STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255269	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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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation (CI) MS #22507 and MS #22555 at the facility on 08/22/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance for CI MS# 22507 and CI MS# 22555 and cited F602 for failure to ensure a resident was free from misappropriation and F609 for failure to report an allegation of misappropriation of resident property to the State Agency. The census at the time of the complaint survey was 108 with a license for 120 bed capacity.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: 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. Findings Include: Record review of facility policy titled: "Abuse,	F 602	• 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, 2023. Follow up pain assessment revealed resident was free of pain. A complete narcotic recount was done on	9/29/23

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

Electronically Signed | 08/30/2023

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F 602	Continued From page 1 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 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	F 602	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: September 29, 2023	

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F 602	Continued From page 2	F 602		

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 she witnessed RN #1 point to the oval white pill in the cup and proceeded to tell her that Percocet

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F 602	Continued From page 3	F 602		

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 facility, they looked at surveillance camera

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F 602	Continued From page 4	F 602		

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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F 602	Continued From page 5	F 602		

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.

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F 602	Continued From page 6 Record review also revealed that RN #1 was 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.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		9/29/23

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F 609	Continued From page 7 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to report an allegation of misappropriation of resident property to the proper authorities for one (1) of three (3) resident reviewed for misappropriation. Resident #1. Findings include: Record review of facility policy titled: "Abuse, Neglect, and Exploitation" with revised date of 10/10/2022, revealed, "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... Reporting/Response A. The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation ...C. When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the	F 609	• Immediately upon reported allegation of misappropriation of resident medication on August 17, 2023, facility Administrator, Director of Nursing, and Assistant Director of Nursing began an investigation. Administrator did not report allegation in a timely manner to the Mississippi Department of Health. Facility administrator will consult with company's Vice President of clinical services on all allegations made to determine appropriate and timely reporting. Vice President of clinical services reviewed the facility's last 3 months' worth of allegations for appropriate and timely reporting on August 21, 2023 with no issues identified. • All admitted residents have the potential to be affected. • Facility Administrator has been in-serviced by facility's Vice President of Clinical Services on reporting allegations of a crime including misappropriation of	

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F 609	Continued From page 8 following procedure will be initiated ...2. The Administrator or designee will: a. Notify the appropriate agencies Immediately, but not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury ...." 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 #1 (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. 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 terminated on 08/21/23 at approximately 4:30 PM by phone call from ADM with DON as witness to the conversation. During an interview with Resident #1 on 08/22/23 at 10:00 AM, she stated 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 Practical Nurse (LPN) #1 was her	F 609	resident property within 2 hours on August 22, 2023. Staff educator began in-services with all staff on abuse, neglect, and misappropriation of resident property on August 17, 2023. • Quality Assurance nurse will audit 3 residents weekly for 2 months beginning August 29, 2023. These residents will be interviewed to ensure that any concerns voiced are identified, promptly investigated, and reported in a timely manner. Findings for this audit as well as all reports misappropriation will be reviewed to ensure reporting guidelines are followed at the Quality Assurance Committee beginning September 28, 2023, and will continue monthly until such time consistent substantial compliance has been met. • Corrective Action Completed: September 29, 2023	

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F 609	Continued From page 9	F 609		

nurse that day, but she was busy at the computer, so Registered Nurse (RN) #1 offered to help and went and got her medicine. Resident confirmed that she looked at her medication that was handed to her by RN #1, and stated to her, "Where's my Percocet?" "I know what that looks like." Resident #1 confirmed that the pill in the cup looked like a Tylenol, and it was oblong and white, and her pain pills were white and round. She stated that she told LPN #1 that she didn't get her Percocet. Resident #1 revealed that the Assistant Director of Nursing (ADON) came in and checked on her a little later, and the doctor came in to see her and they brought her a Percocet. She confirmed that she had a lot of pain issues and had to have her pain medication and she was familiar with what it looked like, and she knew that what RN #1 gave her was not her Percocet.

An interview with LPN #1 on 08/22/23 at 10:35 AM, 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 and she 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 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

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F 609	Continued From page 10	F 609		

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).

A phone interview with the DON on 08/22/23 at 2:20 PM, 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 she immediately contacted the ADM and Assistant DON for an emergency meeting. She stated that when the ADM arrived back at the facility, they looked at surveillance camera footage and saw suspicious activity on the video footage with RN#. 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. She stated that RN#1 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

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F 609	Continued From page 11	F 609		

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 but they failed to report the allegation of misappropriation to the State Agency office.

On 08/22/23 at 3:10 PM, an interview with the ADM, revealed that with this situation she felt like they didn't have enough evidence gathered to report it and was planning on reporting this once the investigation was completed. Administrator confirmed that she failed to report the allegation to the State Agency according to the federal requirements.

Record review of Resident #1's "Controlled Drug Record" was documented that RN #1 signed out an Oxycodone/Apap tablet 5-325mg 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 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, Sciatica, left side, Chronic Pain, and Dystonia.

Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255269	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**

(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 609	Continued From page 12 (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.	F 609		