STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	C 05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 The State Agency (SA) conducted a Complaint Investigation (CI) MS #18775 at the facility from 5/9/22 to 5/11/22. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA substantiated the complaint regarding the facility's failure to provide care in accordance with the physician's orders and cited F656 and F684. The facility held a license for 105 beds, with a census of 82 residents.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		6/28/22

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

Electronically Signed | 05/30/2022

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F 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to follow the comprehensive care plan for one (1) of four (4) residents in the survey sample. (Resident # 1) Findings include: Record review of the facility policy titled "Comprehensive Care Plans" dated 3/20/20 revealed "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment ...The comprehensive care plan will describe, at a minimum, the following: The services that are to	F 656	* On 05/09/2022 The Minimum Data Set (MDS) coordinator reviewed the comprehensive care plan for Resident #1. The comprehensive care plan did not require any revisions. On 05/10/2022 all care plans were audited by MDS assessment nurses for revisions and updates. ** All residents are at risk for this deficient practice. *** All current facility nurses and contract nursing personnel completed an in-service by a Mississippi Board of Nursing staff member, entitled, Recognizing and Utilizing the Plan of	

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F 656	Continued From page 2 be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being". Record review of the current plan of care for Resident # 1, dated 8/23/18 revealed the facility staff documented a problem area as "PSYCH MEDS I am at Risk for side effects related to takes psychotropic meds for depression, bipolar disorder and pain." Interventions included but were not limited to "Administer meds as ordered. (See NUR MAR) (medication administration record)." The current plan of care for Resident # 1, dated 8/23/18 revealed the facility staff documented a problem area as "I am risk for side effects from antipsychotic drug use, due to my diagnosis of bipolar disorder, depression and borderline personality disorder." Interventions included but were not limited to "Administer my medication as ordered by physician". The current plan of care for Resident # 1, dated 8/23/18 revealed the facility staff documented a problem area as "POLYPHARMACY I am receiving multiple medications ...I am ordered narcotics, diuretics, antipsychotics, and antidepressants." Interventions included but were not limited to "Administer meds as ordered. (See NUR MAR) (medication administration record)." On 5/09/22 at 11:00AM, an interview with QA Nurse #1 revealed she stated that the resident had visited a regularly scheduled outpatient appointment and returned with a prescription to increase Lexapro from 10 MG to 15 MG by mouth daily. The order was entered into the electronic health record for Resident #1 by Licensed Practical Nurse (LPN) #1 who is an agency nurse. The order was entered incorrectly into the computer system to be given weekly instead of	F 656	Care, by 05/18/2022. All new nursing personnel will receive the in-service, Recognizing and Utilizing the Plan of Care during the orientation process. **** To sustain the MDS coordinator will begin monitoring care plans with psych meds and review new physician orders with psych meds with Quality Assurance (QA) nurse two times a week for three weeks beginning on 06/06/22 and then monthly times two. Findings will be taken to QA by the MDS coordinator by 06/28/22, then monthly times 3 months.	

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F 656	Continued From page 3 daily as was prescribed. She confirmed it was the policy of the facility follow the individualized care plan for each resident and the care plan for Resident #1 was not followed when the Lexapro was not given as ordered. On 5/11/22 at 1:30 PM, during an interview with the Director of Nurses (DON), she confirmed it was the policy of the facility to follow the individualized care plan for each resident. The care plan was a set of instructions for the care of each resident and the care plan had not been followed for Resident #1 because the Lexapro was not given according to the physician's orders. On 5/11/22 at 2:00 PM, in an interview with the Administrator, she stated it was the policy of the facility to follow each resident's individualized care plan to administer care. She agreed the care plan was not followed for Resident #1 regarding the Lexapro.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to follow physician's orders when a resident's medication was	F 684	* On 5/03/2022, Quality Assurance nurse (QA) #2 notified the Medical Director of medication error, Lexapro 15mg by	6/28/22

