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
	42PM	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW NURSING & REHABILITATION CENTER	1600 WEST CLAIBORNE AVENUE EXTENDED GREENWOOD, MS 38930

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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI MS #23236 and CI MS 23248) at the facility on 11/8/23 and 11/9/23. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operations for Institutions for the Aged or Infirm. The SA investigated CI MS #23236 for Environment Services and Environment. The facility was not in compliance related to CI MS 23248 for Nursing Services and Resident Rights and M 500 was cited. The facility held a license for 91 beds, with a census of 53.	M 000		
M 500	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	M 500		12/22/23

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M 500	Continued From page 1 nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his 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;	M 500		

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M 500	Continued From page 2 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the 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	M 500		

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M 500	Continued From page 3 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 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	M 500	LPN 1 was in-serviced and counselled by the Director of Nursing on 10/18/2023 on	

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M 500	Continued From page 4 Based on staff and resident interviews, facility policy/procedure review, and record review, the facility failed to ensure the resident's rights of one (1) of six (6) residents sampled received care and services that would meet the professional standards of quality as evidenced by Resident #1 not receiving medications as ordered. Findings include: Review of the facility's policy for "Administering Medications" last revised "December 2012" revealed "Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed." Review of the facility's policy for "Adverse Consequences and Medication Errors" last revised "April 2014" revealed the "...Policy Interpretation and Implementation... 5. A "medication error" is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 6. Examples of medication errors include: c. Wrong dose..." Record review of the facility's "Charge Nurse-LPN (Licensed Practical Nurse)" job description dated "2003" revealed the "Duties and Responsibilities" and the section "Drug Administration Functions" are for the LPN (Licensed Practical Nurse) to "Prepare and administer medications as ordered by the physician." Record review of Resident #1's Physician Orders List revealed orders dated 10/6/23 for	M 500	Medication Administration. Resident #1's 8:00am narcotic was ordered by the Medical Director to be held and monitor for 24 hours for adverse reactions. The Assistant Director of Nursing assessed Resident #1 on 10/18/2023 with no adverse reactions noted. Facility conducted an Emergency QA on 10/18/2023 in regards to the medication error and the Medical Director was in attendance. All residents have the potential to be affected. Nursing staff was in-serviced on 11/9/2023 on by the Director of Nursing on Medication Administration to ensure residents receive care and services that would meet the professional standards. On 11/18/2023 the Assistant Director of Nursing performed a Med Pass checkoff on LPN #1 with no negative findings noted. Checkoffs will begin 11/18/2023 and will be performed on all nurses by the Director of Nursing and Assistant Director of Nursing until all nurses have been observed. Facility held monthly Quality Assurance meeting on 11/22/2023 and discussed the potential findings of the alleged deficient practice and steps on how to prevent from further occurrences. Beginning 11/09/2023 the Director of Nursing will observe medication administration with one nurse per shift one (1) time a week covering all three shifts for four (4) weeks and monthly for three (3) months to ensure residents receive their ordered medication and	

