STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLUFFS REHABILITATION AND HEALTHCARE C	2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey, for CI MS #15898 and #15911, at the facility from 05/09/19 to 05/14/19. The SA determined the complaint, CI MS #15911 regarding an allegation of verbal abuse, was unsubstantiated and no deficiencies were cited. The SA determined the complaint CI MS #15898 was substantiated regarding neglect of care and that the facility was not in compliance with the Minimum Standards for The Institutions For The Aged And Infirm. The SA cited the state statute M500. The census at the time of the survey entrance was 96, and the facility was licensed for 107 beds.	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;	M 500		5/31/19

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M 500	Continued From page 1 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 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	M 500		

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M 500	Continued From page 2	M 500		

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 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

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M 500	Continued From page 3 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 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.	M 500		

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M 500	Continued From page 4 This Statute is not met as evidenced by: Level II Based on record review, staff interview, and policy/procedure review, the facility failed to ensure that five (5) of 11 sampled residents were free from neglect as evidenced by Registered Nurse (RN) #1, who worked from 7:00 PM on 4/30/19, until around 12:30 AM on 5/1/19, left the unit after counting narcotics with Licensed Practical Nurse (LPN) #2, leaving the narcotic keys locked in the medication room; and did not notify the Director of Nursing (DON) or the Administrator that she was leaving. LPN #1 and LPN #2 failed to take responsibility for the direct care of the residents that RN #1 was responsible for, on the 100 and 200 halls, from 12:30 AM on 4/30/19, until around 6:15 AM on 5/1/19. It was determined by the facility that 21 of 27 residents on the 100 and 200 Halls did not receive medications/treatments as ordered on the 7:00 PM to 7:00 AM shift, on 04/30/19 to 05/01/19, with no harm identified. Findings include: Review of the facility's policy/procedure for Neglect, with a revision date of 03/18/19, revealed: "Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness". Review of the facility's investigation, dated 5/3/19, revealed a self reported allegation of neglect by employee RN #1 to multiple residents on 5/1/19. RN #1 was assigned to the 100 and 200 Halls on the night of 4/30/19. She was responsible for the care of each resident on these halls. At 12:30 AM, on 5/1/19, RN #1 clocked out and left the	M 500	M500 Resident Rights 1. Resident Identifier(RI)I#1,RI#2,RI#3, RI#4 and RI#5 were assessed by the Assistant Director of Nursing (ADON) on 5/1/2019 at 8:00am, with no negative findings, Physician was notified by ADON of missed medications. Registered Nurse(RN)#1 was suspended on 5/1/2019 pending investigation and terminated on 05/13/2019 for leaving facility without notifying Administrator or Director of Nursing, leaving 100 and 200 Halls unsupervised after 12:30 am on 5/1/2019, by the Administrator. 2. Facility Residents on 100 and 200 Halls have the potential to be affected by deficit practice. Residents on 100 and 200 Hall,with Brief Interview for Mental Status (BIMS) scores of 12 or higher were interviewed by Director of Nursing/Human Resources/Minimum Data Set Registered Nurses/Staff Development Coordinator/Activity Director/Social Services under the direction of the Administrator and Director of Nursing, on 5/01/19, regarding concerns of abuse or neglect; no concerns noted. RN #2/Staff Coordinator arrived at the facility, on 05/01/19 at 6:15 AM. RN #2 and a Licensed Practical Nurse(LPN) checked blood sugars on the 100 and 200 Halls, there was no problems with the blood sugars. The resident's vital signs were checked, blood sugars were checked, signs and symptoms for possible	