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F 684	Continued From page 4 increased twice for one (1) of four (4) residents sampled. (Resident #1) Findings include: Record review of the facility policy titled "Documentation Guidelines for Noting Orders" with a revised date of 3/2020 revealed, "Procedure: ...3. Transcribe orders into the computer, must go on the Medication administration record, treatment administration record, and laboratory record ...7. Pull the carbon copy and place in the Quality Assurance box ..." Record review of the facility policy titled "Physician's Orders Policy" with a revised date of 11/2007 revealed, "Purpose ...Orders either verbal, via telephone or written must be followed by staff members in delivering the service ordered..." Record review of the facility policy titled "Drug Administration Policy" with a revised date of 3/2019 revealed, " ...Physician orders written daily and must be promptly recorded on the eMAR (electronic Medication Administration Record) or paper copy correctly ..." Record review of the "Face Sheet" for Resident # 1 revealed she was admitted by the facility on 10/07/14 with diagnoses including Bipolar Disorder and Borderline Personality Disorder. Record review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/07/22 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated she has no cognitive impairment.	F 684	mouth daily, that was not transcribed correctly by an agency nurse License Practical Nurse (LPN) #1. Resident #1 was currently admitted to a Behavioral Health facility on 04/30/2022. On 5/10/2022, Director of Nursing (DON) notified the staffing agency that LPN #1, transcription error was entered into computer as Lexapro 15mg by mouth every Friday. On 05/06/2022 all physician orders were audited, corrected and completed by administrative nurses. On May 10th 2022 QA #2 notified the Medical Director of medication error, Lexapro 20mg by mouth daily, that was not transcribed on a physicians order in Resident #1 chart. Resident #1 was currently admitted to a Behavioral Health facility on 04/30/2022. ** All residents are at risk for this deficient practice. *** All current facility nurses and contract nurse personnel completed an in-service, by a Mississippi Board of Nursing staff, entitled, Protecting the Patient, An Explanation of Abuse and Neglect, Recognizing and Utilizing the Plan of Care, Accident Prevention and Supervision, and Exploitation/Misappropriations beginning on 05/11/2022 and completed on 05/23/2022.	

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F 684	Continued From page 5 Record review of notes from an "Emergency" Quality Assessment (QA) committee meeting on 5/05/22 revealed, "PRELIMINARY INVESTIGATION: Investigation began 5/03/22 Nurse noted resident is getting Lexapro 15 MG (milligrams) Q (every) Fridays. Order written on 4/01/22, Lexapro 15MG QD (every day), and carbon copy of order remained in chart at this time. Agency nurse (Proper Name of Licensed Practical Nurse #1) input order incorrectly and did not pull carbon copy to QA department. Problems Identified: Agency nurse entered in written order wrong. Order carbon copy is left in chart and never came to QA department ...". Record review of Resident #1's "Physicians Order Sheet" revealed a physician's order dated 4/1/22 for "LEXAPRO 10MG TABLET: GIVE 1 ½ TAB (tablets) (15MG) BY MOUTH EVERY FRIDAY R/T (related to) DEPRESSION". Record review of the eMAR for Resident # 1 for the month of April 2022 revealed the "Description" as "Lexapro 10 MG Tablet. Take 1 ½ Tablets Daily (15MG) Order Date: 4/01/22 Start Date: 4/01/22". The Lexapro was administered on 4/08/22, 4/15/22, and 4/29/22, and not daily as per the physician order. Record review of the "Departmental Notes" revealed a nurses noted dated 4/01/22 at 3:11 PM, for Resident Returned from appt @ (Proper Name of Outpatient Behavioral Facility). New order received: Increase Lexapro 10MG to 15MG (1 ½ Tablets) daily. RP (Responsible Party) Notified." On 5/09/22 at 11:00 AM, an interview with Quality Assurance (QA) Nurse #1 revealed the resident	F 684	All new facility nurses and contract nurses will receive the in-service training during the orientation process entitled, Protecting the Patient, An Explanation of Abuse and Neglect, Recognizing and Utilizing the Plan of Care, Accident Prevention and Supervision, and Exploitation/Misappropriations in the facility beginning 05/24/2022. All physician orders will be audited by administrative nurses monthly beginning 06/02/22 and then monthly, times three months and corrected as needed. All current facility nurses and contract nurses will complete an in-service training on Receiving, transcribing, and discontinuing physician order Policy and Procedure by the Director of Nursing and Medicare Coordinator, beginning 06/06/2022. All new nursing staff will receive the in-service training on Receiving, transcribing, and discontinuing physician order Policy and Procedure by the Director of Nursing and Medicare Coordinator, during the orientation process. All current facility nurses and contract nurses will complete a return demonstration of receiving, transcribing, and discontinuing physician orders policy and procedure by the Director of Nursing and Medicare Coordinator, beginning 06/06/2022.	

