

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER West Point Community Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2056 N Eshman Avenue West Point, MS 39773	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598</p> <p>Based on observation, staff and resident interview, record review, and facility policy review the facility failed to ensure that a resident was free from a significant medication error as evidenced by one drop of mometasone furoate external scalp solution being instilled into a resident's left eye in place of the physician ordered eye drops for one (1) of three (3) residents reviewed. Resident #2.</p> <p>Findings Include:</p> <p>Record review of the facility policy titled Adverse Consequences and Medication Errors with reviewed date of 08/2023 revealed under Medication Errors, 1. A 'medication error' is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 2. Examples of medications errors include: d. Wrong route of administration (e.g., ear drops given in the eye).</p> <p>On 03/20/24 at 9:00 AM, an interview with Administrator (ADM), revealed that on 02/25/24, Licensed Practical Nurse (LPN) #1 worked on the medication cart, and she mistakenly instilled the wrong drops into Resident #2's left eye. ADM revealed that Resident #2 had a bottle of scalp drops setting on her bedside table and LPN #1 picked up the scalp drops by mistake instead of the physician ordered eye drops and instilled one drop into Resident #2's left eye. ADM revealed that LPN #1 called and reported the incident to the Medical Director immediately and he instructed her to rinse Resident #2's eye out with normal saline and assessed the medication situation and informed them that the scalp drops would not hurt her eye. ADM revealed that this incident shouldn't have happened and confirmed that this was a medication error and she stated, I'm glad it wasn't any worse than that.</p> <p>(continued on next page)</p>

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/20/24 at 9:15 AM, an interview with LPN #1 revealed that she was the Minimum Data Set (MDS) nurse, and she normally did not work the medication cart, but that she was on call the weekend of 02/25/24 and due to a call-in, had to come in to work. LPN #1 revealed that she did medication pass, prepared Resident #2's medications by placing each pill in separate medication cups and labeled them just like resident requested. LPN #1 revealed that she had checked the medication labels against the Medication Administration Record (MAR) during preparation, gathered the medications including the eye drops and entered Resident #2's room. She revealed that Resident #2 was lying in her bed and she placed the eye drops on the bedside table on the right side of the resident's bed to prevent getting them mixed up with the scalp drops which were on her bedside table positioned over the bed. LPN #1 revealed that after she gave Resident #2 her oral medications, she picked up the scalp drops by mistake and instilled one drop into resident's left eye. LPN #1 revealed that after a few seconds, Resident #2 complained of her eye burning, LPN #1 looked at the bottle and realized she had administered the wrong medication. LPN #1 revealed that she called the Medical Director and he ordered her to flush her left eye with normal saline and that this medication would not cause damage to the eye, to keep flushing until the drops were cleared from the eye. LPN #1 revealed that she assessed the resident's eye and found no redness, no drainage and examined it two or three times during the night.</p> <p>On 03/20/24 at 10:50 AM, an observation and interview with Resident #2 revealed her lying in her bed with her head raised at 90-degree angle and her bedside table was within her reach and positioned over her legs as she lay in the bed. Resident #2 revealed that she gets eye drops put in her eyes in the morning and at night and that on 02/25/24, LPN #1 brought her medications in including the eye drops. Resident #2 revealed that she kept a box on her bedside table that had a steroid hair solution inside that she had recently gotten from a doctor's appointment. Resident #2 revealed that after she took her oral medications, LPN #1 picked up the scalp drops and put them in her left eye. She revealed that her left eye started burning, and she realized that LPN #1 had put the scalp drops into her eye. Resident #2 revealed that the nurse was supposed to check three times to make sure she had the right medication and she never looked at the box label. Resident #2 stated, This was a medication error and could have cost me my vision. Resident #2 revealed that LPN #1 called the doctor after it happened and flushed her eye out with saline. She revealed that her left eye had hurt for a couple days and she was still having issues with it now. She revealed that she made her own doctor appointments, and had went and was prescribed some different eye drops.