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facility, stating she was unable to work any longer. She placed the medication cart keys in the medication room prior to leaving. RN #1 failed to notify the Administrator and/or the Director of Nursing (DON) of her leaving these halls. It was reported to the Administrator and DON at approximately 8:00 AM on 05/01/19. The investigation revealed an interview with RN #1, revealed she was on call the night of 4/30/19, and had to work Halls 100 and 200. RN #1 said she was not informed that she was to work the halls until 11:00 PM, and she became fatigued and felt she needed to discontinue the medication administration and go home. RN #1 said she asked the other nurses, LPNs #1 and #2, who were on duty on the other halls, to take the keys, but they declined. RN #1 said the only thing she knew to do was place the keys in the medication room. RN #1 said LPN #1 knew where the keys were. RN #1 said she made rounds to check on all the residents on the 100 and 200 Halls prior to leaving, and any resident complaining of pain was provided comfort care, repositioning, and pain medication. RN #1 said she counted the medication cart with LPN #2. The investigation revealed the Administrator interviewed LPN #2 on 5/1/19, who said that at approximately 11:00 PM, on 4/30/19, RN #1 was working the 100 and 200 Halls and stated she was tired and needed to go home. LPN #2 said the medication cart count for those halls was verified. LPN #2 stated RN #1 told him and LPN #1 she was going to lock the keys in the medication room. LPN #2 said he offered to administer pain medications, but RN #1 said "it will be okay until relief comes early in the morning". LPN #2 said at 2:00 AM he called the Staff Development Coordinator and informed her of the situation. The investigation documented that Residents on the 100 and 200 halls with a Brief Interview for Mental Status (BIMS) score of

hypoglycemia and hyperglycemia were assessed, how well the residents rested/slept during the night, any falls/accidents, signs and symptoms of seizure activity was assessed, pain and comfort was assessed, any gastric upset, congestion, and allergies were checked the next morning on 05/01/19, per the facility's nurses. Each resident's physician was notified, and no new orders were received. The ADON arrived at the facility on 05/01/19 at 8:00 AM, and did the assessments on the residents on the 100 and 200 Halls. On 5/1/2019, The Corporate Clinical Specialist completed a "List of Residents Who Missed Medications", the residents' were assessments for possible adverse effects of missing the medications during the night were all negative.

3. Beginning 5/1/19,facility staff participated in abuse/neglect questionnaires to determine knowledge retention on abuse/neglect prohibition training; individuals who could not answer each question correctly were provided one-to-one additional training, In-service education on Abuse/Neglect and Resident's rights By Administrator and Director of Nursing (DON). Beginning on 5/2/2019, facility staff were in-serviced by Corporate Clinical Specialist/Director of Nursing (DON) regarding abuse and neglect prohibition policy, reporting concerns regarding abuse and/or neglect immediately, two hour required reporting timeframe by the facility to the Mississippi

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M 500	Continued From page 6 12 and greater were interviewed and assessed for negative outcomes; none were noted. Residents with BIMS less than 12 were assessed for any negative outcomes, and none were noted. Complete medication (med) review was done to identify any negative adverse reactions from missed meds, and none were identified. Medical Director, resident Physicians and resident Responsible Partys (RPS) were notified. No new orders were received. An AdHOC Quality Assurance (QA) was held with the Medical Director and Interdisciplinary Team (IDT). Education for abuse and neglect, communication, and charge nurse accountability was provided on 5/1/19. RN #1 was suspended pending investigation. Upon completion of investigation, neglect could not be substantiated on the facility's part due to two (2) licensed nurses and a Respiratory Therapist (RT) were in the building after the time RN #1 left, until the start of the next shift. RN #1 was suspended on 05/01/19, and then terminated, LPN #1 was suspended on 05/01/19, for failure to take assignment for halls 100 and 200 between 11:00 PM and 7:00 AM, therefore leaving residents unsupervised. LPN #2 received a verbal warning for 05/01/19, for failure to communicate in a timely. Review of a statement written by RN #1, on 05/01/19, to the Administrator, revealed: Med pass was difficult due to many medications were not on the med cart, the med cart was disorganized, arranged in a chaotic manner which delayed the med pass. Many residents could not receive all of their medications due to the fact the meds were not available, I never received the accessing of the (Name of Pharmacy Automating Dispensing System), but only was given a password. When I checked the computer to see why some of the residents did not have some or	M 500	State Department of Health, Licensure and Certification, protecting residents immediately following allegation of abuse/neglect, Staff communication, Resident Rights, Standards of Practice and notification of Administrator, DON and/or ADON for any concerns. On 5/6/19, representative of the Mississippi Attorney Generals Office provided in-service to facility staff in regards to abuse/neglect prevention, reporting, Vulnerable Adults Act, Medicaid Fraud, types of abuse. On 5/22/19,Corporate Support Administrator/Registered Nurse in-serviced facility staff on Abuse and Neglect Prohibition program including but not limited to the requirement to protect residents, if a staff is involved, they will be suspended, facility is required to report to authorities within two (2) hour time frame, facility is required to conduct a thorough investigation and findings of investigation could lead to staff termination. A Quality Assurance Performance Improvement committee meeting was held on 5/2/19 with the Administrator, the Director of Nursing, the Corporate Clinical Specialist and Medical Director to discuss the incident and the plan. 4. Beginning on 5/27/19, facility department heads including Social Services, Activities, Nursing Leadership, Business Office Manager, Minimum Data Set nurses, Lead Certified Nursing Assistant (C.N.A.), Dietary Manager, Admissions Director, will interview residents in their respective facility areas weekly for twelve (12) weeks, in regards to concerns related to care or treatment from	

