STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25E115	A. BUILDING _____ B. WING _____	C 06/01/2023

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OAK GROVE RETIREMENT HOME	209 OAK CIRCLE DUNCAN, MS 38740

(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 #21624 related to misappropriation of property and pharmaceutical services from 5/31/23 through 6/01/23. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid related to pharmaceutical services and cited F755 and F761 . At the time of survey the facility had a census of 57 residents and was licensed for 60 beds.	F 000		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		6/16/23

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

Electronically Signed | 06/09/2023

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F 755	Continued From page 1 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and facility policy review the facility failed to maintain a sufficient system of receipt and disposition to accurately reconcile controlled drugs and failed to periodically reconcile controlled drugs for one (1) of two (2) medication carts observed. Findings include: A record review of the facility policy titled, "Medication, Controlled Substances Policy and Procedure", with no date, revealed, Policy: "Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special ...record keeping in the facility, in accordance with federal and state laws and regulations... Procedure...4. Accurate accountability of the inventory of all controlled drugs is always maintained. a. Nurses are to perform a count of all controlled substances at the beginning and the end of every shift. b. Controlled substances log is to be maintained for all controlled substances..." A record review of the Controlled Drugs-Count Record dated April, 2023 for the South Hall Unit revealed that on 4/4/23, 4/5/23, 4/6/23, 4/7/23,	F 755	F755 Pharmacy Srvcs/Procedures/Pharmacist/Records 1) On 5/31/2023, The Director of Nursing was in-service by the Administrator of random narcotic count observation with the nursing staff at the start and end of the shifts for accuracy. On 5/31/2023, Director of Nursing terminated nurse #2 and nurse #3 having committed the deficient practice 2) All residents that are administered narcotics have the potential to be affected by this deficient practice. 3) On 5/31/2023, The Director of Nursing and Charge Nurse #4 counted the narcotic box including the Ativan in the refrigerator for accuracy, no negative findings. a) Measures put in place to ensure the alleged deficient practice does not reoccur. - On 5/31/2023, Director of Nursing provided and in-service with all licensed nurses on proper narcotic count at the	

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F 755	Continued From page 2 4/12/23, 4/18/23, 4/19/23, 4/24/23, 4/25/23, 4/26/23, 4/23/23, and 4/28/23 Licensed Practical Nurse (LPN) #4 (the north hall medication nurse) reconciled the narcotic count with the 11-7 nurse for LPN #2 (the south hall medication nurse). There is no documentation that LPN #2 reconciled the narcotic count with LPN #4 when she took over responsibility for the medication cart on those days. On four (4) occasions, 4/1/23, 4/12/23,4/14/23, and 4/29/23 narcotic medications were removed or added from the cart listing no resident or medication name, and five (5) occasions, 4/1/23, 4/14/23, 4/18/23, 4/20/23, and 4/24/23, narcotic medications were removed listing only the names of the residents or the name of the medication, but not both. A record review of the Controlled Drugs-Count Record dated May 2023 for South Hall Unit revealed that on 5/2/23, 5/3/23, 5/4/23, 5/5/23, 5/10/23, 5/11/23, 5/12/23, 5/15/23, 5/16/23, 5/17/23, and 5/18/23, LPN #4 (the north hall medication nurse) reconciled the narcotic count for LPN #2 with the 11-7 nurse. There is no documentation that LPN #2 reconciled the narcotic count with LPN #4 when she took over responsibility for the medication cart on those days. Observation also revealed on four (4) occasions, 5/10/23, 5/15/23, 5/28/23, and 5/29/23 narcotic medications were removed or added from the cart listing no resident or medication name; and on one (1) occasion, 5/16/23, narcotic medications were removed listing only the names of the residents or the name of the medication, but not both. An interview with LPN #4 on 5/31/23 at 11:50 AM, she revealed she counted for the nurse assigned to the medication cart as she was running late, as	F 755	start and end of each shift, and anytime another nurse takes the keys from another nurse. - On 5/31/2023, the Director of Nursing began monitoring narcotic count with ongoing education with licensed nurse. - On 6/1/2023, the Nursing staff was in serviced by the DON on the lock box within the refrigerator that must be counted at the start and end of the shift or any time a nurse takes the keys from another nurse. - On 6/1/2023, the South wing key chain was supplied with the key for refrigerator lock by the Director of Nursing - On 6/1/2023, the Director of Nursing was educated by the Regional Nurse on the utilization and documentation within the new bound narcotic book. - On 6/1/2023, the Director of Nursing and Charge Nurse transferred all narcotics and information into the new narcotic booklets. - On 6/1/2023, all licensed nurses were educated on the proper procedure and use of the new narcotic bound book, documentation of two licensed nurses signatures, date, time, name of the medicine, and quantity remaining that is provided to the Director of Nursing for wasting with monthly pharmacy consultant visits, the additional of a new narcotic, and the removal of a new narcotic whether the drug has been completed or discontinued. - On 5/31/2023, the Director of nursing in-service the licensed nursing staff to ensure the deficient practice does not reoccur.	

