STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255140	A. BUILDING _____ B. WING _____	C 05/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLUFFS REHABILITATION AND HEALTHCARE CENTER	2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a survey for CI (complaint investigation) MS #15898 and #15911, from 05/09/19 to 05/14/19. The SA determined CI MS #15911, regarding an allegation of verbal abuse, was unsubstantiated and no deficiencies were cited. The SA determined the facility was not compliance with the requirements of participation for Medicare and Medicaid, and substantiated complaint CI MS #15898, regarding standards of practice and neglect. The SA cited F600, F656, and F658 related to CI MS #15898. The census at the time of the survey entrance was 96, and the facility was licensed for 107 beds.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy/procedure review, the facility failed to	F 600	Preparation and submission of this plan of correction by The Bluffs Rehabilitation	5/31/19

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

Electronically Signed | 07/07/2019

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F 600	Continued From page 1 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 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	F 600	and Healthcare, does not constitute an admission or agreement by the provider of truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement under the state and federal laws. F600 □ Abuse & Neglect 1. Resident Identifier (RI)#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	

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F 600	Continued From page 2 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 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.	F 600	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 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	

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F 600	Continued From page 3 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 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	F 600	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 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	

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F 600	Continued From page 4 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 medications, provided by the facility, revealed nine (9) of the 17 residents on the 100 Hall did	F 600	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 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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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 "couldn't do it anymore". LPN #1 said she then

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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 Nursing (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

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said she did not know RN #1. The RT stated she 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.

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

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05/01/19 at 8:00 AM, and did the assessments on the residents on the 100 and 200 Halls.

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

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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 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 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 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,

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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 decisions.

Resident #4
Review of the April 2019 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 2019 and May 2019 MARs revealed Resident #5 missed Gabapentin 300 mg

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F 600	Continued From page 13 (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 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.	F 600		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		5/31/19

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F 656	Continued From page 14 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 15 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and policy/procedure review, the facility failed to follow the Care Plan for medication administration for five (5) of 11 sampled residents reviewed, for Residents #1, #2, #3, #4, and #5. On 4/30/19 and 05/01/19, from 7:00 PM to 7:00 AM, these residents, on the 100 and 200 Halls, were not provided their medications/treatments as ordered due to Registered Nurse (RN) #1's failure to administer the medications. Findings include: Review of the facility's Care Plan policy/procedure, with a revision date of December 2016, revealed the policy statement: "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Resident #1 Review of Resident #1's Care Plan revealed a Focus for the potential for hypoglycemia and hyperglycemia. The Interventions included to administer medications as ordered. Review of Resident #1's Medication Administration Records (MARs) for April 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.	F 656	F656 1. Resident Identifier (RI)#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 related to failure to implement comprehensive Care plan. 2. All residents have the potential to be affected. Registered Nurse(RN) #2/Staff Coordinator arrived at the facility, on 05/01/19 at 6:15 AM and an audit of audit was conducted on residents on 100 and 200 Hall to determine who did not receive meds per Plan of Care, and a "List of Residents Who Missed Medications", was developed by Corporate Clinical Specialist, these residents' were assessments for possible adverse effects of missing the medications during the night were all negative. 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 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	

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F 656	Continued From page 16 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 Care Plan revealed a Focus for an alteration in behaviors. The Interventions included to administer medications as ordered. Review of Resident #2'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 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 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.	F 656	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, with no negative findings related to failure to implement plan of care. 3. Beginning on 5/2/2019, facility staff were in-serviced by Corporate Clinical Specialist/Director of Nursing (DON) regarding 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. Including but not limited to Reporting, Standards of Practice, Medication administration and following the residents plan of care. 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. On 5/2/19, the interdisciplinary team members were educated by Corporate Clinical Specialist in regards to requirement of each resident having comprehensive care plan that is developed by the interdisciplinary team based on assessments of resident	

