STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255294	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbough Health and Rehabilitation Center	340 Desoto Ave Extended Clarksdale, MS 38614

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 47158 Based on record review, staff interview and facility policy review the facility failed to ensure residents were free from significant medication errors for seven (7) of 30 residents reviewed. Resident #1, #2, #3, #4, #5, #6, and #7. Findings Include: Record review of the facility policy, titled Administering Medications with a revision date of 04/2019 revealed Policy Statement, Medications are administered in a safe and timely manner and as prescribed . Record review of a facility investigation revealed that on 2/20/25 Registered Nurse (RN) #1 notified the Director of Nursing (DON) that she had not given medication to seven (7) of the residents she was assigned to for the 7:00 AM to 3:00 PM shift. The DON conducted an audit and verified that seven (7) out of 30 residents RN #1 was assigned to for the 7:00 AM to 3:00 PM shift had not received their scheduled medications. Record review of Resident #1 and Resident #7's written statement dated 2/21/25 confirmed the resident did not receive their scheduled medicines on time on 2/20/25. Record review of the Medication Administration Audit Report, Documentation Type: Missed dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/25 for all residents in the facility revealed that Residents #1, #2, #3, #4, #5, #6 and #7 had no documentation of administration of medications scheduled between 7:00 AM and 3:00 PM on 2/20/25. Resident #1 Record review of the Medication Administration Audit Report, Documentation Type: Missed dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #1 had active orders that included Metoprolol Succinate ER Oral Tablet Extended Release 24-hour 25 milligram (mg) give one (1) tablet by mouth one time a day with missed dose at 9:00 AM, Eliquis Oral Tablet 5 mg give 1 tablet by mouth two (2) times a day with missed dose at 9:00 AM, Cozaar Oral Tablet 50 mg give one (1) tablet by mouth one time a day with missed dose at 9:00 AM, and Dilantin Oral Capsule 100 mg 2 capsules three (3) times a day, with a missed dose at 9:00 AM and 1:00 PM. Record review of the Admission Record revealed that the facility admitted Resident #1 on 2/13/25 with diagnoses that included Cerebral Infarction, Hyperlipidemia, Occlusion and Stenosis of Bilateral Carotid Arteries, and Hypertension. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 Record review of Medication Administration Audit Report, Documentation Type: Missed dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #2 had active orders that included Rivaroxaban Tablet 20 mg give 1 tablet by mouth one time a day, with a missed dose at 9:00 AM. Record review of the Admission Record revealed that the facility admitted Resident #2 on 10/29/21 with diagnoses that included Acute Kidney Failure, Protein-Calorie Malnutrition, Peripheral Vascular Disease and Hypertension. Resident #3 Record review of Medication Administration Audit Report, Documentation Type: Missed dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #3 had active orders that included Hydralazine Hydrochloride (HCL) Tablet 100 mg give 1 tablet by mouth 3 times a day, with a missed dose at 9:00 AM and 1:00 PM. Keppra Tablet 500 mg give 1 tablet by mouth 2 times a day, with a missed dose at 9:00 AM. Amlodipine Besylate Tablet 10 mg give 1 tablet by mouth one time a day, with a missed dose at 9:00 AM. Carvedilol Tablet 12.5 mg give 1 tablet by mouth 2 times a day, with a missed dose at 9:00 AM. Spironolactone Oral Tablet 25 mg give 12.5 mg by mouth one time a day, with a missed dose at 9:00 AM. Record review of the Admission Record revealed that the facility admitted Resident #3 on 12/8/18 with diagnoses that included Cerebral Infarction, Hypertension, Congestive Heart Failure, Other Seizures, and Cardiomyopathy. Resident #4 Record review of Medication Administration Audit Report, Documentation Type: Missed dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #4 had active orders that included Hydralazine Hydrochloride (HCL) Tablet 25 mg give 1 tablet by mouth 1 time a day, with a missed dose at 9:00 AM. Keppra Tablet 500 mg give 1 tablet by mouth 2 times a day, with a missed dose at 9:00 AM. Coreg Tablet 3.125 mg give 1 tablet by mouth 2 times a day, with a missed dose at 9:00 AM. Record review of the Admission Record revealed that the facility admitted Resident #4 on 2/1/25 with diagnoses that included Diabetes Mellitus, Hypertension, Chronic Venous Hypertension, Gastro-Esophagel Reflux Disease, and Atherosclerotic Heard Disease. Resident #5 Record review of Medication Administration Audit Report, Documentation Type: Missed dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #5 had active