

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Parkway Health & Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 230 River Oaks Drive Canton, MS 39046	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157</p> <p>Based on observation, staff interview, record review, and facility policy, the facility failed to ensure a resident's right to be free from misappropriation of property when a bottle of Morphine Sulfate was found altered in color composition and not properly accounted for on the medication administration record for (1) one of three (3) residents reviewed for misappropriation. (Resident #1)</p> <p>Findings include:</p> <p>Review of the facility policy titled, Abuse Prevention Program, with no revision date revealed, Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation .</p> <p>Review of the facility policy titled, Controlled Substances, with no revision date revealed under the Policy Statement :The facility complies with the laws, regulations and other requirements related to handling, storage, disposal, and documentation of controlled substances .</p> <p>An interview on 1/14/25 at 8:00 AM, with the Director of Nursing (DON) confirmed there had been a narcotic diversion investigation back in September 2024 regarding Resident #1.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a continued interview with the DON and record review of the facility investigation/video surveillance on 1/14/25 at 9:10 AM, she revealed that on the morning of Monday 9/16/24 the day shift nurse Licensed Practical Nurse (LPN) #1 reported to her that after drawing up Resident #1's morphine from her only vial that was dated 9/6/24, he discovered that the medicine was not the color it was supposed to be. She stated that he immediately brought it to her, and she confirmed that the liquid inside the vial was clear and was supposed to be a light blue. She reported that the Hospice nurse was notified and that they brought a new bottle of morphine, and the medicine was blue in color. The DON stated she immediately contacted all nurses who had access to the morphine on the 100-hall cart and requested that they meet at the clinic on 9/16/24 for a random drug screen related to a narcotic concern. She revealed that all the nurses complied with the random drug screen except for LPN #2. She stated that after LPN #2 did not comply with a drug screen, the Administrator reviewed the video footage of the 100 hallways for the weekend and found on 9/14/24 at approximately 3:00 PM, LPN #2 was observed to position her medication cart in front of room [ROOM NUMBER] with the medication drawers facing the inside of the room. LPN #2 was observed to reach into the narcotic box, pull out the Morphine box, insert the syringe into the morphine bottle, pull back on the syringe, remove the syringe and go into the bathroom of room [ROOM NUMBER]. She then returned to the medication cart, inserted the syringe into the morphine again, pulled back on the syringe, then went back into the bathroom of room [ROOM NUMBER]. The DON also confirmed based on the investigation, the video, and the failure of LPN #2 to submit to a drug screen, the undeniable change in the color of the liquid morphine, the allegation of diversion was substantiated by the facility.</p> <p>An observation and interview on 1/14/25 at 9:20 AM of the Morphine vial dated 9/6/24 compared to the vial dated 9/16/24 with the DON confirmed that the morphine dated 9/6/24 was notably a few shades lighter blue than the one dated 9/16/24. The DON confirmed there were no other bottles of morphine in the 100-hall medication cart at the time of the incident.</p> <p>Record review of the Termination Report for LPN #2 revealed the facility terminated her on 9/17/24 for failure to comply with narcotic investigation. LPN #2's last day to work was 9/15/24.</p> <p>Record review of Resident #2's September 2024 Order Summary Report revealed this residents' location was room [ROOM NUMBER] and there were no orders for any narcotics for this resident.</p> <p>Record review of the Admission Record revealed Resident #2 was admitted by the facility on 6/05/24 and discharged on [DATE].