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	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Point Community Living Center	2056 N Eshman Avenue West Point, MS 39773

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, record review and facility policy review, the facility failed to ensure residents right to be free from abuse for six (6) of 6 residents reviewed for abuse and neglect. Resident #20, #21, #5, #41, #34 and #50. On 06/30/25 the facility reported that a resident with a history of behaviors and aggression towards others, (Resident #65) stood up from his chair while sitting in the dining room, and had gotten behind Resident #20 while he sat in his wheelchair and choked him. Staff heard other residents yelling for help and the staff separated Resident #65 from choking Resident #20. Resident #20 immediately began to have seizures that lasted for three or more minutes and continued to have multiple seizures a day until he was sent out to the hospital on [DATE]. Additionally, the SA determined that Resident #45, Resident #46 and Resident #65 had aggressive behaviors towards other residents in the facility and were not monitored, nor were protective measures taken to prevent the abuse of Resident #5, Resident #20, Resident #21, Resident #34, Resident #41 and Resident #50. These residents sustained verbal, physical and mental abuse.During the annual survey of the investigations of the complaints and the FRI, the SA identified Immediate Jeopardy (IJ) and SQC which began on 06/30/25, when Resident #65 choked Resident #20 who began to have seizures.The IJ and SQC existed at:CFR 483.12(a)(1) Freedom from Abuse and Neglect (F600) Scope/Severity (S/S) =KThe facility's failure to ensure the right to be free from abuse and neglect placed Resident #5, Resident #20, Resident #21, Resident #34, Resident #41 and Resident #50 and other residents at risk and placed them in a situation that has caused and is likely to cause serious injury, serious harm, serious impairment, or death.The SA notified the facility's Administrator of the IJ and SQC on 08/06/25 at 12:20 PM and provided the Administrator with the IJ Template.The facility provided an acceptable Removal Plan on 08/06/25, in which the facility alleged all corrective actions were completed to remove the IJ on 08/06/25 and the IJ removed on 08/07/25.The SA validated the Removal Plan on 8/7/25 and determined the IJ was removed on 8/7/25, prior to exit. Therefore, the scope and severity for CFR 483.12(a)(1) Freedom from abuse and neglect F600 was lowered to a E, while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Record review of facility policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated 10/22, revealed, Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation, (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	or misappropriation of property by anyone including but not necessarily limited to: a. facility staff; b. other residents. Resident #65 and Resident #20 Record review of the Facility Reported Incident revealed on June 30, 2025, it was reported to Administrator that a physical altercation transpired between Residents #20 and #65. According to a resident who witnessed the incident, the residents were all hanging out in their typical hangout spot prior to dinner-the dining area. During their fellowship time, there was a verbal exchange between Residents #20 and #65. Resident stated Resident #65 first acted playfully with his hands, pretending he was going to hit Resident 20. Their verbal exchange then got serious and led to Resident #65 wrapping his arms around the other resident's neck in a choking manner. Resident #65 is ambulatory, but Resident #20 is wheelchair bound. Resident #65 let Resident #20’s neck go before the staff approached them. Resident #20 has a history of having seizures. Because of that, the incident triggered Resident #20 to have a seizure. Administrator attempted to interview Resident #65 who quickly answered, I ain't done s***! Immediately afterwards, Resident #65 approached Social Services and admitted to her that he had choked the other resident due to him always talking s**t. Social Services followed Resident #65 to his room to redo his BIMs (Brief Interview for Mental Status). Prior to beginning her BIMS interview, the resident asked, ls doing this going to help me get the h*** out of here? Resident #65 began answering the questions better than he ever has since being admitted to the facility. The resident had never scored a 15 on his BIMS since being admitted . Resident #65 was placed on 1 :1 per shift from 06/30/2025-07/02/2025 for safety and well-being of all residents' safety. The facility attempted to find an alternate placement for Resident #65. However, the resident was booked into the County Jail due to charges being pressed against him from Resident #20 and his resident representative. The facility does substantiate abuse. During interviews with Resident #20 on 8/4/25 at 3:10 PM and 8/5/25 at 2:45 PM, Resident #20 revealed he was in his wheelchair in the dining room on 06/30/25 when Resident #65 approached him from behind and wrapped his arm around his neck and tightened the grip with his other arm squeezing his neck and choking him. He expressed how this frightened him and said, “He could have killed me”. He stated he had five (5) seizures after the event and was sent to the hospital for evaluation and his last seizure prior to this incident was months ago. He was glad that Resident #65 had to leave the facility but stated he did not feel as safe now as he did before the incident occurred. An interview with the Social Worker on 8/5/25 at 1:35 PM, revealed the facility was aware of Resident #65’s aggressive behaviors towards staff and other residents and had tried several times to get him admitted into a psychiatric facility, but due to his insurance type and his diagnosis of dementia, they could not find placement. She acknowledged the staff held meetings to discuss his behaviors and monitoring needs. They monitored him one-on-one when he showed signs of aggression, they placed him in a private room, and offered tasks and activities for him to participate in. She stated, “I think we did everything possible to monitor him” but acknowledged that if Resident #65 had been on one-on-one supervision, he would have been unable to harm Resident #20. She confirmed that one-on-one monitoring would have kept Resident #65’s aggressive behavior from causing harm to others but the facility failed to consistently have him under this supervision. An interview with the Administrator on 8/5/25 at 1:45 PM revealed Resident #65 was difficult to redirect and had aggressive behaviors with staff and other residents. There were multiple incidents documented of Resident #65’s aggression and physical and verbal altercations. She acknowledged that Resident #65’s aggressive behavior was an ongoing concern, and they had (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	been