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F 656	Continued From page 17 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 the Care Plan revealed a Focus for the potential for hypoglycemia and hyperglycemia. The Interventions included to administer medications as ordered. 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 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 decisions. Resident #4 Review of the Care Plan revealed a Focus for Gastric Esophageal Reflux Disease (GERD), Hypoglycemia and/or Hyperglycemia, and alteration in pain and comfort. The Interventions included to administer medications as ordered. Review of the April and May 2019 MARs revealed	F 656	specific care needs. On 5/22/19 Corporate Support Administrator/Registered Nurse in-serviced facility staff regarding requirement of facility to develop, implement and revise a comprehensive care plan for that addresses each residents specific care needs. 4. Beginning 5/27/19, an audit will be conducted weekly for four (4) weeks, then monthly for three (3) months by the Director of Nursing/Assistant Director of Nursing to review the implementation for three (3) residents care plan for implementation. The Director of Nursing/Assistant Director of Nursing//Staff Development Coordinator/Registered nurse will perform observation of three (3) licensed nurses during medication administration to observe for medications given as ordered weekly for four (4) weeks, then monthly for three (3) months. 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 resident rights, or any concerns such as Medication administratation; any negative concern will be immediately reported to the Administrator or Director of Nursing for further intervention. A report will be submitted to the Quality Assurance	

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F 656	Continued From page 18 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 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 Care Plan revealed a Focus for history of Urinary Tract Infections (UTIs), 04/22/19 currently being treated for a UTI, and alteration in pain and comfort. The Interventions included to administer medications as ordered. 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 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	F 656	Performance Improvement committee monthly for three (3) months by the Director of Nursing for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance.	

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Anxiety Disorder.

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

Interview with RN #1, on 05/09/19 at 11:25 AM, revealed she started to work at 8:00 AM on 04/30/19. 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 said she would attempt to find another nurse to come in to help her, but 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 and LPN #2, the other nurses at the facility, refused to to take the medication cart keys, so she locked them in the medication room, where the nurse's would have access to the cart. RN #1 said she rounded on all of the residents on 100-200 Hall prior to her leaving to ensure they didn't need anything. RN #1 said she did not call or text anyone when she left to let them know she was leaving.

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

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F 656	Continued From page 20 meds were not available. She stated when she checked the computer to see why some of the residents did not have some or none of their medicines available on the cart, the (Name of Pharmacy) would not allow reorder; it read it was to soon to reorder. The RN documented that this was very frustrating, so she 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. An interview with Registered Nurse (RN) #3/Minimum Data Set (MDS) Nurse, on 05/14/19 at 11:00 AM, revealed she stated, "Care plans are done on admit. Comprehensive care plans are done within 21 days of admit. All nurses should follow the care plans."	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, facility policy review, and the Mississippi Nurse Practice Law review, the facility failed to meet professional standards of practice for five (5) of 11 sampled residents reviewed, (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5). This was evidenced by Registered Nurse (RN) #1 clocked out and left the facility at 12:30 AM on 5/1/19, and failed to give some and/or all of the medications that were ordered to residents on the 100-200	F 658	F656 1. Resident Identifier(RI)#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 related to failure to implement comprehensive Care plan. Registered Nurse(RN)#1 was suspended on 5/1/2019 pending investigation and terminated on 05/13/2019 for leaving facility without	5/31/19