</p> <p>An interview with LPN #1 on 1/14/25 at 10:10 AM, revealed that on the morning of 9/16/24 he went in to give Resident #1 some morphine and did not see anything in the syringe. He then revealed he shook the medicine up and attempted to withdraw the morphine again and realized the liquid in the syringe was clear. He stated that he had administered the morphine to Resident #1 on Friday 9/13/24 and the medication was blue at that time. He confirmed that there were no other bottles of morphine on the medication cart at the time that the morphine was found to be a different color. LPN #1 stated he notified the DON, the Administrator, and called hospice to have a new bottle of morphine delivered. LPN #1 stated the new bottle of morphine that was delivered was a much brighter blue color.</p> <p>Record review of the Order Summary Report for Resident #1 revealed an order to admit to Hospice on 9/05/24 related to Chronic Obstructive Pulmonary Disease (COPD) and Morphine Sulfate Oral Solution 20 mg (milligram) 5 (five) ml (milliliters): give 0.5 ml sublingual every 4 (four) hours as needed for pain and wheezing for 14 days, dated 9/05/24.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Individual Patient Narcotic-Controlled Drug form for Resident #1 for Morphine Sulfate 100 mg/5 ml was received on 9/6/24 by LPN #1 with 30 ml in the bottle.</p> <p>A record review of the Individual Patient Narcotic-Controlled Drug form for Resident #1 morphine sulfate revealed on 9/14/24 that five doses of morphine were signed out by LPN #2 at 8:30 AM, 11:00 AM, 2:00 PM, 6:00 PM, and 9:00 PM; on 9/15/24 a dose of morphine was signed out by LPN #2 at 2:00 PM.</p> <p>Record review of the Admission Record revealed Resident #1 was admitted by the facility on 10/14/22 with diagnoses of Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure with Hypoxia.</p> <p>Record review of Resident #1's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/16/24, revealed Section O: Special Treatments, Procedures, and Programs coded as receiving Hospice services while a resident.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157</p> <p>Based on staff interview, record review, and facility policy review, the facility failed to report an allegation of narcotic diversion/misappropriation of property to the State Agency (SA) for one (1) of three (3) residents reviewed for narcotic diversion/misappropriation of property. (Resident #1)</p> <p>Cross Reference F602</p> <p>Findings include:</p> <p>Review of the facility policy titled, Abuse, Neglect, Exploitation, or Misappropriation- Reporting and Investigating, with a revision date of 09/2022 revealed under the Policy Interpretation and Implementation .1. If resident .misappropriation of property .is suspected, the suspicion must be reported immediately to . 2. a. The state licensing/certification agency responsible for surveying/licensing the facility .</p> <p>Upon entrance to the facility on [DATE] at 8:00 AM, the Director of Nursing (DON) confirmed that they had one reportable incident that was a narcotic diversion investigation involving Resident #1 in 09/2024.</p> <p>Record review of the facility investigation, dated 9/19/24 involving Resident #1, revealed there was no notification of the narcotic diversion investigation to the State Agency.</p> <p>In an interview with the DON regarding the narcotic diversion investigation on 1/14/25 at 9:10 AM, she revealed on the morning of Monday 9/16/24 the day shift nurse Licensed Practical Nurse (LPN) #1 came to her and let her know that the liquid narcotic for Resident #1 was not the color it should be. She stated the liquid morphine the facility receives is a clear blue color. The DON and LPN #1 together assessed the morphine to be clear once again when pulled in the syringe. The Hospice nurse was called and brought a new bottle of morphine to the facility for Resident #1. The DON revealed the bottle of morphine delivered on 9/6/24 and the new bottle of morphine was delivered on 9/16/24 for Resident #1 were compared, and the bottle dated 9/6/24 was a lighter clear blue color than the new bottle recently delivered. She stated the Morphine in question was removed from the narcotic count and locked up securely. The DON stated she immediately contacted all nurses who had access to the morphine on the 100-hall cart to meet at the clinic at 1:00 PM on 9/16/24 for a random drug screen related to a narcotic concern. She revealed all the nurses complied with doing the random drug screen with no positive results for narcotics, except for LPN #2. She stated that after LPN #2 did not comply with a drug screen, the Administrator reviewed the video footage of the 100 hallways for the weekend and found on 9/14/24 at approximately 3:00 PM, LPN #2 was observed to position her medication cart in front of room [ROOM NUMBER] with the medication drawers facing the inside of the room. LPN #2 was observed to reach into the narcotic box, pull out the Morphine box, insert the syringe into the morphine bottle, pull back on the syringe, remove the syringe and go into the bathroom of room [ROOM NUMBER]. She then returned to the medication cart, inserted the syringe into the morphine again, pulled back on the syringe, then went back into the bathroom of room [ROOM NUMBER].