

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/03/2020
NAME OF PROVIDER OR SUPPLIER TUPELO NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 BRIAR RIDGE ROAD TUPELO, MS 38804		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Tupelo Nursing and Rehabilitation Center CI MS #17170 Survey Dates: 11-02-2020 through 11-03-2020 Debra Volland - 42875 Initial Comments: E000 The State Agency (SA) conducted a survey investigating MS CI 17170 beginning 11-02-2020 through 11-03-2020. During the survey, The SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated the complaint for missappropriation of residents funds and medication, and cited F602, at a D level. At the time of the survey the facility had a census of 105, with license for 120 beds. F000 The State Agency (SA) conducted a survey investigating MS CI 17170 beginning 11-02-2020 through 11-03-2020. During the survey, The SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated the complaint for missappropriation of residents funds and medication, and cited F602, at a D level. At the time of the survey the facility had a census of 105, with license for 120 beds.	F 000			
F 602 SS=D	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	F 602			12/7/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/01/2020

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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F 602	Continued From page 1 any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure residents were free from misappropriation of property, to include money and the diversion of medication for one (1) of four (4) residents reviewed. Resident #1. Findings include: Review of the facility policy titled, "Abuse Prevention" revised last in 11/2017, revealed, "Policy: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends visitors or any other individual. Definitions: ...g) Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money with or without the resident's consent." The State Agency (SA) was unable to reach the Attorney General's Office, the alleged Certified Nursing Assistant #1 (CNA) or the Complainant by phone for interview. The Social Worker who received the allegation was out of the building due to a diagnosis of COVID-19. On 11-02-2020 at 11:00 AM, during an interview with the Executive Director (ED), she indicated the facility had substantiated the complaint of Resident #1. The facility had interviewed Resident #1, and found him to be accurate in his	F 602	Upon notification of the allegation from Resident #1, C.N.A #1 was immediately suspended by the Administrator pending investigation. Investigative findings did substantiate the allegation and the Administrator notified the Mississippi State Department of Health, the Attorney General, and local police department on 07/14/2020. C.N.A #1 was subsequently terminated on 07/14/20 for refusal to submit to urine drug screening. On 07/29/20, the facility reimbursed the resident in the amount of 12.00. Additionally, the facility replaced the following medications: Methocarbamol, Gabapentin, and Oxycodone on 07/29/20. 102 of 102 residents have the potential to be affected. On 07/14/20, the Social Services Director conducted interviews with interviewable residents regarding misappropriation of resident property and reporting, with no negative finding. On 07/14/20, staff education initiated by the Staff Development Coordinator on the following areas: Misappropriation of Resident Property, Abuse and Neglect and the Mississippi Vulnerable Adults Act. All allegations of misappropriation or abuse/neglect will be immediately investigated and reported to the appropriate agencies by the facility Administrator or Director of Nursing. On 07/15/2020, the Administrator added		

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F 602	Continued From page 2 version of what happened, and how it happened. She indicated during her interview of C.N.A. #1, she had lied at first about seeing the medications, and had refused to give a urine sample due to smoking marijuana. During a second attempt to obtain a urine sample, C.N.A. #1 then was unable to urinate and blamed the nurse on the hallway with her that day of taking the medications. Video surveillance was reviewed which indicated the aide had taken the medication and money out of the room, however, there was no interaction between the aide and nurse during the shift to confirm the medication had been given to her. Review of Resident #1's medical record revealed he was admitted to the facility on 07-09-2020 after surgical replacement of his right hip. Review of his Minimum Data Set (MDS) dated for 07-16-2020, indicated he had a Brief Interview of Mental Status (BIMS) score of 15, which indicates he was interviewable. He required extensive assistance with mobility, transferring, dressing, toileting, and bathing due to his new surgical incision with 32 staples. On 07-14-2020, five (5) days after his admission, he spoke with the social services director and alleged a certified nurse aide (CNA) had taken \$12.00 and 3 prescriptions from his room on 07-10-2020, after breakfast. He was able to describe the event in detail and gave a description of the CNA, stating she was working currently on his hall. An investigation was begun immediately. Review of the facilities investigation revealed, on the morning of 07-10-2020, after breakfast, it was alleged C.N.A. #1 entered Resident #1's room and began assisting him in labeling his personal belongings, following his admission the prior afternoon. She opened one of his chest drawers	F 602	information to the Resident Admission Packet advising that no medications need to be brought with or to the resident while inpatient at the facility. The corrective action will be monitored by the facility Administrator weekly for four weeks then monthly. On 07/15/2020, the Social Services Director and Administrator conducted resident interviews weekly for four weeks regarding misappropriation of property. Any negative findings will be immediately addressed. Results will be reported monthly to the Quality Assurance Performance Improvement Committee (Administrator, Director of Nursing Services, Asst. Director of Nursing, Staff Development Coordinator, Social Services Director, Dietary Services Manager, Activities Director, Maintenance Director, Environmental Services Director and Registered Dietician) for two months.		

