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 _____	08/04/2022

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

(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 an annual recertification survey from 08/01/22 to 08/04/22. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA cited F759 related to medication error rate greater than 5 percent (%), F760 related to significant medication errors and F880 related to infection control during medication administration. At the time of survey, the facility had a census of 60 and was licensed for 66 beds.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to maintain a medication error rate of less than 5 percent (%) as evidenced by a medication error rate for two (2) errors out of 27 opportunities with an error rate of 7.4 %. This affected Resident # 43. Findings include: Review of the facility policy titled "Medication Administration-General Guidelines" with a revision date of 8/25/2014 revealed "Policy: Medications are administered as prescribed in accordance with good nursing principles and	F 759	1. Enteral feeding was immediately stopped on 8/3/2022 by Licensed Practical Nurse #1 and resident's Doctor was notified of medication error. Resident was assessed on 8/3/2022 by Director of Nursing with no negative findings found. New orders received on 8/3/2022 to monitor resident for any signs and symptoms of seizures, obtain Keppra and Dilantin labs the following morning on 8/4/2022. New order received from doctor to change Keppra order to be administered via Percutaneous Endoscopic Gastrostomy (PEG) tube. All	9/2/22

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

Electronically Signed | 08/17/2022

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F 759	Continued From page 1 practices and only by person legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The facility has sufficient staff to allow administering of medications without unnecessary interruptions ..." Review of the facility policy titled "Medication, Administration Through An Enteral Tube" with a revision date of 08/25/2014 revealed "Purpose...To safely and accurately administer oral medication through an enteral tube ...Procedure 2. Turn off pump to stop continuous feeding 1-2 hours prior to administration of medication that should be given on an empty stomach ..." An observation on 8/3/22 at 8:45 AM, revealed Licensed Practical Nurse (LPN) # 1 administered Keppra 500 milligrams (mg) via (by) Percutaneous Endoscopic Gastrostomy (PEG) tube and Dilantin 200 mg by mouth (PO) to Resident # 43. LPN # 1 restarted Resident #43's enteral feeding via PEG tube immediately after administering the medications. An interview on 8/3/22 at 8:55 AM, with LPN # 1 confirmed she administered the Keppra 500 mg via PEG tube, but it was ordered to be given PO. LPN # 1 also confirmed she restarted the resident's enteral feeding via PEG tube immediately after administering the Dilantin 200 mg, but the order was to hold the enteral feeding for one hour before and after administering Dilantin. She confirmed the Keppra should have been given PO and the enteral feeding should have been held until an hour after the Dilantin was administered. She stated, "I am so nervous with you here, I feel like I am back in nursing	F 759	residents with PEG tubes were assessed by Director of Nursing on 8/3/2022 with no negative findings. 2. All residents with a PEG tube have the potential to be affected by this practice. 3. Licensed Practical Nurse #1 was in-serviced on 8/3/2022 by Director of Nursing regarding following physician orders and holding enteral feeding after the administration of Keppra and Dilantin to allow for absorption of medication. Medication administration competency assessment completed on Licensed Practical Nurse #1 by Assistant Director of Nursing on 8/3/2022. Facility nurses in-serviced on 8/3/2022 by Director of Nursing regarding following physician orders and holding tube feeding before and/or after medications as ordered. Director of Nursing or Assistant Director of Nursing will complete medication administration competencies on nursing staff beginning 8/5/2022 to be completed by 8/12/2022. 4. Director of Nursing or Assistant Director of Nursing will complete medication pass observation with two nurses weekly x 4 weeks beginning 8/5/2022. Director of Nursing or Assistant Director of Nursing will immediately correct any negative findings and report to the Quality Assurance Performance Improvement Committee on 9/2/2022 and as needed thereafter for review, revision and/or resolution to the plan.	

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F 759	Continued From page 2	F 759		

school". She revealed that the danger of restarting the enteral feeding immediately after the Dilantin was that the Dilantin might not be absorbed by the stomach which could lead to an increase in seizures. She revealed she is not sure why Keppra is given PO instead of via PEG. She confirmed that she has worked at the facility for 5 years and has been trained on how to do medication administration and understood the orders, but just got nervous.

An interview on 8/3/22 at 11:45 AM, with the Pharmacy Consultant confirmed that the enteral feeding should be held an hour before and after administering Dilantin. He stated, "The resident would need to be monitored for increased seizure activity due to the enteral feeding not being held after the administration of Dilantin". He revealed the Keppra being given by mouth should not hurt the resident and that levels are drawn often.

An interview on 8/3/22 at 12:00 PM, with the Director of Nurses (DON), the Administrator and the Corporate Nurse confirmed that an enteral feeding should be held for one hour before and after Dilantin administration and that Keppra being given via PEG tube instead of PO was a medication error. The Corporate Nurse revealed she would call the resident's Doctor to notify him of the medication errors regarding the Keppra being given via PEG tube instead of PO and the enteral feeding being restarted after the Dilantin administration.