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F 755	Continued From page 3 she often does. LPN #4 stated she normally doesn't re-count the narcotics with LPN #2 when she is running late because she trusts her. LPN #4 confirmed she knows she was wrong and should always count the cart with the oncoming and off going nurse. An interview with LPN # 2 on 5/31/23 at 12:10 PM, revealed she did not count the cart with LPN #4 and confirmed LPN #4 often counts for her because of her child, she confirmed she knows she should count the medicines with LPN #4 but stated, "you know how you just trust some people." An observation of narcotic reconciliation for South Unit medication cart on 5/31/23 at 3:00 PM, with off-going nurse LPN #2 and on-coming LPN #3, revealed neither nurse was observed reconciling the count for Ativan injectable's located in the medication refrigerator. An interview with LPN #3 on 5/31/23 at 3:30 PM, confirmed she did not count the Ativan with LPN #2. She revealed they never count it and revealed she always looks at it after the day shift leaves but confirms she knows she should count with the nurse. An interview with the Administrator on 6/1/23 at 8:42 AM, revealed she terminated LPN # 2 and LPN # 3 related to not counting the refrigerated Ativan when they counted narcotics at 3:00 PM on 5/31/23 with the State Agency (SA) present. During a phone interview with LPN #2 on 6/1/2023 at 11:30 AM, she verified that she did not count the Ativan with LPN #3 on 5/31/23.	F 755	4) 6/1/2023 The Director of Nursing will monitor narcotic count and proper documentation within the narcotic book three times a week for the next 8 weeks and then weekly for ongoing monitoring. On 6/1/2023, The Director of Nursing will discuss narcotic compliance with each daily morning meeting. The Administrator will monitor narcotic booklet monitoring weekly. Any negative findings will be reported immediately to the Administrator for recommendations and corrections/revisions. On 6/16/2023 The Administrator will report to the Quality Assurance monthly and Quarterly meetings all findings for continual recommendations for changes and /or revisions as needed.	

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F 755	Continued From page 4 During an interview with Administrator on 6/1/23 at 12:16 PM, she stated that if narcotics are removed from the medication cart they should be logged and subtracted from the Controlled Drugs-Count Record as removed . During an interview with the Director of Nursing (DON) on 6/1/23 at 12:40 PM, she confirmed that the nurses should have counted the carts each shift and documented medications added or removed from the medication cart by documenting the resident's name and the medication. She verified failure to do so could result in missing narcotics.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		6/16/23

