued From page 4 Review of the document, titled "Change of Shift Controlled Substances Count Sheet", dated 02/20/2019, and signed by the DNS, documented that the bottle of pills obtained from RN #4's lunchbox were seized and secured by the facility's Administrator, and then seized by the local Police Department on 2/20/19, which was also signed by the police officer. Further review of the "Investigation Report, Investigation Template," dated 2/22/19, documented that the facility assessed and interviewed all residents under the direct care of RN #4 on the night of 2/19/19, with no negative effects noted or reported. The facility conducted a 100% audit of the facility's narcotic count with no further discrepancies identified. The facility reported the diversion of drugs to the Ripley Police Department, Mississippi (MS) State Department of Health (via voicemail complaint submission), MS Attorney General's Office (AGO) (via web form submission), and MS Board of Nursing (via web form submission) on 2/20/19. The facility's pharmacy consultant, and MS Board of Pharmacy (via the pharmacist) were notified on 2/20/19. The facility's staff was in-serviced regarding narcotic med administration and documentation, the facility's drug free workplace policy including reporting suspicious behavior of peers to facility management immediately, and the MS AGO's office was contacted to arrange an in-service, which was scheduled on 3/11/19. Resident #323 Review of an email from the facility to the pharmacy, dated 02/19/19, indicated the facility requested the pharmacy to assist with locating a missing card of Clonazepam. The resident	F 602		

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F 602	Continued From page 5 (Resident #323) was discharged from the facility on 02/15/2019, (sic). The facility reordered Resident #323's Clonazepam on 02/14/2019, so the resident would have enough to last him until his follow up appointment with his primary care provider. On 2/15/2019, the medication had not been sent from the pharmacy. The nurse (not identified) again reordered the medication and called the pharmacy to explain that the medication was needed. The pharmacy advised the facility that the medication would be delivered on the Friday nights delivery (02/15/19). Resident #323's family member was going to come back to the facility to pick up the medication for the resident. On Monday (2/18/19) when RN #3 (Supervisor) arrived, she attempted to follow up and found no evidence the medication was delivered to the facility. RN #3 then called the pharmacy who indicated RN #4 signed for the medication. The facility indicated they had no record the medication was delivered and when the facility questioned RN #4 he stated, He did, "not recall receiving the medication." The facility requested the pharmacy to provide the facility with a copy of the signed manifest as the facility continued their investigation. Review of the signed manifest, dated 02/15/19, revealed RN# 4 signed the manifest acknowledging receipt of the medication along with the pharmacy delivery driver. On 02/19/2019, the pharmacy did a "cycle" count and determined there were no discrepancies and the medication was delivered to the facility on 02/15/2019. The facility was unable to account for the missing card of Clonazepam.	F 602		

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F 602	Continued From page 6 Resident #316 Review of Resident #316's admission "Minimum Data Set (MDS)" assessment, dated 1/23/19, documented Resident #316 was admitted to the facility from an acute care hospital on 1/16/19, with diagnoses that included Spinal Stenosis (narrowing of the spinal canal), Low Back Pain, Muscle Weakness, Muscle Spasms, Osteomyelitis, and Difficulty Walking. The MDS assessment specified that Resident #316 was cognitively intact as evidenced by a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, and documented the resident experienced pain and received scheduled, and as needed (PRN) pain medications. Review of Resident #316's discharge "MDS" assessment, dated 2/26/19, indicated Resident #316 was discharged back to the community on 2/26/19. Resident #316 was unavailable for an interview during the survey. Review of an email sent by the facility to the local police department titled, "Victim/Patient Info Requested," dated 2/22/19, documented the facility was unable to account for six (6) of Resident #316's oxycodone/acetaminophen (Percocet) 10 mg/325 mg tablets. While the document indicated the facility was unable to account for six (6) Percocet tablets, there were actually only three (3) Percocet tablets, and two (2) gabapentin capsules unaccounted for. Review of Resident #316's "Controlled Drug Record" for Percocet 10 mg/325 mg tablets indicated that on the night of 02/19/19 to 02/20/19 (night shift), RN #4 signed out four (4) Percocet tablets as follows: 02/19/19: one (1) tablet at 11:00 PM, and one (1) at 11:30 PM; 02/19/19:	F 602		

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F 602	Continued From page 7	F 602		

one (1) tablet at 12:00 AM, and one (1) tablet 4:00 AM. During the facility's reconciliation of the resident's narcotic medications, the facility was able to account for the four (4) Percocet tablets; however, the facility was unable to determine why RN #4 signed out these tablets, since they were not removed from the narcotic medication draw and were not administered to the resident.

