MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36GR	A. BUILDING: _____ B. WING _____	C 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD OXFORD, MS 38655

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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI) MS #22507 and MS #22555 at the facility on 08/22/23. The SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements at M500. The census at the time of the complaint investigation was 108 and the facility held a license for 120 beds.	M 000		
M 500 SS=D	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 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	M 500		9/29/23

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M 500	Continued From page 1	M 500		

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, 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

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M 500	Continued From page 2 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; 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	M 500		

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M 500	Continued From page 3 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 choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, interview, record review and facility policy review, the facility failed to ensure that one (1) of three (3) residents reviewed was free from misappropriation of property, Resident #1.	M 500	• Resident #1 was assessed by Assistant Director of Nursing and Physician on August 17, 2023. The physician gave an order to administer a one-time dose of pain medication. Resident received this order on August 17,	

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M 500	Continued From page 4 Findings Include: Record review of facility policy titled: "Abuse, Neglect, and Exploitation" with revised date of 10/10/2022 documented under "Policy: This facility's policy is to protect each resident's health, welfare, and rights by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property." Record review of Administrator statement on facility letterhead documented on August 22, 2023, the following: RE: Allegation of Narcotic Diversion "The allegation was made on August 17, 2023, at approximately 2:00pm, that RN (Registered Nurse proper name), RN could have possibly taken resident (proper name) 5mg (milligrams) Percocet while administering her 2pm medication ... ...Upon conclusion of the investigation, on Monday August 21, 2023, the employee was terminated, and the MS Board of Nursing and the Attorney General's (AG) office were notified. The final investigation was sent into the MSDH on 08/22/23." This statement was signed by Administrator. On 08/22/23 at 10:00 AM, an observation and interview with Resident #1 revealed her sitting in her wheelchair in her room with her head and neck positioned slightly forward and she was unable to raise her head upright. Resident #1 revealed that there was a situation last week that happened with her medication. Resident #1 revealed that on 08/17/23, she went up to the Nurse's desk between 1:00 PM and 2:00 PM and asked for her pain medicine and afternoon medicines. Resident #1 revealed that Licensed	M 500	2023. Follow up pain assessment revealed resident was free of pain. A complete narcotic recount was done on August 17, 2023 immediately following the allegations with no discrepancies noted. RN #1 was suspended effective immediately by Administrator and DON upon allegation on August 17, 2023, and then terminated upon conclusion of investigation on August 21, 2023, by Administrator and DON. • All residents receiving narcotics have the potential to be affected. • Staff educator began an in-service with all staff on abuse, neglect, and misappropriation of resident property and medication administration on August 17, 2023. • Quality Assurance nurse will conduct an audit of 3 residents narcotic administration weekly for 4 consecutive weeks and then biweekly for 3 months which beginning August 29, 2023. These residents will be assessed for proper narcotic medication administration. These findings will be discussed with the Quality Assurance Committee beginning September 28, 2023, until such a time consistent, substantial compliance has been met. This plan of correction will be discussed at the monthly Quality Assurance meetings at minimum for the next 3 months. • Corrective Action Completed:	

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M 500	Continued From page 5 Practical Nurse (LPN) #1 was her nurse that day, but she (LPN) was busy at the computer, so the Registered Nurse (RN) #1 offered to help, she took the medication cart keys from LPN, and went and got her medicine. Resident #1 revealed that she looked at her medication that was handed to her by RN, and stated to her, "Where's my Percocet?" Resident #1 revealed that the pain pill she had given her looked like a Tylenol and said, "I know what that looks like." Resident #1 revealed that RN told her that sometimes the suppliers change, and the medicine can sometimes come in different shapes and colors. Resident also revealed that she took the Tylenol; but this didn't help with the pain. Resident #1 revealed that she told LPN #1 that she didn't get her Percocet and the LPN went to the Director of Nursing (DON) and reported this, the staff came in to talk to her, and the RN got fired. Resident #1 said, "I don't' think she's (RN) mean and tried to withhold it from me; I have no idea what happened to the Percocet." Resident #1 revealed that the Assistant Director of Nursing (ADON) came in and checked on her a little later, the doctor came in to see her and they brought her a Percocet. She revealed that she had a lot of pain issues and had to have her pain medication and she was familiar with what it looked like. On 08/22/23 at 10:35 AM, an interview with LPN #1, revealed that on 08/17/23 at 1:30 PM, she was sitting at the desk updating doctors' orders when Resident #1 walked up to the desk using her rollator walker and asked for her 2:00 PM medications. LPN revealed that RN #1 was the Unit Manager that day, offered to get the medications for Resident #1 and brought Resident #1's pills to her in a medication cup. LPN #1 revealed that a couple minutes later, Resident #1 asked where her Percocet was, and	M 500	September 29, 2023	

