STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255092	A. BUILDING _____ B. WING _____	**07/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BOYINGTON HEALTH AND REHABILITATION	**1530 BROAD AVE GULFPORT, MS 39501**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and facility policy review, the facility failed to assure Resident #1 was discharged home with her own home medications for one (1) of four (4) Residents discharged home (Resident #1). Findings include: Record Review of the facility policy titled, Release of Medications, November 2019, revealed the purpose of this procedure is to establish uniform guidelines concerning the release of medications to residents upon their discharge or absence from the Center. The policy stated both the nurse disbursing the medications and the person receiving the medications must count and sign verifying the amount and type of medication. Record review of the facility policy titled, Discharge Drugs, dated November 2019, revealed unless otherwise specified by Center Policy, or contradicted by current law, resident drugs will be sent with resident upon discharge if ordered by the physician. Controlled substances may not be released upon discharge of the resident unless ordered by the physician. The charge nurse should check the label of discharge drugs with the most current physician's orders to assure that directions for their use are correct. Controlled substances may not be released upon discharge of the resident, unless ordered by physician. The Charge Nurse must review drug direction with the resident or representative prior to the resident leaving the Center. On, 6/29/2020, Resident #1's daughter called in the complaint to the State Agency (SA) stating that her mother was discharged from the nursing home with somebody else's medication in the zip lock bag of home medications with her mother's name on it. The zip lock bag with the resident's home meds was presented to the facility from the hospital on the date of the resident's admission to the nursing home for rehabilitation. Resident #1 was discharged from the nursing home on 6/21/2020 with her daughter via private vehicle. The daughter stated Registered Nurse (RN) #1 went over her mother's discharge instructions with her and her mother and understood the resident was only to take the medications from the bubble packs. Resident #1 asked about the home medications and RN #1 went back into the facility, found the zip lock bag with the resident's name on it and took it to the car to deliver the home medications as Resident #1 requested. On 6/26/2020, Resident #1's daughter came to the resident's home to get the resident's medications refilled due to she was running out of some of the medications. The daughter looked in the zip lock bag and discovered two (2) medication bottles with other names on the bottles. The daughter said she asked her mother if she had taken any of these medications and she said that she had because she thought they were hers. The daughter said she called the facility and reported to the Administrator her mother was sent home with two (2) bottles of medication with two (2) other resident names on them, which turned out to be Resident #2 and Resident #3. The daughter said the Administrator told her they would have to investigate and call her back. Review of the facility's Resident Abuse Investigation Report, revealed the incident occurred on 6/21/2020 and was reported on 6/26/2020. The incident was reported by a family member and the type was related to medication. The resident did not exhibit any signs or symptoms of injury. The person accused was (Name)/RN #1. The summary interview with the daughter revealed the wrong bag of home medications had been given to her mother when she was discharged from the facility. Corrective Action: 100% in-service on Abuse and Neglect. In-service all nurses on discharge process, reconciliation of medications (checking for correct medications with MD/Medical Doctor). The Five Rights of medication administration. Two nurses will check the medication before medications are given to resident/family. Nurse suspended pending investigation. Review of the facility's In-Service Sign-In Sheet, dated 6/26/2020, revealed the facility provided an in-service titled: Five Rights of Medication Administration, Discharge Procedure including medication education, Elderly Rights and Abuse. The in-service included the new facility procedure regarding home meds to be checked by two nurses and the Social Services Director will be notified and obtain the meds and notify the family to come and pick up the medications. During an interview, on 7/10/2020 at 9:00 AM, Resident #1's daughter revealed Resident #1 was admitted to the facility due to a fall which resulted in a left ankle fracture. The daughter also said her mother had [MEDICAL CONDITION] removed from her right eye on 5/25/2020. The daughter said her mother's vision is poor in the left eye. The daughter said Resident #1 lives alone, was driving to [MEDICAL TREATMENT] Monday, Wednesday, and Friday and taking her medication prior to the fall. The daughter said Resident #1 was released from the rehabilitation facility on 6/21/2020. Registered Nurse (RN #1) assisted Resident #1 to the car and explained the discharge instructions on the bubble wrapped medication. Resident #1 asked RN #1 for her home medication. RN #1 went into the facility and returned with a Ziploc bag of medication with Resident #1's name on it. Resident #1's daughter said, on 6/26/2020, she came to get her mother's prescriptions refilled. The daughter said she went through Resident #1's Ziploc bag and noticed two bottles of medication with other resident names on them Resident #2 and #3. Resident #1's daughter said she asked Resident #1 if she took medication out of those bottles. Resident #1 said, Yes, I took both of them. The daughter said Resident #2's name was on a bottle of Bicalutamide 50 milligrams (mg) orally daily. The daughter also said Resident #3's name was on the other bottle with [MEDICATION NAME] 125 mg by mouth (po) every (q) six hours (6 hrs) daily. Resident #1's daughter said she notified the facility and explained to the administrator her mother took someone else's medication. The daughter said the administrator said she will have to investigate it and call her back. During the interview, the daughter also stated the home health nurse visited her mother on 6/23/2020 to assess the resident and medications/treatments. There was no mention of the home health nurse reviewing or checking the home medications in the zip lock bag. Review of the Physician's Orders revealed an order confirmed Resident #1's discharge from the facility. During an interview, on 7/10/2020 at 1:00 PM, RN #1 said Resident #1 was assisted to the car in a wheelchair by her. RN #1 said discharge instructions was given to Resident #1 and her daughter. RN #1 stated Resident #1 and her daughter voiced understanding to only take the medications in the bubble packs. Resident #1 asked RN #1 for her home medication. RN #1 said she went into the facility and found a Ziploc bag in the medication room with Resident #1's name on the bag. RN #1 confirmed she failed to look inside of the bag to make sure the medication was Resident #1's medication. RN #1 said she looked for a home medication list and could not find one. RN #1 said she had not worked for the facility long and was not aware of the policy for home medication. During an interview, on 7/10/2020 at 4:00 PM, Resident #1 stated the discharge instructions was given to her and her daughter in the car by RN #1 on 6/21/2020. Resident #1 said she asked RN #1 for her home medication. Resident #1 said RN #1 went into the facility and returned with a Ziploc bag with her name on it. Resident #1 said she took the medication out of the Ziploc bag and took them due to being out of some of her medications. Resident #1 also said she has problems with blurred vision at times. Resident #1 said her name was on the bag and she thought the medication in the bag was hers. An interview, on 7/13/2020 at 9:00 AM, with the Administrator, revealed Resident #1's daughter called the facility on 6/26/2020, reporting her mother received someone else's medication upon discharge from the facility. The Administrator said she told the daughter the facility would investigate it and call her back. The Administrator said she notified RN #2 to start an investigation. An interview on 7/13/2020 at 9:30 AM, revealed RN #2 said she did an investigation on Resident #1 receiving someone else's medication. RN #2 said Licensed Practical Nurse (LPN) #1 and RN #1 were suspended until the investigation was finished. RN

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

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) #2 said she found RN #1 failed to check the Ziploc bag. RN #2 said she could not find out who placed the medication in the Ziploc bag and put Resident #1's name on the bag. RN #2 said the facility does not have a policy on what to do with home medication. RN #2 said normally when a resident brings home meds with them from the hospital the medication is placed in the med room. An interview on 7/13/2020 at 10:00 AM, with the DON, confirmed the facility did not have a policy on home medication. The DON said the facility practice is to put the medication in the med room until the resident is discharged . The DON said the facility has developed a facility procedure for home medication. Two nurses will check the home medication the day the resident is admitted . The home medication will be bagged by the nurse and given to Social Services. Social Services will call the family to pick them up. An interview on 7/13/2020 at 1:00 PM, with the Medical Doctor revealed Resident #1 was not in any immediate or long term danger by taking the medication. The Medical Doctor said the medication would not cause any harm to Resident #1. The Medical Doctor also said the Bicalutamide is a hormone drug that would not cause any problems except may increase in [DIAGNOSES REDACTED] and oral [MEDICATION NAME] would not cause a problem because the resident receives [MEDICAL TREATMENT] three times a week and would not stay in her system. Review of Resident #2 and #3's June 2020 Medication Administration Records revealed both residents received the medications Bicalutamide (Resident #2) and [MEDICATION NAME] (Resident #3) as ordered by their physicians. Resident #3's [MEDICATION NAME] had been discontinued and a new antibiotic was ordered. Interviews with several residents, who were discharged in June 2020, family members reported the residents were discharged with the correct medication and discharge instructions. Record review of the Medication Administration Records (MARs) for several residents in June 2020 revealed all of the residents received their correct medications. The residents did not miss any doses of medication Review of the Face Sheet revealed the facility admitted Resident #1 on 6/1/2020, with the included [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS), with the Assessment Reference Date (ARD) of 6/8/2020, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) of 15, which indicated Resident #1 was cognitively intact.