Review of a second "Controlled Drug Record" for Resident #316's Percocet 10 mg/325 mg tablets indicated RN #4 signed out two (2) 10 mg/325 mg tablets on 2/19/19 (one at 7:45 PM, and one (1) at 12:45 AM (sic), and one (1) 10 mg/325 mg tablet on 2/20/19 at 12:45 AM. On 2/20/19, during the AM change of shift, the facility reconciled the resident's medications; however, the facility was unable to account for three (3) of Resident #316's Percocet tablets.

Review of Resident #316's February 2019 "Medication Administration Record (MAR)" indicated Resident #316 was ordered to receive one (1) 10 mg/325 mg Percocet tablet every four (4) hours 'as needed' (PRN) for pain. Further review of the MAR failed to reveal any documentation that Resident #316 requested or received, Percocet on 2/19/19 or 2/20/19.

Review of Resident #316's "Controlled Drug Record" for Gabapentin 600 mg capsules indicated RN #4 signed out two (2) 600 mg capsules on 2/19/19 at 11:00 PM or 11:30 PM (time is not written clearly). On 2/20/19, during the AM shift change, the facility reconciled Resident #316's medications; however, the facility was unable to account for the two (2) 600 mg Gabapentin capsules.

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F 602	Continued From page 8	F 602		

Review of the 2/20/19 "MAR" indicated Resident #316 was ordered to receive 600 mg of Gabapentin three (3) times a day (9:00 AM, 1:00 PM, and 5:00 PM). On 2/19/19, the "MAR" showed Resident #316 was provided 600 mg of Gabapentin as ordered; however, RN #4 did not administer these medications. Further review of the "MAR" failed to reveal any documentation to support the administration of the two (2) 600 mg gabapentin capsules RN #4 signed out on the "Controlled Drug Record" (see above) on 2/19/19 at 11:20 PM. It should be noted that the "Victim/Patient Info Requested" document, dated 2/22/19, did not include the missing Gabapentin capsules.

On 5/9/19 at 6:01 PM, and 5/10/19 at 10:44 AM, two (2) attempts were made to contact Resident #316 to conduct an interview. A message was left on Resident #316's voicemail requesting a return call; however, he never returned the call.

Resident #317
Review of Resident #317's admission "MDS" assessment, dated 1/14/19, indicated Resident #317 was admitted to the facility, from an acute care hospital, on 1/7/19. Resident #317 was cognitively intact as evidenced by a BIMS score of 13 out of 15. Resident #317's pertinent admission diagnoses Included Hip Fracture, Muscle Weakness, Difficulty Walking, Insomnia, Polyneuropathy (Peripheral Neuropathy), and Chronic Pain. The MDS assessment indicated Resident #317 had pain, and received scheduled and PRN pain medications.

Review of Resident #317's discharge "MDS" assessment, dated 3/7/19, indicated he was discharged back to the community on 3/16/19.

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F 602	Continued From page 9 Resident #317 was unavailable for an interview during the survey. Review of the "Victim/Patient Info Requested" document, dated 2/22/19, indicated the facility was unable to account for one (1) of Resident #317's Gabapentin 300 mg capsules. Review of Resident #317's "Controlled Drug Record" for Gabapentin 300 mg capsules indicated he last received a scheduled 300 mg dose of Gabapentin on 2/19/19, which was administered by LPN #6 at 9:00 PM. The next scheduled dose of Gabapentin was not due to be administered until 2/20/19 at 9:00 PM. On 2/20/19, during the AM shift change, the facility reconciled Resident #317's medications; however, the facility was unable to account for one (1) of Resident #317's Gabapentin 300 mg capsules. Review of an untitled document, dated 2/19/19, indicated RN #1 interviewed Resident #317 at 4:20 PM. The interview indicated Resident #317 was asleep during the night. He did not recall RN #4 from 2/19/19, and did not remember who the nurse aide was. Resident #317 stated he did not note anything different about the nurse's behavior during the night. He stated he did not request any help from team members, did not ask for pain medications, did receive his schedule (normal) medications at bedtime on 2/19/19, and on the morning of 2/20/19, and felt all of his needs were met on 2/19/19. On 5/9/19 at 6:58 PM, and 5/10/19 at 10:47 AM, two (2)attempts were made to contact Resident #317 to conduct an interview. A message was left on Resident #317's voicemail requesting a return	F 602		

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F 602	Continued From page 10	F 602		

call; however, he never returned the call.

