| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255212 | A. BUILDING _____ B. WING _____ | C 06/02/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COURTYARDS COMM LIVING CENTER | 907 EAST WALKER STREET FULTON, MS 38843 |

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|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted a complaint survey at the facility from 5/31/22 through 6/2/22, for CI#18429 related to pressure ulcer care and treatment, and for facility reported incidents CI#18101 related to drug diversion and CI#18859 related to reported verbal abuse of a resident. 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 facility reported incident for verbal abuse (CI MS #18859) and the facility reported incident for misappropriation and drug diversion (CI MS #18101) and cited F600 and F602. The SA did not substantiate the complaint for resident care for pressure ulcers. The facility had a census of 58 and held a license for 66 beds. | F 000 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by: | F 600 | | 6/29/22 |

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

Electronically Signed | 06/15/2022

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 600 | Continued From page 1<br>Based on observations, staff and resident interviews, record review and facility policy review the facility failed to prevent verbal abuse of a resident as evidenced by an employee calling a resident a profane name for one (1) of seven (7) residents reviewed. Resident # 5.<br><br>Findings Include:<br><br>Review of the facility policy titled, "Freedom from Abuse, Neglect, and /or Exploitation Prevention Plan" "Staff Screening" with no revision date revealed under "policy" " The facility has a zero-tolerance policy for abuse, involuntary seclusion, neglect, and misappropriation of resident property. The facility will attempt to identify and will investigate any reported violation or allegation of abuse."<br><br>Review of the facility policy titled, "Resident Rights " with a revision date of 11/28/2016 revealed under (a) (1) "A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident."<br><br>Review of the facility policy titled, "Freedom from Abuse, Neglect, and /or Exploitation Prevention Plan" "Staff Training" with a revision date of 8/23/2017 revealed under "policy" "The facility will provide mandatory training to new and existing employees during orientation and annually including the necessary forms with complete instruction to assist employees with their obligation to report suspected crimes under the Federal Elder Justice Act as well as related to | F 600 | Resident reported incident of abuse to Administrator on 5/18/22 at 2:42pm in a care plan meeting. Administrator initiated investigation and reported allegation to Mississippi Department of Health and Attorney General office. Resident was immediately assessed for any injury or emotional distress with none found. Nursing Assistant #3 was immediately suspended from work pending investigation. Nursing Assistant #3 was terminated on 5/18/22.<br><br>All residents have the potential to be affected.<br><br>Facility staff in serviced on Abuse/Neglect and Misappropriation Policy and Procedure and Prevention Plan on 6/3/22 by Director of Nursing. Staff will be in serviced on Abuse/Neglect and Misappropriation upon hire, annually and as needed. Administrator will make walking rounds weekly x4 weeks and will interview 5 residents beginning on 6/1/22 to ensure compliance. The facility will report alleged allegations of Abuse/Neglect and Misappropriation to the appropriate state agencies within 2 hours of incident.<br><br>Allegations of Abuse/Neglect and Misappropriation will immediately be reported to the Administrator who will initiate an investigation. The administrator will report findings to the Quality Assurance Performance Improvement Committee monthly beginning 6/23/22 x 2 months and as needed thereafter. | |

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|---|---|---|---|---|
| F 600 | Continued From page 2 | F 600 | | |

policies on abuse prohibition practices."

An interview on 6/1/22 at 10:15 AM with Resident # 5 revealed that NA # 3 had provided care for him at least the last 6 months. He revealed that NA # 3 had always been a "smartass" and we had never really got along, so I wasn't hurt by what he said. He revealed he debated on even reporting the incident. He revealed he cannot think of what happened to lead up to NA # 3 calling him an ugly word or what the word was. The resident asked that the State Agency (SA) give him some time to think and maybe he can remember the details. Resident #5 revealed that he asked the Director of Nurses (DON) not to fire him, but just to give him a slap on the hand. He confirmed that he had never been injured by NA # 3 or been neglected. He confirmed that NA # 3 came back to his room the morning of the incident, stuck his head in my room door and stated, "I apologize" then shut the door and left. He revealed he did not give me a chance to respond to the apology.

An interview on 6/1/22 at 10:50 AM with CNA # 2 revealed she had not witnessed or had any complaints from residents about staff being rough or talking ugly to them. She revealed that NA # 3 was a good worker and would help you do anything. She revealed she never heard him talk ugly to residents. She stated, "He just sort of talked cocky, so you had to just know how to take him."