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M 500	Continued From page 6	M 500		

she witnessed RN #1 point to the oval white pill in the cup and proceeded to tell her that Percocet comes in different shapes and sizes. LPN #1 revealed that this threw up a red flag to her because she identified the white pill as a Tylenol because it was white and oval shaped. She revealed that she reported this immediately to the DON. LPN #1 revealed that she and RN #1 then counted the entire cart, and a Percocet was missing from the Resident's drug card and had been signed out by RN #1; but was not in Resident #1's cup. LPN #1 stated, "I would recognize it, because I have been giving it to her on a regular basis." She revealed that Resident #1 was concerned that her medications were wrong, and she was assured by LPN #1 that it would be taken care of. LPN #1 revealed that the Percocet was the same shape, size and color as before which was a round white pill and it had been signed out of the Narcotic book; but had not been signed off on the Medication Administration Record (MAR).

On 08/22/23 at 2:20 PM, a phone interview with the DON, revealed that last Thursday, August 17, 2023, LPN #1 had reported to her that she was afraid that RN #1 had taken Resident #1's Percocet. DON revealed that LPN #1 had reported to her that resident had walked up to the nursing station and asked for her 2:00 PM medications, and RN #1 offered to help and took the medication cart keys and gave resident her medications. DON revealed that LPN #1 had told her that she didn't see the Percocet in the medication cup, that she saw what looked like a Tylenol. The DON revealed that she, LPN #1, and RN #1 went immediately and completed a narcotic count, and she sent out a message to the ADM and ADON for an emergency meeting. DON revealed that when ADM arrived back at the

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M 500	Continued From page 7	M 500		

facility, they looked at surveillance camera footage and saw suspicious activity on the video footage with RN#1. She stated that RN #1 shuffled her hands back and forth with the Percocet in her hand, turned the medication cup upside down in her hand and clenched her fist closed and threw the medication cup in the trash can. DON stated that when they interviewed RN #1 that she denied the allegation, and told them that she put Resident #1's Tylenol in one medication cup and put the Percocet and other scheduled medications in a second medication cup. RN #1 revealed that Resident #1 had refused the Tylenol, so she gave her the cup of pills and threw the Tylenol in the trash. DON revealed that they looked through all trash bags and could not find any medication. The DON revealed that they had RN #1 do a urine drug screen and she tested positive for Oxycodone, Benzos, and Amphetamines. RN #1 had informed DON that she had taken an oxycodone on Monday night, 08/14/23 but did not have a prescription for it. The DON revealed that they reported this to the Attorney General's Office and to the Mississippi State Board of Nursing on 08/21/23.

On 08/22/23 at 3:50 PM, a phone interview with RN #1, revealed that on 08/17/23, she was asked to give Resident #1 her 2:00 PM medications because LPN #1 was busy. She stated that Resident #1 was very serious about her medications, and she came up to the desk asking for her Percocet and her other scheduled medications and that Resident #1 normally asked for Tylenol as well. She revealed that she pulled her regular medications and put in one medication cup and put her Tylenol in a different medication cup. She revealed that Resident #1

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M 500	Continued From page 8	M 500		

refused the Tylenol and she put the Tylenol in the trash. She stated that she handed the resident her medications, left the med cart, and went into the break room to get her coffee and then returned to the nursing station. She then revealed that Resident#1 came up to the nursing station and questioned whether she got her Percocet, and I pointed it out to her in the cup. She stated that she was required to take a drug test and it was positive for opioids; but she had taken an oxycodone on Monday night from her family member's bottle. She also revealed that the next day on 08/18/23, she went to Urgent Care and had another drug screen and results were negative. RN stated, "I did not take the Percocet."

Record review of Resident #1's "Controlled Drug Record" was documented that RN #1 signed out an Oxycodone/Apap tablet 5-325 mg on 08/17/23 at 1:30 PM.

Record review of "Daily Staff Roster" dated 08/17/23 revealed that RN #1 was B-Unit Manager, and that LPN #1 was B Unit Nurse.

Record review of "Employee Timecards" revealed that RN#1 was working on 08/17/23 with start time of 7:21 AM and a stop time of 4:57 PM.

Record review of "Employee Timecards" for LPN #1, revealed that she was working on 08/17/23 with start time of 6:32 AM and stop time of 6:49 PM.

Record review of Facility Investigation documented that the allegation was reported to the Mississippi Board of Nursing and confirmation was received on August 21, 2023, at 3:44 PM. Record review also revealed that RN #1 was

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M 500	Continued From page 9 terminated on 08/21/23 at approximately 4:30 PM by phone call from ADM with DON as witness to the conversation. Record review of Resident #1's "Face Sheet" revealed that she was admitted to the facility on 07/21/20 with the following diagnoses to include: Conversion disorder with seizures or convulsions, Polyneuropathy, Age-related Osteoporosis without current pathological fracture, Other Muscle Spasm, Repeated Falls, Sciatica, left side, Chronic Pain, and Dystonia. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/20/23 documented under Section C a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that resident was cognitively intact.	M 500		