An interview on 8/3/22 at 1:50 PM, with the Corporate Nurse revealed she called the resident's doctor and made him aware of the medication errors. She revealed the staff are going to draw Keppra and Dilantin levels in the

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F 759	Continued From page 3 morning, they have completed an incident report, staff are to monitor seizure activity every shift for 3 days. An interview on 8/4/22 at 9:15 AM, with the LPN-Infection Control Nurse revealed she has not been able to find any skills check offs for LPN # 1. LPN-Infection Control Nurse revealed she has been here two months, so she is unaware if skills check offs were being done on the nurses prior to her starting here. Record review of Resident # 43's Admission Record revealed she was admitted to the facility on 03/08/22 with medical diagnoses that included Dysphagia following cerebral infarction, Aphasia following cerebral infarction, Unspecified convulsions, Essential primary hypertension and Gastro-esophageal reflux disease without esophagitis. Record review of Resident # 43's Order Summary Report revealed the following orders: 07/14/22-Hold tube feeding 1 hour before and 1 hour after administration of Dilantin four times a day. 07/21/22-Dilantin capsule 100 mg, give 200 mg by mouth one time a day for convulsions. 07/21/22-Keppra tablet 500 mg, give 500 mg by mouth two times a day for convulsions. Record review of Resident #43's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/08/22 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated Resident #43 is cognitively intact.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		9/2/22

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F 760	Continued From page 4 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to ensure residents were free from significant medication errors as evidenced by medication given by wrong route and failing to hold an enteral feeding for one hour post Dilantin administration for one (1) of four (4) resident's observed. Resident # 43 Findings include: Review of the facility policy titled "Medication Administration-General Guidelines" with a revision date of 8/25/2014 revealed "Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by person legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The facility has sufficient staff to allow administering of medications without unnecessary interruptions ..." During an observation on 08/3/22 at 8:45 AM, revealed Licensed Practical Nurse (LPN) # 1 administer Keppra 500 milligrams (mg) via (by) Percutaneous Endoscopic Gastrostomy (PEG) tube and Dilantin 200 mg by mouth (PO) to Resident # 43. LPN # 1 then restarted the resident's enteral feeding via PEG tube immediately after administering the medications. On 08/3/22 at 8:55 AM, during an interview with	F 760	1. Enteral feeding was immediately stopped on 8/3/2022 by Licensed Practical Nurse #1 and resident's Doctor was notified of medication error. Resident was assessed on 8/3/2022 by Director of Nursing with no negative findings found. New orders received on 8/3/2022 to monitor resident for any signs and symptoms of seizures, obtain Keppra and Dilantin labs the following morning on 8/4/2022. New order received from doctor to change Keppra order to be administered via Percutaneous Endoscopic Gastrostomy (PEG) tube. All residents with PEG tubes were assessed by Director of Nursing on 8/3/2022 with no negative findings. 2. All residents with a PEG tube have the potential to be affected by this practice. 3. Licensed Practical Nurse #1 was in-serviced on 8/3/2022 by Director of Nursing regarding following physician orders and holding enteral feeding after the administration of Keppra and Dilantin to allow for absorption of medication. Medication administration competency assessment completed on Licensed Practical Nurse #1 by Assistant Director of Nursing on 8/3/2022. Facility nurses in-serviced on 8/3/2022 by Director of Nursing regarding following physician orders and holding tube feeding before and/or after medications as ordered. Director of Nursing or Assistant Director of	

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F 760	Continued From page 5 LPN # 1, she confirmed she administered the Keppra 500 mg via PEG tube, but it was ordered to be given PO. LPN # 1 also confirmed she restarted the resident's enteral feeding via PEG tube immediately after administering the Dilantin 200 mg, but the order was to hold the enteral feeding for one hour before and after administering Dilantin. She confirmed the Keppra should have been given PO and the enteral feeding should have been held until an hour after the Dilantin was administered. She stated, "I am so nervous with you here, I feel like I am back in nursing school". She revealed that the danger of restarting the enteral feeding immediately after the Dilantin was that the Dilantin might not be absorbed by her stomach which could lead to an increase in seizures. She revealed she is not sure why Keppra is given PO instead of via PEG. At 11:45 AM, on 8/3/22 during an interview with the Pharmacy Consultant confirmed that the enteral feeding should be held an hour before and after administering Dilantin. He stated, "The resident would need to be monitored for increased seizure activity due to the enteral feeding not being held after the administration of Dilantin". He revealed the Keppra being given by mouth should not hurt the resident and that levels are drawn often. During an interview on 08/3/22 at 12:00 PM, with the Director of Nurses (DON), the Administrator and the Corporate Nurse confirmed that an enteral feeding should be held for one hour before and after Dilantin administration and that Keppra being given via PEG tube instead of PO was a medication error. The Corporate Nurse revealed she would call the resident's Physician to notify him of the medication errors regarding	F 760	Nursing will complete medication administration competencies on nursing staff beginning 8/5/2022 to be completed by 8/12/2022. 4. Director of Nursing or Assistant Director of Nursing will complete medication pass observation with two nurses weekly x 4 weeks beginning 8/5/2022. Director of Nursing or Assistant Director of Nursing will immediately correct any negative findings and report to the Quality Assurance Performance Improvement Committee on 9/2/2022 and as needed thereafter for review, revision and/or resolution to the plan.	

