STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255127	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tishomingo Comm Living Center	1410 West Quitman Street Iuka, MS 38852

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41878 Based on resident and staff interviews and record review, and the facility policy the facility failed to notify the provider of an increase in blood pressure for one (1) of three (3) residents reviewed for blood pressure monitoring. Resident #55 Findings include: Record review of facility policy titled, Blood Pressure, Measuring dated 8/25/24, revealed, Hypertension is usually defined as blood pressure over 140/90 mm/Hg (although the elderly often have persistent systolic readings from 140 to 160 mm/Hg). Hypertension should be reported to the physician. Record review of facility policy titled, Notification of Changes in a Resident's Condition or Status, undated, revealed, It is the policy of this facility to inform the resident, consult with his or her physician, and notify, consistent with his/her authority, the resident's representative of changes in the resident's condition and/or status. The policy also revealed, 1. Nursing services shall be responsible for notifying the resident's attending physician when: . b. There is a significant change in the resident's physical, mental, or psychosocial status . f. Notification is deemed necessary or appropriate in the best interest of the resident. Record review of facility policy titled, Change in a Resident's Condition or Status, dated 8/2023, revealed, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. 1. The nurse will notify the resident's attending physician or physician on call when there has been a . d. significant change in the resident's physical/emotional mental condition. Record review of Vital Signs In service dated March 14, 2008, revealed, Vital signs are important indicators of how well the vital organs of the body such as the heart and lungs are functioning. Changes in vital signs are a good indicator of a person's health. Blood Pressure shows how well the heart is working. The normal range for the systolic is between 100 - 140 and 60 to 90 for the diastolic. Always report abnormal or changes in vital signs to the nurse. During an interview on 7/30/24 at 8:50 AM, Resident #55 revealed he had hypertension and his blood pressure had been elevated several times recently and he wondered if his medications had been changed. He stated he had mentioned this to the nurses and had been told they would continue to monitor his blood pressure. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 11:15 AM, an interview with the Director of Nursing (DON) revealed she had not been able to determine for certain how this resident's blood pressure readings were not reported, but it appeared the vital signs may have been entered by the Certified Nursing Assistants (CNA)'s and the nurses did not monitor these values closely enough. She confirmed the nurses should monitor the blood pressure values and should notify the provider if the blood pressure is not within the normal parameters and document this into the resident's record and there was a failure in this process. She stated the facility did not have a standing order on when to notify the physician, but they used the attached Vital Signs In service for acceptable parameters and anything outside those values should be reported. The DON confirmed the facility failed to notify the physician of changes of the resident's condition that could have indicated a clinical complication or led to devastating results such as a stroke. She stated notification to the provider should be done for each resident with a change of their clinical condition to ensure proper treatment was given. During a phone interview on 7/31/24 at 9:30 AM, Resident #55's Medical Doctor revealed on admission, she was concerned that the resident had some hypotensive episodes and his blood pressure was within normal limits at that time and no blood pressure medications were ordered at the facility. She stated she was uncertain, but thought she had been notified of his increased blood pressure once and treatment was given, but she was not aware of any other times she was notified due to increased blood pressure. She stated if she had been notified of other times Resident #55 had increased blood pressure, she would have made changes, as needed. Record review of Resident #55's Weights and Vitals Summary revealed multiple blood pressure values that exceeded the facility's policy's definition of hypertension of 140/90. Record review of increased values over the past eight days included: 7/21/24 - 177/125; 7/22/24 - 164/91; 7/22/24 - 170/55; 7/23/24 - 175/93; 7/23/24 - 187/98; 7/24/24 - 174/123; 7/25/24 - 170/116; 7/26/24 - 160/100; 7/29/24 - 160/90; 7/29/24 - 186/128; 7/30/24 - 152/95. Review of resident's record revealed none of these blood pressure values had been reported to the provider. Record review of Resident #55's Admission Record revealed the facility admitted the resident on 4/9/24. Diagnosis included an admission diagnosis of hypertension. Record review of Resident #55's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/16/24 revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated this resident was cognitively intact.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 41878 Based on resident and staff interviews and record review, the facility failed to notify the resident's representative in writing and the Ombudsman of the emergency transfer to the hospital for one (1) of two (2) residents reviewed for hospitalization . Resident #22 Findings include: Record review of letter dated 7/31/24 on facility letterhead revealed, The facility does not have a policy that states the Responsible Party and/or Ombudsman must be notified in writing of Emergency Transfers. During an interview on 07/29/24 at 11:55 AM, Resident #22 revealed she had been in the hospital recently but she did not remember the date of this. An interview with the Administrator on 7/30/24 at 2:10 PM, revealed the notification to the Ombudsman was not provided and the written notification to Resident #22's representative was not provided. She stated the Medical Records Nurse was the person responsible for this and failed to send these notifications due to the resident returning within a few hours of leaving facility and her name was accidentally removed from the transfer list. She confirmed the notifications were needed to ensure the required people were aware of an emergency transfer and the facility failed to provide the notifications as required to the resident's representative and to the Ombudsman. On 7/31/24 at 8:15 AM, an interview with the Medical Records Nurse revealed she was responsible for the notifications to the Ombudsman and to the resident's representative. She stated the resident only stayed at the hospital briefly and her name was inadvertently removed from the transfer system and therefore, she overlooked it. She confirmed it was an oversight on her part and she was making an additional check list so this would not occur again. Record review of Progress Note dated 5/2/24 at 11:29 AM, revealed, . MD notified and order to send to ER for evaluation and treatment. Record review of