An interview on 6/1/22 at 3:00 PM with Resident #5 revealed he remembered what happened on the morning of the incident with NA # 3. He revealed that he told NA # 3 to handle his feet a different way and that NA # 3 stated, "What, I am perfect". He revealed he told NA # 3 there was

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|---|---|---|---|
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|---|---|---|---|---|
| F 600 | Continued From page 3 | F 600 | | |

only one perfect man and then NA # 3 stated, "Oh God." He revealed he then told NA # 3, "No, his son" and then NA # 3 called me a "smartass". He confirmed that this did not hurt his feelings, nor did it make him feel nervous or afraid to be around NA # 3.

An attempted call to conduct a phone interview on 6/1/22 at 9:37AM with Nurse Assistant (NA) # 3 revealed no answer with a voice mail left for him to return my call.

Attempted another call to conduct a phone interview to NA # 3 on 6/1/22 at 3:15 PM revealed no answer and left voice mail for him to return my call.

An interview on 6/2/22 at 11:15 AM with the Director of Nurses (DON) revealed she was the DON when the incident happened with NA # 3 and Resident #5. She revealed she was shocked when Resident #5 reported the incident, because it was out of character for NA # 3. She revealed that NA # 3 was a hard worker that always wanted things done right for the residents, was soft spoken and never called in. She revealed that the way Resident # 5 talks, you must know how to take him. She stated, "I don't believe NA # 3 had a mean bone in his body." She revealed that she has had a lot of residents reveal they miss him. She revealed that NA # 3 never had any disciplinary actions toward him, and she hated this happened.

An interview on 6/2/22 at 11:50 AM with the Administrator revealed that she never had any complaints on NA # 3 prior to this incident. She revealed NA # 3 was a likeable person, happy go lucky, came in and did his job and was helpful.

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|---|---|---|---|
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|---|---|---|---|---|
| F 600 | Continued From page 4 | F 600 | | |

She revealed she was surprised when Resident #5 reported the incident, because it did not sound like something NA # 3 would do. She revealed that Resident #5 told her he would have accepted NA # 3's apology, but he did not give me a chance to respond. She revealed that when she interviewed NA # 3, she asked him "what he was thinking?" and that NA # 3 stated, "I wasn't". She revealed she asked NA # 3 why he did not talk with Resident #5 when he apologized instead of just leaving the room and NA # 3 stated, "I was ashamed."

Record review of the facilities investigation of the employee to resident incident with NA # 3 and Resident #5 on 5/18/22 revealed that the resident reported during a care plan meeting on 5/18/22 at 2:42 PM that NA # 3 used profanity toward him that morning. The resident revealed to the Administrator and the Social Worker that "he did not feel unsafe at any time during or after the event." The investigation revealed that notifications were made on 5/18/22 to: SA at 4:12 PM and the Attorney General's Office at 4:23 PM. The investigation revealed that NA # 3 was placed on suspension on 5/18/22 until the investigation was completed. The investigation revealed that an interview with NA # 3 confirmed that he called the resident an "asshole" on the morning of 5/18/22 and went back and apologized to the resident. The investigation revealed that all interviewable residents were interviewed regarding if any staff members had talked ugly to them or been rough with them and all denied that any staff member had talked ugly or been rough with them. The investigation revealed that all interviewable residents were questioned regarding NA # 3 and whether he had ever said anything inappropriate or been rough

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|---|---|---|---|---|
| F 600 | Continued From page 5 | F 600 | | |

with them and all replied "No." The conclusion of the investigation revealed that NA # 3 had been trained regarding all types of abuse including verbal and he admitted making the profane comment toward Resident #5. Record review revealed the facility terminated NA # 3 on 5/18/22 due to the facility having no tolerance for verbal abuse toward any/all residents.

Record review of NA # 3's personnel file revealed he was hired at the facility on 9/20/21 and his criminal record check came back clear on 11/2/2020. The review revealed he completed a "Temporary Nurse Aide" training on 9/17/2021 and has not completed a certification course. The review revealed he was terminated from employment on 5/18/22.

Record review of NA # 3's personnel file revealed he signed the "Vulnerable Adults' Prevention Policy" as he read on 09/15/2021.

Record review of the facility in-services revealed NA # 3 attended an in-service on 1/19/22-1/20/22 titled, "Misappropriation of Property/Abuse/Resident Rights.

Record review of the facility "Daily Schedule" revealed that NA # 3 worked 11 PM-7AM on the South Hall and was called off the schedule for 11 PM-7 AM shift on 5/18/22.

Record review of Resident # 5's face sheet revealed an admission date of 9/15/2020 with medical diagnoses that included: Chronic Inflammatory Demyelinating Polyneuritis, Pain Unspecified and Spastic Quadriplegic Cerebral Palsy.