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M 500	Continued From page 7 none of their medicines available on the cart, the (Name of Pharmacy) would not allow reorder. It read it was to soon to reorder. This was very frustrating, so I triaged, prioritized by doing accu-checks and administering insulin to the diabetics per the sliding scale (s/s) MD (Doctor) orders, and provided comfort care as stated in previous letter. Interview with RN #1, on 05/09/19 at 11:25 AM, revealed on 04/30/19, she arrived at work at 8:00 AM. RN #1 stated at approximately 5:30 PM, she was notified by RN #2 that she was going to have to work 7:00 PM to 11:00 PM, due to a call in from an Agency Nurse that was scheduled to work the 7:00 PM-7:00 AM shift. RN #1 stated that RN #2 had told her she would attempt to find another nurse to come in to help. RN #1 stated between 10:30 PM and 11:00 PM, RN #2 called and said she couldn't find a replacement nurse and to give the medication cart keys to LPN #1 and LPN #2; for them to split the halls. RN #1 stated she was exhausted and was afraid she would make an error. RN #1 stated that LPN #1 refused to to take the keys and refused to count the narcotics on the medication cart. She stated that LPN #2 did count the narcotic medications for the 100-200 Halls. RN #1 said she rounded on all of the residents on the 100-200 Hall prior to leaving. RN #1 stated neither LPN #1 or LPN #2 would take possession of the narcotic keys for 100-200 Hall, so she left the medication cart keys locked in the medication room. She stated that LPN #1 had the keys to the medication room and saw where the medication cart keys were placed. RN #1 said she did not call or text anyone when she left to let them know she was leaving; she'd already talked to RN #2. Review of the List of Residents who missed	M 500	staff related to abuse and/or neglect issues; any negative concern will be immediately reported to the Administrator or Director of Nursing for further intervention. Beginning on 5/27/19, the Administrator will review the incident log weekly to ensure reportable events have been investigated and reported as required. Beginning on 5/27/19, the Administrator will review the grievance log weekly to ensure any allegations have been investigated and reported as required. A report will be submitted by the Administrator to the Quality Assurance Performance Improvement committee monthly for three (3) months for review and recommendations. The Administrator is responsible for monitoring and compliance.	

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medications, provided by the facility, revealed nine (9) of the 17 residents on the 100 Hall did not receive their medications, accu- checks with sliding scale insulin, and in-and-out Catheterizations at 9:00 PM, on 04/30/19; two (2) of the 10 residents on the 200 Hall did not receive their medications at 8:00 PM; and one (1) resident didn't receive tube flushes every (q) two (2) hours, and Ensure at 8:00 PM. Further review of the list revealed seven (7) of the 17 residents on the 100 Hall did not receive their 1:00 AM medications/treatments, and one (1) resident of the 10 residents on the 200 Hall did not receive their medication at 1:00 AM. Five (5) of the 10 residents on the 200 Hall did not receive their 6:00 AM medications/treatments/accu-checks. There was also two (2) residents who did not receive their tube flushes at 4:00 AM/5:00 AM.

Interview with RN #2, on 05/09/19 at 10:20 AM, revealed she received a text from LPN #2 at 4:05 AM, but did not see it until 4:30 AM. The text stated that no nurse had been on the 100-200 Halls since 11:00 PM. RN #2 stated she had texted LPN #1 and told her and LPN #2 to split the 100-200 Halls. RN #2 texted LPN #2 after 5:00 AM, and told him to do as much as he could, and she was on her way to the facility. RN #2 stated she arrived and clocked in at 6:15 AM, and began working on the 100-200 Halls, after counting the medication carts with LPN #1. She said she assessed the residents on the 100-200 Halls, and there had been no harm.

