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M 000	Initial Comments The State Survey Agency (SSA) conducted a Complaint Investigation (CI), MS #18692, MS #18814, and MS #18817 at the facility from 07/25/2022 to 07/26/2022. During the survey, the SSA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Inform and cited M500. The SSA substantiated the complaint MS #18692 for medication diversion and cited F602. MS #18814 was not substantiated for misappropriation and MS #18817 were not substantiated for responsible party notification of resident change in condition, resident rights, and pressure sores. Based on the facility's corrective actions initiated on 03/22/2022 and completed on 03/25/2022, prior to the SSA's entrance on 07/25/2022, the SSA determined M500 was past noncompliance.	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	M 500		7/26/22

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M 500	Continued From page 1 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 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,	M 500		

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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 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;

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M 500	Continued From page 3 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 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	M 500		

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M 500	Continued From page 4 choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to protect a resident from misappropriation of a medication for one (1) of three (3) sampled residents. Resident #1 Findings Include: A record review of the facility's policy, "Freedom from Abuse, Neglect and/or Exploitation Prevention Plan Education", with a revision date of 11/14/17, revealed "The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation ..." On 07/25/2022 at 12:15 PM, during an interview with the Director of Nursing (DON), she explained that on 03/22/2022, she received a call from the Administrator that the facility had a narcotic discrepancy and she needed to come and investigate. She instructed all nurses to lock the carts and she would be on her way. It was discovered that Resident #1 was missing a card of Norco 5/325 milligram (mg) tablets that had been received from the pharmacy the week before on 03/14/2022. The medication card could not be located after a thorough search and an investigation was initiated. The DON notified the Corporate Regional Nurse Consultant and the Corporate Regional Director of Operations who came and assisted in the investigation. The DON interviewed all nurses related to the missing medication card. The procedure is that at shift change, the nurses compare a resident's individual narcotic sheet located on the narcotic book to the individual narcotic card that is kept in	M 500	No Plan of Correction Required.	

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the locked drawer of the medication cart. They also ensure the master narcotic log matches the total number of narcotic medication cards for all residents. The master narcotic log is used to log in every card of a narcotic for residents when it is received from the pharmacy. The same log is used to subtract an empty or "depleted" card of narcotics for residents so that a running total of all narcotic cards is kept and compared to the overall number of narcotic medication cards on the medication cart for residents at every shift change. During the investigation, there was no discrepancy noted in the individual narcotic sheets kept in the narcotic book on each cart when compared to the individual narcotic medication cards kept in the narcotic drawer of the medication cart. There was also no discrepancy in the total number of narcotic cards as compared to the master narcotic log, however, the investigation concluded there were four (4) medication cards that were logged out (empty/depleted cards) on the master narcotic log by Licensed Practical Nurse (LPN) #1 past the receipt date of the Norco on 03/14/2022 and the individual narcotic sheets were not located. All empty cards that are logged out of the master narcotic log should be witnessed and signed by another nurse, and these 4 entries did not have a witnessed signature. The Pharmacy found that two (2) of the four (4) cards that had been logged out as depleted by LPN #1 had correct prescription numbers and matched with the names of residents, and one (1) card had an incorrect prescription number but matched a resident and medication. There was one entry in the master narcotic log for one (1) card that had a prescription number that did not match any of the residents' prescription numbers or medications in the facility. The investigation concluded that LPN #1 had taken Resident #1's Norco medication