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F 658	Continued From page 21 Hall. RN #1 failed to notify the Administrator and Director of Nursing (DON) of her departure, and Licensed Practical Nurse (LPN) #1 and LPN #2 did not take responsibility for the residents on the 100 and 200 Halls that had been assigned to RN #1. There were medications/treatments for 21 of the 27 residents residing on the 100 and 200 Halls on 04/30/19 to 05/01/19, during the 7:00 PM to 7:00 AM shift, that the facility identified as affected, per investigation. No resident had any adverse effects per facility assessment. Findings include: Review of the Mississippi Nursing Practice Law, with an effective date of July 1, 2010, revealed on pages three and four (3 & 4) of 26: 73-15-5 Definitions. (2) The practice of nursing by a registered nurse means the performance for compensation of services which requires substantial knowledge of biological, physical, behavioral, psychological, and sociological sciences, and of nursing theory as the basis for assessment, diagnosis, planning intervention, and evaluation in the promotion, maintenance of health; management of individual's responses, to illness, injury or infirmity; the restoration of optimum function; or the achievement of a dignified death. Nursing practice includes, but is not limited to, administration, teaching, counseling, delegation, and supervision of nursing, and execution of the medical regimen, including the administration of medications, and treatments prescribed by any licensed or legally authorized physician, or dentist. (5) The practice of nursing by a licensed practical nurse means the performance for compensation of services requiring basic knowledge of the biological, physical, behavioral, psychological, and	F 658	notifying Administrator or Director of Nursing, leaving 100 and 200 Halls unsupervised after 12:30 am on 5/1/2019, by the Administrator. 2. All residents have the potential to be affected. RN #2/Staff Coordinator arrived at the facility, on 05/01/19 at 6:15 AM and an audit was conducted on residents on 100 and 200 Hall to determine who did not receive meds per Plan of Care, and a "List of Residents Who Missed Medications", was developed by the Corporate Clinical Specialist, these residents' were assessments for possible adverse effects of missing the medications during the night were all negative. 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 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, with no negative findings related to failure to administer	

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F 658	Continued From page 22 sociological sciences, and of nursing procedures which do not require the substantial skill, judgement, and knowledge required of a registered nurse. These services are performed under the direction of a registered nurse, or a licensed physician, or licensed dentist, and utilize standardized procedures in the observation, and care of the ill, injured, and infirm; in the maintenance of health; in action to safeguard life and health; and in the administration of medications, and treatments prescribed by any licensed physician, or licensed dentist authorized by state law to prescribe. Record review of the facility's "Position Description", updated on 04/2017, for a Registered Nurse, revealed: Registered Nurses oversee the activities of the nursing staff. The RN is responsible for overseeing each patient's overall health and medical histories so the RN can ensure that each individual receives the best care possible. The RN plans, implements and documents nursing care. The RN performs various patient tests and administers medications within the scope of practice of the RN. Record review of the facility's "Position Description", updated 04/2017, for a Licensed Practical Nurse, revealed that the LPN is to "Perform delegated independent nursing functions using established procedures, policies, guidelines and standards as observed by the registered nurse" and to "Administer medication accurately, observing patient response, as evidenced by documentation in the medical record and lack of negative outcomes." Review of the facility's investigation, dated May 3, 2019, revealed a self reported allegation of	F 658	medications as ordered per the plan of care. 3. Beginning on 5/2/2019, facility staff were in-serviced by Corporate Clinical Specialist/Director of Nursing (DON) regarding 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. Including but not limited to Reporting, Standards of Practice, Medication administration and following the residents plan of care. 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. On 5/2/19, the interdisciplinary team members were educated by Corporate Clinical Specialist in regards to requirement of each resident having comprehensive care plan that is developed by the interdisciplinary team based on assessments of resident specific care needs. On 5/22/19 Corporate Support Administrator/Registered Nurse in-serviced facility staff regarding requirement of facility to develop, implement and revise a comprehensive care plan for that addresses each	

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F 658	Continued From page 23 neglect by employee (Name of Registered Nurse) RN #1 to multiple residents on May 1, 2019. RN #1 was assigned to the 100 and 200 Halls on the night of April 30, 2019. She was responsible for the care of each resident on these halls. At 12:30 AM, on May 1, 2019, RN #1 clocked out and left the 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 report documented an interview with RN #1, by the Administrator, and RN #1 stated she was on call the night of April 30, 2019 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, Licensed Practical Nurses (LPNs) #1 and #2, that were on duty on the other halls, to take the keys, but they refused. 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 were provided comfort care, repositioning, and pain medication. RN #1 said she counted the medication cart with LPN #2. The Administrator interviewed LPN #2 on May 1, 2019. LPN #2 said that at approximately 11:00 PM, April 30, 2019, RN #1 was working the 100 and 200 Halls, and stated she was tired and needed to go home. LPN #2 said he verified the medication cart count for those halls. LPN #2 stated RN #1 told him and LPN #1 she was going to lock the keys in the	F 658	residents specific care needs. 4. Beginning 5/27/19, an audit will be conducted weekly for four (4) weeks, then monthly for three (3) months by the Director of Nursing/Assistant Director of Nursing to review the comprehensive care plan and its implementation for three (3) residents. 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 staff related to abuse and/or neglect issues or services provided; any negative concern will be immediately reported to the Administrator or Director of Nursing for further intervention. A report will be submitted to the Quality Assurance Performance Improvement committee monthly for three (3) months by the Director of Nursing for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance.	