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F 760	Continued From page 6	F 760		

the Keppra being given via PEG tube instead of PO and the enteral feeding being restarted after the Dilantin administration.

On 08/3/22 at 1:50 PM, the Corporate Nurse revealed during an interview she called the resident's Physician and made him aware of the medication errors. She revealed the staff are going to draw Keppra and Dilantin levels in the morning, they have completed an incident report, staff are to monitor seizure activity every shift for 3 days.

An interview on 08/4/22 at 9:15 AM with the Infection Control Nurse revealed she has not been able to find any skills check offs for LPN # 1. The Infection Control Nurse revealed she is unaware if skills check offs were being done on the nurses prior to her starting here.

Record review of Resident # 43's Admission Record revealed she was admitted to the facility on 03/08/22 with medical diagnoses that included Dysphagia following cerebral infarction, Aphasia following cerebral infarction, Unspecified Convulsions, Essential primary hypertension and Gastro-esophageal reflux disease without esophagitis.

Review of Resident # 43's Order Summary Report revealed the following orders:
07/14/22-Hold tube feeding 1 hour before and 1 hour after administration of Dilantin four times a day. 07/21/22-Dilantin capsule 100 millgrams (mg), give 200 mg by mouth one time a day for convulsions. 07/21/22-Keppra tablet 500 mg, give 500 mg by mouth two times a day for convulsions.

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F 760	Continued From page 7 Review of the Resident #43's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/08/22 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident is cognitively intact.	F 760		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		9/2/22

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F 880	Continued From page 8 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to prevent the likelihood of the spread of infection as evidenced by the lack of use of a barrier during medication	F 880	1. On 8/3/2022, Registered Nurse #1 was immediately provided with paper plates to use as a barrier during medication pass by Director of Nursing. Registered nurse	

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F 880	Continued From page 9 administration of oral medications, eye drops and an inhaler for one (1) of four (4) residents reviewed. Resident # 4 (Unsampled resident) Findings Include: Review of the facility policy titled, "Standard Precautions" with a revision date of 05/30/22 revealed under "Policy Statement...Standard precautions will be used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents". Record review of a document on letterhead dated 8/4/22 and signed by the Administrator, revealed "Courtyards Community Living Center does not have a policy regarding placing a barrier during medication administration." An observation on 08/3/22 at 8:15 AM, revealed Registered Nurse (RN) # 1 prepared by mouth (PO) medications, placed those, along with a hand-held inhaler and a bottle of eye drops on top of her medication cart with no barrier. RN # 1 then entered Resident # 4's room and put all the prepared medications on top of the residents overbed table with no barrier and did not disinfect the table prior to placing the medications there. This observation revealed RN # 1 administered all the medications then returned to her medication cart and put the bottle of eye drops and the hand held inhaler on top of the medication cart with no barrier and no prior disinfecting. RN # 1 then opened her medication drawers and put the bottle of eye drops and the	F 880	was also in-serviced on 8/3/2022 by Director of Nursing regarding using a barrier when preparing and administering medication to provide a safe and sanitary environment. 2. All residents receiving medication have the potential to be affected by this practice. 3.Facility nurses in-serviced by Director of Nursing on 8/4/2022 regarding Infection Control policy and procedures and using a barrier when preparing and administering medications. Director of Nursing or Assistant Director of Nursing will complete medication administration competencies on nursing staff beginning 8/5/2022 to be completed by 8/12/2022. Root Cause Analysis for Directed Plan of Correction completed on 8/10/2022 by facility's Infection Preventionist, Administrator, Director of Nursing and Assistant Director of Nursing. Center for Disease Control's Sparkling Surfaces training began with all staff on 8/10/2022 by Infection Preventionist to be completed by 8/24/2022. 4. Director of Nursing or Assistant Director of Nursing will complete medication pass observation with two nurses weekly x 4 weeks beginning 8/5/2022. Director of Nursing or Assistant Director of Nursing will immediately correct any negative findings and report to the Quality Assurance Performance Improvement Committee on 9/2/2022 and as needed thereafter for review, revision and/or	

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F 880	Continued From page 10 hand held inhaler back in their boxes and returned them to the drawer that included other resident's medications. An interview on 08/3/22 at 8:30 AM, with RN # 1 confirmed she did not use a barrier for Resident # 4's medication preparation and administration, but she should have. She confirmed that it is the policy of this facility that a barrier should be used to prevent cross contamination and infection control issues. She stated, "I know better, I have to use a barrier when I do treatments, I just got nervous". An interview on 08/4/22 at 11:15 AM, with the Director of Nurses (DON) confirmed RN # 1 should have put a barrier down before setting the resident's medications on top of her overbed table to prevent infection control issues and contamination. An interview on 08/4/22 at 12:20 PM, with the DON revealed the facility does not have a policy regarding having a barrier down when administering medication, but it is expected to be done to prevent contamination.	F 880	resolution to the plan.	