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card from the narcotic drawer on the cart and the individual narcotic sheet from the narcotic book. She then entered a "made up" prescription number and medication for the resident to subtract from the master narcotic log so the overall count and the master log would match. Therefore, the counts would always match when the nurses counted at shift change. LPN #1 was suspended during the investigation and was terminated on 03/25/2022. The DON said that the nurses were not specifically trained to ensure there was another nurse to witness when a completed medication card was removed from the master narcotic log, but she thought that it was "rules of nursing". After the incident, every nurse received training to obtain two signatures on the master narcotic log when adding or subtracting a narcotic card. Prior to the incident, the nurses would remove a completed card from the locked narcotic box on the cart and the induvial narcotic sheet from the narcotic book and place them together in a medical record box, but now all narcotic sheets for depleted narcotic medication cards must be turned in to the DON. Every nurse that had been on the cart with Resident #1's medication had a drug test, a 100% audit of all narcotic drawers on medication carts were completed, in-service training was completed for all nurses on signing in and removing a narcotic medication card, and 100% pain assessments were completed on each resident. The Attorney General Office, Board of Nursing, and Board of Pharmacy was notified of the findings after the investigation was completed.

At 4:30 PM on 07/25/2022, during an interview with Registered Nurse (RN) #2, she stated that on 03/22/2022 during shift change report, she overheard a nurse saying that Resident #1 was

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out of Norco and needed a new written prescription. She told the nurses that Resident #1 had received a new card of 60 tablets of Norco last week from pharmacy and she and LPN #4 had logged it into the master narcotic count log. All nurses looked for the missing Norco card but was unable to locate it. The Administrator and the DON were notified. The master narcotic log matched the overall narcotic card count, but the card of Norco that had been logged in on 03/14/2022 could not be located.

On 07/26/2022 09:00 AM, during an interview with Resident #1, she explained a few months ago a nurse had stolen her pain medications, but she didn't know exactly who took the medication.

On 07/26/2022 at 11:30 AM, during an interview with the Corporate Regional Director of Operations, she stated that she and the Regional Nurse Consultant assisted with the investigation of the missing narcotic card, and they, along with the Pharmacy, reviewed the errors made by LPN #1 in removing completed narcotic cards from the master narcotic log. The missing card of Norco was never located. LPN #1 was terminated on the last day of the investigation on 03/25/2022. LPN #1 denied making up the prescription numbers and did not recall seeing the card of Norco, even though she was the last nurse to administer Norco to Resident #1.

On 07/26/2022 at 12:20 PM, during an interview with the Administrator, she explained she was at the facility when two nurses, RN #5 and RN #2, came to her on 03/22/2022 to inform her there was a problem with the Resident #1's Norco. A new nurse, RN #4, had worked the cart and was leaving and RN #5 was coming on. RN #2 said a medication was there for Resident #1 four (4)

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days ago because she had signed them in with another nurse, but the medication was missing. She called the DON right away and she came to the facility and began the investigation.

On 07/26/2022 at 12:30 PM, during an interview with RN #4, she explained she was working an eight (8) week contract for the facility back in March 2022. On the day of the incident, she had completed her shift and was giving report to the oncoming nurse. She gave report that Resident #1 had asked for a Norco, but she did not have any on the cart and she needed a new prescription. Another nurse, RN #2, heard the conversation about the Norco and said that Resident #1 had just received Norco about four (4) days ago because she signed the Norco in with the night shift nurse. After hearing what RN #2 said, they all went straight to the Administrator and informed her of the missing medication and waited for the DON to return to the facility.

On 07/26/2022 at 2:15 PM, during a phone interview with the facility's Pharmacist, he confirmed the DON notified him of the missing medication in March 2022 and he notified the Board of Pharmacy. He and someone from the Board of Pharmacy visited the facility and investigated the incident and concluded there was a drug diversion. The LPN had made up false prescription numbers on the master narcotic log.

On 07/26/2022 at 2:30 PM, during an interview with the DON, she reported the Attorney General (AG) office came to the facility and investigated the drug diversion. The outcome of their investigation was four (4) medication cards and matching narcotic sheets that had been subtracted from the master narcotic log by LPN #1 were never found. The DON also stated the

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facility held an Emergency Quality Assurance and Performance Improvement (QAPI) meeting, Hospice was notified, and the resident and responsible party was notified. The incident was also reported to the State Agency (SA).