</p> <p>On 03/20/24 at 1:00 PM, an interview with Director of Nursing (DON), revealed that she was familiar with the incident that occurred with Resident #2's eye drops. She revealed that LPN #1 who was on-call, was working on the weekend of 02/25/24 and that LPN #1 had mistakenly put scalp drops into Resident #2's left eye in place of her ordered eye drops. DON revealed that LPN #1 called the Medical Director, and he gave her orders to flush her eye and to monitor her. DON revealed that Resident #2 had received the prescription scalp oil drops from a prior dermatology appointment she had scheduled herself and that when she had returned to the facility she kept the scalp drops in her room on her overbed table. The DON stated that she had completed a one-on-one in-service on eye drop administration including the five rights with LPN #1 and the other administrative nurse who was not accustomed to doing medication pass. The DON revealed that she also observed medication passes with them which included eye drops. The DON revealed that the pharmacist also came in and in-serviced the med cart nurses on safely administering medications including eye drops and inhalers. DON revealed that the pharmacist observed medication passes with the nurses with 100% pass rate. The DON stated that leaving medications in a resident's room was a medication error waiting to happen. DON agreed that if the scalp drops had been locked up in the medication cart on 02/25/24, this medication error with Resident #2 receiving the wrong drops in her eye might have been avoided.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's Incident Note on 02/25/24 revealed: Note Text: During morning med pass this nurse went into residents room to administer medications and eye gtts (drops). This nurse placed eye gtts on right bedside table and medications on overbed bedside table and after recalling medications to resident and administering them this nurse picked up mometasone scalp tx (treatment) from the resident's overbed table and administered 1 gtt to the resident's left eye. Resident c/o (complained of) burning sensation and after realizing, this nurse immediately rinsed resident's eye and assessed for irritation. No redness abnormal drainage or irritation was noted. This nurse contacted proper name (Medical Director) and notified him of the situation. New order received to flush with saline as long as resident tolerates. This nurse flushed the resident's eye as ordered. The resident tolerated the flushing well. No c/o pain or discomfort during flushing. Resident states her eye continues to burn after the flushing. Stated its not the eyeball, the inner corner and lining still burns a little. Proper name (Medical Director) notified. New order received to check resident q (every) 2 hrs x 24 hrs (every two hours for twenty-four hours) then q shift x 3 (every shift for three days.) Medical Director informed this nurse to reassure resident flushing with saline is all that is recommended and it should eventually subside. Proper name (Medical Director) recommended administering scheduled eye lubricant gtts after flushing. This nurse notified the resident of the recommendation. Resident stated she does not want the lubricant gtts right now. Resident's eye was reassessed and remains normal color, no redness, drainage, or irritation noted. Resident is able to blink and move eyeball without discomfort. Resident's responsible party (RP) arrived to unit and was notified of incident. After several attempts to administer lubricant eye gtts, resident agreed to allow this nurse to administer gtts. Resident asked if her eye felt the same, resident stated it just feels more dry than usual. q 2 hrs (Every two hours) checks in progress. Resident continues to show no irritation or complications at this time. Administrator notified. This progress note was signed by LPN #1.</p> <p>Record review of Resident #2's Order Summary Report with active orders as of 3/20/24 revealed the following:</p> <p>09/24/23 - Systane Ultra Ophthalmic Solution 0.4-0.3 % (percent) - Instill 2 drops in both eyes four times a day for dry eyes.</p> <p>01/05/24 - Mometasone Furoate External Solution 0.1 % - Apply to Scalp topically every 24 hours as needed for Itching.</p> <p>Record review of Resident #2's Admission Record revealed an original admitted [DATE] and a readmitted [DATE] with the following diagnoses to include Segmental and Somatic Dysfunction of Cervical Region, Quadriplegia, and Morbid Obesity.</p> <p>Record review of Resident #2's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 03/06/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive deficits.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598</p> <p>Based on observation, resident and staff interview, record review, and facility policy review the facility failed to ensure a medication was properly stored as evidenced by a tube of Hydrocortisone Topical Cream being left on a resident's overbed table for one (1) of three (3) residents reviewed. Resident #2.