unsuccessful in finding a behavioral health facility placement for him. She stated they implemented interventions such as one-on-one observations when he had aggressive behaviors, but once behaviors improved, the interventions were discontinued. She acknowledged that one-on-one supervision was “sporadic” during his stay depending on his behaviors and if he had remained on this constant supervision, Resident #20 and other residents would have been protected, but this did not occur. When the incident occurred, Resident 65 was not on one-on-one supervision. He was unsupervised in the dining room with other residents. Resident #65 was ambulatory, and Resident #20 was in his wheelchair and Resident #65 went behind the wheelchair and choked Resident #20. She stated Resident #20 had a history of seizures with his last documented seizure dated 4/11/25 and with the choking incident, the resident was “traumatized” and this incident “triggered” his seizures. At that time, Resident #65 was placed on one-on-one supervision, which continued until he left the facility. The Medical Director was notified of the incident, and Resident #20 was treated in-house until the third day, and he was then sent to the hospital with a physician’s order for evaluation. Resident #20’s family chose to press charges. Resident #65 remained in facility until he was arrested. She acknowledged that each resident had the right to be free from abuse and should feel safe in their home. She confirmed residents with known aggressive behaviors, such as Resident #65, required more supervision to ensure safety of all residents. She confirmed the facility failed to protect residents by not providing adequate supervision to ensure each resident was free from abuse from other residents. During an interview with Registered Nurse (RN) #2 on 8/5/25 at 3:00 PM, she revealed she did not witness the incident of Resident #65 choking Resident #20, but after it occurred, Resident #20 was upset and embarrassed” about what happened to him. She stated she asked Resident #65 why he did that, and he told her, “So I could shut him up” An interview with the Interim Director of Nursing on 8/5/25 at 3:15, revealed Resident #65 had aggressive behaviors towards staff and residents and had previously hit other residents. He could not be redirected and was not compliant with following requests by the staff. She was not in the dining room when the incident between Resident #65 and Resident #20 occurred, but she came in quickly when she heard other residents calling out for assistance. Resident #20 appeared upset and embarrassed and was crying. He complained of a sore throat and neck pain and soon had a seizure. She acknowledged that Resident #65 had been on one-on-one monitoring at times due to his aggression, but he was not on this supervision when this incident occurred and if he was under this supervision, the incident would not have occurred. She confirmed the facility failed to adequately supervise Resident #65 with known aggressive and physical behaviors, therefore allowing Resident #20 to be choked. An interview on 8/5/25 at 3:25 PM with Certified Nursing Assistant (CNA) #4 revealed she came into the dining room when incident occurred. Resident #65 had released his hold from Resident #20’s neck but was attempting to get back to him and Resident #65 told Resident #20 that he was “going to choke him again”. She stated she asked Resident #65 why he did that and was told to get him to shut up and that he didn't care, and he would choke him again. Resident #20 was crying after the incident. She stated Resident #65 had a history of being difficult to redirect and had behaviors which included physical and verbal aggression towards staff and other residents. He had been in one-on-one supervision at times but was not when this incident occurred. During a phone interview on 8/6/25 at 11:40 AM, the facility’s Medical Director stated he was notified of the incident when Resident #20 was choked by Resident #65 but was uncertain if it was immediately when the incident occurred or shortly after that. He stated he did not remember specifically that the resident had multiple seizures after the incident and if he had been notified that the resident was having recurrent seizures, he would have given the order to send to the emergency (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	room for evaluation. If the seizure was a one-time event he would attempt to treat it in house, with medication, monitoring, lab work, and observation of how the resident responded. He acknowledged that stress could be a contributing factor and an altercation like what Resident #20 went through would be stressful and could stimulate a seizure. He acknowledged his expectation was if a resident had behaviors that escalated to the point that they were abusive to residents that could not protect themselves, the psychiatric Nurse Practitioner (NP) should evaluate them, and the resident should remain on one-on-one supervision until evaluated by the NP for safety. The Medical Director stated that this was not occurring in the facility. Record review of a Progress Note dated 6/30/25 for Resident #20 revealed “After residents were separated, he began sobbing and shaking. Resident went into full clonic seizure activity that lasted 3 (three) minutes. RP (responsible party) made aware, and PRN (as needed) given…” Record review of a Progress Note dated 7/2/25 at 8:19 AM revealed Resident sitting among peers talking and began having a seizure. Seizure lasted two minutes PRN Nayzilam Nasal Solution given. Resident assisted to bed via two staff with mechanical lift. RP notified MD notified orders to send to ER for evaluation. Record review of Resident #20’s Order Summary Report revealed an order dated 3/20/25 for Nayzilam Nasal Solution 5 (five) milligrams (mg)/0.1 milliliter (ml) 5 gram in both nostrils every six (6) hours as needed for seizures related to conversion disorder with seizures or convulsions. Record review revealed an order dated 2/24/24 for Acetaminophen 650 mg by mouth every 4 (four) hours as needed for general discomfort. Record review of Resident #20’s electronic “Medication Administration Record” revealed the resident received Acetaminophen 650 mg for neck pain on 7/1/25 at 3:25 AM. Resident received no Acetaminophen during the month of June 2025. Record review revealed the resident received Nayzilam Nasal Solution as needed for seizures on 6/30/25 at 5:10 PM and on 7/2/25 at 8:05 AM. He did not receive this any other time during the months of June or July 2025. Record review of Resident #20’s “admission Record” revealed the facility admitted the resident on 11/09/24, with diagnoses that included conversion disorder with seizures or convulsions. Record review of Resident #20’s Minimum Data Set (MDS) Section C dated 6/2/25 revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated a moderate cognitive impairment. Record review of Resident #65’s “admission Record” revealed