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F 761	Continued From page 5 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to store controlled drugs locked and in permanently affixed compartments for storage as evidenced by 15 white pills identified by facility as Hydrocodone pills that were missing and found in the possession of a resident. A card of Hydrocodone for a resident with 11 pills remaining on the card was found in the Assistant Director of Nursing's (ADON) office drawer, and three (3) vials of Ativan in a clear bag was placed in the medicine room refrigerator and not secured for three (3) of 25 narcotics records reviewed. Findings include: A record review of the facility policy titled, "Medication, Controlled Substances Policy and Procedure", with no date, revealed " ... Policy: Medications included in the Drugs Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, and recordkeeping in the facility, in accordance with federal and state laws and regulations. Procedure: 1. ...Only authorized licensed nursing and pharmacy have access to controlled medications...2. All controlled substances ... are stored and maintained in a locked cabinet or compartment...4. Accurate accountability of the inventory of all controlled drugs is always maintained ...8. Controlled medications remaining in the facility after ... discontinuation ... is to be counted, locked in	F 761	F761 Label/Store Drugs and Biologicals 1) On 5/31/2023, the Administrator and Director of Nursing reviewed the narcotic log and compared it to the narcotics located in the secured area for accuracy. 2) All residents that are administered narcotics have the potential to be affected by this deficient practice. 3)Measures put in place to ensure the alleged deficient practice does not reoccur. a) On 5/31/2023, The Director of Nursing and Pharmacist Consultant wasted all discontinued medicines located in the secured double locked area managed by the Director of Nursing. b) On 5/31/2023, Licensed nurses were in-serviced by the Director of Nursing and Administrator on proper storage of narcotics under double lock. Education included when a drug has been discontinued the narcotic must remain under double lock until the Director of Nursing only is present. Then both the charge nurse and Director of Nursing must sign in the bound booklet the removal of the drug, date, resident name, and quantity and both must take the drug to the secured area and lock for future wasting between the Director of Nursing	

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F 761	Continued From page 6 double secure area ...." An interview with the Administrator on 5/31/23 at 9:10 AM, regarding the self-reported incident, revealed during her investigation of possible drug diversion, she determined the hydrocodone reported to the State Agency (SA) as missing for Resident #4 was found in the possession of Resident #2. The Administrator revealed the narcotic sheet for Resident #4 had 16 pills left. 15 pills were found on Resident #2 on 5/24/23, after he was seen coming out of the Director of Nursing's (DON) office. The door was not locked. The Minimum Data Set (MDS) nurse found a white pill in the whirlpool on the South Hall on 5/18/23 where Resident #2's room is located. The pill was given to the DON and was destroyed. The Administrator revealed that all the hydrocodone was accounted for. An observation and interview with Resident #2 on 5/31/23 at 9:25 AM, stated "I did not take any pills." Resident #2 would not answer as to where he got them and would only shrug his shoulders and grunt. Resident #2 was noted ambulating independently around the facility as the State Agency (SA) walked with him. An interview with the DON on 5/31/23 at 11:00 AM, revealed she was notified by the ADON on 5/17/23 at approximately 3:00 PM about the missing narcotics. She revealed she re-counted all medication carts, checked her office in the locked narcotic storage cabinet and the card was not there. The DON also confirmed that if a resident had those narcotics in their possession, they could have taken the pills and overdosed or even given them to another resident causing harm to them as well. The DON revealed she is	F 761	and Pharmacy consultant each month. c) On 5/31/2023, the Director of Nursing was in-service by the Administrator on proper receiving, documentation, logging, and storage of discontinued medicines that is to be included monthly with pharmacist consultant visit for wasting. d) On 5/31/2023, Licensed nurses were in-serviced by the Director of Nursing and Administrator on proper storage of narcotics under double lock. Education included when a drug has been discontinued the narcotic must remain under double lock until the Director of Nursing only is present. Then both the charge nurse and Director of Nursing must sign in the bound booklet the removal of the drug, date, resident name, and quantity and both must take the drug to the secured area and lock for future wasting between the Director of Nursing and Pharmacy consultant each month. e) On 6/1/2023, the previous Assistant Director of Nursing was terminated for failure to follow policy related to storage of narcotics. f) On 6/1/2023, the Nursing staff was in serviced by the DON on the lock box within the refrigerator that must be counted at the start and end of the shift or any time a nurse takes the keys from another nurse. g) On 6/1/2023, the South wing key chain was supplied with the key for refrigerator lock by the Director of Nursing h) On 5/31/2023, the Director of Nursing in-service the licensed nursing staff to ensure the deficient practice does not reoccur.	

