STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255277	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greene County Health and Rehabilitation	1017 Jackson Street Leakesville, MS 39451

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)
F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	Based on interviews, record review, and facility policy review, the facility failed to ensure that medications were administered in accordance with accepted standards of nursing practice and professional guidelines for one (1) of four (4) sampled residents (Resident #1) as evidenced by Licensed Practical Nurse (LPN) #1 failed to verify the resident's identity before administering medications and pre-pulled medications without immediate administration, resulting in Resident #1 receiving another resident's medications. This error caused the resident to experience an adverse drug reaction, decreased level of consciousness, and required transfer to an acute care hospital for intravenous (IV) fluids, potassium therapy, oxygen therapy, and observation.Findings include:A review of the facility's policy titled Administering Medications, revised April 2019, revealed, .Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation.9. The individual administering the medication verifies the resident's identity before giving the resident his/her medications.A record review of the facility's investigation revealed that on 5/15/25, at 10:09 AM, Licensed Practical Nurse (LPN) #1 administered medications to Resident #1. Resident #1 was assessed at 11:47 AM and received an order for evaluation at the emergency room (ER) at 12:10 PM. A Certified Nurse Aide (CNA) reported that she attempted to wake Resident #1 for lunch and saw a medication cup in the resident's trash can labeled with another resident's name. Resident #1 was treated with intravenous fluids and potassium replacement and remained in the ER overnight for observation.A review of the Medication Error Report, dated 5/16/25, revealed, .resident received wrong medication. Meds had been placed in cups with res (resident) names on cups. Wrong med cup given to resident. AEB (As evidenced by) a cup with another resident's name found in trash can.A record review of a handwritten statement by LPN #1, dated 5/18/25, revealed, On 5/15/25 during my med (medication) pass I accidentally administered the wrong medication to a resident.I take full responsibility for this error and deeply regret any distress or risk caused to the resident.A record review of the acute hospital documentation for Resident #1 revealed, .Brought from rehab with report of possible seizure less than 30 minutes ago.Upon assessment by staff she was noted to be drowsy but would clasp hands together and move extremities spontaneously. Upon arrival to ED (Emergency Department), CNA from the rehab disclosed she saw a cup of pills that may have not belonged to the patient. Nursing staff reported she may have received another patient's meds to include Vimpat, Keppra, Gabitril, hydrocodone, and clonazepam. Further review revealed the resident received Intravenous (IV) Normal Saline with potassium and was administered four (4) liters of oxygen at the hospital. A record review of the admission Record revealed the facility admitted Resident #1 on 5/10/25 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and Type 2 Diabetes Mellitus.A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/21/25, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.On 7/24/25 at 11:40 AM, during an interview, CNA #1 stated that when she entered Resident #1's room, she found the resident slumped in a chair, unresponsive to voice, and minimally responsive to physical stimulation. She noted this was not normal for the resident. While assisting the resident, CNA #1 observed a medication cup in the resident's trash can labeled with another resident's name. Recognizing a potential error, she immediately notified Registered Nurse (RN) #1.On 7/24/25 at 12:12 PM, during an interview, RN #1 stated that after being informed of a change in Resident #1's responsiveness, she immediately assessed the resident and noted the altered mental status. She notified the Nurse Practitioner (NP), who recommended transfer to the emergency department. RN #1 reported that CNA #1 informed her of the medication cup found in the room and that it was labeled with another resident's name. RN #1 stated that when she became aware that the medications given to the resident were not hers, she provided the NP with the full medication list that matched the other resident.On 7/24/25 at 1:00 PM, during an interview with Director of Nursing (DON), she confirmed that on 5/15/25, LPN #1, an agency nurse, pre-pulled Resident #2's medication and labeled the cup. The DON explained that the resident was in the shower, and the nurse intended to administer them once the resident returned. However, LPN #1 later administered the medication to Resident #1 without confirming the residents' identity. The DON acknowledged that this action violated the facility's medication administration policy and the professional nursing standard known as the five rights (right resident, right medication, right dose, right