resident was admitted to the facility on [DATE], with diagnoses that included dementia and psychosis. Record review of Resident #65’s Minimum Data Set (MDS) Section C dated 6/11/25 revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated a moderate cognitive impairment. The latest MDS dated [DATE] indicated a BIMS score of 15. Resident #65 and Resident #21 Record review of Facility Investigation revealed that around lunch time on 05/24/25, a physical altercation occurred between Resident #21 and Resident #65. According to CNA #3 (Proper Name) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #65 slapped Resident #21 on the side of the head. CNA #3 heard (Proper Name) Resident #65 say to (Proper Name) Resident 21, “Stop stealing my stuff! Do not come in my room anymore.” CNA #2 (Proper Name) helped CNA #3 (Proper Name) separate the two residents to de-escalate the situation. Resident (Proper Name) #65 was immediately moved to another room on a different hall. Residents were assessed with no injury to either resident. Upon notification of the incident, Administrator questioned Resident (Proper Name) #65 and he stated, “I did not slap him. I pushed him against the side of his head for taking my snacks….” Resident (Proper Name) #65 received counsel and education that physical contact was not allowed and to report further issues to personnel. Record review of Witness Statement completed by CNA #3 (Proper Name), revealed that On Saturday, May 24, 2025, during lunch. (Proper Name) Resident #65 turned and slapped (Proper Name) Resident #21 on the side of his head. Then yelled at him ‘stop stealing my stuff, don't come in my room anymore.’ I told (Proper Name) CNA #2 what happened, and she stood between the two men to deescalate the situation. Then nurse, (Proper Name), was notified of the incident. An interview with Certified Nursing Assistant (CNA) #2 on 08/05/2025 at 11:05 AM, revealed that there was an altercation between Resident #21 and Resident #65 back in May. She revealed that she did not witness the incident, but she was called by CNA #3, and she assisted with the two residents. CNA #2 revealed that the incident occurred in the hallway near the opening of the small dining area at the end of the 400 hall. She revealed that CNA #3 witnessed Resident #65 slap Resident #21 in the head with an open hand. She revealed that Resident #21 went into Resident #65’s room and took some snacks, Resident #65 followed Resident #21 down the hall and slapped him. CNA #2 revealed that they separated the residents to de-escalate the situation and Resident #65 was moved to another room on a different hall. CNA #2 revealed that Resident #21 and Resident #65 had adjoining rooms and shared a bathroom. She revealed that Resident #21 often wandered and took snacks from wherever he could find them. She revealed that he had taken Resident #65's snacks more than once and on that particular day, it made Resident #65 mad. CNA #2 revealed that Resident #65 was a “handful” and always kept other residents “worked up.” She revealed that it was the best thing to get him out of there. She revealed that Resident #65 was always grabbing at the staff and residents, cursing loudly, and it was chaos while he was there. CNA #2 revealed that they had to redirect Resident #65 frequently, he knew he was messing up, but he wouldn’t listen to them. CNA #2 stated, “I hope he’s at a place to get some help; we never knew what he would do or say here.” An interview with Administrator on 08/05/25 at 3:10 PM revealed that on 05/24/25 Resident #21 went into Resident #65’s room and took his snacks. She revealed that this made Resident #65 mad and he (Resident #65) hit him (Resident #21). She revealed that she investigated the incident, they moved Resident #65 to another room and educated him that he could not hit other people and told him to report further issues to staff. An interview with Interim Director of Nursing (DON) on 08/06/25 at 8:50 AM, revealed that Resident #21 and Resident #65 stayed in adjoining rooms and shared a bathroom at the time of the incident. She revealed that Resident #21 often went into Resident #65 and other residents’ rooms and took their snacks. DON revealed that on 05/24/25, staff reported to her that Resident #21 went into Resident #65’s room and took some of his snacks. Interim DON revealed that Resident #65 got mad, came up the hall behind Resident #21, he yelled at and slapped him on the head. Interim DON revealed that CNA #3 witnessed the incident, separated the two residents and the nurse checked them out and there were no injuries identified. Interim DON revealed that they should have monitored (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #65 more closely and that he should have had 1:1 supervision from the day he slapped the other three residents. Interim DON revealed that had the staff been closely monitoring Resident #65, they could have redirected him and prevented the incident. She revealed that they implemented 1:1 monitoring after this altercation, but it did not continue when his behavior improved. She stated, “The close monitoring should have continued.” Record review of Resident #21's Progress Note dated 05/24/25 revealed: Nurse was notified by CNA (Certified Nursing Assistant) that resident was hit in head by another resident with open hand. Nurse immediately assessed resident, neuros complete…., no c/o pain or discomfort, no bruises or wounds noted. Nurse separated from peer. Nurse noted that resident took resident snacks from room…” Record review of Resident #65’s “Progress Note” dated 05/24/25 revealed: “Nurse was notified by CNA that resident hit peer in head with open hand. Nurse immediately separated resident from peer and completed an assessment, neuros completed…… .no c/o (complain of) pain or discomfort, no bruises or wounds noted. Resident (#65) stated, ‘that mother f****r (explicit language) stealing my stuff out my room.’ .” Record review of Resident #21 admission Record revealed an admission date of 02/20/25 and that he had diagnoses that included Cerebral Infarction due to Unspecified Occlusion or Stenosis of Basilar Artery Aphasia, Schizoaffective Disorder and Aphasia. Record review of Resident #21’s Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/10/25 under Section C revealed that Brief Interview for Mental Status (BIMS) should not be completed due to resident is rarely/never understood. Resident #65 and Resident #5 Record review of the facility “Resident-to-Resident Abuse Investigation” revealed, “On August 14, 2024, Unsampled Resident #1, Unsampled Resident #2, and Resident #5 all came to Nursing Home Administrator (NHA) between 4:30 and 5:00 PM to report that they were all hit by Resident #65. Unsampled Resident #2 stated she was sitting in her chair earlier that day in her bedroom when Resident #65 entered her room and hit her on the top of the head. Unsampled Resident #1 stated Resident #65 forcefully slapped her on the right cheek in the dining