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F 761	Continued From page 7 the only person that removes discontinued or expired narcotics from the medication carts and logs them on the destruction log to be destroyed with the pharmacist. She is the only one that has both keys to get in the locked storage cabinet with narcotics in it. She also revealed she shares the office with the ADON and confirmed the office should always be locked when they are not in there. The DON confirmed she does not recall removing the hydrocodone off the cart for Resident #4. An interview with Licensed Practical Nurse (LPN) #4 on 5/31/23 at 11:50 AM, revealed if a resident had access to the pills they could have overdosed or given them to another resident and they may have had an adverse reaction. She also revealed staff must watch Resident #2 because he will take things that don't belong to him. An interview with the ADON on 5/31/23 at 2:00 PM, revealed she saw Resident #2 coming out of her office on 5/24/23. She stopped him and asked him what he had taken and he took a marker out of his pocket. She asked again and she saw a white pill. She asked Resident #2 to walk with her and the Infection Control Nurse to the administration office to show the DON and Administrator the pills and confirmed there was a total of 15 pills that were found in his pocket by staff. The ADON revealed the office door should have been locked but confirmed it was not. An interview with the Administrator on 5/31/23 at 2:10 PM, revealed Resident #2 could only have gotten the Hydrocodone he was found to have in his pockets, due to a breach in the nursing staff practices, stating "he either got it off the top of the medicine cart or from the DON's office being left	F 761	4) On 6/1/2023, The Director of Nursing will monitor proper narcotic storage, narcotic count, and proper documentation within the narcotic book three times a week for the next 8 weeks and then weekly for ongoing monitoring. On 6/1/2023 The Director of Nursing will discuss narcotic compliance with each daily morning meeting. On 6/1/2023 The Administrator will montior weekly the the narcotic book. Any negative findings will be reported immediately to the Administrator for 16recommendations and corrections/revisions. On 6/16/2023 The Administrator will report to the Quality Assurance monthly and Quarterly meetings all findings for continual recommendations for changes and /or revisions as needed.	

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F 761	Continued From page 8	F 761		

open and narcotics stored in the office unsecured." The Administrator confirmed the resident has had no visitors in the facility and she even called his family who denied him being in the facility. The Administrator revealed that during her interview with Resident #2 he told her he got the medication off the top of the cart but would not say anything else.

An interview with LPN #3 on 5/31/23 at 2:15 PM, revealed the DON/ADON office is often open, and residents will go in and she has redirected them and closes the door due to treatment supplies and the narcotic storage file cabinet being in there.

An interview with the MDS nurse on 6/1/23 at 12:24 PM, revealed she found a white elongated tablet on 5/19/23 in the whirlpool room near the base of the tub on the South Hall where Resident #2's room is located and turned it in to the DON.

An interview with the DON on 6/1/23 at 12:28 PM, revealed the MDS nurse gave her a white pill on 5/19/23 she found in the shower and stated the pill was worn and unable to tell what it was, and she placed it in the Destroyer bottle for immediate destruction.

A review of the narcotic sheet for Resident #2's Hydrocodone 5/325 milligrams (mg) with the DON on 5/31/23 at 12:30 PM, revealed 20 pills of hydrocodone was dispensed from the pharmacy on 11/12/23, four (4) pills are documented as administered with 16 pills left to count. The SA observed 15 hydrocodone pills in a clear bag that the facility found in Resident #2's pocket.

Record review of the Admission Record revealed

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that the facility admitted Resident #2 to the facility on 9/10/20 with diagnoses of Bipolar disorder and Kleptomania.

Record review of the MDS Section C with an Assessment Reference Date (ARD) on 3/03/23, revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated that he was moderately cognitively impaired.

During an interview with the Administrator on 6/1/23 at 12:16 PM, she stated that if Resident #4's Hydrocodone had been removed from the medication cart it should be logged on the Controlled Drugs-Count Record. If narcotics are removed from the medication cart they should be logged and subtracted from the Controlled Drugs-Count Record as removed and logged on the Drug Destruction Log to be destroyed.

A record review of the facility's Controlled Drugs-Count Records dated December 2022 through May 2023 revealed no documentation that Resident #4's Hydrocodone 5-325 mg, which was discontinued on 12/11/22, was removed from the South Hall medication cart.

A record review of the facilities Drug Destruction Log from December 2022 through April 2023 revealed that Resident #4's Hydrocodone-5-325 mg, that was discontinued on 12/11/22, was not logged on the Drug Destruction Log to be destroyed.

Record review of the Admission Record revealed that the facility admitted Resident #4 to the facility on 7/29/19 with diagnosis of Unspecified psychosis.

