STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255329	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison CO NH	1421-A East Peace Street 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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on staff interview, record review, and facility policy review the facility failed to ensure a resident was free from abuse and misappropriation of resident property when a resident was found to have 36 oxycodone pain pills missing from the narcotic box for (1) one of (6) six residents narcotics reviewed. (Resident #1) Findings include: Review of the facility policy titled, Abuse Policy & Procedure, with no revision date, revealed that each resident of the facility has the right to be free from misappropriation of property. The policy further defines misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful use of a resident's belongings without the resident's consent. During an interview on 5/12/25 at 11:30 AM with the Director of Nursing (DON) related to a facility reported incident of drug diversion, she confirmed that narcotic drug diversion occurred involving Resident #1. The DON reported that on the morning of 2/13/25, staff notified her that a card of oxycodone 10 mg, delivered on 2/3/25, was missing from the medication cart. Staff indicated that it was unlikely the resident had taken 60 pills in a week's time. Upon investigation, it was discovered that 120 pills of oxycodone were delivered for Resident #1 on 2/3/25. On 2/12/25, a card of oxycodone was deducted from the Controlled Drug Record for Resident #1. However, upon reviewing the Medication Administration Record for Resident #1, it was noted that only 24 oxycodone pills had been signed out as administered between the time the Oxycodone card was added and removed from the medication cart. The DON revealed she questioned Licensed Practical Nurse (LPN) #1, who had removed the card from the count. She stated that LPN #1 verbalized that she administered the last dose of oxycodone, deducted the card from the count, and placed the narcotic card in the shred box, with the completed narcotic sheet placed in the medical record's box. The DON confirmed that she holds the only key to the shred box and was unable to locate the medication card for Resident #1 in the box. Additionally, no narcotic sheet for the oxycodone was found in the medical record box. The DON confirmed that upon completing the investigation, she validated there was a narcotic diversion because 36 of the 120 oxycodone pills delivered on 2/3/25 for Resident #1 were unaccounted for. Record review of the Physician's Order Report for Resident #1 from 2/1/25-2/28/25 revealed an order dated 12/30/24 for oxycodone 10 mg, one tablet by mouth every six (6) hours as needed for pain. (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a written statement from LPN #2 revealed that on the morning of 2/13/25, she noticed that the first card of 120 oxycodone pills was missing from the medication cart. LPN #2 reported the missing medication to the DON because the medication was ordered every six hours, and the calculation did not add up. Record review of a written statement from LPN #1 indicated that she worked on the medication cart from 7:00 AM to 3:00 PM, Monday through Friday, and dosed Resident #1 with oxycodone daily. On 2/12/25, she administered the last two pills from the card and placed the card in the shred box. Record review of the pharmacy receipt dated 2/3/25 revealed Resident #1 had prescription (RX) # N803917 two cards of oxycodone 10 mg with a total quantity of 120 pills delivered to the facility. Record review of the Controlled Drug Record revealed that on 2/3/25, 120 pills (two cards of 60 pills) of oxycodone, RX #N8039713, were added to the narcotic count form on the dayshift. On 2/12/25, a card of oxycodone, RX #N8039713, was deducted from the narcotic count form on the dayshift. Record review of the 'Medication Record' for Resident #1 with the DON on 5/12/25 at 12:10 PM revealed that, from 2/3/25-2/12/25, during the time oxycodone for Resident #1 was added and removed from the narcotic count, 24 pills were documented as administered. Review of the Face Sheet revealed that Resident #1 was admitted to the facility on [DATE] with diagnoses that included Unspecified Pain. Record review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/13/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on staff interviews, record review, and facility policy review, the facility failed to ensure a resident was free from a significant medication error resulting in harm for one (1) of (6) six residents reviewed for narcotic medication administration (Resident #2). Findings include: A review of the facility policy titled, Adverse Consequences and Medication Errors, revealed under Policy Interpretation and Implementation: 5.) A Medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer specifications, or accepted standards and principles of the professional providing services. Section 6 listed wrong dose as an example of a medication error. During an interview with the Director of Nursing (DON) on 5/12/25 at 11:30 AM regarding a facility-reported significant medication error, she stated that on 4/23/25 at 10:00 PM, Resident #2 was administered the incorrect dosage of morphine sulfate. The DON reported receiving a call at approximately 