area. Resident #5 stated Resident #65 also slapped him on the right cheek in the dining area. Resident #15 and Resident #1 said they both witnessed Resident #5 and Unsampled Resident #1 being slapped by Resident #65 in the dining room. Resident #65 was immediately separated from the other residents.” Further review revealed, “Due to Resident #65 being Medicaid only and having a primary diagnosis of dementia, psych facilities have denied him entry. The facility will continue one-on-one supervision and proper monitoring until alternate placement is found.” According to the facility investigation, Resident #65 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment and had a diagnosis of Dementia with Behavior Disturbance. Resident #65 received counsel and was instructed not to hit others, although he denied hitting either of the residents. An interview with Resident #5 on 8/04/2025 at 10:52 AM revealed he had an altercation with another male resident a while back ago (unsure of the exact date). He explained that he was in the dining room, and he saw Resident #65 cursing and hit a female resident in the face. He stated he went over to Resident #65 and told him, “You don't hit on women” and stated the resident slapped (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	him in the face. The resident stated the facility took no effective action and allowed Resident #65’s violent behavior toward others to continue in the facility. He revealed Resident #65 was frequently touching the nurses, physically assaulting residents, verbally abusing staff and residents before the incident, and it continued afterward. He stated Resident #65 was arrested recently and in jail due to an altercation with another resident in the facility. When asked how the incident made him feel and if he felt safe now since the resident was arrested, he replied, No, I don't feel safe. That’s why I don't go out of my room. The resident explained that Resident #65 was his roommate at the time of their altercation. He revealed the staff did move Resident #65 out of the room that day and stated, They moved him because I told them if they left him in the room, he was going to have a pillow over his face in the morning. Record review of Resident #5’s “Progress Note” dated 8/14/25 revealed, “Resident stated that he was slapped by Resident #65 on his right cheek. Resident does appear to have some swelling under his right eye.” Record review of the “Proper name of police department Incident Report” dated 8/15/25 revealed an officer responded to the facility in reference to the altercation that occurred on 8/14/24 with no indication charges were filed. An interview with the Administrator on 8/4/25 at 3:10 PM revealed Resident #65 was admitted to the facility with a diagnosis of dementia on 9/14/23. She explained that he had a lot of behaviors on admit such as inappropriately touching the nurses, cursing, hitting other residents and was aggressive toward the staff and residents. She stated he was unable to be redirected by staff, and they had tried to get him into psych facilities, but no one would accept him because he had Medicaid and a primary diagnosis of dementia. She revealed at the time of the altercation on 8/14/24, the staff separated the residents involved and they did one-on-one monitoring for Resident #65. However, she could not account for any one-on-one monitoring and could not verify how long the facility did these actions to keep the other residents safe since Resident #65 remained in the facility. She revealed they did move Resident #65 from the room with Resident #5 and acknowledged Resident #65 continued to pose a threat to the safety of all residents residing in the facility. An interview on 8/4/25 at 3:30 PM with Resident #15, who witnessed the event on 8/14/24 confirmed he did see Resident #65 slap Resident #5 across the face in the dining room. He stated, “It was a while ago, but I remember it was in the dining room while the residents were just sitting around.” Record review of the “admission Record” revealed the facility admitted Resident #5 on 9/6/19 with medical diagnosis of Sarcoidosis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #5 was cognitively intact. Resident #46 and Resident #41 Record review of the “Facility Investigation” of the altercation between Resident #41 and Resident #46 on 07/21/25, revealed that CNA #1 witnessed the aftermath of a physical altercation between the residents. They were tussling over Resident #41’s walker. CNA #1 called CNA #2 for assistance to help separate the two residents. Both CNAs saw bleeding on Resident #46’s (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	hand and bleeding and swelling on Resident #41’s eye. Administrator interviewed both residents. Resident #46 stated Resident #41 kicked his foot out to trip him up, which led to the physical altercation. Resident #41 stated he was sitting on the side of the room watching television and was suddenly hit in the eye with a closed fist by Resident #46. Resident #41 stated that he was not in any pain but was confused as to why he was hit by his roommate. Assessments were completed by the Interim DON and injury was noted to both residents. Resident #41 had a cut above the left eyebrow open 2 inches by 1 inch. Resident #46 had a skin tear to the knuckle on the right hand. They both received counsel that physical contact was not allowed and to report any issues to staff for proper handling. First aid was provided to both residents. On 07/21/25, Resident #46 was transported to (Proper Name) behavioral health facility for psych treatment and behavior management. Resident #41 was transported to hospital on [DATE] due to his swollen eye worsening with no orbital fracture or major concerns noted. Behavioral Health facility called and notified the facility staff that Resident #46’s right hand began to swell which led to x-ray conducted on 07/23/25. The x-ray findings revealed that Resident #46 had a right-hand fracture because of the recent physical altercation. There were no signs of pain and showed good hand mobility prior to leaving the facility following the physical altercation. Record review of “Statement” written by CNA #1 revealed, “I had got up to go get more linen before the next shift started. Passing by resident room I noticed (Proper Name) Resident #46 and Resident #41 both tussling over the walker. I called for my partner we immediately separated them. (Proper Name) Resident #46 hand was bleeding. (Proper Name) Resident #41 had a gash on left eye, bleeding.” This written statement was dated 07/21/25 and signed by CNA #1. Record review of “Statement” written by CNA #2 revealed, “The other CNA was down the hall. She yelled up the hall for me. I came running got to the room (Proper Names) Resident #46 and Resident #41 was tussling over the walker and we took it from them. Both of them was bleeding. (Proper Name) Resident #46 was bleeding on the hand, and (Proper Name) Resident #41 was