Interview with LPN #1, on 05/09/19 at 7:00 AM, revealed she did work on 04/30/19 to 05/01/19 on the 7:00 PM to 7:00 AM shift. LPN #1 said she finished her medications at approximately 10:45 PM to 11:00 PM, when RN #1 came to her "about 30 minutes" later and said she was tired and

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"couldn't do it anymore". LPN #1 said she then refused to take the 100-200 Hall medication cart keys from RN #1. LPN #1 stated the nurse from the prior shift had said she (LPN #1) and LPN #2 would have to work three (3) halls that evening. LPN #1 said she had texted the Assistant Director of Nurses (ADON), letting her know she was not going to take three (3) halls. LPN #1 stated that she never got a response from the ADON. LPN #1 said RN #1 showed her where she put the 100-200 Halls medication cart keys in the medication room and left. LPN #1 stated, "No, I didn't call anyone. I felt like I had informed the ADON that I was not taking the keys, and RN #1 should have covered her own residents." LPN #1 stated, "The Certified Nurses Aides (CNAs) never reported anyone was hurt. At that time most residents are sleeping." LPN #1 stated "My shift ended at 7:00 AM. I left when I was done."

Interview with LPN #2, on 05/09/19 at 6:35 AM, revealed that no one took the 100-200 Halls when RN #1 left the facility. LPN #2 said at 4:00 AM, he texted and talked to RN #2/Staff Coordinator Nurse, who said she'd be at the facility in an hour. LPN #2 stated, "I'm not aware of anyone checking on those residents. I assume a CNA was on the hall." LPN #2 stated, "I don't know if RN #1 called anyone before she left.". LPN #2 stated that LPN #1 told him she refused to take those halls. LPN #2 stated that "the bosses" came in and started taking statements. LPN #2 said that no one reported any harm and to his knowledge,no resident was harmed during the night shift.

During an interview, on 05/10/19 at 10:40 AM, the ADON stated, "I got a text from LPN #1 at 7:48 PM stating: "I was just told I had to work three (3) halls again. But I will not be doing that, that is a

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liability to my license and hall 5-6 are the longest halls and they have the most medicare. I don't know who else to go to". The ADON stated she did not see that text until 8:57 PM. The ADON stated, "I called RN #2 when I read the message. I let her know LPN #1 texted and didn't want to split halls. The ADON stated that RN #2 said RN #1 was staying to 11:00 PM, and they (LPN #1 and LPN #2) would split the night shift (11-7). The ADON stated she asked if that was acceptable for the facility, and RN #2 said "yes". The ADON stated she did not call LPN #1. The ADON said she arrived at the facility at 8:00 AM (5/1/19) and did the assessments on the residents on 100 and 200 Halls, and there were no falls or injuries and blood sugars were okay.

An interview, with Certified Nurse Aide (CNA) #1, on 05/09/19 at 9:00 AM, revealed she was assigned to the residents on the 100 Hall and the top of the 200 Hall. She stated that none of her residents fell that shift, or had any adverse events. CNA #1 reported that one (1) resident requested a pill at 1:00 AM, and she went to LPN #2, because he was the first nurse she saw, and reported it to him. CNA #1 said she checked back later with the resident and she said the man nurse brought her the pill (Tylenol) for pain and she was okay. CNA #1 reported no other resident requested any medication, and they all slept throughout the night. CNA #1 reported she was not aware RN #1 had left the building.

An interview, on 05/10/19 at 7:35 AM, with the Respiratory Therapist (RT), revealed she had been working at the facility on a PRN (as needed) basis, and had been an RT for eight (8) years. The RT said she was working on 05/01/19, and was unaware RN #1 had left the building. The RT said she did not know RN #1. The RT stated she

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was taking care of all the resident with tracheostomies (trachs) in the facility and had no problems that night. The RT said she did not really pay much attention to the nurses here or what they were doing. The RT said she had received in-services on abuse and neglect in the last week.

