STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A178	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jasper County NH	15 A South Sixth Street Bay Springs, MS 39422

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42807 Based on interviews, record reviews, and facility policy review, the facility failed to ensure services provided met current professional standards when Licensed Practical Nurse (LPN) #1 prepared two (2) residents medications simultaneously and administered the wrong medications to Resident #1, resulting in the resident being admitted to the intensive care unit (ICU) of a local acute care hospital due to an adverse reaction for one (1) of four (4) sampled residents. Resident #1 Findings Included: A review of the facility policy titled Medication Set-Up and Administration, revised 5/31/2023, revealed, Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice .8. Identify residents by photo in the electronic medication administration record (EMAR). (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	Record review of the facility's Incident Note revealed, 12/15/2024 22:56 (10:56 PM) Incident Note .@1930 (7:30 PM) arrived to station 4 and notified of cart nurse (LPN #1) medication error. Logged into point click care to observe medications given in error. Obtain resident's allergies and medication list. While gathering data, delegated to cart nurse to obtain vitals. Resident awake, alert, and oriented. Vitals 99/55bp (blood pressure), 80p (pulse), O2 95% (oxygen saturation) . (At) 1945 MD notified of medication error and resident's condition. Order given to monitor resident bp for three hours; every 15 minutes the first hours, then thirty minutes the last two hours. Notified cart nurse of order. Cart nurse notified that resident bp decreased to 81/28. Resident awake, alert, oriented, and voice no c/o (complaints of) discomfort at time. Explained to resident that he will be placed in Trendelenburg position to help reduce bp from decreasing significantly. Placed in Trendelenburg with feet propped on pillow. (At) 1948 (7:48 PM) DON notified of med error. 1950 (7:50 PM) RR (Resident Representative) notified of medication error and order to be monitor for three hours. RR wanted to explanation as to how medication error occurred. Explained that Charge Nurse (CN) was unaware of the exact details of the error, apologized for error, and if any changes CN will notify of changes. 2200 (10:00 PM) Cart nurse notified that resident was c/o difficult of breathing in Trendelenburg position and that she has to raise his head for comfort. Vitals was obtained with bp resulting in 63/19 and Md was notified immediately. Order obtained to send to (local hospital). 2205 Emergency service was called. 2208 RR . notified that resident was being sent to ER (emergency room). RR stated, I am not happy and will be meeting with y'all tomorrow. (At) 2222 (10:22 PM) Emergency service arrived. vitals obtained with bp resulting to 60/40. EMT (Emergency Medical Technician) stated that he had to get bp stable before moving resident. IV (Intravenous) line started in right forearm by EMT. IV bolus given by EMT. Vitals obtain with bp 90/70. Resident then moved to stretcher. Resident awake, alert, and oriented. Resident asked for cell phone to be transferred with him. Placed on lap. Resident left facility with Emergency Service at 2242 (10:42 PM). Record review of the Physician Orders for Resident #1 revealed physician's order, 12/15/2024 to SEND TO (Acute hospital) DUE TO ADVERSE REACTION one time only for Prophylaxis (Prevention) . Record review of the written Witness Statement, signed by LPN #1 and dated 12/15/24 revealed LPN #1 had given the wrong medications to Resident #1 accidentally and immediately realized it wasn't his medications. The statement included measures taken by LPN #1 following the error, which included notification of the LPN #2, the Charge Nurse, the resident's physician, Resident Representative (RR), and the Director of Nursing (DON). Record review of the acute hospital's Final Report, dated 12/26/24, revealed Resident #1 was admitted to the acute care facility following transfer from (the facility) for accidental medication ingestion. Patient was given the wrong medications by nursing staff at the facility .Medications included Lisinopril 40 mg (milligrams), Lipitor 20 mg, Carvedilol 25 mg, Hydroxyzine 25 mg, and Seroquel 50 mg. Upon arrival to ER (emergency room) patient was noted to be bradycardic and hypotensive requiring IV fluids and Levophed for blood pressure control .Patient is being admitted to ICU . On 1/02/24 at 1:30 PM, an interview Resident #1 stated that he recalled receiving the wrong medications on 12/15/24 and said he was told he received medications that were prescribed for his roommate. He stated, I have had a time. It was rough. I had to go and stay in the hospital. I hope that never happens again. (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 0658 Level of Harm - Actual harm Residents Affected - Few	On 1/02/24 at 2:00 PM, an interview with the RR for Resident #1 revealed the facility nursing staff had notified him on the evening of 12/15/24 that Resident #1 had accidentally been administered the wrong medications and then later that Resident #1 was being transferred to an acute care hospital due to his blood pressure being too low after having been given two antihypertensive medications in error. He stated that he reported to the hospital and the resident was admitted to the ICU. On 1/02/24 at 2:35 PM, an interview the Director of Nurses (DON) stated that current standards of practice for medication administration included resident rights for medication administration. This would include the right medication and dose. She confirmed that nurses were expected to adhere to the current standards of practice and to make sure they were administering the right medications to the right resident. She stated that during her investigation as to the cause of medication error involving Resident #1 on the evening of 12/15/24, she determined that LPN #1 had not followed current standards of practice or facility policy for medication administration because she had pre-poured medications when she prepared the medications for both residents at the same time and took the medications into the room at the same time. She reported that failure of LPN #1 to prepare, administer