</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Order Summary Report for Resident #1 revealed an order for Morphine Sulfate Oral Solution 20 mg (milligram) 5 (five) ml (milliliters): give 0.5 ml sublingual every 4 (four) hours as needed for pain and wheezing for 14 days, dated 9/05/24.</p> <p>In an interview with the DON on 1/14/25 at 9:00 AM, she revealed she thought she had reported it to the SA, but she was unable to find any documentation that she had reported the incident and confirmed that she should have reported it. She then confirmed the allegation of narcotic diversion should have been immediately reported as part of the investigation process to ensure thorough investigation and follow-up is completed for the investigation.</p> <p>Review of the Admission Record revealed Resident #1 was admitted by the facility on 10/14/22 with diagnoses of Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure with Hypoxia.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>47157</p> <p>Based on staff interview, record review, and facility policy review, the facility failed to accurately document the administration of PRN (as needed) pain medication in the electronic medication system for one (1) of three (3) residents reviewed for narcotic administration. Resident #1</p> <p>Findings include:</p> <p>Review of the facility policy titled, Controlled Substances, with no revision date revealed, Policy Statement: The facility complies with the laws, regulations and other requirements related to handling, storage, disposal, and documentation of controlled substances .</p> <p>Review of the facility policy titled, Charting Documentation, with revision date 07/2017 revealed, Policy Interpretation and Implementation: 2.) The following information is to be documented in the resident medical record .b. Medications administered .</p> <p>Record review of the Order Summary Report for Resident #1 revealed an order of Morphine Sulfate Oral Solution 20 mg (milligram)/5 (five) ml (milliliters): give 0.5 ml sublingual every 4 (four) hours as needed for pain and wheezing for 14 days dated 9/5/24.</p> <p>Record review of the individual Patient Narcotic -Controlled Drug form for Resident #1 morphine sulfate revealed on 9/13/24 a dose was signed out by LPN #1 at 9:30 PM; on 9/14/24 five doses of morphine were signed out by LPN #2 at 8:30 AM, 11:00 AM, 2:00 PM, 6:00 PM, and 9:00 PM and on 9/15/24 revealed a dose of morphine was signed out by LPN #2 at 2:00 PM.</p> <p>Record review of Resident #1's Medication Administration Record (MAR) dated 9/1/24-9/30/24 revealed there was no documentation of a dose of Morphine being given on 9/13/24 at 9:30 PM; on 9/14/24 at 8:30 AM, 11:00 AM 2:00 PM, 6:00 PM and 9:00 PM or on 9/15/24 at 2:00 PM.</p> <p>In an interview with LPN #1 on 1/14/25 at 10:10 AM, he confirmed that he did administer morphine to Resident #1 on 9/13/24 at 9:30 PM and failed to document the medication that was given. He stated that it is important to sign the MAR, to prove it was given, to let other staff know the time of the last medication, and if it was effective. He also stated it could be reflective of diversion of narcotics.</p> <p>In an interview with LPN #3 on 1/14/25 at 3:00 PM she revealed all narcotics should be signed out on the narcotic sheet and on the MAR. She stated if a narcotic is not documented given on the MAR, then it looks like staff did not administer the medication and provides an inaccurate record.</p> <p>In an interview with the Director of Nursing (DON) on 1/14/25 at 3:05 PM, she confirmed that narcotics should be signed out on the narcotic sheet and on the MAR, otherwise it could appear as if staff were diverting narcotics, or they were missing. She revealed the purpose of documenting narcotic medications given on the medication record is to show staff gave it and are following physician's orders.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Admission Record revealed Resident #1 was admitted by the facility on 10/14/22 with diagnoses of Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure with Hypoxia.</p>