bleeding on the head and his eye was swollen.” This statement was signed by CNA #2 and dated 07/21/25. An observation and interview on 08/04/25 at 11:40 AM with Resident #46, revealed him sitting up on the side of bed eating lunch with his two sisters present at his side. He had a brace intact on his right arm and had bruising to the top of his right hand down to his knuckles of his thumb, index, middle, and fourth fingers. Resident #46 revealed that he had been out of the facility and had just returned today. An observation and interview on 08/06/25 at 8:05 AM with Resident #46 revealed him in his bed in his room and a brace was intact to his right arm. Resident #46 revealed that while he was out, his hand started hurting, they x-rayed it and found that his hand was broken. He revealed that another resident smarted off to him and he popped him in the eye. Resident #46 stated, “He (Resident #41) sure backed up when he found out I was the boss. An interview with Certified Nursing Assistant #1 on 08/06/25 at 8:20 AM, revealed that she worked on the day that Resident #46 hit Resident #41. She revealed that these two residents were roommates at the time, and they had not had any prior issues. CNA #1 described Resident #41 as a quiet resident who kept to himself and enjoyed watching westerns on television. CNA #1 revealed that on 07/21/25, she walked down the hall and saw that Residents #41 and #46 were in their room and were tussling with a walker. She revealed that she called another staff member to help, and they separated the two residents. CNA #1 revealed that she observed that Resident #41’s eye was bloody and that there was blood on Resident #46’s knuckles. CNA #1 revealed that she removed Resident #46 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	from the room, and they watched him until he went out to behavioral health. CNA #1 revealed that there was no yelling going on, they were just fighting over a walker. She revea

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to investigate a resident's allegation of sexual abuse by another resident for one (1) of six (6) residents reviewed for abuse. The facilities failure to investigate and implement protective interventions made the resident feel angry, violated, and unsafe, and lead him to avoid leaving his room for fear of being watched by the alleged perpetrator. This failure placed Resident #34 at risk for further abuse, emotional distress, and significant harm to his sense of safety and well-being. Resident #34Findings Include:Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revision date of 10/22 revealed under, 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations.An observation and interview with Resident #34 on 8/04/2025 at 10:30 AM revealed he was sitting in his wheelchair in his room. He explained that he was admitted to the facility in February 2025 and his only concern was another male resident residing in the facility had been making sexually inappropriate statements to him asking him to Suck his d*** and telling him he wanted to have sex with him. He stated the encounter happened in July near 100 hall but he could not remember the exact date. He explained that he told the staff after the incident and the resident named the Administrator (ADM) and Registered Nurse (RN) # 1 as the staff members he told. The resident stated, I'm not gay and I'm not down for that s***. The resident explained that after the incident he came back to his room and could not get it off his mind. He stated it made him angry, and he felt violated. The resident explained that the incident occurred with other residents and staff around. He stated he wanted to handle things by stabbing him because if he did not do anything to the perpetrator, he felt as though it made him look like a punk (in the eyes of people who may have witnessed the event).He stated after he reported the incident to the ADM, he came away with the feeling nothing would be done. He revealed he called the Long-Term Care Ombudsman, and she came out to talk to him on July 29th. He stated, I still don't know what was done about it. He revealed the perpetrator's name was (Resident #45). He revealed Resident #45 had not said anything else to him since the incident, but stated, He always watches me, and I don't like that s***. The resident stated, I went up to him and stuck my finger in his eye and told him, I am not like that and to stop staring at me. The resident explained that he did not want to be the one that might go to jail because he retaliated against another resident. He stated Resident #45 made him uncomfortable and he did not want to come out of his room. He stated they have a lot of resident-to-resident interactions in the facility and stated that administration did not do anything about the resident's behaviors of cursing, threats, and aggression when they first start and wait until things are out of control before they react. When asked whether he felt safe in the facility and felt as though the staff would protect him, he stated, I will protect myself.A telephone interview with the Long-Term Care Ombudsman on 8/4/25 at 1:36 PM revealed Resident #34 called her to come out and speak with him and she did so on 7/29/25. She explained it was regarding another male resident that was making obscene sexual comments to him. She stated the resident reported he had notified the Administrator (ADM) previously about the incident, but he felt that nothing was going to be done, so he called me. She revealed she spoke with the ADM on 7/29/25 and was told they had other complaints about the perpetrator, and she would be sending the resident out to Geri psych. She revealed Resident #34 never told her the name of the alleged perpetrator.An interview with the Administrator (ADM) on 8/05/25 at 1:42 PM confirmed Resident #34 came and reported an incident to her regarding Resident #45. She explained that Resident #34 stated that Resident #45 threatened to interact with him sexually and Resident #34 had inquired whether Resident #45 was gay. She confirmed the Ombudsman did come by and speak with her, but she thought it was just a misunderstanding. She explained that she did not investigate or do anything about Resident #34's (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	concerns and stated, He keeps changing his story. The ADM revealed Resident #34 had told the Interim Director of Nursing, ?He did not know these types of things (male to male sexual interactions) happened in a nursing home.' She revealed they tried to send Resident #45 out to Geri psych, but they could not find anyone to accept him. An interview with Registered Nurse (RN) #1 on 8/06/25 at 8:15 AM revealed Resident #34 did report to her the incident with Resident #45. She explained that she did not overhear anything, but Resident #34 had told her that Resident #45 made sexually inappropriate statements to him. She also stated that she saw Resident #34 telling a housekeeper about it, but she could not recall who the housekeeper was or the details of the incident and stated, I have a lot to do. RN #1 confirmed she did not document or report it to anybody and acknowledged what Resident #34 reported was resident to resident abuse.Record review of the Abuse and Neglect sign in sheet dated 6/30/25 revealed Registered Nurse #1 was in attendance for the in-service.Record review of the admission Record revealed the facility admitted Resident #34 on 2/26/25 with a medical diagnosis of Multiple Sclerosis.