A record review of the investigation of the event "Narcotic Diversion from South Hall Narcotic Box" dated 03/22/2022 at 5:29 PM, and completed by the DON, revealed a narcotic diversion was reported and investigated. The DON advised that no nursing staff should leave the facility and that all medication carts remain locked until she arrived. Written statements were recorded from each nurse, and all denied knowledge of any aberrant behaviors, knowledge of diversion by any staff member or personal drug abuse or the whereabouts of any missing narcotics. All narcotics were counted for each medication cart and Emergency Kits (E-Kits). It was determined that the narcotic count and card count was accurate for each cart. "Facts of investigation" revealed the DON identified by review of the South Hall (Master) Narcotic Log in Sheet that two nurses logged in Norco for Resident #1 on 03/14/2022. The DON reviewed Resident #1's electronic Medication Administration Record (MAR) to determine if Norco had been administered past the receiving date of 03/14/2022. The DON attempted to locate Resident #1's narcotic administration sheet for the Norco with an RX of 81565859. The DON was unable to locate the sheet. The DON reviewed Resident #1's MAR and noted that the last nurse to document removing and administering a Norco to Resident #1 was LPN #1 on 03/15/2022 at 7:57 PM. The MAR did not identify the recording of administering 60 doses of Norco past the date the medication card was received on 03/14/2022. The DON notified the

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M 500	Continued From page 10 Regional Nurse Consultant at 6:30 PM on 03/22/2022 of a possible drug diversion. A record review of the facility's "Potential Narcotic Diversion" investigation dated 03/29/2022 revealed on 03/22/2022, RN #2 reported to the Administrator that Resident #1 did not have a card of Norco in the medication cart, and she had just received one last week. The Administrator contacted the DON and instructed all nurses to wait until she arrived. On 03/23/2022, the DON verified with the pharmacy that a card of Norco was received for the resident on 03/14/2022 and signed by RN #2 and was logged into the (master) narcotic log. The DON began interviewing nurses to determine if anyone could recall the last time the card was present, and if any doses administered that may not have been documented on the MAR. The DON also searched for the individual narcotic sheet to determine if information was logged incorrectly on the log and the card was removed. 03/24/2022, the DON was unable to locate the individual narcotic sheet for Resident #1 and no one had been able to recall the last time the card was present. The DON began searching for the individual narcotic logs for all the cards that were logged as removed since the Norco was delivered. The investigation was primarily focused specifically on South Hall narcotic recordings to compare all RX numbers with each narcotic recorded in and out for the month of March on the cart to determine how the card count would be consistent but still missing a card of 60 Norco. The "Focus" was determined that to make an accurate count, the thought or concern would be that one of the prescriptions that were entered into the South (master) narcotic log after the date of receipt (03/14/2022) would have to be non-existing or altered in number and /or	M 500		

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removed without witness. Further findings included that it was noted that LPN #1 was removing and documenting that she was removing "depleted" cards of narcotics without witness. Past the date of receipt (03/14/2022), it is noted and recorded that four narcotics on the South (master) narcotic log were removed by LPN #1 without being witnessed by another nurse; and none of these four "depleted" individual narcotic sheets were provided to the DON or medical records department. It is noted and recorded that one of the four that were removed unwitnessed from the south (master) narcotic log was a suspicious prescription number that did not exist, as confirmed by the pharmacy. The DON confirmed through back up pharmacy that no such RX existed as being delivered to the facility. The RX number was written and recorded as removed by LPN #1 on 03/15/2022 the following morning after RN #2 and LPN #4 had logged the medication into the South (master) log.

A record review of a Pharmacy "Packing Slip", dated 03/14/2022, revealed Hydroco/Apap (Generic medication for Norco) 5-325 mg tablet for Resident #1, RX number 81564859, with a quantity of 60.00, was delivered to the facility and signed by RN #2.

A record review of the south master narcotic log revealed an entry recorded on "3-14" (03/14/2022) on "3-11" shift for "+1" package with an RX number of 81564859 for Resident #1/ Norco. The "Quantity in Package" was entered as "60" and was signed by RN #2. An entry is also recorded on "3-15" (03/15/2022) on "3-11" shift for "-1" package with an RX number of 81556232 for Lyrica/(Proper Name of Unsampled Resident). The "Quantity in Package" was

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entered as "0" and was signed by LPN #1.