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| F 600 | Continued From page 6<br>Record review of Resident #5's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/16/22 revealed a Brief Interview of Mental Status (BIMS) of 15, which indicated that the resident was cognitively intact. | F 600 | | |
| F 602 SS=D | Free from Misappropriation/Exploitation<br>CFR(s): 483.12<br><br>§483.12<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interviews, staff interviews, record review, and facility policy review the facility failed to prevent the misappropriation of a resident's property in the diversion of the resident's medications for one (1) of five (5) residents sampled. Resident #6<br><br>Findings include:<br><br>Record review of facility policy titled, "Freedom from Abuse, Neglect, and/or Exploitation Prevention Plan Policy", undated, revealed, "The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation as defined below ....Misappropriation of resident property - Deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent ....The facility's goal is to protect the resident from abuse, neglect, | F 602 | Registered Nurse #2 notified Director of Nursing of narcotic discrepancy on 9/17/21. Investigation was initiated immediately, and Mississippi Department of Health and Attorney General office was notified of allegation of misappropriation. Licensed Practical Nurse #2 was suspended pending investigation on 9/17/21 and terminated following completion of investigation on 9/21/21.<br><br>All residents have the potential to be affected.<br><br>Facility staff in serviced on Abuse/Neglect and Misappropriation Policy and Procedure and Prevention Plan on 6/3/22 by Director of Nursing. Nursing staff (Registered Nurses and Licensed Practical Nurses) were in serviced on | 6/29/22 |

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|---|---|---|---|
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| F 602 | Continued From page 7<br>exploitation or misappropriation of property."<br><br>An interview with the Administrator on 3/31/22 at 4:25 PM, revealed that Resident #6 was in the hospital and pain medications had been signed out and dispensed and the staff realized that there was an issue with the misappropriation of the resident's medications. She stated that an investigation started, and the incident was reported as required. She also revealed the resident did not miss a dose of his medication. An audit of the medication carts and medication cards was done and there were no other discrepancies found and the medications were replaced by the facility at facility cost.<br><br>The State Agency (SA) attempted to contact Licensed Practical Nurse (LPN) #2 on the two phone numbers that were listed on the facility record on 6/1/22 at 9:15 AM, 6:32 PM, and on 6/2/22 at 10:28 AM. Each call to the first number went immediately to the message that the voice mail box had not been set up. Each call to the second number went directly to message that the number is not reachable.<br><br>An interview with Registered Nurse (RN) #2 on 6/2/22 at 11:00 AM, revealed the controlled medication count is done each shift and the count must be correct to continue with shift change. This is done by first counting the actual number of cards in the controlled medication's locked box and this count is compared with the total card count log. Then, each card's individual count is done and matched with the resident's paper narcotic sheet for that medication. She stated she worked with Resident #6 frequently, and he did require pain medications at times. She stated she found the questionable drug diversion during | F 602 | facility's narcotic policy and procedures and reporting discrepancies on 6/3/22. Director of nursing will audit narcotic book weekly x 4 weeks beginning 6/6/22 and monthly thereafter indefinitely.<br><br>Allegations of Abuse/Neglect and Misappropriation will immediately be reported to the Administrator who will initiate an investigation. Director of Nursing will audit narcotic book weekly x 4 weeks beginning 6/6/22 and monthly thereafter indefinitely to ensure nurses are accurately signing out narcotics for residents, to ensure no medications are removed for residents while they are out of the facility and will check narcotic cards against the EMAR to ensure there are no discrepancies. Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly beginning 6/23/22 and as needed thereafter. | |

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|---|---|---|---|
| | 255212 | A. BUILDING _____ B. WING _____ | C 06/02/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 602 | Continued From page 8 | F 602 | | |

a narcotic count at shift change on 09/16/21. She stated she knew Resident #6 was in the hospital and noticed that medications had been signed out to him. She asked LPN #2 if the resident had returned to the facility from the hospital and was told Resident #6 was still in the hospital. RN #2 stated she notified the person who was Director of Nursing (DON) at that time, and an investigation was done. She stated she has been in-serviced on medication counts and misappropriation of property.

An observation on 6/2/22 at 11:00 AM of RN #2's medication cart revealed each controlled substance narcotic sheet matched the actual count in the narcotic lock box.

An interview with Registered Nurse (RN) #3 on 6/2/22 at 11:15 AM, revealed the controlled medication count is done with each shift change and if the count is not accurate, she does not accept the keys to the cart. She stated if there was a discrepancy with the controlled medication count, she would notify the DON. She stated this has not occurred, but this is what she would do if there was a discrepancy. She stated at each shift change, the card count is verified first, then, the count for the medication on each individual cards is verified with the narcotic form. She stated she has been in-serviced on medications administration and misappropriation of resident property.