Resident #318
Review of Resident #318's admission "MDS" assessment, dated 2/5/19, documented Resident #318 admitted to the facility from an acute care hospital on 1/29/19. Resident #318 was cognitively intact as evidenced by a BIMS score of 15 out of 15. His pertinent admission diagnoses included Cancer, Insomnia, Chronic Pain, Muscle Weakness, and Difficulty Walking. The MDS assessment indicated Resident #318 had pain, and received scheduled and PRN pain medications.

During the survey, Resident #318 was unavailable for an interview. On 5/9/19 at 10:39 AM, the DNS indicated Resident #318 discharged to the hospital where he later passed away (unrelated to current allegation).

Review of the "Victim/Patient Info Requested" document, dated 2/22/19, indicated the facility was unable to account for one (1) of Resident #318's Tramadol 50 mg tablets and one (1) Gabapentin 300 mg capsule.

Review of Resident #318's "Controlled Drug Record" for Tramadol 50 mg tablets indicated RN #4 did not sign out any Tramadol as being administered to Resident #318 during the night shift on 2/19/19. On 2/20/19, during the AM shift change, the facility reconciled Resident #318's medications; however, the facility was unable to account for one (1) 50 mg Tramadol tablet.

Review of Resident #318's "Controlled Drug Record" for Gabapentin 300 mg capsules indicated the last dose administered to Resident

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F 602	Continued From page 11 #318 was on 2/19/19 at 5:00 PM, by LPN #6. The "Controlled Drug Record" did not show RN #4 signed out any Gabapentin on 2/19/19. On 2/20/19, during the AM shift change, the facility reconciled Resident #318's medications; however, the facility was unable to account for one (1) 300 mg Gabapentin capsule. Review of Resident #318's February 2019 "MAR" indicated RN #4 did not administer any PRN Tramadol to Resident #318 during the nightshift on 2/19/19. Further review of the "MAR" showed LPN #6 administered the last scheduled dose of Gabapentin to Resident #318 on 2/19/19 at 5:00 PM. Review of an untitled and undated document indicated the facility conducted an interview with Resident #318. Per the document, Resident #318 stated he rested "fair" during the night. He stated he did interact with the team members, and received help with his needs for the most part. Resident #318 identified RN #4 as the nurse who worked during the nightshift on 2/19/19. Resident #318 indicated RN #4, "was not his normal self, talking out of his head, almost like he was drunk as 'Cooter Brown'." Resident #318 stated that RN #4 sat down in the wheelchair beside him and pushed his whole medication cart in the room. Resident #318 stated RN #4 had never done that before and that RN #4, "was acting really strange." Resident #318 stated he did not ask for any pain meds, and that he gets a "small" pain pill at bedtime. Resident #318 stated he did not think he received his scheduled (normal) medications at bedtime on the night of 2/19/19, or on the morning of 2/20/19. Resident #318 stated RN #4 told him that LPN #6 had already given him his medication, but he did not think it was his bedtime	F 602		

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DIVERSICARE OF RIPLEY	101 CUNNINGHAM DR RIPLEY, MS 38663

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F 602	Continued From page 12 pills. Resident #318 stated he had been a patient (sic) at the facility before, and had been there long enough to know that "this [name of RN #4] was not the [name of RN #4]" he knew. Resident #318 indicated he had never seen RN #4 like that before. Review of Resident #318's February 2019 "MAR" failed to show RN #4 signed out any of Resident #318's medications that were scheduled to be administered on 2/19/19 at 9:00 PM, including one (1) tablet of 25 mg Tramadol, and that all morning medications scheduled to be administered on 2/20/19, were signed off as being administered by LPN #6. Resident #319 Review of Resident #319's admission "MDS" assessment, dated 1/7/19, documented Resident #319 admitted to the facility from the community on 12/28/18. Resident #319 was cognitively intact as evidenced by a BIMS score of 14 out of 15. Resident #319's pertinent admission diagnoses included Arthritis, Unspecified Pain, and Restless Leg Syndrome. The MDS assessment indicated Resident #319 had frequent pain and received PRN pain medications. Review of Resident #319's discharge "MDS" assessment, dated 3/15/19, documented that Resident #319 discharged back to the community on 3/15/19. Resident #319 was unavailable for an interview during the survey. Review of the "Victim/Patient Info Requested" document, dated 2/22/19, indicated the facility was unable to account for one (1) of Resident #319's Hydrocodone 10 mg/Acetaminophen 325 mg (Norco) tablets.	F 602		