A record review of Resident #1's "Order Summary Report" for active orders as of 03/01/2022 revealed a Physician's Order dated 9/17/21 for "Norco Tablet 5-325 MG give one 1 tablet by mouth every 6 hours as needed for pain" and "Acetaminophen Tablet 325 mg give two (2) tablets by mouth every 6 hours as needed for pain".

A record review of Resident #1's MAR for March of 2022 revealed Norco 5-325 mg was administered on 03/04/2022 at 8:22 AM, 03/06/2022 at 1:47 PM, 03/07/2022 at 11:40 AM, 03/09/2022 at 9:00 AM, 03/09/2022 at 3:47 PM, and 03/15/2022 at 7:57 PM. The last dose administered on 03/15/2022 at 7:57 PM was administered by LPN #1 and was after the new card of 60 tablets was received from the pharmacy on 03/14/2022. The MAR also revealed that Acetaminophen Tablet 325 mg two tablets was also administered on 03/15/2022 at 7:57 PM by LPN #1, which is the exact time and date that Norco is also recorded as administered by LPN #1 for Resident #1.

A record review of the "Admission Record" for Resident #1 revealed the facility admitted her on 09/21/2021 with diagnoses including Chronic Obstructive Pulmonary Disease, Heart Failure, and Type 2 Diabetes Mellitus.

A record review of Resident #1's "Quarterly Minimum Data Set" (MDS) with an Assessment Reference Date (ARD) of 06/08/2022 revealed "Section C0500 Brief Interview for Mental Status (BIMS) Summary score of 15", which indicated she was cognitively intact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34NH	A. BUILDING: _____ B. WING _____	C 07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY LIVING CENTER	1036 WEST DRIVE LAUREL, MS 39440

(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) COMPLETE DATE
M 500	Continued From page 13 A record review of personnel file for LPN #1 revealed her hire date as 01/05/2022 and her termination date as 03/25/2022. LPN #1 had a criminal background check showing no disqualifying events and confirmed suitability for employment based on the criminal record. Her license was verified with an expiration date of 12/31/2023. LPN #1 completed in-service training for "Vulnerable Adults' Prevention", "Abuse, Neglect, and Exploitation" and "Drugs, Narcotics", on 01/05/2022. On 07/26/2022, the State Agency validated through interviews, record review, facility policy review and observations with residents and staff, the facility had begun an immediate investigation when the suspicion of misappropriation of the resident's medications had occurred. The facility held a QAPI meeting on 03/25/2022 with all required disciplines present, gathered interviews and statements, completed a pain assessment on 100% of residents, audited all resident's narcotic medications at 100%, reported the incident to all appropriate authorities, and terminated the nurse involved. The facility also completed in-service trainings regarding having two signatures when logging narcotics into and out of the master narcotic log and the proper procedure when a narcotic card is completed. The SSA validated that the facility had taken all necessary measures to be at past noncompliance by 03/25/2022 with the deficient practice that occurred on 03/22/2022. A record review of sign in sheets for in-service trainings dated 03/25/2022 revealed the titles "Narcotic Diversion" and "Narcotic Control/Recording/Securing" revealed ... "Nursing staff will immediately begin and continue throughout employment safe and required	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 500	Continued From page 14 practice at all times with the receiving, recording, administering, wasting, and/securing of narcotics in this facility. 1. Narcotics entered into this facility will be recorded and logged into the medication carts by two nurses. 2. Each narcotic sheet will have two nursing signatures when logging in any and all narcotics. 3. Narcotics that have been depleted by a zero recording will additionally be recorded by two nurses ... 4. All narcotic sheets that are zeroed out will be signed out by two nurses and this sheet will be provided in hand to the DON or placed under her door ..."	M 500		