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Resident # 5

An interview with the Administrator on 6/1/23 at 10:00 AM, revealed on 5/23/23 during her continued search for the missing narcotics she and the MDS nurse were looking in the DON's office and she found a card of Hydrocodone for Resident #5 in the ADON's desk drawer covered by clothing, and revealed the drawer does not lock. The Administrator confirmed the Hydrocodone should have been secured in the narcotic file cabinet that was double locked.

During an interview with the ADON on 6/1/23 at 11:15 AM, she stated that she did not know how Resident #5's Hydrocodone got into her desk drawer. She denied receiving the medication from the floor nurse, stating. "I do not take narcotics off of the cart, the DON does."

During a phone interview with LPN #2 on 6/1/2023 at 11:30 AM, she stated that on 4/24/23, Resident #5 returned from a follow-up appointment with an order to discontinue his Hydrocodone. She then clarified that she removed the Hydrocodone from the cart on 4/24/23 not 4/25/23 and gave it to the DON or ADON that were both at her cart. LPN #2 stated that she does not recall if the DON or the ADON took the medication to the office to lock up in the office.

An interview with the DON on 6/1/23 at 11:48 AM, stated that she was not present in the building on April 24th.

An interview with the Administrator, on 6/1/23 at 12:18 PM, verified that the DON was on vacation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25E115	A. BUILDING _____ B. WING _____	C 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE RETIREMENT HOME	209 OAK CIRCLE DUNCAN, MS 38740

(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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and not in the building on April 24th. She stated that the DON does not use a time clock, so she does not have a timecard showing that she was not in the building.

An interview with the MDS nurse on 6/1/23 at 12:24 PM, revealed she was at the facility and with the Administrator on 5/18/23 when the narcotics were found in the ADON's drawer.

A record review of the Controlled Drugs-Count Record for 4/20/23, for the South Hall revealed documentation that 1 card of Hydrocodone 5-325 mg was removed for Resident #5 on the 7-3 shift on 4/24/23 and on the 7-3 shift on 4/25/23. Review of pharmacy manifest reveals that only one (1) card of 20 Hydrocodone 5-325 mg tablets were sent for Resident #5.

A record review of the Hydrocodone card and narcotic sheet for Resident #5 with the Administrator and DON on 6/1/23 at 10:00 AM, revealed 20 pills had been sent on the card from the pharmacy. 9 pills were administered to the resident and 11 pills remained on the card.

Record review of the Admission Record revealed that the facility admitted Resident #5 to the facility on 2/27/23 with diagnosis of Cerebral vascular disease.

On 5/31/23 at 3: 00PM an observation of narcotic reconciliation for the South Unit medication cart with off-going nurse LPN #2 and on-coming LPN #3, revealed neither nurse was observed reconciling the count for Ativan injectables located in the medication refrigerator.

An interview with LPN #3 on 5/31/23 at 3:30 PM,

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confirmed she did not count the Ativan with LPN #2. She revealed they never count it and confirmed she checked it after the day shift nurse left. She confirmed she knows she should count with the nurse coming and going. The SA observed LPN #3 open the locked refrigerator, pick up a clear box with no medication in it, she then began to look at all the medications in the refrigerator and found a bag with 3 vials of Ativan in it. She also revealed the Ativan should be in a secure locked box not out in the open in the refrigerator and confirmed someone else could have taken that medication because all the staff nurses and charge nurses have keys to the medication room refrigerator. The SA observed no secure locked box in the refrigerator.

An interview with the DON on 6/1/23 at 9:08 AM, revealed that both the north and south medication nurses and both charge nurses have access to the medicine room refrigerator and confirmed only the south medication nurse counts the Ativan in the refrigerator. The DON confirmed that the Ativan should not have been lying in the refrigerator, it should have been locked up and stored in a secured locked box in the refrigerator and confirmed another nurse could have taken the Ativan.

LPN reported during a phone interview on 6/1/2023 at 11:30 AM, she verified that she did not count the Ativan with LPN #3 on 5/31/23.

A review an in-service dated 5/19/23 signed as in attendance by the ADON, titled, "Proper storage of Narcotics" Summary: Narcotics after removal from medicine carts are to be placed in the file cabinet in the DON's office behind two (2) locks after being logged in on the destruction log

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F 761	Continued From page 13 awaiting pharmacy for destruction.	F 761		