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F 684	Continued From page 6 had visited a regularly scheduled outpatient appointment and returned with a prescription to increase Lexapro from 10 MG to 15 MG by mouth daily. The order was entered into the electronic health record for Resident #1 by Licensed Practical Nurse (LPN) #1 who is an agency nurse. The order was entered incorrectly into the computer system to be given weekly instead of daily as was prescribed and the carbon was let on the chart and not put in the QA box. On 5/10/22 at 9:00 AM, the State Agency (SA) observed a medication cart which contained Resident #1's medications. The SA observed a medication card for Resident #1 which contained fourteen tablets labeled as "Lexapro 20MG Tablet by mouth daily ...Issue 4/27/22." Record review of the Physician Orders for Resident #1 for May 2022 revealed a physician's order dated 4/1/22 for "LEXAPRO 15MG TABLET: GIVE 1 ½ TAB (10MG) BY MOUTH DAILY R/T DEPRESSION" which did not match the medication card dated 4/27/22 For Lexapro 20MG found in the medication cart by the SA. Record review of a "Prescription" dated 4/27/22 revealed the Family Psychiatric Mental Health Nurse Practitioner (FPMHNP) from an outpatient behavioral facility had written a prescription to "CHANGE ORDER Lexapro 20 MG Tablet, Oral. Take one (1) tablet by mouth daily Order Date: April 27, 2022, Start Date: April 27, 2022, ..." Record review of Resident #1's electronic clinical chart revealed no documentation related to increasing the Lexapro to 20 MG daily. On 5/10/22 at 1:00 PM, during an interview with	F 684	Agency LPN #1 received an in-service training on 05/21/22 receiving, transcribing, and discontinuing physician orders policy and procedure and performed a return demonstration of the procedure with the Director of Nursing. **** To ensure improvements are sustained the Quality Assurance nurses or Medicare Coordinator will audit receiving, transcribing, and discontinued order procedures with 3 nurses (1 nurse per shift) bi-weekly for 1 month, then 3 nurses (1 nurse per shift) weekly for 3 months, then 3 nurses (1 nurse per shift) monthly for 3 months, beginning on 06/06/2022. Quality Assurance nurses will monitor and maintain that all return demonstrations are completed by nursing services and will present the results for review at QA meeting on 06/28/2022.	

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F 684	Continued From page 7	F 684		

the Pharmacy Consultant and QA Nurse #2, the Pharmacy Consultant confirmed he was at the facility to perform Medication Regimen Reviews (MRR) and had reviewed medications for Resident #1. He was unaware of an order to increase the Lexapro dosage for Resident #1 to 20 MG as per the medication card discovered by the SA. After conferring by telephone with the pharmacy, the Pharmacy Consultant stated he had been able to confirm the pharmacy had received a faxed prescription from the facility to increase Resident #1's Lexapro to 20 MG daily. QA Nurse #2 stated she found out about this additional dosage increase when the SA made her aware of the medication card found in the medication cart. She confirmed that this new order was never entered into the computer system and was not given to the resident.

On 5/11/22 at 4:00 PM, an interview with the Director of Nursing (DON), she confirmed LPN #1, who is an agency nurse, failed to correctly enter the physician's order into the computer system on 4/01/22 to increase the Resident #1's Lexapro 15 MG. This resulted in a medication error. Prior to working for the agency, LPN #1 had worked at the facility and therefore had experience working entering orders into the computer. She verified the facility was made aware on 5/10/22 that Resident #1's Lexapro was increased to 20 mg and this order was not entered into the computer at all.