and document each resident's medications for one resident at a time, that LPN #1 had confused the medications and administered the medications prescribed for Resident #4 to Resident #1. She confirmed that following administration of the wrong medications to Resident #1, LPN #1 had notified the Charge Nurse, LPN #2, the resident's physician, the resident's RR and the DON. She confirmed that the physician issued instructions to monitor Resident #1's blood pressure and notify him if the resident's blood pressure decreased because two of the medications were antihypertensive agents. The DON explained that when the resident's blood pressure decreased, the nursing staff notified the resident's physician and received orders for transfer to acute care hospital for treatment of hypotension. The DON stated that the facility had provided In-Service training for all nurses beginning 12/16/24 which included Resident Drug Administration Rights, identification of the right resident prior to administration of medications and avoidance of pre-pouring medications and preparation of medications for more than one resident at a time. She stated that the facility had also implemented a one hundred percent (100%) mandatory competency check-off for all nurses for medication administration. She stated that the incident had been investigated and reported to all agencies per federal and state guidelines with LPN #1 placed on suspension pending conclusion of the investigation. She stated that the employment of LPN #1 had been terminated upon conclusion of the investigation due to her failure to follow facility policy. She stated that the incident and investigation results were presented to the Quality Assurance (QAPI) committee during the committee meeting on 12/18/24, which was attended by the facility Infection Preventionist and the Medical Director. She confirmed that Resident #1 returned to the facility on [DATE]. On 1/02/24 at 3:00 PM, an interview with the Administrator confirmed that nurses were expected to follow the facility policy and current standards of practice for medication administration. He stated that the facility investigation concluded that the cause of the incident was that LPN #1 had prepared medications for more than one resident at a time and taken both residents medications into the room at the same time and become distracted/confused and administered the wrong medications to Resident #1. He confirmed that that the incident and investigation results were presented to the QAPI committee during the committee meeting on 12/18/24, which was attended by the facility Infection Preventionist and the Medical Director, during which the facility policy was reviewed with no revisions made. A record review of the Admission Record revealed the facility admitted Resident #1 on 8/1/24 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and Hypertension. (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 0658 Level of Harm - Actual harm Residents Affected - Few	A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/26/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident's cognition was moderately impaired. Based on the implementation of the facility's corrective actions on 12/18/2024, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 12/19/2024. Validation: The State Agency (SA) validated on 1/2/2025, through interview and record review that all corrective actions had been implemented as of 12/18/24, and the facility was in compliance as of 12/19/24, prior to the SA's entrance on 1/2/2025.

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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** 42807 Based on interviews, record review, and facility policy review, the facility failed to prevent a significant medication error when Licensed Practical Nurse (LPN) #1 administered blood pressure medications to a resident that were prescribed for his roommate, resulting in Resident #1 being admitted to the intensive care unit (ICU) of a local acute care hospital due to an adverse reaction for one (1) of four (4) residents reviewed. Resident #1 Findings Included: Record review of the facility's policy titled Medication Set-Up and Administration, dated 5/31/23 revealed, . Policy .Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice .Policy Explanation and Compliance Guidelines .8. Identify residents by photo in the EMAR (electronic medication administration record) . Record review of the facility's Incident Note revealed, 12/15/2024 22:56 (10:56 PM) Incident Note .@1930 (7:30 PM) arrived to station 4 and notified of cart nurse (LPN #1) medication error. Logged into point click care to observe medications given in error. Obtain resident's allergies and medication list. While gathering data, delegated to cart nurse to obtain vitals. Resident awake, alert, and oriented. Vitals 99/55bp (blood pressure), 80p (pulse), O2 95% (oxygen saturation) . (At) 1945 MD notified of medication error and resident's condition. Order given to monitor resident bp for three hours; every 15 minutes the first hours, then thirty minutes the last two hours. Notified cart nurse of order. Cart nurse notified that resident bp decreased to 81/28. Resident awake, alert, oriented, and voice no c/o (complaints of) discomfort at time. Explained to resident that he will be placed in Trendelenburg position to help reduce bp from decreasing significantly. Placed in Trendelenburg with feet propped on pillow. (At) 1948 (7:48 PM) DON notified of med error. 1950 (7:50 PM) RR (Resident Representative) notified of medication error and order to be monitor for three hours. RR wanted to explanation as to how medication error occurred. Explained that Charge Nurse (CN) was unaware of the exact details of the error, apologized for error, and if any changes CN will notify of changes. 2200 (10:00 PM) Cart nurse notified that resident was c/o difficult of breathing in Trendelenburg position and that she has to raise his head for comfort. Vitals was obtained with bp resulting in 63/19 and Md was notified immediately. Order obtained to send to (local hospital). 2205 (10:05PM) Emergency service was called. 