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/26/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #34 was cognitively intact.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, staff interviews, record review, and facility policy review, the facility failed to prevent the possibility of the spread of infection during medication administration as evidenced by failing to ensure Enhanced Barrier Precautions (EBP) were utilized and ensuring a multi-use glucometer was properly cleaned and disinfected for two (2) of four (4) medication observations. Resident #21, Resident #40Findings include:Record review of the facility policy titled, Enhanced Barrier Precautions with no revision date revealed Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents.3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: . g. device care or use (.feeding tube) . Record review of the facility policy titled, Blood Sampling-Capillary (Finger Sticks) undated, revealed Purpose: The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employee. Equipment and Supplies: 6. Approved EPA registered disinfectant for cleaning of sampling device. General Guidelines 1. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses . Resident #21 An observation on 8/6/2025 at 8:20 AM revealed Personal Protective Equipment (PPE) hanging on Resident #21's room door. Licensed Practical Nurse (LPN) #1 entered Resident #21's room to provide medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube. LPN #1 administered the medications through the PEG tube without donning a gown. During an interview on 8/06/2025 at 8:35 AM, LPN #1 revealed that any residents with wounds or PEG tubes are under enhanced barrier precautions. She confirmed that Resident #21 is under EBP due to having a PEG tube and acknowledged that she failed to wear a gown, and she should have protected herself and the resident from potential exposure to bodily fluids and infections. During an interview on 08/07/2025 at 10:45 AM, the interim Director of Nurses (DON) revealed that she had conducted in-services on infection control January 2025, which included EBP requirements. She revealed that LPN #1 and all nursing staff were trained to wear the proper PPE while providing care to any resident under enhanced barrier precautions. She confirmed Resident #21 is under enhanced barrier precautions, and a gown should have been worn by LPN #1 while administering his PEG medications. Record review of Resident #21's admission Record revealed an admission date of 02/20/2025 with medical diagnoses that included Dysphagia following Cerebral Infarction. Record review of Resident #21's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of July 10, 2025, revealed, under Section C' that the resident is rarely/never understood. Resident #40 An observation and interview on 8/06/2025 at 8:45 AM, revealed Registered Nurse (RN) #1 performed an Accu-Check on Resident #40 using a multi-use glucometer. After using it, she placed the glucometer on the medication cart, then put it into a blue basket in the top drawer without disinfecting it. The State Agent (SA) inquired if she needed to clean the glucometer. The nurse stated, Oh yeah. RN #1 opened the bottom right drawer on the medication cart, and a white container with a blue top was observed. The nurse looked down and then shut the drawer. She picked up an alcohol swab from the top of the medication cart, briskly cleaned the glucometer, and placed the glucometer back into the top-drawer basket. RN #1 revealed she may not have cleaned the glucometer correctly, but they were out of disinfectant wipes, and she just cleaned with what she had, which was an alcohol swab. The SA prompted RN #1 to look in her bottom drawer again. RN #1 opened the right bottom drawer of her medication cart, and the same white container with a blue top, labeled Micro-kill bleach Germicidal Bleach Wipes, was noted. RN #1 stated, Oh yeah, there are some disinfectant wipes here. She removed the glucometer from the top-drawer basket, wiped it briskly with the disinfectant wipe, and then laid the glucometer back on top of the medication cart, not utilizing a clean barrier. During an interview on 8/7/2025 at 11:00 AM, the interim Director of Nurses revealed that usually each diabetic resident has their own personal glucometer that is kept in their room; however, Resident #40 is relatively new and doesn't have her personal glucometer yet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She revealed that regardless of whether she did not have her own glucometer, the glucometer on the cart was available for her use, and it should have been cleaned and disinfected appropriately. She confirmed it is never an acceptable nursing practice to clean with only alcohol swabs, and the nursing staff knows that is not acceptable. She revealed it is our expectation and practice to clean and disinfect the multi-use glucometer with the Germicidal bleach wipes, and leave it wet for two to three minutes on a clean barrier to ensure it is thoroughly disinfected. Record review of Resident #40's admission Record revealed an admission date of 06/12/2025 with medical diagnoses that included Type 2 Diabetes Mellitus. Record review of Resident #40's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of June 18, 2025, revealed, under Section C' a Brief Interview Mental Status (BIMS) score of 11, which indicated the resident was moderately cognitively impaired.