An observation on 6/2/22 at 11:15 AM of RN #3's medication cart revealed for each of the controlled medications verified all medication counts were accurate to paper documentation.

An interview with the Administrator on 6/2/22 at

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|---|---|---|---|---|
| F 602 | Continued From page 9 | F 602 | | |

11:55 AM, revealed LPN #2 took medications from the resident's stock of medications. She stated it was discovered during shift change when a nurse noted medications had been signed out on a resident that was hospitalized and it was reported to the previous DON and an investigation was done. She stated during the investigation, it was determined that on another occasion, the nurse signed out medications for the resident at two different times on two different cards therefore signing out four medications and administering two of the four to the resident, while the other two were unaccounted for. She stated LPN #2 was placed on suspension during the investigation and once the investigation was complete, LPN #2 was terminated. She stated LPN #2 clocked in on 9/21/21 at 10:58 PM and clocked out on 9/21/21 at 11:05 PM. Stated she was brought in to discuss the termination. She stated they tried multiple times to get her to come in for a urine drug screen, but she would not come in and when she did, she was unable to produce a urine sample even after drinking water. She stated the staff was in-serviced on abuse, neglect, and misappropriation of resident's property. Stated this incident was reported to the State Department of Health, the State Board of Nursing, and the Attorney General Office. She stated there were no previous incidents or disciplinary actions on this nurse. She confirmed the facility failed to prevent the misappropriation of a resident's medication by a Licensed Practical Nurse employed by the facility.

An interview with the Regional Nurse Consultant on 6/2/22 at 12:05 PM revealed she completed an 100% audit in facility to check for any discrepancies in the controlled medications and none were found.

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|---|---|---|---|---|
| F 602 | Continued From page 10 | F 602 | | |

A phone interview with the previous Director of Nursing (DON) working at the time of the incident on 6/2/22 at 2:35 PM, revealed he was the DON when this incident occurred. He stated the resident was in the hospital and the nurse signed out two pain tablets and she also signed out the resident's medications from 2 different cards at the same time therefore getting two medications out at two different times and giving the resident one of those at each time. He stated prior to this incident there were no indications that LPN #2 would have done this. He stated she was suspended during the investigation and was then terminated. He confirmed the facility failed to prevent the misappropriation of a resident's medication by a nurse employed by the facility.

Record review of "Summary for Investigation" reported on 9/17/21 revealed, "Resident #6 (proper name) was sent to the hospital from a doctor's appointment on 9/15/21 at approximately 1:19 PM. Resident #6 had two cards of Norco 10-325mg, give one tablet every 6 hours as needed PRN for pain. He had one card of Norco 10 mg with seven pills remaining and the other card had 30 pills remaining. On 9/13/21 at 2310 and 9/14/21 at 0510, nurse (proper name) LPN #2 signed out medication as given on both cards, which would be 2 extra pills than what was ordered for resident. On 9/16/21, nurse (proper name) LPN #2, signed out she gave resident 10 mg at 2310 and 0431. Resident was in the hospital at the time and not in facility. Nurse (proper name) was suspended pending investigation on 9/17/21. Director of Nursing attempted to contact nurse multiple times to come to facility to complete a drug screen with no answer from nurse. (Proper name), LPN

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|---|---|---|---|
| | 255212 | A. BUILDING _____ B. WING _____ | C 06/02/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| (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 |
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| F 602 | Continued From page 11 | F 602 | | |

employment was terminated on 9/21/21."
Investigation also included, "Conclusion: Misappropriation was substantiated due to resident (proper name for Resident #6) not being in facility on 9/16/21 when two Norco tablets were charted as given by (proper name for LPN #2). (Proper name for LPN #2) had also signed out 4 pills on 9/13/21 (night shift) in the early morning of that shift (9/14/21) and only two pills had been given to resident (proper name of Resident #6). The nurse was suspended pending investigation and then terminated. Report sent to (proper name of State Department of Health), (proper name of State Board of Nursing) and (proper name for State Bureau of Narcotics) for further investigation."
Record review of investigation revealed this incident was reported to the State Department of Health, State Board of Nursing, and the Attorney General's Office.

Record review of the "Application for Employment" for LPN #2 revealed she was hired on 6/29/21.