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medication room. LPN #2 said at 2:00 AM he called the Staff Development Coordinator/RN #2, and informed her of the situation. The investigation documented that Residents on 100 and 200 hall with BIMS 12 and greater were interviewed and assessed for negative outcomes and none were noted. Residents with BIMS less than 12 was assessed for any negative outcomes, and none were noted. Complete medication review was performed to identify any negative adverse reactions from missed meds, and none were identified. The Medical Director, resident Physicians and resident RPs were notified. No new orders were received. An AdHOC Quality Assurance (QA) was held with Medical Director and Interdisciplinary Team (IDT) about the situation. Education for abuse and neglect, communication, charge nurse accountability was initiated 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 an 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 PM and 7 AM, therefore leaving residents unsupervised. LPN #2 received a verbal warning on 05/01/19, for failure to communicate to administration in a timely manner.

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. At approximately 5:30 PM, RN #1 stated she was notified she would have to work from 7:00 PM to 11:00 PM, by RN #2,due to a call in from an Agency Nurse that was scheduled to work the

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7:00 PM-7:00 AM shift. RN #1 stated that RN #2 told her she would attempt to find another nurse to come in to help her. 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, and for them to split the halls. RN #1 stated she was exhausted and was afraid she would make an error if she stayed. RN #1 stated that both LPN #1 and LPN #2 refused to to take the keys and LPN #1 refused to count the narcotics on the medication cart. RN #1 stated that LPN #2 did count the narcotic medications for 100-200 Halls. RN #1 said she rounded on all of the residents on 100-200 Hall prior to her leaving. RN #1 stated she left the medication cart keys locked in the medication room, where LPN #1 was aware and had keys to the room. RN #1 said she did not call or text anyone when she left to let them know she was leaving.

Review of the List of Residents who missed 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, and two (2) of the 10 residents on the 200 Hall did not receive their medications at 8:00 PM, and one resident was to receive 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

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receive their tube flushes at 4:00 AM/5 AM.

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 of 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 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 #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. She 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 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,

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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 "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 LPN #1 and LPN #2 would have to work three (3) halls that evening. LPN #1 said she had texted the Assistant Director of Nursing (ADON), and told the ADON that the previous shift nurse had said LPN #1 and LPN #2 would have to split three halls. LPN #1 said she texted the ADON saying she was not going to take three 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 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 RN #2/Staff Coordinator Nurse, and he talked to RN #2 and she 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." "I don't know if RN #1 called anyone before she left." LPN #2 stated, LPN #1 told me she refused to take those halls." LPN #2 stated that "the bosses" came in and

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started taking statements." LPN #2 said no resident was harmed.

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, and 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.

An interview, on 05/10/19 at 10:40 AM, revealed the Assistant Nursing Director (ADON) stated, "I got a text from LPN #1 at 7:48 PM stating, "I was just told I had to work three halls again. But I will not be doing that, that is a 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. RN #2 said RN #1 was staying to 11:00 PM, and they would split the night shift 11-7. I 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 and did the assessments on the residents on 100 and 200 Halls, and there were no falls or injuries

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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 anything. CNA #1 reported one (1) resident requested a pill at 1 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). CNA #1 reported no other resident requested any medication, and they all slept through out the night. CNA #1 reported she was not aware RN #1 had left the building.

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 facility, 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

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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 AM, and did the assessments on the residents on the 100 and 200 Halls.

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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255140	A. BUILDING _____ B. WING _____	C 05/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLUFFS REHABILITATION AND HEALTHCARE CENTER	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) COMPLETION DATE
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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 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.

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	255140	A. BUILDING _____ B. WING _____	C 05/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 32	F 658		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255140	A. BUILDING _____ B. WING _____	C 05/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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.