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F 602	Continued From page 13 Review of Resident #319's "Controlled Drug Record" for Norco 10 mg/acetaminophen 325 mg indicated the words, "popped open" but nothing else. There was no second nurse signature to indicate the medication was destroyed. On 2/20/19, during the AM shift change, the facility reconciled Resident #319's medications; however, the facility was unable to account for one (1) 10 mg/325 mg Norco tablet. Review of Resident #319's February 2019 "MAR" revealed Resident #319 did not request, or receive PRN Norco during the night shift on 2/19/19. Review of an untitled document, dated 2/20/19 (no time noted), indicated the facility conducted an interview with Resident #319. The interview indicated Resident #319 did not sleep much during the night. She indicated that she did interact with the team and received the help she needed. Resident #319 indicated RN #4 as the nurse who worked the night and there was a "a tall lady" who was the nurse aide. Resident #319 stated RN #4 knocked her glass over, and stated "he acted weird." She stated she did not ask for any pain medication and did not take any during the night. She stated she received her scheduled (normal) medications at bedtime on 2/19/19, and received her morning medications from LPN #6 on 2/20/19. She stated she felt like all her needs were met on the night of 2/19/19. On 5/9/19 at 6:58 PM an attempt to interview Resident #319 was made; however, when the phone number listed in the medical record was called, a gentleman answered the phone and stated the person must have changed their	F 602		

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F 602	Continued From page 14 number. On 5/10/19 at 10:47 AM, a second attempt to contact Resident #319 was made by calling a family member listed in the medical record; however, when the phone number was called a message indicated the person with this number had not set up their mailbox; therefore, a message could not be left for Resident #319. Further review of the "Victim/Patient Info Requested" document dated, 2/22/19, indicated the facility was unable to account for a total of 10 pills missing from the facility's count, and were not signed out on narcotic log sheets for Resident #316, Resident #317, Resident #318, and Resident #319 as outlined above. While the facility found 21.5 pills (outlined above) inside RN #4's lunch box, the facility determined these were most likely resident meds, which could not be identified, as it was uncertain where the other 11.5 pills came from; however, the facility indicated these pills were probably medications the nurse (RN #4) signed out on the log sheets on 2/19/19. In an interview conducted during the survey on 4/11/19 at 11:15 AM, LPN #6 stated everything started as usual on 2/20/19. However, when she came on shift to count the narcotics with RN #4, the count was off on first drug. LPN #6 stated RN #4 told her, "I don't know what happened, let's go on." The LPN #6 stated that when they continued to count the narcotics, more discrepancies were noted and RN #4 again told her, "I don't know what happened." LPN #6 stated that she informed RN #4 that RN #1 (Supervisor) needed to check the discrepancies. During a second interview with LPN #6 on 5/10/19 at 11:36 AM, LPN #6 indicated she had	F 602		

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F 602	Continued From page 15 worked at the facility for 24 years. She stated that when she came to work on the morning of 2/20/19, she received report from RN #4, and then they both started counting the narcotic medications. She stated when she came to the first pack of pills, there was a pill missing. She stated RN #4 said he was not sure what happened and would come back to that, and that RN #4 continued to count the medications. LPN #6 stated that as they continued to reconcile the medications, she noticed "more and more" issues with missing medications. She stated she went to get RN #1, who came to the desk to recount the narcotic medications. She stated the facility's process was to count the narcotics after receiving report from the nurse during shift change. If discrepancies are noted, the staff is supposed to go and get the RN in the building to review the discrepancies. If the discrepancies are confirmed, the RN will call the DNS. LPN #6 stated RN #4 had worked at the facility for about three (3) years. She stated, in those three (3) years, she had not noticed any concerns with RN #4 and this was the first time she noticed anything out of the ordinary. LPN #6 stated that she had not received any reports of concerns regarding this type of behavior by RN #4. An interview conducted during the survey on 4/11/19 at 11:29 AM, indicated that RN #1 stated after being called by LPN #6, she re-counted the narcotics and the same narcotics were missing. RN #1 stated that RN #4 said, "I gave them to the resident." RN #1 stated she told RN #4, "you never charted them and he (RN #4) acted like nothing happened." RN #1 stated she had never seen any action from RN #4 like that before. RN #1 stated she instructed RN #4 not to leave the facility, and she then called the DNS, who said	F 602		

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F 602	Continued From page 16	F 602		

she was on her way, and to notify the Administrator, which RN #1 notified of the concern.