During an interview, on 05/14/19 at 12:50 PM, LPN #3 revealed she worked on the 300 and 600 Halls until 7:00 PM on 4/30/19. LPN #3 said at 7:00 PM, LPN #2 stated she wasn't going to take Hall 100 at 7:00 PM. LPN #3 said she could not recall what RN #1 said, she had already worked all day. LPN #3 stated she knew RN #1 would not want to deal with it at 11:00 PM. LPN #3 stated RN #1 was to leave at 11:00 PM, and LPN #1 and #2 would split the 100 and 200 Halls, the last she knew.

Review of the facility's Daily Assignment sheet, dated 04/30/19, revealed RN #1's name was written in the Charge Nurse block for 7:00 AM to 3:00 PM, with 8:00 AM to 6:00 PM was written in also. RN #1's name was also written in the Nurse block for the 100 and 200 Hall on the 3:00 PM to 11:00 PM shift, and LPN #1's name was written in the 11:00 PM to 7:00 AM block for the 500 and 600 Halls. LPN #2's name was written in the 11:00 PM to 7:00 AM block for the 300 and 400 Halls. Further review of the sheet revealed a Certified Nursing Assistant (CNA) was assigned to Rooms 101 to 202-D (Door), and another CNA was assigned to Rooms 202-W (Window) to 306-W. The name of the 3rd LPN on the 11:00 PM to 7:00 AM shift block for the 100 and 200 Halls was crossed out.

Interviews with Residents #6 thru #11, and several random residents during the survey from

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M 500	Continued From page 12 05/09/19 to 05/14/19, revealed the residents did not identify any concerns with getting their medications. Residents #6 thru #11 had Basic Interview for Mental Status (BIMS) scores ranging from 6 to 15. Only one (1) had a BIMS of 6, one had a BIMS of 11, and one (1) was 14, and three (3) had BIMS of 15. (BIMS of 0-6 means severe cognitive impairment, 7-12 means moderate cognitive impairment and 12-15 means no cognitive impairment). Review of the facility's "List of Residents Who Missed Medications" revealed the residents' assessments for possible adverse effects of missing the medications during the night were all negative. RN #2/Staff Coordinator arrived at the facilty, on 05/01/19 at 6:15 AM. RN #2 checked the computer and discovered some of the bedtime medications/treatments and the medications/treatments due during the night on the 100 and 200 Halls were not administered. RN #2 and a LPN who had arrived already for the day shift began checking blood sugars on the 100 and 200 Halls. RN #2 stated there was no problems with the blood sugars. The resident's vital signs were checked, blood sugars were checked, signs and symptoms for possible hypoglycemia and hyperglycemia were assessed, how well the residents rested/slept during the night, any falls/accidents, signs and symptoms of seizure activity was assessed, pain and comfort was assessed, any gastric upset, congestion, and allergies were checked the next morning on 05/01/19, per the facility's nurses. Each resident's physician was notified, and no new orders were received. The ADON's interview on 05/10/19 at 10:40 AM, revealed she arrived at the facility on 05/01/19 at 8:00 AM, and did the assessments on the residents on the 100 and 200 Halls.	M 500		

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Resident #1
Review of Resident #1's Medication Administration Records (MARs) for April 2019 and May 2019, revealed that on 7:00 PM through 7:00 AM, she missed her 9:00 PM dose of Amitripylline 10 milligrams (MG). The Amitripylline was ordered for Diabetic Neuropathy on 11/07/17. Review of the resident assessments revealed Resident #1 slept great, was up in her wheelchair, up and about smiling, and in good spirits. No pain or discomfort. Vital Signs (v/s) and Oxygen Saturation (O2 Sat) was checked, and no concerns were identified.

Review of the Admission Record revealed Resident #1 was admitted by the facility, on 07/15/15, with diagnoses including Diabetes Type II, Hemiplegia and Hemiparesis, Hypertension, Malignant Neoplasm of Unspecified Female Breast.

Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/14/19, revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated resident was cognitive and able to make her own decisions regarding activities of daily living.

Resident #2
Review of Resident #2's April 2019 and May 2019 MARs revealed on the 7:00 PM to 7:00 AM shift, on 04/30/19 to 05/01/19, she missed Depakote 1000 mg (11/22/17 order date) at 9:00 PM, prescribed for Schizophrenia and Rectiv 0.4% (11/01/18 order date) at 9:00 PM, prescribed for an Annal Fissure on 04/30/19, and Clonidine 0.1 mg (02/14/17 order date) at 1:00 AM, for Hypertension on 5/1/19. Review of the resident assessments revealed Resident #2 slept well with

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no concerns. No dizziness, anxiety, chest pain, or nausea. V/S and O2 Sat was checked, and concerns were identified.