orders that included Metformin HCL Oral Tablet 500 mg give 1 tablet by mouth 2 times a day with a missed dose at 9:00 AM. Lisinopril Oral T ablet 2.5 mg give 1 tablet by mouth 1 time a day, with a missed dose at 9:00 AM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Admission Record revealed that the facility admitted Resident #5 on 1/30/25 with diagnoses that included Diabetes Mellitus, Hypertension, and Dementia. Resident #6 Record review of Medication Administration Audit Report, Documentation Type: Missed dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #6 had active orders that included Amlodipine Besylate Oral Tablet 5 mg give 1 tablet by mouth 1 time a day with a missed dose at 9:00 AM. Lacosamide Oral Tablet 200 mg give 1 tablet 1 time a day with a missed dose at 9:00 AM. Levetiracetam Oral Tablet 750 mg give 1 tablet in the morning with a missed dose at 9:00 AM. Cephalexin Oral Tablet 500 mg give 500 mg by mouth 2 times a day with a missed dose at 9:00 AM. Hydralazine HCL Oral Tablet 50 mg give 1 tablet by mouth 2 times a day with a missed dose at 9:00 AM. Lasix Oral Tablet 40 mg give 1 tablet by mouth 2 times a day with a missed dose at 9:00 AM. Sinemet Oral Tablet 25-100 mg give 1 tablet by mouth 3 times a day with missed doses at 10:00 AM and 2:00 PM. Record review of the Admission Record revealed that the facility admitted Resident #6 on 2/28/24 with diagnoses that included Parkinsonism, Angina Pectoris, Congestive Heart Failure, Myoclonus, Visual Hallucinations, Tremor, and Unspecified Convulsions. Resident # 7 Record review of Medication Administration Audit Report, Documentation Type: Missed dated and timed 2/20/25 at 3:59 PM for medications scheduled for 2/20/2 revealed Resident #7 had active orders that included Enalapril Maleate Oral Tablet 10 mg give 1 tablet 1 time a day with a missed dose at 9:00 AM. Record review of the Admission Record revealed that the facility admitted Resident #7 on 2/21/24 with diagnoses that included Protein-Calorie Malnutrition and Hypertension. An interview with the Staff Development Nurse (SDN) on 2/26/25 at 10:00 AM, she confirmed that on 2/20/25 RN #1 was assigned to the medication cart for 7:00 AM to 7:00 PM due to a call in. She stated that if there is a call in then an on-call nurse or supervisor is pulled to the cart to cover. She stated that she offered to assist RN #1 but was told she did not need any help. She stated that she offered to assist RN #1 again by checking blood sugars and vital signs around lunch but was told that she did not need help. She stated later in the afternoon she overheard RN #1 complaining to other staff and she called her into the DON ' s office to talk with her. She stated at that time RN #1 became agitated and turned in her resignation. She stated at that time RN #1 informed the DON of a list of residents that she had not yet administered medications to. SDN stated she assisted the DON with the care of the residents in that section. An interview with RN #2 on 2/26/25 at 10:30 AM, she stated that the Supervisor may get pulled to work the med cart once about every two (2) weeks. She stated that all staff is trained to administer medications and if they are not comfortable then they can notify the Supervisors or DON in order to get more training. She stated that she tries to watch staff to see if they need help and help them. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse (LPN) #1 on 2/26/25 at 10:45 AM, she stated that she worked on 2/20/25 and was assigned the opposite hall from RN #1. She revealed that she did hear the SDN offer to assist RN #1 with med pass. LPN #1 revealed she did not have any trouble getting assistance if needed and that administrative staff was very helpful. A telephone interview with RN #1 on 2/26/25 at 11:16 AM, she revealed that she had worked at the facility for about a month and 2/20/25 was the first time she had worked independently on medication administration and no one offered her any assistance. She then admitted that she had previously followed a nurse on medication administration. She revealed that around 3:00 PM the SDN called her into the DON's office about her attitude and at that time she gave report, counted narcotics and gave the DON a list of residents that she had not given medications to yet. She stated she had just not gotten to those residents yet. A follow up interview with the SDN on 2/26/25 at 11:30 AM, she stated that RN #1 had never complained about working on the medication cart before and that she had previously worked on the med cart on 2/10/25, 2/14/25 and 2/19/25 with no issues noted. An interview with the Administrator on 2/26/25 at 2:05 PM he verified that he was present and heard the SDN offer RN #1 assistance, but she declined it. He verified that it was his expectation that RN #1 would have administered the residents' medications timely as ordered.