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and facility policy review, the facility failed to follow the requirements for obtaining a Preadmission Screen (PAS) for a resident in the facility for greater than 30 days for one (1) of five (5) residents reviewed. Resident #10Findings include: Record review of facility policy titled, admission Criteria, dated 4/10/23, revealed, .9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process . During an interview on 8/6/25 at 8:20 AM, the Social Worker stated Resident #10 was admitted to the facility for therapy with plans to be discharged home within 30 days, but her therapy was extended. She acknowledged the resident had diagnoses of bipolar disorder and anxiety disorder. She confirmed the Pre-admission Screening (PAS) process evaluated residents for proper placement in nursing facilities and she confirmed the facility failed to submit a PAS for a resident that was admitted in the facility for greater than 30 days. An interview with the Administrator on 8/6/25 at 9:00 AM, revealed a PAS was part of the process to help ensure residents were appropriate for nursing home care. She acknowledged that Resident #10 had diagnoses of bipolar disorder and anxiety disorder. She confirmed the facility failed to complete the required PAS for a resident in the facility for greater than 30 days. Record review of Resident #10's admission Record revealed she was admitted to the facility on [DATE]. Her diagnoses included bipolar disorder and anxiety disorder.Record review of Minimum Data Set (MDS) Section C dated 6/24/25, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to develop a comprehensive person-centered care plan for a resident with a diagnosis of post-traumatic stress disorder (PTSD) (Resident #5), Bipolar and anxiety disorder (Resident #10), and failed to implement a care plan for a resident receiving nectar thickened liquids (Resident #27) for three (3) of 22 care plans reviewed. Resident #5, #10, #27Findings Include: Resident #5 Review of the facility policy titled “Care Plans, Comprehensive Person-Centered” reviewed 10/2022, revealed under, “Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident’s physical, psychosocial and functional needs is developed and implemented for each resident . Record review of Resident #5’s Care Plans revealed a care plan was not developed for past traumatic events or potential triggers. On 8/4/25 at 10:52 AM, an observation and interview with Resident #5 revealed he was lying in bed with the curtains closed and the room dark. The resident stated he suffered from depression and took an antidepressant. He explained that he served in the [NAME] Corps for 17 years and was diagnosed with post-traumatic stress disorder (PTSD). He stated that having to kill people during his service deeply affected him. He reported trouble sleeping due to nightmares and said almost everything bothers him, including crowded areas, noise, and loud environments. An interview with Social Services (SS) #1 on 8/6/25 at 8:45 AM confirmed Resident #5 did not have a care plan for post-traumatic stress disorder. She revealed the care plan should be developed because staff need to know the residents' triggers and the things that cause the resident distress such as loud noises so they can better care for him. On 8/7/25 at 9:10 AM, an interview with the Interim Director of Nursing revealed Resident #5 was a veteran and confirmed he should have a care plan to address his triggers so that staff were aware of the things to avoid. Record review of the “admission Record” revealed the facility re-admitted Resident #5 on 4/7/24 with medical diagnoses of post-traumatic stress disorder dated 1/9/25 and schizophrenia affective disorder, bipolar type. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #5 was cognitively intact. Resident #27 Record review of Resident #27’s “Care Plans” revealed under, “Focus: I have a nutritional problem or potential nutritional problem r/t (related to) my dysphagia mechanical soft diet restrictions.” Also revealed under, “Interventions: Provide, serve diet as (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered.” A record review of the “Order Summary Report” revealed the following diet order dated 5/19/25: “Dysphagia mechanical soft texture, nectar consistency, add ground meats.” On 8/4/25 at 11:20 AM, during an observation of Resident #27’s lunch meal, she was provided a carton of 2% milk (non-thickened) with a straw inserted. A record review of Resident #27’s meal ticket dated 8/7/25 revealed the following note: “Nectar liquids, nectar milk, nectar water.” On 8/4/25 at 11:28 AM, an observation and interview with Dietary Staff #1 confirmed Resident #27 was served the wrong consistency milk. An interview with the MDS Nurse on 8/7/25 at 8:38 AM revealed the purpose of the care plan was to alert staff of what care to provide for the residents. She confirmed the care plan was not followed for Resident #27 in relation to the nectar thickened liquids. Record review of the admission Record revealed the facility re-admitted Resident #27 on 6/16/25 with medical diagnoses that included Dementia with Anxiety, Dysphagia, and Conversion Disorder with Seizures or Convulsions. A record review of the MDS with an ARD of 6/30/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Resident #10 During the record review of Resident #10's care plan, it was revealed that the resident did not have a care plan for her diagnoses of anxiety disorder and bipolar disorder. During an interview with the Licensed Practical Nurse (LPN) MDS Coordinator on 8/6/25 at 10:05 AM, it was revealed that care plans guide the residents' care and preferences for the staff to follow. She acknowledged Resident #10 had diagnoses of bipolar disorder and anxiety disorder and the care plan failed to include the individualized care plan for these mental health diagnoses. She confirmed she was responsible for developing the care plan and due to an oversight, she failed to develop the care plan for her mental health diagnoses. An interview with the Administrator on 8/6/25 at 10:15 AM, revealed the care plan offers a guide for each resident's care and Resident #10 did not have a care plan developed for her diagnoses of bipolar disorder and anxiety disorder. She confirmed the facility failed to develop care plan for a resident's mental health diagnoses. Record review of Resident #10's admission Record revealed she was admitted to the facility on [DATE]. Her diagnoses included bipolar disorder and anxiety disorder. Record review of MDS Section C dated 6/24/25, revealed resident had a BIMS score of 15 which indicated the resident was cognitively intact.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and facility policy review, the facility failed to assess and identify potential triggers for a trauma survivor for one (1) of three (3) residents reviewed for post-traumatic stress disorder (PTSD). Resident #5Findings Include:Review of the facility policy titled Trauma-Informed and Culturally Competent Care, revised 8/22, revealed under Purpose: To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice, and to address the needs of trauma survivors by minimizing triggers and/or re-traumatization.An observation and interview with Resident #5 on 8/4/25 at 10:52 AM revealed he was lying in bed with the curtains closed and the room dark. The resident stated he suffered from depression and took an antidepressant. He explained that he served in the [NAME] Corps for 17 years and was diagnosed with post-traumatic stress disorder (PTSD). He stated that having to kill people during his service deeply affected him. He reported trouble sleeping due to nightmares and said almost everything bothers him, including crowded areas, noise, and loud environments.Record review of Resident #5's Psychiatry Note dated 1/9/25 revealed: In [NAME] Corps for 17 years; when I first got out of the military, I stuck a gun in my mouth, then had to go to a mobile mental health center; nightmares every