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 _____	10/19/2022

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 #19674 and MS #19594, and a COVID-19 Focused Infection Control survey, at the facility from 10/17/22 through 10/19/22. The facility was found to be in compliance with infection control regulations and the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19 and there were no deficiencies cited for infection control. The SA did not substantiate MS #19594 related to infection control, grooming, and facility staffing. The SA did substantiate MS #19674 and cited F684 for a Physician Order transcription error. The facility had a license for 105 beds, with a census of 83.	F 000		
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 interviews, record reviews, and facility policy review, the facility failed to prevent a Physician's Order transcription error for two (2) of four (4) residents sampled. Resident #1 and Resident #2	F 684	1. On 10/3/2022, Med Error Investigation from the Emergency QAPI (Quality Assurance Performance Improvement) Meeting on 10/3/2022 revealed Resident (#1) was administered Lovenox 40mg	11/15/22

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

Electronically Signed | 11/04/2022

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F 684	Continued From page 1 Findings included: Record review of the facility's "Receiving and Transcribing Physician Orders Policy" with a "Reviewed/Revised By:" date of 6/14/22 revealed, " ...Policy Explanation and Compliance Guidelines: 4. Documentation of Medication Orders: ...d. If using electronic medication records, input the medication order according to the electronic health record (EHR) instructions and facility policy. f. Transcribe newly prescribed medications on the MAR (Medication Administration Record) or treatment record or ensure the order is in the electronic MAR..." Record review of the facility's "Med Error Investigation" from the "Emergency QA (Quality Assurance) Meeting" dated 10/03/22 revealed, " ...Resident (#1) was administered Lovenox 40 milligram (MG) SQ (subcutaneous) on Oct (October) 1, 2022. Medication was entered on (Proper Name of Resident #1) due to same last name as another resident. Resident (#1) received one dose of Lovenox without any adverse reactions noted. Will continue to monitor for any reactions. RP (Responsible Party) and physician notified. No new orders were received from physician on 10/01/22." Resident #1 On 10/18/22 at 10:00 AM, during an interview with Resident #1, he confirmed he received the incorrect medication on one day, but the next day when the staff attempted to administer the shot, he refused until the facility received clarification with the order.	F 684	subcutaneous on October 1, 2022. Medication was entered on (Proper Name of Resident #1) due to same last name as another resident. Responsible party and physician was notified of medication error. No new orders were received. On 10/7/2022 Family Nurse Practioner-Certified (FNP-C) did follow -up with resident (#1) in regards to medication error for any concerns, questions, or adverse reactions. Resident (#1) denied any complaints at this time. On 9/30/2022 Resident #2 had a handwritten physician□s order for Lovenox 40 mg subq daily x 21 days. Resident #2 did not have an electronic physician□s order on Medication Administration Record (MAR) until 10/1/2022 for Lovenox 40mg/0.4 ml subq daily x 21 days and was not administered until 10/2/2022. Responsible party and physician was notified that medication was not administered until 10/2/2022. Resident scored a BIMS of 15/15 and was notified of the Lovenox medication error. Resident was prescribed Lovenox prophylactically status post amputation. No new orders were received. 2. All residents are at risk for this deficient practice. 3. On 10/03/2022 staff was in-serviced on medication administration	

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F 684	Continued From page 2 Record review of the "Face Sheet" revealed Resident #1 was admitted by the facility on 6/19/15 with diagnoses including Quadriplegia and Unspecified Convulsions. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/01/22, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact. Record review of the electronic "Physician Orders" for the month of October 2022 revealed a Physician Order for Resident #1, dated 10/01/22, for "Lovenox 40 MG/0.4 ML syringe SUBQ x 21 days ...Discontinue Date: 10/03/22..." Record review of the "Medication Administration Record" for Resident #1 "For the month of: October 2022" revealed "Description" as "Lovenox 40 MG/0.4 ML syringe subq x 21 days Order Date: 10/01/22 Start Date: 10/01/22 Discontinue Date: 10/03/22" was documented as being administered on 10/1/22 and 10/2/22, however Resident #1 confirmed he only received the medication one time on 10/1/22. Resident #2 Record review of the "Face Sheet" revealed the facility admitted Resident #2 on 9/30/22 at 8:00 PM with diagnoses including Acute Respiratory Failure, Pneumonia, and Osteomyelitis. Record review of Resident #2's "Physician's Order Sheet" revealed a handwritten Physician's Order dated 9/30/22 for Lovenox 40 MG subq daily x 21 days. The Physician Order was noted by Registered Nurse (RN) #1.	F 684	policy by Quality Assurance (QA) nurse and red labels placed on charts to indicate residents with same last name. On 10/21/22 the Quality Assurance (QA) nurse in-serviced the night shift nurses on 24 hours chart check policy. Which included identifying new physician orders and ensuring transcribed order in the computer are the same with the correct resident. Initial in the chart that the 24 hours chart check was completed. On 10/22/22 a systemic check with each medication cart was performed by Minimum Data Set (MDS) staff and Director of Nursing (DON) to ensure that the medication matched the physician orders for each resident. On 10/24/22 Quality Assurance (QA) brought all new admission charts for the week in to check and verify right patient and right orders. To ensure medication policy was being followed. Quality Assurance (QA) will check orders daily. 4. Administrative staff will bring all new admission charts to stand up every morning for review beginning on 10/24/22 and this will be ongoing as part of the new system process. 10/24/22 Unit Clerks began checking charts daily to ensure 24 hours chart	

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F 684	Continued From page 3 Record review of the electronic "Physician Orders" revealed Resident #2 did not have an electronic Physician Order until 10/01/22 for "Lovenox 40 MG/0.4 milliliters (ML) syringe SUQ daily x 21 days ...Stop Date: 10/22/22". Record review of the "MAR" for Resident #2 for the month of October 2022 revealed the "Description" as Lovenox 40 MG/0.4 ML syringe subq x 21 days with an Order Date of: 10/01/22 revealed the medication was not administered until 10/2/22. On 10/17/22 at 9:50 AM, during an interview with the Director of Nursing (DON) revealed Resident #1 received Lovenox 40 mg/0.4 ml syringe suq on 10/01/22. Resident #1 refused the medication on 10/02/22 and requested the facility receive clarification of the order. The facility has two (2) residents with the same last name and Registered Nurse (RN) #1 transcribed the medication incorrectly on Resident #1. On 10/19/22 at 10:00 AM, during an interview with Registered Nurse (RN) #1, she confirmed that when she transcribed the Lovenox medication for Resident #2, there were two residents with the same last name, and she choose Resident #1's name from the drop-down box on the computer instead of Resident #2's name. This is what caused the incorrect resident to receive the medication.	F 684	checks to verify all new orders have been addressed. An incomplete chart check list will be provided to the DON within 24 hours. This is an ongoing new system process for 24 hours chart check. To ensure improvements are sustained the Quality Assurance nurses, Medicare Coordinator, and/or Admission/Charge nurse will perform checks of two of four medication carts weekly x 3 beginning 10/22/22, then every month x 3 months thereafter to ensure medication matches the physician orders for each resident, results will be brought to QA meeting on 11/15/22. QA committee will make recommendations depending on results and findings x 3 months.	