STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255191	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Attala County Nursing Center	326 Highway 12 West Kosciusko, MS 39090

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 - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47158 Based on staff interview, facility policy review, and record review, the facility failed to ensure a resident's right to be free from misappropriation of property as evidenced by a medication diversion affecting four (4) of six (6) residents reviewed for misappropriation of medication. Residents #1, #2, #3, and #4. Findings Include: Record review of the facility policy titled, Incident Investigation & Reporting revised [DATE] revealed Purpose: 1. Each resident residing in this facility has the right to be free from any type of abuse including: verbal, sexual, mental, physical abuse, neglect, exploitation, misappropriation of resident property . Record review of the facility policy titled, Destruction of Unused, Expired, or Discontinued Medications revised ,d+[DATE] revealed, A. Destruction of Non-Controlled Non-Hazardous Pharmaceutical Waste. The facility will maintain all unused medications and destroy them routinely in compliance with the State and Federal guidelines. Once a prescription is dispensed for a specific person, it is illegal for use for anybody else . A review of the facility investigation dated [DATE] revealed that the Administrator (ADM) received a phone call from the local police department regarding an employee of the facility. According to the police, Licensed Practical Nurse (LPN) #1 was involved in an investigation that led to a search of her home. During the search, authorities discovered multiple blister packs of non-controlled medications belonging to residents of the facility. The facility investigation determined that LPN #1 had removed residents' medications from the medication room after they were discontinued or after a resident expired. Facility staff were re-educated on policies related to ordering, receiving, and discontinuing medications. An Ad Hoc Quality Assurance (QA) meeting was held at the conclusion of the investigation. LPN #1 was terminated and reported to the Board of Nursing. The medication that was taken included Cardizem, Pravastatin, Glucophage, Cipro and Lasix. The only current resident that was affected was assessed with no adverse findings noted. During an interview with the Administrator on [DATE] at 9:55 AM she verified that the facility was notified by the local police department that multiple blister packs of non-controlled medications belonging to residents of the facility were found in LPN #1's home. She stated that they believed that LPN #1 removed the medications from the medication room after the medications had been discontinued or the resident had expired. (continued on next page)

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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:00 AM, LPN #2 stated that when a medication was discontinued, changed, or when a resident expired, the floor nurse was responsible for removing the medication from the medication cart, logging it onto the Discontinued Medication Log and placing the medication into the secured cabinet in the medication room. She further stated that as far as she knew, only the Director of Nursing (DON) had a key to the cabinet. She added that the DON and another nurse were responsible for destroying medications, although she did not know how often this was done. LPN #2 stated that Administrative Nurses occasionally performed medication reconciliations on the medication carts to ensure there were no discontinued medications left, but she was unsure how frequently this occurred. On [DATE] at 10:30 AM, during an interview with the Medical Records Nurse (MRN), she confirmed that she occasionally worked the medication cart when on call. She verified that the process for handling discontinued medications was the same as described by LPN #2. She further stated that she assisted with random medication reconciliations on medication carts but did not keep a record of them. A full medication reconciliation was conducted after the discovery of LPN #1's theft. She did not recall when the last reconciliation was done before the incident and confirmed no reconciliations had been conducted since. In a telephone interview on [DATE] at 11:49 AM, with the former DON, she verified that while she was the DON it was the practice of a facility that when a medication was discontinued, changed or the resident expired the floor nurse was responsible for removing the medication from the med cart, logging it on to the Discontinued Medication Log and placing it into the secured cabinet in the medication room. She stated that she was the only one with a key to the discontinued medication cabinet and that she destroyed the medications monthly and as needed. She verified that based on the facility investigation they felt that LPN #1 took the identified medications out of the medication room after they were discontinued, or the resident expired. She stated that sometimes the newer nurses will just lay the cards on the counter and not log them in or put them in the secured cabinet and that is how they felt LPN #1 gained access to the medications. The DON stated that she did not identify which nurses specifically were not following the protocol she just in serviced everyone on how it was to be done. The DON further stated that she did not initiate any audits to ensure that the staff was following the protocol and did not perform any further medication reconciliations on the med carts. During an interview on [DATE] at 11:56 AM, the Administrator (ADM) stated that she was not aware of any audits or follow-up medication reconciliations being performed. Resident #1 Record review of the medication card, with the MRN, for Resident #1 revealed that it was labeled with the residents name, the medication name Metformin Hydrochloride (HCL) 500 milligram (mg) tablet, and a delivery date of [DATE]. There were 53 tablets left on the card. Record review of the Physicians Order List for Resident #1 revealed an active order for Metformin 500 mg tablets from [DATE] through [DATE], when the medication was discontinued. Record review of the Face Sheet revealed the facility admitted Resident #1 on [DATE] with a diagnosis of Diabetes Mellitus and the resident discharged on [DATE]. Resident #2 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the medication card #1, with the MRN, for Resident #2 revealed that it was labeled with the residents name, the medication name Diltiazem 24 Hour Extended Release (ER) 240 mg capsule , and a delivery date of [DATE]. There were five (5) capsules left on card. Record review of the medication card #2, with the MRN, for Resident #2 revealed that it was labeled with the residents name, the medication name Diltiazem 24 Hour Extended Release 240 mg capsule, and a delivery date of [DATE]. There 12 capsules left on card. Record review of the Physicians Telephone Order for Resident #2 revealed an active order for Diltiazem ER 240 mg tablet extended release 24 hour, take by mouth every day from [DATE] through [DATE] when the medication was discontinued. Record review of the Face Sheet revealed the facility admitted Resident #2 on [DATE] with a diagnosis of Atrial Fibrillation and Heart Failure. The resident was discharged [DATE]. Resident #3 Record review of the medication card, with the MRN, for Resident #3 revealed that it was labeled with the residents name, the medication name Ciprofloxacin HCL 500 mg tablet, and a delivery date of [DATE] with six (6) tablets left on card. Record review of the Physicians Order List for Resident #3 revealed an active order for Ciprofloxacin 500 mg tablet twice a day daily for seven (7) days from [DATE] through [DATE] when it was discontinued. Record review of the Admission Record revealed the facility admitted Resident #3 on [DATE] with a diagnosis of Diabetes Mellitus. The resident remains in the facility. Resident #4 Record review of the medication card, with the MRN, for Resident #4 revealed that it was labeled with the residents name, the medication name Pravastatin Sodium 40 mg tab with a delivery date of [DATE], with 29 tablets left on the card. Record review of the Physicians Order List for Resident #4 revealed an active order for had an active order for Pravastatin 40 mg tablet. Administer 1 tablet by mouth at night daily from [DATE] through [DATE] when it was discontinued. Record review of the Face Sheet revealed the facility admitted Resident #4 on [DATE] with a diagnosis of Hyperlipidemia, and the resident discharged on [DATE]. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:30 PM, during an interview and review of delivery dates and active order dates of the medications discovered at LPN #1's home with the ADM, she verified that they had no logs showing if or when the medication cards were removed from the cart. She stated that based on the dates there was no way to determine when LPN #1 removed the medication cards from the facility; or if she removed them from the medication cart or the medication room after they were discontinued. She stated that it was her expectation that the nurse would not have taken the residents' medications. She agreed that misappropriation of a resident's medication could lead to a resident not receiving medications ordered by their physician.