STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255163	A. BUILDING _____ B. WING _____	01/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL WOODLAND VILLAGE NURSING CENTER	5427 GEX ROAD DIAMONDHEAD, MS 39525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Survey Agency (SSA) conducted an annual recertification along with a Complaint Investigation (CI), MS #17905 at the facility from 01/25/2022 through 01/28/2022. During the survey, the SSA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F641 and F756. The SSA did not substantiate MS #17905 related to resident had a missing purse with money, debit cards, and identity cards, resident was being evicted, and had not received any rehabilitation therapy services due to a lack of sufficient evidence. The census at the time of the survey was 98 with a bed capacity of 134.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for a resident taking an antipsychotic medication for one (1) of 20 residents sampled for MDS accuracy. Resident #74. A record review of the signed statement by the Nursing Home Administrator revealed the facility used the Resident Assessment Instrument (RAI) for coding the MDS. A record review of the "Face Sheet" revealed the	F 641	.On 1/28/2022, the Minimum Data Set (MDS)nurse, audited and corrected the MDS assessment for Medication Administration for resident #74. .The facility recognizes that all residents on antipsychotic medication are at risk to be affected by the deficient practice. An audit was completed by MDS Coordinator of residents on antipsychotics for accuracy on 1/27/2022, and no deficient practices were noted.	2/25/22

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

Electronically Signed | 02/16/2022

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F 641	Continued From page 1 facility admitted Resident #74 on 06/16/21, with diagnoses including Personal History of Traumatic Brain Injury, and Personal History of Other Mental and Behavioral Disorders. A record review of Resident #74's "Physician Orders List" revealed a physician order with a start date of 06/16/21 for Zyprexa 5 milligram (mg) tablet one (1) tablet by mouth (PO) every hour sleep (QHS). A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/05/22 revealed N0410A was coded as zero (0) which indicated Resident #74 did not receive an antipsychotic medication during the seven (7) day look-back period. A review of the question for N0450A, "Resident received antipsychotic medications" was coded as "No - Antipsychotics were not received". A record review of Resident #74's electronic-Medication Administration Record (e-MAR) for December 2021 and January 2022 revealed Resident #74 was administered Zyprexa, which is an antipsychoitc medication, on 12/30/2021, 12/31/2021, 01/01/2022, and 01/02/2022, totalling four (4) days of the seven (7) day MDS look-back period. On 01/28/22 at 11:30 AM, during an interview with the facility's MDS Coordinator, LIcensed Practical Nurse (LPN) #1, she confirmed the MDS submitted on 01/05/22 for Resident #74 was entered incorrectly and was inaccurate. She explained the facility uses the RAI manual as guidance for accurately coding the MDS. On 01/28/22 at 11:40 AM, during an interview with	F 641	.The Director of Nursing (DON)in-serviced the MDS Department on the accuracy of assessments, 1/28/2022. MDS initiated audits on Medication Administration of antipsychotics, 1/28/2022. These audits will occur weekly for 4 weeks and then monthly for 3 months to determine compliance. .MDS began antipsychotic medication administration audits 1/28/2022, and will continue to audit the Minimum Data Set assessments for antipsychotic medication administration monthly for 3 months. The DON will present the MDS audit findings to the Quality Assurance Committee(QA) meeting monthly for four months for action and review to determine if the plan of correction (POC) is effective and sustained. The initial QA meeting is scheduled for 2/21/2022.	

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F 641	Continued From page 2 the Director of Nursing (DON) , she confirmed the facility uses the RAI manual for guidance in coding the MDS. She stated she expects the MDS to be coded accurately. On 01/28/22 at 11:45 AM, during an interview with MDS LPN #2, she confirmed the MDS submited by her on 01/05/22 for Resident #74 was a documentation error. After she reviewed Resident #74's e-MAR, she verified he had received Zyprexa, which is an antipsychotic medication, during the seven (7) day look-back period of the MDS.	F 641		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		2/25/22

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F 756	Continued From page 3 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interviews, the facility failed to act upon a Consultant Pharmacy (CP) recommendation for one (1) resident of seven (7) residents reviewed for unnecessary medications. Resident #22 A record review of the facility's policy, "Medication Regime Reviews" with a revised date of April 2007 revealed, "...7. The Consultant Pharmacist will document his/her findings and recommendations..." A record review of the "Note to Attending Physician/Prescriber" revealed "...Please consider if GDR (Gradual Dose Reduction) is appropriate for: Lexapro 10 mg (milligrams) po (by mouth) daily...RECOMMENDATION: If a gradual dose reduction is appropriate, please consider reducing dose to Lexapro 5 mg po daily...Physician/Prescriber Response...Agree". The recommendation was signed by the Nurse Practitioner (NP) and dated 10/13/21.	F 756	. On 1/26/2022, the Medical Director (MD), wrote a new order to address the Consultant Pharmacist (CP) gradual dose reduction recommendation for Resident #22. .The facility recognizes that all residents with gradual dose reduction recommendations have the potential to be affected by the deficient practice. All gradual dose reduction recommendations were audited by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) 1/26/2022, and no other residents were affected. .In-service initiated by the Administrator and DON on 1/28/2022 to the Nurse Practitioner, Medical Records Nurse, Minimum Data Set Nurse, DON and ADON on Drug Regimen Review, Report Irregularities, and Act on CP	

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F 756	Continued From page 4 A record review of the medical record for Resident #22 revealed there was no physician order to reduce the Lexapro from 10 mg to 5 mg as was recommended by the CP and agreed upon by the NP. A record review of the electronic-Medication Administration Records (e-MAR's) from October 2021 through December 2021 revealed Resident #22 continued to receive Lexapro 10 mg with an order date of 4/27/21, instead of the Lexapro 5 mg that was recommended on 10/13/21 by the CP and agreed upon by the NP. On 01/26/22 at 4:30 PM, during an interview with the Director of Nursing (DON), she confirmed a CP recommendation was written for Resident #22 on 10/13/21 to decrease Lexapro from 10 mg to 5 mg daily and that the NP did agree with the recommendation. The DON stated that staff missed carrying out the recommendation and no dose reduction was completed. On 01/26/22 at 4:45 PM, during a phone interview with the facility's Medical Director, he confirmed the CP recommendation was not acted upon and gave the facility a new order on 01/26/22 to decrease the Lexapro to 5 mg PO daily. A record review of Resident #22's "Face Sheet" revealed the the resident was originally admitted on 06/16/17, and was re-admitted by the facility on 09/22/2019 with diagnoses including End Stage Renal Disease, Anxiety Disorder, and Other Recurrent Depressive Disorders.	F 756	recommendations. The CP audited and wrote new gradual dose recommendations 1/31/2022. DON will audit gradual dose recommendations weekly x 4 weeks. .The DON/ADON audited gradual dose reduction recommendations 1/26/2022 will continue to audit the CP recommendations monthly for three (3) months beginning 2/7/2022. The DON/ADON will present the audit findings monthly x 4 months to the Quality Assurance Committee meeting for action and review to determine if the plan of corrections is effective and sustained. The QA meeting is scheduled for 2/21/2022.	