11:00 PM when the end-of-shift narcotic count was found to be incorrect. She stated Licensed Practical Nurse (LPN) #3 reported that the morphine sulfate was delivered without a syringe, so she used a plastic medication cup to administer the dose. The DON stated the medication cup had the lowest measurable line of 2.5 ml (milliliter), while the prescribed dose was only 0.25 ml. She reported that LPN #3 was asked to mark on the cup where she had poured the dose, and the mark was at the 2.5 ml line. The DON confirmed the resident required Narcan (a medication primarily used to reverse opioid overdoses) due to a significant change in condition and respiratory status following the medication error. She stated the Narcan was effective, and the residents' vital signs began to recover. The DON reported that the day prior to receiving the morphine, Resident #2 had attended bingo activities twice. An observation of the plastic medication cup with the DON on 5/12/25 at 11:45 AM confirmed a black line marked at the 2.5 ml level, which LPN #3 had indicated was the amount she administered. During an interview with LPN #4 on 5/12/25 at 1:20 PM, she stated that at the start of her shift on 4/23/25 at 11:00 PM, she and LPN #3 completed the narcotic count and found the morphine sulfate count was incorrect. She stated that LPN #3 reported the pharmacy did not send a syringe, so she used a medication cup and indicated the 2.5 ml line as the amount given. LPN #4 confirmed the medication cup's lowest measurement line was 2.5 ml. She stated she immediately reported the error to the provider, Hospice, and the DON, and monitored the resident closely due to observed changes in respiratory status. During a phone interview with LPN #3 on 5/12/25 at 3:33 PM, she confirmed she worked the 3:00 PM-11:00 PM shift on 4/23/25 and administered the first dose of morphine sulfate to Resident #2 from the new bottle. She confirmed the pharmacy did not send a syringe and she could not locate one, so she used a plastic medication cup. When asked how she measured the dose, she stated she poured to the lowest line on the cup. LPN #3 confirmed she again she did not locate a syringe or call for direction before administering the medication. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Pharmacy Consultant on 5/12/25 at 3:40 PM, he confirmed he was aware of the significant medication error involving Resident #2. He stated that morphine sulfate should never be administered without a calibrated measuring syringe and that the use of an inaccurate measuring device increases the risk for overdose, sedation, respiratory depression, and other complications. Record review of the Physician Order Report dated 4/1/25 through 4/30/25 revealed an order dated 4/22/25 for morphine concentrate 100 mg (milligrams)/5 ml (20 mg/ml), to administer 0.25 ml every hour as needed by mouth (PO) or sublingually (SL) for pain or air hunger. A subsequent order dated 4/24/25 directed Narcan (naloxone) nasal spray 2 mg to be administered one time now. Record review of the Medication Administration Record for Resident #2 revealed morphine concentrate was signed off as administered on 4/23/25 at 10:20 PM by Licensed Practical Nurse (LPN) #3. Record review of the Progress Notes dated 4/23/25 at 3:33 PM for Resident #2 documented that the resident was alert, awake, and responsive to verbal and physical stimuli. On 4/24/25 at 2:01 AM, progress notes documented oxygen saturation at 81%, heart rate of 55, and respiratory rate of 12. Despite cueing to breathe deeply and continued oxygen use, the resident's saturation levels did not improve. Record review of the Progress Notes for Resident #2 dated 4/24/25 at 10:14 AM documented that the resident had an altered mental status and was difficult to arouse. At 10:21 AM, the resident was noted to be unresponsive. The medical doctor was notified and gave a now order for Narcan. Vital signs at that time included a blood pressure of 131/78, heart rate of 33, respiratory rate of 11, and oxygen saturation of 68%. Emergency services were contacted, and Narcan was administered. Post-administration vital signs showed improvement: BP 131/78, HR 111, RR 16, O2 79%. Review of a document from the Food and Drug Administration (FDA), last revised 12/2023, titled Morphine Sulfate Oral Solution under Warnings and Precautions, stated: Instruct caregivers to always use the enclosed calibrated oral syringe when administering morphine oral concentrate to ensure the dose is measured and administered accurately. Under Use in Specific Populations: Renal Impairment, the document stated that morphine pharmacokinetics are altered in patients with renal failure, with increased exposure and reduced clearance, and that metabolites may accumulate to higher plasma levels. Review of a document from the FDA, last revised 11/2015, titled NARCAN Nasal Spray described Narcan as an opioid antagonist indicated for the emergency treatment of known or suspected opioid overdose, as manifested by respiratory and/or central nervous system depression. Record review of the Face Sheet revealed that Resident #2 was admitted to the facility on [DATE] with medical diagnoses that included Chronic Kidney Disease, Stage 3. Record review of Resident #2's Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 4/7/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #2 was cognitively intact.