STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255111	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Point Community Living Center	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)
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** 41878 Based on staff interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from misappropriation of a resident's medication for one (1) of five (5) residents reviewed for misappropriation. Resident #1 Cross Reference F610 Findings include: Record review of facility policy titled, Freedom from Abuse, Neglect, and/or Exploitation Prevention Plan Education dated [DATE], revealed, The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardian, friends, or other individuals. Misappropriation of resident property - Deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Record review of facility policy titled, Resident Rights dated [DATE], revealed, The facility must protect and promote the rights of the resident. Record review of facility policy titled, Controlled Substances, undated, revealed, . 5. Controlled substances are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. 6. All keys to controlled substance containers are on a single key ring that is different from any other keys. 7. The charge nurse on duty maintains the keys to controlled substance containers. The director of nursing services maintains a set of back-up keys for all medication storage areas including keys to controlled substance containers . During an interview on [DATE] at 9:45 AM, the Administrator stated she had reported the incident of missing narcotic medication to the required entities and acknowledged that Licensed Practical Nurse (LPN) #1 had left the medication keys unattended at the nurses station while she went outside for a break and also left the keys on the medication cart unattended while the corporate nurse checked the medication cart. When LPN #1 returned from her break she went to the medication cart to obtain a PRN (as needed) medication for Resident #1 and realized that a medication card for a 30 count Norco Oral Tablet ,d+[DATE] milligram was missing, and she reported it and an investigation was initiated immediately. (continued on next page)

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	During an interview on [DATE] at 4:00 PM, the Registered Nurse (RN) Supervisor revealed that around 2:30 PM - 3:00 PM on [DATE], LPN #1 informed her that one of Resident #1's pain medication cards was missing. They immediately searched for this card but were unable to locate it. An investigation began, and drug screens and statements were obtained on each staff member that worked that day. The RN Supervisor determined that LPN #1 had gone outside for a break earlier that day and left the narcotic keys unattended on the desk in the nurses' station. She had also left these keys on the medication cart while the corporate nurse checked her cart for expired and unlabeled medications. She acknowledged the medication keys were to remain with the nurse on their person at all times to prevent an unauthorized person having access to the residents' medications and confirmed that LPN #1 had failed to prevent the misappropriation of a resident's medication by leaving her narcotic keys unattended. A phone interview with LPN #1 on [DATE] at 5:30 PM, revealed she had worked in the facility from around 7:00 AM until 11:00 PM on [DATE], the day the medications went missing. She stated on that morning she made a careless mistake and when she went outside to take a break that she left the medication cart and narcotic box keys on the nurses' desk. When she returned, the keys were where she left them, and she was unaware of any concern. She stated around 2:00 PM - 2:20 PM, she opened the medication cart for the corporate nurse to check her cart and left her keys on top of the cart and she was nearby, but the corporate nurse did not go into the controlled medication locked box on the cart. Then around 2:30 PM - 3:00 PM, she unlocked the medication cart to get Resident #1's medication and noticed that one of the narcotic medication cards was missing for that resident. She reported this to the nurse supervisor, and they began searching for the medication which they did not locate. LPN #1 confirmed that she was tested for drugs, which was negative, and wrote a statement about what occurred. She confirmed she left the keys unsecured at the desk and on the medication cart and a resident's narcotic medication was missing. She confirmed she had been in-serviced on this and knew not to leave the keys unattended and it was a careless mistake that I won't do again. She stated this occurred around 3:00 PM and she was told to finish her shift which was a shift from 7:00 AM - 11:00 PM and then she was off for two days after that. She completed her assignment for that evening which included the medication pass for the evening shift. She stated she was not told to turn in her keys or leave the facility immediately and she returned to work after her two days off. She acknowledged that she had been in-serviced on abuse/neglect/misappropriation, resident rights, and medication administration which included keeping keys in her possession and locking the medication cart. During an interview on [DATE] at 2:15 PM, the Administrator confirmed that Resident #1 had narcotic medication that was missing and had not been located, and LPN #1 was the nurse responsible for that medication cart. She acknowledged LPN #1 left her keys on the desk while she went outside and on the medication cart while the corporate nurse was checking the cart for expired medication. She acknowledged the medication keys were to remain with the nurse on their person at all times to prevent an unauthorized person having access to the residents' medications. She confirmed the facility failed to prevent the misappropriation of a resident's medication by not ensuring that the keys remained in a nurse's possession and not left unattended. Record review of Order Summary Report revealed an order dated [DATE] for Norco (Hydrocodone) Oral Tablet ,d+[DATE] milligram; give one tablet by mouth every six (6) hours as needed for severe pain. Record review of Controlled Drug Receipt/Record/Disposition Form revealed two cards of 30 count Hydrocodone/APAP tablets each were delivered to the facility on [DATE] and two more cards with 30 tablets each was delivered to the facility on [DATE]. One of these cards was the one that was missing, and the other of these medication cards was completed being used by the resident. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Controlled Drugs Count Record for February 2025 revealed on [DATE], LPN #1 signed that the narcotic medication count was correct when she came in at 7:00 AM and signed again when she was leaving at 11:00 PM that the narcotic medication count was correct. Record review of LPN #1's Employee Time Cards revealed on [DATE], she clocked in at 6:37 AM and clocked out at 11:36 PM, and she did not return to work until [DATE]. Record review of in-service signature sheets revealed that LPN #1 had been trained on Medication Administration, Compliance Requirements (Abuse/Neglect), Resident Rights, Code of Conduct, Medication Administration, Five Rights, and Documentation. Record review of Resident #1's Admission Record revealed she was originally admitted to the facility on [DATE] with the most recent admission being [DATE], with diagnoses that included displaced midcervical fracture of left femur, aftercare following joint replacement surgery, and dementia. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) of 11 which indicated this resident had a moderate cognitive impairment.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41878 Based on staff interviews, record review, and facility policy review, the facility failed to prevent further potential medication misappropriation by allowing a nurse to continue to work during an investigation for one (1) of five (5) residents reviewed for misappropriation of property. Resident #1 Cross Reference F602 Findings include: Record review of facility policy titled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated 10/22, revealed, All reports of .theft/misappropriation of resident property are .thoroughly investigated by facility management. 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete . Record review of facility policy titled, Controlled Substances, undated, revealed, . 5. Controlled substances are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. 6. All keys to controlled substance containers are on a single key ring that is different from any other keys. 7. The charge nurse on duty maintains the keys to controlled substance containers. The director of nursing services maintains a set of back-up keys for all medication storage areas including keys to controlled substance containers . During an interview on 4/7/25 at 9:45 AM, the Administrator stated the facility had a 30-count card of Hydrocodone medication for Resident #1 that was reported missing on 02/18/25 by Licensed Practical Nurse (LPN) #1. On 4/7/25 at 5:30 PM, a phone interview with LPN #1 revealed she had worked in the facility from around 7:00 AM until 11:00 PM on 2/18/25, the day Resident #1's medications went missing. She admitted that she left the medication cart keys unattended on the desk while she went outside and left the keys on the medication cart while the corporate nurse checked the cart that day. She stated the missing medication was noticed around 2:30 PM - 3:00 PM and was reported to the nurse supervisor. She stated she continued to complete her assignment and give medications to the residents which included the medication pass for the evening shift until around 11:00 PM the night of 02/18/25. She revealed she was not told to turn in her keys or leave the facility during the investigation and she continued to work her remaining shift and the next shift that evening and clocked out after 11:00 PM that night. On 4/8/25 at 2:15 PM, during an interview the Administrator confirmed that Resident #1 had narcotic medication that was missing and had not been located, and LPN #1 was the nurse responsible for that medication cart. She acknowledged the facility allowed the nurse to continue to work on the medication cart and did not require her to turn in the keys and leave the facility during the investigation. She confirmed the facility failed to prevent the misappropriation of a resident's medication and she confirmed the facility failed to prevent further potential misappropriation of a resident's medication by not removing LPN #1 from the facility during the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Police Department Incident Report, dated 02/19/25, stated that on 02/18/25 they responded to the facility for a report of missing pack of Norco. The police report revealed that LPN #1 was then drug tested and went back to her duties at work. Record review of LPN #1's Employee Time Cards revealed on 2/18/25, she clocked in at 6:37 AM and clocked out at 11:36 PM. Record review of Controlled Drugs Count Record for February 2025 revealed on 2/18/25, LPN #1 signed for the total narcotic medication cards count as being correct when she came in at the beginning of her shift at 7:00 AM, the end of that shift at 3:00 PM, the beginning of the 3:00 PM shift, and at the end of that shift at 11:00 PM. She left for the day at 11:36 PM.