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F 602	Continued From page 3 and found a yellow pharmacy bag with medications in it, and told him he couldn't have them in his room. She took the pharmacy bag with 3 pill bottles and \$12.00 in it, out of the room. Prior to leaving the room, Resident #1 asked her if there was paperwork he needed to sign for her to have those medications, and his money. C.N.A. #1 told him "no" and left the room. On 07-14-2020 at 3:09 PM, a faxed confirmation receipt from the Tupelo Family Pharmacy, dated 07-09-2020, revealed, three (3) prescriptions, Methocarbamol 500 mg (milligram) tablets, Gabapentin 300 mg capsules, and Oxycodone Hcl 5 mg tablets, had been picked up and paid for by Resident #1, prior to his arrival at the facility. On 07-14-2020, C.N.A. # 1 was immediately suspended from work, and was taken to the ED's office for interview. She indicated she was assigned to Resident #1 on 07-10-2020, and had assisted him in labeling his clothes. When questioned about the medications in his possession, C.N.A. # stated she didn't know anything about medications, she hadn't seen them at all. When asked about the yellow pharmacy bag with \$12.00 dollars in it, she denied seeing that also. Per facility policy, C.N.A. #1 was asked to submit a urine sample for a drug screen. She refused to do the drug screen and stated "sometimes I smoke weed at home." The ED stated she would note that on the drug screen, however, controlled substances were in question and they still needed a urine sample. After drinking water and waiting, C.N.A. #1 stated she couldn't urinate, and that she wasn't going to "go down by herself", and stated she had given the medications to Licensed Practical Nurse (L.P.N.) #1 on the hall that day. C.N.A. #1 was	F 602			

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F 602	Continued From page 4 terminated from employment for refusing to submit a urine sample for drug screening. On 07-14-2020, L.P.N. #1 was suspended pending investigation, and called to the office for interview. She voluntarily submitted a urine sample, which was clear. During her interview she stated she had never received any medications from C.N.A #1. During her time spent in Resident #1's room, she had seen an empty pharmacy bag with no medication or money in it, and had thrown the bag into the trash. On 07-14-2020, the ED reviewed camera footage from the "B" hallway for 07-10-2020, and saw C.N.A. #1 in possession of the medications however, did not substantiate any interaction between C.N.A. #1 and LPN #1, in which she would have given the medications to her that were taken from Resident #1's room. On 07-14-2020, after her refusal to submit a urine sample for a drug screen, C.N.A. #1 was terminated from her position at the facility, the Mississippi Department of Health and Attorney Generals office were notified, as well as Resident #1's responsible party. L.P.N. #1, was able to return to work after the investigation was brought to a close due to her negative drug screen, and review of the video footage in which she was not given the medications brought out of REsient #1's room on 07-10-2020 by C.N.A. #1. The facility was able to substantiate C.N.A. #1 removed Resident #1's medications and \$12.00 out of his room without his permission and did not give them to the nurse for safe keeping, as she	F 602			

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F 602	Continued From page 5 had indicated in her interview. She was terminated due to a refusal to submit a urine sample for a drug screen, missappropriation of Resident #1's medications and money, and falsification of her statement that she had given the medications to the nurse. Resident #1 was discharged from the facility on 07-29-2020 after 20 days of therapy for his right hip replacement, and was not available for interview. Review of Resident #1's medical record revealed he was admitted to the facility on 07-09-2020 after surgical replacement of his right hip. Review of his Minimum Data Set (MDS) dated for 07-16-2020, indicated he had a Brief Interview of Mental Status (BIMS) score of 15, which indicated he had full cognitive ability.	F 602			