During a second interview with RN #1 on 5/10/2019 at 11:42 AM, she stated she had worked for the facility for the last nine (9) years. She stated that she was the RN on duty the morning of 2/20/19. When she clocked in she noticed the two (2) nurses (LPN #6 and RN #4) were counting the narcotic medications. She stated within five (5) minutes, LPN #6 came to her and said the count was off. She stated she then went out and started to count the narcotic medications with RN #4. She stated the first three (3) cards were off, so she texted the DNS to see where she was. She stated she told RN #4 he could not leave the facility, and she stayed with RN #4 until the DNS arrived at the facility and took over the investigation. RN #1 stated RN #4 had worked at the facility for about three (3) years, and during that time she had never noticed anything out of the normal. RN #1 denied that any staff reported any special concerns to her the morning of 2/20/19.

An interview conducted during the survey on 4/11/19 at 11:35 PM, indicated the DNS explained she had never seen anything like that before. The DNS explained that around 7:30 AM, RN #1 called and told RN #4 not to leave because the DNS was coming into the facility. The DNS told RN #1 to let the Administrator know (since the Administrator was already in the facility). The DNS stated, "We conducted lots of interviews, interviewed the residents, staff, audited all the medications carts, and re-educated all the nurses on the drug free policy. All the residents' medications were refilled, and we could not find

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F 602	Continued From page 17 any residents that missed doses of medications. An interview conducted during the survey on 4/11/19 at 11:45 AM, indicated the Administrator said he received a call at 7:30 AM to go immediately to the E/F hall because the narcotic count in the medication cart was incorrect. The Administrator said they checked all medications carts, and that after the investigation was completed, one (1) action plan was developed to change all the door codes because RN #4 knew the codes. In an interview with Certified Nurse Aide (CNA) #4 on 5/10/19 at 12:17 PM, the CNA stated she had worked at the facility for 10 years and was familiar with RN #4. She stated she was not there on 2/19/19, and was not aware of concerning behaviors by RN #4. She stated when she came to work he (RN #4) was always doing his job, and she had never heard any resident or staff member comment on any "odd behaviors" in the past. In an interview with CNA #3 on 5/10/19 at 12:19 PM, the CNA stated she had worked at the facility for approximately three (3) years. She stated she was familiar with RN #4 and had no knowledge of any "odd behaviors" by the RN other than the day this all occurred . CNA #3 stated RN #4, "was acting odd as though he was out of it." The CNA stated none of the residents or staff had made any comments regarding RN #4 having these types of behaviors in the past. In an interview with RN #3 (supervisor) on 5/10/19 at 11:54 AM, she stated she had worked at the facility for five (5) years. She stated she has been the unit manager (UM) on the E/F wing	F 602		

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F 602	Continued From page 18 for the past year. She stated when she came to work on the morning of 2/20/19, the DNS was looking at the narcotic book at the nursing station, talking with the Director of Clinical Education (DCE), and reviewing the narcotic count. RN #3 stated she overheard the DNS ask RN #4 why there were so many pills missing. She stated this was the only time she had noticed RN #4 acting differently. RN #3 stated she had not received any reports from staff or residents with concerns regarding RN #4 other than the day this all occurred and we began interviewing residents. She stated one (1) or two (2) residents had noticed RN #4 acting differently the night of 2/19/19. The RN stated that the nurses are to conduct daily counts of the narcotics and if there is anything abnormal, the staff are to get the RN in the building, and the oncoming nurse is not allowed to take the keys or start their shift. In an interview with the Director of Clinical Education (DCE) on 5/10/19 at 12:38 PM, the DCE stated she came in to the facility on 02/20/19, and noticed RN #1 and RN #4 at the medication cart. She could overhear RN #1 talking to RN #4 about the narcotic count. The DCE stated, "At that point, the Administrator was over here on the E/F wing and we could see [RN #4] was out of character [e.g., drowsy, slurred speech] and just not himself." The DCE stated the DNS interviewed RN #4, looked through the narcotic book, and questioned RN #4 on where the narcotics were. Then the DNS and facility's Maintenance Director escorted RN #4 to the hospital, and contacted the police.	F 602		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		6/20/19

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F 623	Continued From page 19 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (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. (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 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (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. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (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 (E) A resident has not resided in the facility for 30	F 623		

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F 623	Continued From page 20 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (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; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (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 (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. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F 623		

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F 623	Continued From page 21 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure 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). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of policy and procedure, the facility failed to provide written notices of facility-initiated transfers to the resident, the resident's Responsible Party (RP), and/or State Long-Term Care Ombudsman for three (3) of four (4) sampled residents, Resident #79, Resident #114, and Resident #117, who were transferred to the hospital. The facility's failure to provide written notices when the facility initiated resident transfers, failed to provide added protection to ensure the residents' transfers were appropriate. This failure had the potential to affect all four (4) residents identified by the facility as facility-initiated transfers from the facility. Finding include: Review of the facility policy titled, "Notification of Change in Resident/Resident Health Status," dated June 2017, directed the staff, "To notify the resident and/or the responsible party of the need	F 623	F623 Notice of Requirements before Transfer/Discharge Each Resident in the Center has the potential to be effected by this deficient practice. The Responsible Party of Resident #79 #114, #117 were notified in writing via mail by the Administrator on April 1, 2019 of past transfers for their resident. ¿ An audit of Center resident discharges for the past 30 days was completed by the Administrator ensuring written notification was made.¿ This audit was completed on April 12, 2019 by the Administrator and, if needed, the Administrator made proper past notification on this date. ¿ Leadership staff including the Administrator, Director of Nursing,	

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F 623	Continued From page 22 to transfer the resident to the hospital immediately and in writing ... Before a facility transfers or discharges a resident, the facility must ... (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." Resident #79 Review of the electronic medical record "Face Sheet" documented Resident #79 was admitted to the facility on 3/27/17, with diagnoses that included Kidney Failure. Review of Resident #79's annual Minimum Data Set (MDS) assessment, dated 1/28/19, documented she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #79's discharge MDS assessment, dated 2/22/19, documented she was discharged from the facility to an acute care hospital on 2/22/19. Review of Resident #79's "Progress Notes," dated 2/22/19 at 2:14 AM, indicated she was discharged to the hospital for evaluation and treatment after an unwitnessed fall. The resident returned to the facility via ambulance at 6:27 AM. She was transferred back to the hospital at 12:40 PM, for an evaluation and treatment. Further review of Resident #79's "Progress Notes" provided no evidence to indicate the staff notified the resident and/or their responsible party (RP) in writing of the resident's transfer to the hospital.	F 623	Assistant Director of Nursing, two Unit Managers and Weekend Supervisors were inserviced on completion of written transfer/discharge notices. Transfers/Discharges will be monitored/completed daily by the Administrator and/or the Director of Nursing Services in the Morning Connect Meeting and documented in the resident chart beginning on April 13, 2019. ¿ The Center s Medical Records Coordinator will audit each discharged residents chart to ensure a Notice was provided beginning April 13, 2019.¿ All charts will be audited weekly, beginning April 13, 2019, by the Medical Records Coordinator for the first two months, and bi-weekly for months three and four. Monthly, results of these audits will be forwarded to the Quality Assurance Performance Improvement Committee by the Medical Records Coordinator. This Committee is comprised of the Medical Director, Administrator, Director of Nursing Services and three other department managers. This Committee will review the audits for additional monitoring and continued improvement. Compliance Date: June 20, 2019	

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F 623	Continued From page 23 Resident #79 returned from the hospital on 2/26/19. On 5/9/19 at 12:00 PM, and on 5/10/19 at 2:33 PM, two (2) attempts to interview Resident #79 were made. Resident #79 was unavailable for an interview during each attempt. In an interview with Registered Nurse (RN) #3 on 5/10/19 at 2:15 PM, the RN stated Resident #79 was transferred to the hospital for an evaluation and treatment post-fall. She stated the facility's process was to notify the resident's family by phone and to document the change on a "Situation Background Assessment Recommendation (SBAR)" form or in the resident's progress note. She stated that the facility was not providing residents and/or their resident representatives (responsible parties) with written documentation when they were transferred out of the facility, since this information (notification) was documented in the clinical record upon the resident's transfer. Resident #114 Review of the electronic medical record "Face Sheet" identified Resident #114 was admitted to the facility on 6/16/16, with diagnoses that included Type II Diabetes Mellitus Without Complications, Generalized Edema, Chronic Pain Syndrome, Essential Primary Hypertension, and Vitamin D Deficiency Unspecified. Review of the 5-day MDS assessment, dated 2/28/19, documented Resident #114 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Review of the discharge MDS assessment, dated	F 623		

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F 623	Continued From page 24 3/15/19, documented the facility discharged Resident #114 to an acute care hospital on 3/15/19. Review of a "Progress Note," dated 2/15/19 at 3:28 PM, indicated the staff spoke with Resident #114's RP regarding the resident's high-grade fever and Urinary Tract Infection (UTI), and informed the RP that staff were sending the resident to the local hospital. The "Progress Note" documented that Resident #114's RP verbalized understanding of the resident's UTI, and stated they would meet resident at the hospital. The medical record documentation failed to indicate the staff notified Resident #114 and/or their RP in writing of the resident's transfer to the hospital. Resident #114 returned from the hospital on 02/21/19 at 4:47 PM. Review of a "Progress Note," dated 3/15/19 at 10:24 PM, indicated the staff reported to the Physician Assistant that Resident #114's lactic acid level was 3.3, and the physician ordered the staff to transfer Resident #114 to the local hospital. The "Progress Note" further indicated the staff notified Resident #114's brother-in-law, who was at the facility, of the resident's transfer to the hospital. The medical record documentation failed to indicate the staff notified Resident #114 and/or their RP in writing of the resident's transfer to the hospital on 3/20/19 at 2:19 PM. In an interview with Resident #114 on 5/10/19 at 1:40 PM, Resident #114 stated he did not recall if the facility provided him with anything in writing when he was discharged to the hospital. He stated his brother-in law was at the facility on 3/15/19, and the facility did notify him of the transfer verbally, but he was not sure if the facility	F 623		

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	255102	A. BUILDING _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF RIPLEY	101 CUNNINGHAM DR RIPLEY, MS 38663

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F 623	Continued From page 25 provided him with anything in writing. In an interview with the RN #2 on 5/10/19 at 2:03 PM, the RN stated Resident #114 was discharged to the hospital on 3/15/19, due to an elevated lactic acid level. The resident's family was in the facility, and were verbally notified of the transfer and agreed. She stated that she was not in the facility when the resident was transferred to the hospital; however, the process was to call and notify the family and the nurse would then complete an SBAR or "Nurses' Note" in the clinical record. She acknowledged the facility's process did not include providing residents or resident representatives with a notice in writing when they were transferred to the hospital. She stated that she was not aware that written notice was required since they notified them verbally and documented this information in the resident's clinical record. Resident #117 Review of the electronic medical record "Face Sheet" identified Resident #117 was admitted to the facility on 12/28/18, with diagnoses including Bipolar Disorder and History of Behaviors. Review of the admission MDS assessment, dated 1/4/19, documented Resident #117 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Review of the discharge MDS assessment, dated 1/15/19, documented Resident #117 was discharged to a psychiatric hospital on 1/15/19. Resident #117 was not available for an interview during the survey. Review of the "Progress Notes," dated 1/15/19,	F 623		

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	255102	A. BUILDING _____ B. WING _____	05/10/2019

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F 623	Continued From page 26 indicated the staff notified Resident #117's physician (MD) of the resident's increased behaviors, and received new orders for a psychiatric evaluation and treatment. The "Progress Notes" further indicated the LPN spoke with staff at the receiving facility that accepted the resident, spoke with resident, who agreed to go to the facility, and spoke with the resident's RP by phone who stated he understood the need to send Resident #117 to facility. Further review of Resident #117's medical record documentation failed to indicate the staff provided Resident #117 or their RP with written notice of the resident's transfer. Interview with the Administrator on 4/11/19 at 10:30 AM, confirmed the facility failed to provide written notification to Resident #79, Resident #114, and Resident #117, their respective RP, and the Ombudsman when the residents were transferred to the hospital. The Administrator stated it is her expectation that all transfers be accompanied with a written notice to the RP and the Ombudsman. In an interview with the RN #3 (Unit Manager) on 5/10/19 at 2:20 PM, RN #3 stated Resident #117 was transferred to a psychiatric facility related to increased behaviors. The family was notified via phone and approved of the transfer to the psychiatric facility, which was documented in the resident's "Nurses' Notes." The RN stated the facility's process was to notify the family by phone, and to document the change on an SBAR form or in the resident's "Progress Notes," which she did. RN #3 stated the facility is now providing the residents and/or residents' RPs with written notice when the residents are transferred out of the facility.	F 623		