route, and right time). The DON confirmed that this failure did not reflect the standard of nursing care expected at the facility. She confirmed that LPN #1 did not pre-pull medications for any other residents and that this was an isolated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Based on interview, record review, and facility policy review, the facility failed to ensure that a resident was free from a significant medication error for one (1) of four (4) sampled residents, as evidenced by Resident #1 received another resident's medications, which caused a change in mental status requiring hospital evaluation, overnight observation, and treatment, including intravenous (IV) fluids, potassium replacement, and oxygen therapy. Findings include:A review of the facility's policy titled, Administering Medications, revised April 2019, revealed, .Medications are administered in a safe and timely manner, and as prescribed . 9. The individual administering the medication verifies the resident's identity before giving the resident his/her medications.Resident #1A record review of the admission Record revealed the facility admitted Resident #1 on 5/10/25 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and Type 2 Diabetes Mellitus.A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/21/25, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.Resident #2A record review of the admission Record revealed the facility admitted Resident #2 on September 29, 2021, with diagnoses of Epilepsy and Type 2 Diabetes Mellitus.A record review of Resident #2's Order Summary Report confirmed active orders for, Allopurinol 300 mg (milligram), Bacid oral capsule, Clonazepam 0.5 mg, Ergocalciferol 1.25 mg (5000 units), Hydrocodone-Acetaminophen 5-325 mg, Lacosamide 200 mg, Levetiracetam 750 mg (two tablets), Mag Ox 400 oral tablet, Metformin HCL 1000 mg, Sitagliptin Phosphate 100 mg, and Tiagabine HCL 4 mg.A record review of the facility's investigation revealed that on 5/15/25, at 10:09 AM, Licensed Practical Nurse (LPN) #1 administered medications to Resident #1. Resident #1 was assessed at 11:47 AM and received an order for evaluation at the emergency room (ER) at 12:10 PM. A Certified Nurse Aide (CNA) reported that she attempted to wake Resident #1 for lunch and saw a medication cup in the resident's trash can labeled with another resident's name. Resident #1 was treated with intravenous fluids and potassium replacement and remained in the ER overnight for observation.A review of the Medication Error Report, dated 5/16/25, revealed, .resident received wrong medication. Meds had been placed in cups with res (resident) names on cups. Wrong med cup given to resident. AEB (As evidenced by) a cup with another resident's name found in trash can.A record review of a handwritten statement by LPN #1, dated 5/18/25, revealed, On 5/15/25 during my med (medication) pass I accidentally administered the wrong medication to a resident.I take full responsibility for this error and deeply regret any distress or risk caused to the resident.A record review of the acute hospital documentation for Resident #1 revealed, .Brought from rehab with report of possible seizure less than 30 minutes ago.Upon assessment by staff she was noted to be drowsy but would clasp hands together and move extremities spontaneously. Upon arrival to ED (Emergency Department), CNA from the rehab disclosed she saw a cup of pills that may have not belonged to the patient. Nursing staff reported she may have received another patient's meds to include Vimpat, Keppra, Gabitril, hydrocodone, and clonazepam. Further review revealed the resident received Intravenous (IV) Normal Saline with potassium and was administered four (4) liters of oxygen at the hospital.During an interview conducted on 7/24/25 at 11:40 AM, CNA #1 stated that Resident #1 slumped in her chair and was unresponsive. This was unusual for the resident so she reported the change to the Registered Nurse (RN). She also found a medication cup in the resident's trash can that had another resident's name on it. During an interview on 7/24/25 at 12:12 PM, RN #1 confirmed that after being informed of the resident's condition, she assessed Resident #1, noted altered mental status, and contacted the Nurse Practitioner (NP) for evaluation. RN #1 confirmed that the medication cup in the room did not belong to Resident #1 and that the medications matched the profile of another resident (Resident #2).During an interview on 7/24/25 at 1:00 PM, the Director of Nursing (DON) confirmed that LPN #1, an agency nurse, administered another resident's medications to Resident #1 without verifying the resident's identity. She confirmed that this was a significant medication error resulting in the resident's transfer to the hospital for treatment.During an interview on 7/24/25 at 1:30 PM, the Administrator confirmed that LPN #1 failed to follow facility protocols and the five (5) rights of medication administration (right resident, medication, dose, time, and route).During a phone interview conducted on 7/24/25 at 5:00 PM, LPN #1 admitted she mistakenly administered another resident's medications to Resident #1 causing a significant medication error.