Review of the Admission Record revealed Resident #2 was admitted by the facility, on 02/01/12, with the included diagnoses of Unspecified Sequelae of Unspecified Cerebrovascular Disease, Dysphagia, Schizoaffective Disorder and Unspecified Seizures.

Review of the Quarterly MDS, with an ARD of 04/01/19, revealed a BIMS score of 10, which indicated the resident required some assist to make decisions regarding her activities of daily living.

Resident #3
Review of Resident #3's April and May 2019 MARs revealed on the 7:00 PM to 7:00 AM shift on 04/30/19 to 05/01/19, she missed Metformin 1000 mg (08/15/17 order date) at 6:00 AM, prescribed for Diabetes Mellitus Type II, and Baclofen 20 mg (03/02/19 order date) at 1:00 AM, prescribed for Muscle Spasms. Review of the resident assessments revealed Resident #3 slept good, everything was fine. No pain or spasms. No signs and symptoms (s/s) of hypoglycemia or hyperglycemia. Up in chair.

Review of the Admission Record revealed Resident #3 was admitted by the facility, on 06/28/06, with the included diagnoses of Cerebral Infarction, Muscle Weakness, Diabetes Type II, and Spastic Quad Cerebral Palsy.

Review of the Quarterly MDS, with an ARD of 03/21/19, revealed a BIMS score of 15, which indicated the resident was able to make her own

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decisions.

Resident #4
Review of the April and May 2019 MARs revealed Resident #4 missed Prevastatin 40 mg. (02/21/14 order date) at 9:00 PM on 04/30/19, prescribed for Hyperlipidema, Zantac 300 mg (12/23/14 order date) at 9:00 PM on 04/30/19, prescribed for Gastric Esophageal Reflux (GERD), Zyrtec 10 mg (02/10/18 order date) at 9:00 PM on 04/30/19, prescribed for Pruritus, and Metformin 500 mg (03/03/19 order date) at 1:00 AM on 05/01/19, prescribed for Diabetes Mellitus Type II. Review of the resident assessments revealed Resident #4 was pleasant and smiling. No concerns with congestion, no signs of allergies, no watery eyes or drainage. No Gastric-Intestinal (GI) upset, and no complaints of heartburn. Resident sitting up eating.

Review of the Admission Record revealed Resident #4 was admitted by the facility, on 09/27/13, with the included diagnoses of Hemiplegia and Hemiparesis, Muscle Weakness, and Major Depressive Disorder.

Review of the Quarterly MDS, with an ARD of 01/08/19, revealed a BIMS score of 15, which indicated the resident can make his own decisions.

Resident #5
Review of the April and May 2019 MARS revealed Resident #5 missed Gabapentin 300 mg (11/08/18 order date) at 9:00 PM and Bactrim DS 800-160 mg (04/22/19 order date) at 9:00 PM, prescribed for bacterial infection. Resident #5 refused his in/out catheter at 10:00 PM. Review of the resident assessments revealed Resident #5 refused his medications, which were also

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reoffered by other nurses, and was continued to be offered. Education regarding antibiotic therapy and elevated temperature was provided. V/S and O2 Sat was checked. No concerns were identified, temperature was 99.2 Fahrenheit (F).

Review of the Admission Record revealed Resident #5 was admitted by the facility, on 08/18/17, with the included diagnoses of Cerebral Palsy, Spina Bifida, Depressive Disorder and Anxiety Disorder.

Review of the Quarterly MDS, with an ARD of 01/30/19, revalued a BIMS score of 13, which indicated the resident was able to make his own decisions.

On 05/14/19 at 12:20 PM, an interview with the Administrator revealed she thought RN #1 neglected her residents by leaving and not directly assigning her residents to anyone, and by not calling the DON or herself, to relay the problem. Review of the facility's policy at this time, with the Administrator, for Routine Resident Checks, revealed residents should be checked on by a nurse at least once per eight (8) hour shift. The Administrator stated, RN #1 left at 12:30 AM, and RN #2 arrived to the facility at 6:10 AM.