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M 500	Continued From page 5 Roxicodone 30 MG (milligrams) 1 tablet every (q) four (4) hours (hr) and Dilaudid 4 MG tablet three (3) tablets q 4 hrs PRN. All medications are taken by mouth (PO). Record review of the Report of Investigation signed by the Administrator and Director of Nursing (DON) on 11/10/23 revealed, "Date of occurrence: 10-18-23 Time of occurrence 7:00 AM ...9. Unusual occurrence ...Medication Error ...Injury: NO ...Details of investigation ...On 10/18/2023 at approximately 6:25am while conducting a medication count with the oncoming nurse, (Proper Name Licensed Practical Nurse (LPN) #1 noticed she performed a medication error on resident (Proper Name Resident #1). Resident #1's order was for 3 (three) dilaudid and 1 (one) roxicodone to be administered and (LPN#1) administered 1 dilaudid and 3 roxicodone. The medication error occurred two times, once at 12:00am and again at 4:00am on 10/18/2023. (LPN#1) then notified the on-call nurse who in turned notified the Director of Nursing. The facility MD (Medical Doctor) was notified and gave the order to hold (Resident #1's) 8:00am narcotics and monitor for 24 hours for any adverse reactions. The Director of Nursing notified the Pharmacy of the medication error and conducted a narcotic count on all carts with no discrepancies noted with the exception of the medication error. Based on resident interview by the Assistant Director of Nursing, (Resident #1) stated she did not notice the difference in appearance of the medication given but consumed them anyway ..." In an interview with the facility Administrator at 11:20 AM revealed there was a medication error with Resident #1.	M 500	receive care and services that would meet the professional standards. Findings will be reported to the Quality Assurance Performance Improvement Committee by the Assistant Director of Nursing for three (3) months for review and recommendations. The next Quality Assurance meeting is scheduled 12/20/2023 to review the facility findings. The Administrator is responsible for on-going monitoring and compliance.	

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M 500	Continued From page 6 In an interview with the facility's DON on 11/8/23 at 1:20 PM, revealed that nurses are supposed to follow the care plans and that care plans have the medications listed. The care plans are updated when there are changes in the resident's care. She stated that LPN #1 was counseled and re-inserviced on medication administration. She stated she did not in-service the other nurses on medication administration when this incident occurred. Nurses are observed during medication pass by her, the Assistant Director of Nursing (ADON) and pharmacy consultant frequently. She stated the pharmacy consultant will watch medication pass during most visits. In an interview with the ADON on 11/8/23 at 12:40 PM, she revealed, "on 10/18/23 12:00 AM and 4:00 AM (Resident #1) received 3 Roxicodone tablets and 1 Dilaudid tablet at each of those medication passes. She was supposed to get 1 Roxicodone tablet and 3 dilaudid tablets. When I explained to her there was a medication error, she stated she did notice there were 3 blue pills instead of 3 white pills. She never said anything to anyone. This nurse did it twice that shift. The nurse discovered the error at the end of the shift narcotic count. She was counseled and in-serviced on medication errors. The resident's vital signs were monitored for 24 hours. There was no increase in pain and no harm. She said she didn't want the nurse fired. We held all the narcotic pain medication until the 12:00 PM doses. Interview with Resident #1 on 11/8/23 at 2:25 PM, revealed, "What I got was 3, 30 MG Roxicodone and 1, 4 MG Dilaudid. I got it at 12 midnight and again at 4:00 AM on October 18th. I do not know the nurse's name. I did not need any emergency care. The nursing home staff told me about the	M 500		

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M 500	Continued From page 7	M 500		

medication error. They held my other pain meds until 11:00 AM. They wake me up for my pills and it is in the middle of the night. So, I felt 4 pills in my mouth, I didn't see them."

On 11/17/23 at 12:10 PM, a post survey interview with LPN #1 confirmed that she gave Resident #1 the wrong pain medication twice in 1 night. She was unable to recall the date. She said that Resident #1 always sleeps with the television on and she always turns the light on when she goes into the room to give Resident #1 her medications. She stated that Resident #1 will always ask where her Dilaudid is when you take her the Roxicodone. This was found at shift change when I was counting narcotics with the on-coming nurse. The medication count was off. I notified the ADON. Someone else told Resident #1. She confirmed she was counseled and re-inserviced on medication administration. She confirmed that nurses are trained on abuse, neglect, following the care plan and MD orders and med pass administration. She stated that the care plans do include the medications and that staff is supposed to follow the interventions. She stated "No, Ms. (Resident #1) did not act any differently that shift. There were no noted side effects of the medications being given wrong."

Record review on 11/8/23 of Resident #1's Face Sheet revealed she was admitted into the facility on 10/6/23 with diagnoses including Intraductal carcinoma in situ of right breast, Anxiety and Secondary malignant neoplasm of bone.

Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/23 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that Resident #1 is cognitively intact.

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