</p> <p>Findings Include:</p> <p>Record review of the facility policy titled Medication Storage in the Facility dated December, 2006, revealed under Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p> <p>An observation and interview on 03/20/24 at 10:50 AM, with Resident #2 revealed her lying in her bed with her head raised at 90-degree angle and she was on her phone. Resident #2's bedside table was within reach positioned over her legs and there was a tube of prescription steroid cream sitting on her bedside table. The tube was inside a prescription box with the following label: Hydrocortisone - External Cream 2.5% (topical) Apply to skin topically q (every) 12 hrs (hours) as needed for dermatitis. Apply to face and ears as needed. This prescription box was dated as filled on 01/05/24. Resident #2 confirmed that she makes her own doctor appointments and when she returns she keeps the medications in her room sometimes and that this medication was prescribed to her from an earlier appointment that she had made herself.</p> <p>On 03/20/24 at 12:00 PM, an interview with the ADM revealed that the only time a medication should be left in a resident's room was if the resident was considered appropriate to self-administer. ADM revealed that to qualify to self-administer medication, an evaluation had to be completed with the resident and the resident had to demonstrate competency. ADM confirmed that Resident #2 was not able to lift her arms and was unable to self-administer her own medications and that a previous medication error had occurred with this resident because she wants to keep her medications in her room. The ADM stated Resident #2's Hydrocortisone cream should not be kept in her room, that it should be locked up in the medication cart.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/20/24 at 12:25 PM, an interview with Registered Nurse (RN) #1 revealed that Resident #2 made her own doctor appointments and called the ambulance service for transportation to these appointments, and would often bring medications back with her from these appointments and not tell anyone. RN #1 revealed that they had explained to Resident #2 that she was not allowed to keep medication in her room. She also revealed that they have had to take medications from her room before and lock them up. RN #1 revealed that Resident #2 was manipulative and her mom had brought medications from home into the facility and left them in Resident #2's room before without letting the staff know. RN #1 revealed that the Director of Nurses (DON) completed an evaluation on Resident #2 and determined that the resident was not able to self administer her medications because she could not lift her arms or safely demonstrate competency with this. RN #1 entered Resident #2's room during the interview and confirmed that the hydrocortisone cream was laying on her bedside table in front of the resident. RN #1 revealed that another resident could come into Resident #2's room, get the medication, or someone could come into her room, give the medication to Resident #2 and the facility nurses not know. RN #1 stated, This throws up a lot of red flags. RN #1 confirmed that the hydrocortisone cream was ordered by the Medical Director and was dated 01/05/24 and that she would get the medication out of her room and lock it up in the medication cart.</p> <p>An interview with the DON on 03/20/24 at 1:00 PM, revealed that all medications were supposed to be under lock and key unless a resident had an evaluation for self-administration and was able to demonstrate safe self medication administration and stated, No one in here self-administers at this time. DON revealed that leaving medications in a resident's room was a medication error waiting to happen. DON agreed that if the scalp drops had been locked up in the medication cart on 02/25/24, the medication error with Resident #2 receiving the wrong drops in her eye might have been avoided. The DON also confirmed that the prescription steroid cream which was found on Resident #1's bedside table today should not be in her room and should be locked up in the medication cart. She revealed that they had some residents who walked around and stated, Another resident could get in there and get away with the medication before anyone could get it.</p> <p>Record review of Resident #2's Order Summary Report with active orders as of 3/20/24 revealed the following:</p> <p>01/05/24 - Hydrocortisone External Cream 2.5% (percent) (Hydrocortisone (Topical) - Apply to skin topically every 12 hours as needed for dermatitis apply to face and ears as needed.</p> <p>Record review of Resident #2's Admission Record revealed an original admitted [DATE] and a readmitted [DATE] and she had the following diagnoses to include Segmental and Somatic Dysfunction of Cervical Region, Quadriplegia, and Morbid Obesity.</p> <p>Record review of Resident #2's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 03/06/24 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated no cognitive deficits.</p>		