now and then-last one about a week ago (revisiting the past). The resident was diagnosed with PTSD.Record review revealed the facility did not complete a trauma assessment for Resident #5.An interview with Social Services (SS) #1 on 8/5/25 at 4:01 PM revealed she was responsible for conducting trauma-informed care assessments. She learned in January 2025 that Resident #5 had post-traumatic stress disorder (PTSD) after the nurse practitioner saw the resident. She confirmed no assessment had been completed and stated it should have been done to inform staff about his PTSD and potential triggers that could cause re-traumatization.An interview with the Interim Director of Nursing on 8/7/25 at 9:10 AM revealed Resident #5 was a veteran. She stated that trauma assessments should be conducted quarterly to ensure his psychosocial needs and mental well-being were met.Record review of the admission Record revealed the facility re-admitted Resident #5 on 4/7/24 with medical diagnoses of post-traumatic stress disorder dated 1/9/25 and schizophrenia affective disorder, bipolar type.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #5 was cognitively intact.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and facility policy review the facility failed to maintain a medication error rate of less than 5% by ensuring that residents received all physician-ordered medications for three (3) of 28 medication administration opportunities observed during medication pass. The medication error rate was 10.71%.Review of the facility policy titled, Medication Administration dated November 1, 2008 revealed, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so . B. Administration . 2) Medications are administered in accordance with written orders of the attending physician . On 8/06/2025 at 9:35 AM, a medication administration observation with Registered Nurse (RN) #1 revealed a medication administration to Resident # 5. The medications administered were Diazepam tablet 5 mg (milligrams), Linzess oral capsule 145 mcg (micrograms) Prednisone tablet 5 mg (3 tablets) Pantoprazole Sodium tablet delayed release 40 mg, Keppra tablet 500 mg, Gabapentin capsule 100 mg, Imuran tablet 150 mg, Eliquis tablet 5 mg, and Glycolax powder (polyethylene Glycol 3350) 17 grams. The total number of medications administered to Resident #5 was nine (9). During medication reconciliation, a record review of the Order Summary Report and Medication Admin Audit Report revealed that Resident #5 did not receive three (3) medications that were prescribed by the Physician to be given during that medication administration time. Medications omitted were Metformin HCl Tablet 500 mg, Oxybutynin Chloride ER (extended release) tablet 24-hour 10mg, and Risperdal tablet 0.5 mg. Review of the Medication Admin Audit Report revealed that the three omitted medications were documented as given under the administration time as 09:38 and the documented time as 09:40 during the medication observation with RN #1. During an interview on 8/6/25 at 11:10 AM the interim Director of Nurses (DON) revealed it is our expectation that our nurses administer to the residents all of the medications that the physician has ordered. She revealed that not giving a resident their medications is not acceptable, and if a medication is unavailable, the nurse must call the physician and notify the DON. In an interview on 8/6/2025 at 1:30 PM, RN #1 revealed she returned after the Medication administration pass and later gave Resident #5 the other medications. SA inquired why the medications were not given simultaneously with the other morning medications listed on Resident #5's physician orders. RN #1 revealed she needed some time and exited the room where the interview was being held. A record review of the facility admission Record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus, Post-Traumatic Stress Disorder, Schizoaffective disorder, Bipolar type, and Overactive bladder.A record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of July 24, 2025, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #5 is cognitively intact.

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	08/07/2025

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, staff interview, and record review, the facility failed to serve a therapeutic diet as ordered for one (1) of six (6) residents reviewed for the dining task. Resident #27Findings Include:An interview with the Administrator on 8/7/25 at 10:06 AM revealed the facility did not have a policy regarding serving diets as ordered.An observation of Resident #27's lunch meal on 8/4/25 at 11:20 AM revealed she received a meal in the dining room consisting of cornbread dressing with cranberry sauce, rice with gravy, diced carrots, a roll, milk, and apple cobbler. The resident was provided with a carton of 2% milk (non-thickened) with a straw inserted. She was observed feeding herself.A record review of Resident #27's meal ticket revealed the following note: Nectar liquids, nectar milk.An observation of Dietary Staff #1 on 8/4/25 at 11:28 AM revealed she brought a carton of nectar-thickened milk to Resident #27's meal tray and removed the regular consistency milk. In an interview, Dietary Staff #1 confirmed that the resident had been served regular milk. She explained she came out of the kitchen to get another resident a sausage and noticed the error at that time. She stated the resident was supposed to be on nectar liquids and said, I caught it; I don't think she drank any of it. She acknowledged that aspiration was a possible risk. She also explained she had a new tray line server who was still in training but emphasized that the server should be reading the tray cards before sending trays to the dining room.A record review of the Order Summary Report revealed the following diet order dated 5/19/25: Dysphagia mechanical soft texture, nectar consistency, add ground meats.An interview with the interim Director of Nursing (DON) on 8/7/25 at 9:10 AM revealed her expectation was for certified nurse aides to check the meal ticket against the food provided at mealtime to ensure the correct diet was served. She confirmed Resident #27 was on nectar liquids and acknowledged that the resident could have choked, aspirated, and developed an infection.An interview with the Speech Therapist (ST) on 8/7/25 at 9:49 AM revealed Resident #27 was on the speech therapy caseload due to poor dentition and a history of aspiration pneumonia. She stated she had trialed thin liquids with the resident but decided to maintain thickened liquids because the resident's condition fluctuated and she experiences seizure episodes.Record review of the admission Record revealed the facility re-admitted Resident #27 on 6/16/25 with medical diagnoses that included Dementia with Anxiety, Dysphagia, and Conversion Disorder with Seizures or Convulsions. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/30/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment.