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M 000	Initial Comments The State Agency (SA) conducted a recertification survey from 1/28/2020 to 1/31/2020. 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 statute M500. The census at the time of entrance was 88, and the facility was certified for 95 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or 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		2/24/20

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medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the

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M 500	Continued From page 2 facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately 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 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to ensure the residents right to be free from physical and verbal abuse, and	M 500	1. Certified Nursing Assistant (C.N.A) #1 was terminated from employment with the facility by the Nursing Home Administrator on 01/20/20. Resident #1 expired on 2/10/2020. Resident #2 continues to be monitored and display aggression towards	

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M 500	Continued From page 4 misappropriation of property for three of eight (3 of 8) residents reviewed, Residents #1, #2 and #8. Findings include: Review of the facility's policy entitled, "Prohibition of Abuse, Neglect and Misappropriation of Property," dated 05/01/01, revealed: Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse. Review of the facility's policy entitled, "Controlled Substances," dated, December 2012, revealed, Policy Interpretation and Implementation: 1. Only authorized licensed nursing and/or pharmacy personnel shall have access to Schedule II controlled drugs maintained on the premises. 5. Controlled substances must be stored in the medication room in a locked container, separate form containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medication for residents. 6. All keys to controlled substance containers shall be on a single key ring that is different from any other keys." Resident #1 and #2 Review of the Intake of Information form received by the Mississippi State Department of Health (MSDH) on 1/23/2020, for CI MS #00016566 revealed the facility self reported an incident, on 1/16/2020, regarding verbal abuse between Certified Nursing Assistant (CNA) #1 and Resident #2. CNA #1 was heard by the facility's Activity's Director (AD) on 1/16/2020 speaking loudly to Resident #2, telling her she needed to get a shower because she pees on herself and	M 500	staff and refusal of care. Social Service completed wellness visits with Resident #1 and Resident #2 on 01/16/20, 01/17/20, 01/18/20, and 01/19/20, with no additional negative findings, and continues to visit with Resident #2 weekly related to refusal of care. Life Satisfaction Rounds were completed on 01/16/20 by the Social Services with all Residents residing on A+ Wing with specific questions related to care provided by CNA #1, with no additional negative findings. Resident #8 did not miss a dose of prescribed narcotic medication as evidenced by review of medication administration record by the Director of Nursing on 12/27/19. 2. Residents who received care provided by C.N.A. #1 had the potential to be affected by this alleged deficient practice. Residents that were provided care by C.N.A. #1 were interviewed by Social Services on 01/16/20. Body Audits were performed by the Licensed Practical Nurse (Treatment Nurse) on 01/16/20, as a part of the initial investigation with no further negative findings. 3. On 02/16/2020 In-services on Abuse / Neglect Prevention Program, Vulnerable Adults, Residents Rights and Customer Service were initiated to facility staff by Staff Development Coordinator. On 2/17/2020 Licensed nurses were in-serviced by Staff Development Coordinator regarding not giving medication room nor cart keys to unlicensed staff, maintaining narcotic count record with each narcotic	

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M 500	Continued From page 5 stinks. The AD stated she felt like what she heard was rude and loud. The AD went into Resident #2's room and asked her and her roommate (Resident #5 whose Basic Interview For Mental Status/BIMS was 14/no cognitive impairment) about the incident, however Resident #5 asked the AD if she had heard how CNA #1 talked to Resident #2. The AD said yes, that was why she was there. The AD asked Resident #2 why she did not want to get a shower, and Resident #2 stated she (CNA #1) was to rough with her. The AD and Human Resources staff person reported the incident to the Administrator and an investigation was started immediately. CNA #1 was removed from the hallway, and suspended pending the investigation. CNA #1 was provided in-services on Customer Services, Resident Rights, Abuse and Neglect Prevention Program, and Vulnerable Adult Act. The Social Services Designee (SSD) conducted Life Satisfaction Rounds on residents with BIMS score of 12 and higher. Questions specific to CNA #1 were asked. Staff Peer interviews were initiated related to CNA #1, with questions asked specific to CNA #1. In-services on Abuse/Neglect Prevention Program, Vulnerable Adults, Resident's Rights and Customer Service were initiated to all staff. In conclusion, the facility substantiated CNA #1 spoke to Resident #2 in an unacceptable manner. CNA #1 had been properly trained in on the way to speak to residents and had received an in-service related to Customer Service on 1/14/2020. CNA #1 was terminated by the Nursing Home Administrator. Review of the Intake Information form, received by the MSDH for the complaint CI MS #16567, on 1/23/2020, revealed the facility reported Resident #1's allegations regarding CNA #1's rough	M 500	administered, performing narcotic count at beginning and end of shift, administering medications per orders, documentation of medication administration including as needed orders, no use of medications from the facility carts/medication rooms/central supply. 4. Beginning the week of 02/24/20, Social Service will conduct Life Satisfaction Rounds with specific questions related to treatment by Certified Nursing Assistants with ten (10) Residents that have a Brief Interview for Mental Status score of 12 and above weekly for four (4) weeks, then monthly to ensure Residents are satisfied with the treatment and care provided by the Certified Nursing Assistants. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly by Social Services for three (3) months for review and recommendations. The Administrator is responsible for on-going monitoring and compliance. Beginning the week of 02/24/2020 the narcotic counts are verified for every narcotic during medication pass observation to be conducted weekly for four (4) weeks by Director of Nursing / Assistant Director of Nursing / Staff Development Coordinator / RN Supervisor, then monthly for three (3) months. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Nursing for three (3) months for review and recommendations. The Director of Nursing is responsible for on-going monitoring and compliance.	

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handling of her, and the bruises on her right arm. The Intake Information form stated Resident #1 made the allegation at the time of the SSD's Life Satisfaction Rounds during the investigation regarding CNA #1's verbal abuse towards Resident #2. Resident #1 stated CNA #1 was rough with her, and she was awful with her about getting up. Resident #1 told the SSD CNA #1 would her she needed to transfer on her own, but she was not able to do that. The SSD asked Resident #1 to explain what she meant by CNA #1 being rough with her. Resident #1 showed the SSD bruises on her right forearm and left upper arm. The SSD asked Resident #1 to show her how CNA #1 would hold her. Resident #1 placed the SSD's right hand on her right forearm and said hold my arm. See the fingerprints. Resident #1 was not able to recall the date of the incident. The SSD asked Resident #1 if she told CNA #1 she was hurting her. Resident #1 responded she would say ouch that hurts, but CNA #1 wouldn't say anything. An interview with Resident #1's roommate, Resident #4, with a BIMS of 14 (cognitive intact) confirmed Resident #1's statements. Resident #4 stated CNA #1 was not loud with her, but she did jerks Resident #1 around and she has bruises on her arm. The Medical Director and Resident #1's Responsible Party (RP) were notified of the incident. Body audits were conducted on residents on the A Wing and A+ Wing with not negative findings. Peer Reviews were initiated related to CNA #1 (same questions as described in CI MS #00016566) with results that CNA #1 was loud when speaking to resident, had to be instructed several times to provide care to residents at times and is rough with residents. In conclusion the facility substantiated Resident #1 had bruises on arms related to the way she was transferred by CNA #1. CNA #1 has been properly trained on the

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proper ways to transfer. CNA #1 remained suspended at this time.

Review of the facility's Sign In Sheet, dated 1/16/2020, revealed an in-service was provided to the facility staff titled Abuse/Neglect Prevention Program, Vulnerable Adults, Resident's Rights and Customer Service.

Review of an investigation conducted by the facility revealed an allegation of verbal abuse, on 01/16/2020, involving Certified Nursing Assistant (CNA) #1 and Resident #2. The written investigation stated, on 01/16/2020 the Activity Director (AD) was in room A24 visiting with a resident when she heard CNA #1 speaking loudly to Resident #2 in room A25 and stated, "You need to get a shower because you pee on yourself and you stink." The AD felt like CNA #1 was rude and loud with Resident #2. The AD then went and spoke with Resident #2 and asked if she was okay and the resident stated she did not want to take a shower because CNA #1 was too rough with her. The AD then went and told the Administrator and the facility immediately began an investigation, suspended the CNA and reported the incident to the State Department of Health.

Review of the facility's investigation, on 1/16/2020, revealed the SSD conducted the Life Satisfaction Rounds on residents with BIMS scores 12 and higher. Resident #1 reported to the SSD that CNA #1 was awful with her about getting up in the chair and in the bed. Resident #1 said CNA #1 was mean to her, just hateful and rough with her. Tells her she should be transferring herself, but she can't. The SSD asked Resident #1 what did she mean by rough with her. Resident #1 showed the SSD her right

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forearm and left upper arm where bruises were present. Resident #1 could not recall the day it happened, but said it was recent. The SSD asked Resident #1 to show her how CNA #1 holds her. Resident #1 placed her hand on the SSD's right hand and forearm and said hold her arm. See the fingerprints. The investigation concluded as stated in the Intake Information form received by the MSDH on 1/23/2020.

On 01/28/2020 at 12:20 PM, an interview with CNA #1 via phone conversation confirmed she became a CNA on 01/04/2020 and stated they said I yelled at a resident but that's just the way I talk. I'm a loud spoken person and they told me I needed to be quieter. I was trained on abuse and neglect but that wasn't abuse. I was trying to get her (Resident #2) to go to the shower and I did tell her she smelled like pee, but she kept saying she didn't want a bath. I do remember saying that a resident called me like six times, but they talked to me about that, and I didn't think anything of it.

Review of the facility's Vulnerable Adult Act form revealed CNA #1's signature and the date 9/26/19 on the form.

Review of the facility's Resident's Rights Acknowledgement form revealed CNA #1's signature and the date 9/26/19 on the form.

Review of the facility's Associate Acknowledgement of Abuse Policy revealed CNA #1's signature and the date of 9/26/10 on the form.

Review of the facility's Sign In Sheet titled, Customer Service, dated 1/14/2020, revealed CNA #1's signature on the form. Further review of the form revealed a stapled paper with Customer

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M 500	Continued From page 9 Service typed on the form stating Customer Service - Speak to residents with calm voice, where they can hear you and not too loud. No sarcasm. Be mindful of how you say things to resident. It is how they perceive it that matters. Record review revealed, on 01/16/2020, the Social Services Designee (SSD) conducted Life Satisfaction Rounds (interviews) with all the residents that had a Brief Interview for Mental Status (BIMS) score of 12 or higher. The questions asked were: Do you know CNA #1 (Proper Name)? Has CNA #1 ever been loud with you? Has CNA #1 ever been mean to you? Is CNA #1 rough with you? The resident interviews revealed Resident #4 stated, "She is not a good CNA, she needs to get out of here, she's not loud with me but she better not be, but she jerks her (Resident #1) around, she has bruises on her." An interview with Resident #1 revealed she stated, "I heard her yell this morning that she wasn't changing me. Nobody changed me for four hours, so I got back into the bed. She brings my tray in and just plops it down and walks out. I still have not had a bath today and she has probably left. She is awful with me about getting me up in the chair and in the bed. She is mean to me, just hateful. She says I should be transferring myself, but I just can't do it, I try but I'm not able. She is rough with me." The SSD asked Resident #1 to explain what she meant by the CNA was rough with her and Resident #1 showed her bruises on her right forearm and left upper arm. Resident #1 could not recall what day it happened but stated that it was recent, and she stated that CNA #1 would grab her and pull her and that the resident let the CNA know that she was hurting her, and the CNA ignored her. An interview with Resident #3 revealed CNA #1 had told her to stop calling her name and she stated that she is mean and	M 500		

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hateful and doesn't want to do anything for us.

On 01/28/2020 at 10:40 AM, an interview with Resident #2 revealed she was unable to recall the events of 01/16/2020, but the resident's roommate (Resident #5) was present in the room at the time of the interview and stated, "She (Resident #2) can't remember what happened, but I was sitting here on my bed when she hollered at (Proper Name) Resident #2, it was so loud you could have heard her four doors down and she said you're going to get up right now and go take a shower. She finally left out of here because she (Resident #2) wouldn't go with her. She (CNA #1) was mad when she left out of the room."

On 01/28/2020 at 10:15 AM, an interview revealed Resident #1 stated CNA #1 had transferred her for about a week and she would pull on her arms and hurt her during the transfers. She stated she would tell her, your hurting me but she wouldn't say anything. Resident #1 said she never told anyone because she was a big girl and felt like she didn't need to say anything. Resident #1 said she thinks she's gone now. They fired her. Resident #1 said she was glad, she felt safe now, and she had never had a CNA like her. Resident #1 confirmed that she told the staff when they asked, on 01/16/2020, that CNA #1 had left bruises to her forearms and upper arms from pulling on her during transfers from her chair to her bed.

Review of the facility's Personnel Action Form, dated 1/20/2020, for Separation/Termination revealed CNA #1 was terminated.

On 01/28/2020 at 10:30 AM, an interview with Resident #4 revealed she CNA #1 never did her

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like that, but she didn't like the way she saw her treat her (Resident #1). She's gone now, they got rid of her and she was glad.

On 01/28/2020 at 10:50 AM, an interview with CNA #2 revealed CNA #1 had a really loud voice and would yell commands at the residents.

On 01/28/2020 at 10:55 AM, an interview with CNA #3 revealed she didn't like the way she talked to residents, she seemed annoyed and she didn't answer her call lights.

On 01/28/2020 at 11:05 AM, an interview with Licensed Practical Nurse (LPN) #1 revealed she heard CNA #1 the day that she yelled out in the hallway that she was sick of (Resident's Name) calling her name. That was on the 14th of January. LPN #1 said she called her to the nurse's desk and talked to her and told the Director of Nursing (DON) what she had said. LPN #1 said she knew they talked to CNA #1.

On 01/28/2020 at 12:45 PM, an interview with the Staff Development Nurse revealed during the orientation class that she didn't know if she was going to like her (CNA #1) because she was loud and sarcastic during the orientation, but she thought we'd give her a chance and see how it went. The DON and I counseled her, on 01/14/2020, for customer service and her tone with the residents. Then on 01/16/2020 the Administrator came and got me, and I talked to her (CNA #1), had her write a statement and she was suspended and later terminated after our investigation.

On 01/28/2020 at 1:45 PM, an interview with the Director of Nurses (DON) confirmed that she and the Staff Development Nurse sat down with CNA

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M 500	Continued From page 12 #1 and counseled her on 01/14/2020 and completed a one on one in-service on customer service and we talked to her about how to speak to residents and to lower her tone. The DON stated, "I just don't think she got it. She was a new CNA and after that occurred on 01/16/2020 we terminated her and reported the incident to the State." On 01/28/2020 at 1:20 PM, the Activity Director (AD) stated that she was in room 24 when she heard CNA #1 talking loud and rough with Resident #2 and CNA #1 told her, you are always down here telling somebody to change you because you pee on yourself and you stink. The Activity Director then stated that she went to Resident #2's room and the Resident stated, "She's too rough with me and I didn't want to go take a shower." The Activity Director stated that she went right away and reported the incident to the Administrator. On 01/30/2020 at 1:00 PM an interview with LPN #2 stated that she remembered telling CNA #1 four different times that day that Resident #1 needed to be changed or I had to continuously ask her to answer her call lights. LPN #2 stated that she did find out later that day that she had not changed Resident #1 or had not given her a bath that day. LPN #2 stated that Resident #1 had recently gotten weaker and required more assistance and stated, "I guess (CNA #1) didn't want to help her." Review of CNA #1's Employee File Records revealed CNA #1 was hired at the facility on 09/26/19 as a Student Nursing Assistant. CNA #1 completed her training and received her CNA Certification on 01/06/2020.	M 500		

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M 500	Continued From page 13 Review of the Admission Record revealed Resident #1 was admitted by the facility, on 12/12/13, with diagnoses which included, Anxiety Disorder, Major Depressive Disorder, Pain in Left Upper Arm and Parkinson's Disease. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/10/19, revealed a Basic Interview for Mental Status (BIMS) score of 14, indicating the resident had full cognitive ability. Review of the Admission Record revealed Resident #2 was admitted by the facility, on 07/20/09, with diagnoses which included, Severe Intellectual Disabilities, Anxiety Disorder, and Cognitive Communication Deficit. Review of the most recent MDS with an Assessment Reference Date (ARD) of 01/01/2020, revealed a BIMS score of 8, indicating the resident had mild cognitive ability. Resident #8 Review of the Complaint/Incident Investigation Report, received by the Mississippi State Department of Health (MSDH) on 1/3/2020 regarding a facility self reported incident regarding misappropriation of resident property. The Intake Detail revealed this was a follow up to an event reported to MSDH on 12/27/19. On 12/19/19, Resident #8 had three cards of Norco 5 milligrams (mg) and three cards of Ativan 0.5 mg received and added to the narcotic count by Licensed Practical Nurse (LPN) #2. At the time, the narcotic box was full, so LPN #2 placed one care of the Norco and one card of the Ativan on the med (medication) cart and two cards of the Norco and two cards of the Ativan in the backup	M 500		

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M 500	Continued From page 14	M 500		

lock box in the med room. On 12/24/19, LPN #2 stated the cards were in the lock box at shift change, but the other nurse did not verify. On 12/27/19, LPN #2 returned to work and verified the count on the cart was correct with LPN #5, but not the lock box. LPN #2 said after LPN #5 left she checked the lock box and the Ativan cards were there but not the Norco. LPN #2 called LPN #1, #5 and #6, who all said they had verified the count on the cart, but not the lock box to verify medications. The Medical Director, Resident #8's Representative Party (RP) were notified. The Mississippi Board of Nursing , the State Attorney General's Office, the Mississippi Board of Pharmacy were notified. The Narcotic Counts were all verified on every cart with no further discrepancies found on 12/27/19. Back up lock box has been eliminated and all narcotics will be placed on the med carts. LPNs #1, #2, #5, and #6 were individually in-serviced and disciplinary actions issued for those nurses regarding Narcotic Shift Counts. In-service was initiated with nurses to include Abuse/Neglect, Resident Rights, Vulnerable Adult Act, Misappropriation of Narcotics, Narcotic Administration and Narcotic Shift Count. The facility did substantiate Resident #8's cards of Norco 5 mg tablets were missing, while in the possession of the nursing staff. The resident's Narco 5 mg tablets were replaced by the facility.
Review of the facility's In-Service sheet revealed an in-service was provided to the staff, on 12/27/19, regarding Misappropriation of Narcotic/Controlled Substances, Abuse and Neglect, Resident's Rights, and Vulnerable Adult Act.

Review of the facility's investigation revealed, on 12/19/19, revealed Resident #8 had three cards of Norco 5 milligrams (mg) tablets with a quantity

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M 500	Continued From page 15	M 500		

of thirty pills per card delivered to the facility and signed in by Licensed Practical Nurse (LPN) #2. One of the medication cards was placed on the medication cart and the other two were placed in the lock box in the refrigerator in the medication room on the A Hall. The facilities investigation dated 12/27/19 revealed that the nurses had failed to count the two cards of Norco 5 mg. with a quantity of 30 tablets per card in the medication room at the end of each shift and they were discovered missing on 12/27/19 by LPN #2.

On 01/29/2020 at 12:05 PM, an interview with LPN #2 confirmed she had received the Norco 5 mg cards on 12/19/19 and she stated, "I put two cards of Norco in the medication room and I put the other card on the medication cart because the medication cart was so full. I put it in a lock box in the refrigerator and it was the only narcotic in the refrigerator. The cards were labeled as one of three with the other two being in the refrigerator. When I came back to work on 12/23/19 and 12/24/19 the narcotics were there, but when I came back to work on 12/27/19 the nurse going off the shift and I had counted the medication cart, but she finished giving a breathing treatment and she left before we could count the lock box in the refrigerator. So, when I went to count it, the Norco cards were not there. I thought it had been discontinued so I called hospice to verify the order and the resident (Resident #8) was still receiving it, so I notified the Director of Nursing (DON) and we counted the medication cart and couldn't find it." LPN #2 confirmed that she had given her keys to other staff to get into the medication room where the narcotics are stored in the refrigerator. LPN #2 stated that the microwave is in the medication room and the staff store their personal belongings in there, so they need the key to get in, "But now I unlock the door

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M 500	Continued From page 16 for them and stand there until they get what they need." Review of the facility's Shift Change Controlled Substance Inventory Log revealed on 12/19/29, Resident #8 had 3 cards of Norco. On 01/28/2020 at 2:50 PM, an interview with LPN #3 revealed she had failed to perform a narcotic count for the medications in the lock box in the medication room and stated, "I guess I was just in a hurry and I didn't do it." LPN #3 confirmed she had given her keys to other staff to allow them access to the medication room to get their personal belongings. On 01/29/2020 at 1:30 PM, the Director of Nurses (DON) stated only the medication nurses who have medication carts are the only staff that have keys to the narcotics that were in the refrigerator, on 12/27/19, when this incident of drug diversion occurred. The DON stated that during the investigation all the nurses were given a drug test and no staff failed a drug test. The DON stated the facility discontinued the use of the lock box in the medication room and all controlled substances are kept on the medication carts. The DON confirmed the two packages of thirty count Norco cards were never found and the facility replaced the missing narcotics for Resident #8. The DON confirmed Resident #8 had Norco 5 mg tablets still available on the medication cart during this investigation and was not without pain medications. Review of the facility's Disciplinary Records revealed the LPN #2 received in-services on narcotic count at shift change due to her failure to perform an accurate narcotic count according to the facility's policy.	M 500		

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M 500	Continued From page 17 Review of the Admission Record revealed Resident #8 was admitted by the facility, on 11/21/19, with diagnoses which included, Cerebral Palsy, Major Depressive Disorder and Spondylolysis. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date of 12/31/19, revealed a Basic Interview for Mental Status (BIMS) score of 12, indicating full cognitive ability.	M 500		