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F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to provide a sanitary environment for three (3) of four (4) residents with bathrooms equipped with high-rise toilet seats on Hall B. This failure had the potential to affect all four (4) resident bathrooms identified by the facility using high-rise seats on Hall B, Resident #2, Resident #36, and Resident #86. The facility's failure to follow their policy caused an unsanitary environment for residents. Findings include: The facility policy titled "Housekeeping, 7-Step Daily Washroom Cleaning," dated 1/1/00, documented the following procedure for cleaning and sanitizing bathroom fixtures, "Use Germicide to clean ... make sure it is disinfected." During an interview on 4/9/19 at 10:03 AM, Resident #2, on Hall B, reported a concern about the unsanitary condition of her bathroom. She elaborated that the stool is never really cleaned. She said she usually cleaned all bathroom surfaces with a bleach wipe before she used the facilities in the morning, but she had not cleaned her bathroom that morning. She said her concern about bathroom cleanliness was serious because often there is feces and urine on the stool even after it is cleaned. Resident #2 invited the surveyor to observe her bathroom and said, "See	F 921	F921 Safe/Functioning Environment Each resident in the Center has the potential to be effected by this deficient practice. The B Wing toilet seat risers have been cleaned by the Healthcare Services Group Manager on April 13, 2019 and the Health Care Services Group staff members retrained by the Healthcare Services Group Manager on appropriate procedure on April 13,2019. Procedure instructions also laminated and put on each cart for reference as needed on April 13, 2019. ¿ Environmental rounds were completed on April 13, 2019 by the Administrator and Healthcare Services Group Manager and items identified were addressed and new items are being addressed with ongoing follow up at Morning Connect meetings. ¿ Weekly environmental audits will be completed by the Administrator and the Healthcare Services Group (HCSG) Manager beginning on April 13, 2019 and results will be addressed immediately by the HCSG team. ¿ The results of these audits will be	6/20/19

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F 921	Continued From page 28 for yourself." Observation of Resident #2's bathroom on Hall B, on 4/8/19 at 10:11 AM, revealed the toilet was equipped with a toilet seat riser, affixed to a frame with four (4) legs and was positioned over the bowl of the toilet. Raising the toilet seat affixed to the metal frame revealed the flat surface of the bowl surround. The toilet seat initially affixed to the toilet bowl had been removed. The flat surface around the toilet bowl top contained six (6) black/brown spots, which measured 3.0 centimeter (cm) by 3.0 cm in diameter, and five (5) yellow/ brown raised spots/smears that measured approximately 4.0 cm by 5.0 cm. The stool bowl top surface smelled strongly of urine and feces. Observation of Resident #86's bathroom on Hall B, on 4/8/19 at 11:20 AM, revealed the toilet was equipped with a high-rise toilet seat mounted to the frame with four (4) legs. The flat surface of the toilet bowl contained five (5) partially dry yellow/brown circular spots, and six (6) black/brown spots, 7.0 cm by 6.0 cm, located around the bowl surface. The room had a strong odor of urine and feces. Observations on 4/11/19 at 8:47 AM, of the toilets on Hall B in rooms 2, 6, and 8 was initiated with the Account Manager/Housekeeping Supervisor contracted with the facility for housekeeping services. The Account Manager observed and verified the presence of brown/black and yellow/brown spots on the surface of the commode bowls. The Housekeeping Supervisor explained the Housekeeper assigned to this wing started working at the facility on 4/8/19, and had little experience with cleaning in a nursing home	F 921	submitted to the Quality Assurance Performance Improvement Committee monthly by the Healthcare Services Group Manager for the next three months. This Committee is comprised of the Medical Director, Administrator, Director of Nursing Services and three other department managers. This Committee will review the audits for additional monitoring and continued improvement. Compliance Date: June 20, 2019	

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F 921	Continued From page 29 environment. He said, "She probably cleaned these bathrooms like she does at home." He said the new Housekeeper probably didn't know how to clean a toilet with a high rise seat, not knowing she should have cleaned the entire seat surface, not only the seat on top of the high rise toilet seat. Observation and interview on 4/11/19 at 1:52 PM, revealed Licensed Practical Nurse (LPN) #4 counted the number of resident bathrooms on Hall B equipped with high rise toilet seats. LPN #4 reported there were four (4) rooms on the Hall B equipped with a high-rise toilet seat.	F 921		

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	255102	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/10/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 05/05/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	255102	A. BUILDING **02 - BUILDING 02** B. WING _____	**04/10/2019**

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 4/10/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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