Record review of the timecard of LPN#2 revealed she clocked into work on 9/13/21 at 11:04 PM and clocked out on 9/14/21 at 07:15 AM. Timecard revealed she clocked in to work on 9/16/21 at 10:57 PM and clocked out on 9/17/21 at 8:02 AM. Timecard revealed she clocked into work on 9/21/21 at 10:58 PM and clocked out on 9/21/21 at 11:05 PM.

Record review of the "Personnel Action Notice" for LPN #2, revealed the LPN's last day worked was 9/21/21.

Record review of "Notice of Termination" for LPN

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| | 255212 | A. BUILDING _____ B. WING _____ | C 06/02/2022 |

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|---|---|---|---|---|
| F 602 | Continued From page 12 | F 602 | | |

revealed her date of hire was 6/29/21 and she signed the notice of termination on 9/22/21.

Record review of the "(Proper name of state) State Department of Health" letter dated 6/29/2021, regarding criminal history record check revealed, "the state and national criminal history record check processed by this agency found no violations that prevent (proper name of LPN #2) from working with patients, residents or clients being served by a licensed hospital, nursing home, personal care home, home health agency or hospice."

Record review of the "Vulnerable Adults' Prevention Policy" revealed LPN #2 signed this form on 6/29/21. Record review of "Freedom from Abuse, Neglect, and/or Exploitation Prevention Plan Education" dated 8/23/17, revealed the LPN signed and dated this form on 6/29/21. Record review of the in-service sign in sheet for "Abuse and Neglect, Misappropriation of Property, Resident's Rights, and Reporting Alleged Violations" revealed the LPN attended this in-service on 6/25/2021. Record review of in-service sign in sheet revealed the LPN attended the in-service on 'Medication Administration" on 8/10/2021.

Record review of "Preliminary Drug Screen Result Form" dated 9/22/21 at 11:05 AM revealed the LPN was "unable to produce specimen" and drug screen was not done.

Record review of LPN's Licensed Practical Nurse license revealed an active status for license with an issue date of 8/26/2019 and an expiration date of 12/31/21.

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|---|---|---|---|---|
| F 602 | Continued From page 13 | F 602 | | |

Record review of LPN #2's personnel record revealed there were no previous disciplinary actions.

Record review of face sheet and the "Census List" revealed the resident was admitted to the facility with the original admission date of 2/18/2020 and was discharged on 3/6/2020. The resident was readmitted to the facility on 7/24/21 and was discharged from facility to the hospital on 9/15/21. The resident was readmitted to the facility on 9/21/2021 and passed away in the facility on 10/17/2021.

Record review of hospital report revealed the resident was admitted to the hospital on 9/15/21 and was discharged on 9/21/21.

Record review of "Health Status Note" dated 9/15/21 revealed "Resident sent to (proper name of hospital) from urology clinic related to kidney stones and nephrology tube placement. Admitted to (floor of hospital)."

Record review of "Admission Summary" dated 9/21/21 revealed "resident arrived from (proper name of hospital)."

Record review of resident's Physician's Orders revealed an order dated 7/23/21 for Norco Tablet 10-325 mg give 10 mg by mouth every 6 hours as needed for pain related to pain, unspecified. Record review of resident's Electronic Medication Administration Record revealed on 9/13/2021 at 11:10 PM the resident was administered one Norco and on 9/14/21 at 05:10 AM, the resident was administered one Norco. Record review of the Controlled Drug Receipt/Record/Disposition Form revealed on prescription number 81465066,

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|---|---|---|---|---|
| F 602 | Continued From page 14 | F 602 | | |

the nurse signed out a Norco on 9/13/21 at 2310 and on 9/14/21 at 0510 AM the nurse signed out a Norco and subtracted these from the count. Then on the other medication card prescription number 81468716, the nurse signed out one Norco on 9/13/21 at 2310 and another one on 9/14/21 at 0510 and subtracted these from the count. Record review of resident's Electronic Medication Administration Record for 9/16/21 and 9/17/21 revealed no medications documented as given to the resident. Record review of the Controlled Drug Receipt/Record/Disposition Form revealed the nurse signed out Norco tablets on 9/16/21 at 2310 and on 9/17/21 at 0431 - but not marked on the Electronic Medication Administration Record - resident was in the hospital during this time frame.

Record review of face sheet revealed that Resident #6 was admitted to the facility on 7/24/21. Diagnoses included: Metabolic Encephalopathy, Type 2 Diabetes Mellitus, Calculus of Kidney, Hypertension, Atherosclerotic Heart Disease, Urinary Tract Infections, Unspecified Pain.

Record review of Minimum Data Set (MDS) dated 8/2/21 Section C for Cognitive revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.