Physician's Orders revealed there was not an order to send to the emergency room . Record review of letter on facility letterhead dated 7/31/24 revealed, We are unable to provide the Physician Order in Point Click Care to send resident to the ER to be evaluated and treated on 5/2/24. Attached is a letter from the Medical Doctor (proper name of Resident #22's physician) verifying that she gave a verbal telephone order to the nurse on duty to send this resident to the ER to be evaluated and treated. Record review of letter from Resident #22's physician revealed, Nurse at (proper name of facility) was given verbal orders over the telephone to send resident (proper name of Resident #22) to the emergency department after a fall on 5/2/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #22's Admission Record revealed the facility admitted the resident on 12/20/23. Diagnoses included heart failure, type 2 diabetes mellitus, dementia, hypertension, and repeated falls. Record review of Resident #22's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/12/24, revealed a Brief Interview for Mental Status (BIMS) of 11 which indicated moderate cognitive impairment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41878 Based on staff interview, record review and the facility policy the facility failed to develop a care plan for a resident with a history of hypertension for one (1) of 19 care plans reviewed. Resident #55 Findings included: Record review of facility policy titled, Care Plans, Comprehensive Person-Centered, dated 11/22, revealed, 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. The policy also revealed, 7. The comprehensive, person-centered care plan . b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, . e. reflects currently recognized standards of practice for problem areas and conditions. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. An interview with Resident #55 on 7/30/24 at 8:50 AM revealed he had a history of hypertension and his blood pressure had been high several times recently and the staff informed him they would continue to monitor this. Record review of Resident #55's care plan revealed there was no care plan for hypertension or for a history of hypertension. An interview on 7/31/24 at 8:30 AM, with the Minimum Data Set (MDS) Registered Nurse (RN)revealed she was responsible for MDS entries and care plan development. She stated when this resident was admitted , she failed to list hypertension since he was not actively receiving treatment for hypertension. She stated the diagnosis of history of hypertension should have been added and she failed to do this. With this diagnosis, parameters and interventions would have been added to the care plan. She confirmed the care plan should address the resident's needs and preferences and guide the staff in the care of the resident and it was human error that she failed to address the resident's history of hypertension. During an interview on 7/31/24 at 9:15 AM, the Director of Nursing (DON) confirmed the resident had a history of hypertension and the facility failed to develop a care plan with interventions for the staff to use as a guide for care. She stated a care plan would have offered interventions and parameters's for the resident's blood pressure monitoring. Record review of Resident #55's Admission Record revealed the facility admitted the resident on 4/9/24. Diagnosis included an admission diagnosis of hypertension. Record review of Resident #55's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/16/24 revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated this resident was cognitively intact.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 Based on observation, resident and staff interview, record review and facility policy review, the facility failed to prevent the possibility of an accident while administering medications for one (1) of four (4) residents observed for medication administration. Resident #34 Findings Include: Review of the facility policy titled, Medication Administration-General Guidelines with a revision date of 8/25/14 revealed under Procedure .#1. Preparation: e. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing . An interview and observation on 07/29/24 at 10:44 AM with Resident #34 revealed that her only problem was a huge pill they give her, and she cannot swallow it. She stated it gets stuck in her throat and she just has to let it dissolve. She revealed she told the nurse this morning, but she told her it would not be much longer, and she would not have to take them anymore. An interview on 7/30/24 at 8:00 AM with Licensed Practical Nurse (LPN) #1 confirmed that Resident #34 had complained in the past that the Amoxicillin tablet was big but had never asked to have it split or crushed. An observation on 7/30/24 at 8:05 AM revealed LPN #1 administered the following medications. 1.) Amlodipine Berate 5 mg (milligram) PO one time per day 2.) Metoprolol 50 mg PO one time per day 3.) Potassium 99 mg PO one time per day 4.) Cholecalciferol 1000 units =2 tabs (tablets) one time per day 5.) Amoxicillin 875/125 mg PO BID 6.) Phenytoin 100 mg PO BID 7.) [NAME] lax 1 scoop=17 gm (gram) with water one time per day An observation and interview on 7/30/24 at 8:05 AM revealed LPN #1 ask Resident #34 if she would like for her to break the Amoxicillin in half since it was so big. The resident stated yes please that thing gets stuck in my throat, and it just sits there all day. An interview on 7/30/24 at 8:20 AM with LPN #1 revealed when Resident #34 had complained of the pill being so big in the past, she had not offered to split the pill. She stated that she should have offered to split it or get an order to crush it. She stated that the residents last swallow test was good, but again that is a big pill, and she could have choked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 7/30/24 at 10:50 AM with the Director of Nurses (DON) admitted that if Resident #34 was complaining of the pill being too big then the nurse should have offered to have split the pill, because she could have choked. An interview on 07/30/24 at 3:11 PM with the Consultant Pharmacist revealed there would have been no problem crushing that Amoxicillin. An interview on 07/30/24 03:17 PM with the DON confirmed that the Amoxicillin could have been crushed or the nurse could have called and got an order for liquid. An interview on 8/1/24 at 8:50 AM with LPN #1 confirmed that she attended the in-service about what medications were crushable, but she just did not think about crushing Resident #34's large antibiotic pill, because none of her other medications were getting crushed. Record review of the facility in-services revealed an in-service on 6/4/24 that included crushable medications and was attended by LPN #1. Record review of Resident #34's Physicians orders revealed an order dated 7/23/24 for Amoxicillin-Pot Clavulanate Tablet 875-125 MG (Milligrams). Give 1 tablet by mouth two times a day for UTI (Urinary Tract Infection) related to Urinary Tract Infection, site not specified for 7 (seven) days. Record review of Resident #34's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Wedge Compression Fracture of First Lumbar Vertebra, Subsequent encounter for fracture with routine healing.