2208 (10:08 PM) RR .notified that resident was being sent to ER (emergency room). RR stated, I am not happy and will be meeting with y'all tomorrow. (At) 2222 (10:22 PM) Emergency service arrived. vitals obtained with bp resulting to 60/40. EMT (Emergency Medical Technician) stated that he had to get bp stable before moving resident. IV (Intravenous) line started in right forearm by EMT. IV bolus given by EMT. Vitals obtain with bp 90/70. Resident then moved to stretcher. Resident awake, alert, and oriented. Resident asked for cell phone to be transferred with him. Placed on lap. Resident left facility with Emergency Service at 2242 (10:42 PM). Record review of the Physician Orders for Resident #1 revealed physician's order, 12/15/2024 to SEND TO (Acute hospital) DUE TO ADVERSE REACTION one time only for Prophylaxis (Prevention) . (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	Record review of the written Witness Statement, signed by LPN #1 and dated 12/15/24 revealed LPN #1 had given the wrong medications to Resident #1 accidentally and immediately realized it wasn't his medications. The statement included measures taken by LPN #1 following the error, which included notification of LPN #2, the Charge Nurse, the resident's physician, RR and the Director of Nursing (DON). Record review of the acute hospital's Final Report, dated 12/26/24, revealed Resident #1 was admitted to the acute care facility following transfer from (the facility) for accidental medication ingestion. Patient was given the wrong medications by nursing staff at the facility .Medications included Lisinopril 40 mg (forty milligrams), Lipitor 20 mg, Carvedilol 25 mg, hydroxyzine 25 mg, and Seroquel 50 mg. Upon arrival to ER (emergency room) patient was noted to be bradycardic and hypotensive requiring IV fluids and Levophed for blood pressure control .Patient is being admitted to ICU (Internsive Care Unit) . During an interview with Resident #1 on 1/2/2025 at 1:30 PM, he recalled receiving the wrong medications on 12/15/2024 and was told it was his roommate's medications. He described the experience as a rough time because he had to stay in the hospital and expressed hope that it would never happen again. During an interview on 1/2/2025 at 2:00 PM, the RR confirmed being notified by the facility on 12/15/2024 of the medication error and the Resident #1's subsequent transfer to the hospital due to low blood pressure as a result. The RR also confirmed Resident #1 was transferred and admitted to the ICU of an acute hospital. (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	During an interview on 1/02/24 at 2:35 PM, the DON revealed she stated that during her investigation as to the cause of medication error involving Resident #1 on the evening of 12/15/24, she determined that LPN #1 had not followed current standards of practice or facility policy for medication administration because she had pre-poured, or pre-pulled medications when she prepared the medications for both residents simultaneously and took both cups of medications into the room for the residents. She reported that failure of LPN #1 to prepare, administer and document each resident's medications for one resident at a time, LPN #1 had confused the medications and administered the medications prescribed for Resident #4 to Resident #1. She confirmed that following administration of the wrong medications to Resident #1, LPN #1 had notified the Charge Nurse, LPN #2, the resident's physician, the resident's RR, and the DON. She confirmed that the physician issued instructions to monitor Resident #1's blood pressure and notify him if the resident's blood pressure decreased because two of the medications were antihypertensive agents. The DON explained that when the resident's blood pressure decreased, the nursing staff notified the resident's physician and received orders for transfer to an acute care hospital for treatment of hypotension. The DON stated that the facility implemented corrective actions immediately by providing In-Service training for all nurses beginning 11/16/24 which included Resident Drug Administration Rights, identification of the right resident prior to administration of medications, and avoidance of pre-pouring medications and preparation of medications for more than one resident at a time. She stated that the facility had also implemented a one hundred percent (100%) mandatory competency check-off for all nurses for medication administration. She stated that the incident had been investigated and reported to all agencies per federal and state guidelines with LPN #1 placed on suspension pending conclusion of the investigation. She confirmed LPN #1 was terminated upon conclusion of the investigation due to her failure to follow facility policy. She stated that the incident and investigation results were presented to the Quality Assurance (QA) committee during the committee meeting on 12/18/24, which was attended by the facility Infection Preventionist and the Medical Director and reported Resident #1 returned to the facility on [DATE]. During an interview on 1/02/24 at 3:00 PM, the Administrator confirmed that nurses were expected to follow the facility policy and current standards of practice for medication administration. He stated that the facility investigation concluded that the cause of the incident was that LPN #1 had prepared medications for more than one resident at a time and taken both residents medications into the room at the same time and became distracted and administered the wrong medications to Resident #1. He confirmed that that the incident and investigation results were presented to the QAPI committee during the committee meeting on 12/18/24, which was attended by the facility Infection Preventionist and the Medical Director, during which the facility policy was reviewed with no revisions made. A record review of the Admission Record revealed the facility admitted Resident #1 on 8/1/24 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and Hypertension. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/26/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident's cognition was moderately impaired. Based on the implementation of the facility's corrective actions on 12/18/2024, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 12/19/2024. Validation: (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	The SA (State Agency) validated on 1/2/2025, through interview and record review that all corrective actions had been implemented as of 12/18/24, and the facility was in compliance as of 12/19/24, prior to the SA's entrance on 1/2/2025.