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 _____	C 02/03/2025

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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F 000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI), MS #27003 at the facility on 02/03/25. During the survey, the SA determined the facility was in compliance with the requirements for participation in Medicare and Medicaid. The deficient practice F 609 was cited and determined to be Past Non-Compliance based on implementation of the facility's corrective actions on 11/08/24, and the facility was determined to be in compliance at the time of the survey. The facility held a license for 100 beds and had a census of 63 at the time of this survey.	F 000	Past noncompliance: no plan of correction required.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		

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

Electronically Signed | 02/11/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review the facility failed to report an allegation of abuse timely for one (1) of three (3) residents reviewed. Resident #1. Based on the implementation of the facility's corrective actions taken on 11/08/2024, the deficient practice was determined to be Past Non-Compliance, and the facility had put measures in place to correct the deficient practice prior to the State Agency's (SA) entrance into the facility on 02/03/25. Findings Include: Record review of the facility policy titled, "Freedom from Abuse, Neglect, and/or Exploitation Prevention Plan Education" with revision date of 11/14/17 revealed "......Reports must be within 24 hours (if the allegation does not involve abuse or there is not serious bodily injury) after forming your reasonable suspicion. Within 2 (two) hours (if the allegation involves abuse or there is serious bodily injury) after forming your reasonable suspicion...." In an interview on 02/03/25 at 9:40 AM, with the Administrator (ADM) she revealed that she reported an allegation of abuse on 11/07/24 when	F 609	Past noncompliance: no plan of correction required.	

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she found out about it. She revealed that on 11/07/24, Certified Nursing Assistant (CNA) #3, came to her and reported that she overheard a conversation that morning about an allegation of abuse. ADM revealed that this was the first she heard about it and that she didn't know how long ago it happened until she investigated it. ADM revealed that she initiated an investigation, and during interviews, found that the incident occurred on 10/10/24. She revealed that she found out that Licensed Practical Nurse (LPN) #1 had sent a message to the Director of Nursing (DON) on 10/11/24 that a staff member had hit a resident the day before. ADM revealed that she suspended LPN #1 pending investigation for not immediately reporting the incident. ADM revealed that she questioned LPN #1 about not reporting and she told her that she went to DON's office to report the incident, and she was not at the facility at that time, and she had gotten busy and had forgotten about it.

A phone interview on 02/03/25 at 11:35 AM, with Licensed Practical Nurse (LPN) #1 revealed that she witnessed the last part of the incident between CNA #1 and Resident #1. She stated that on 10/10/24, she was working on the medication cart on 400 hall during lunch time when she heard a commotion in the dining room. LPN #1 revealed that she walked to the dining room and saw CNA #1 standing over Resident #1. LPN #1 revealed that later, CNA #2 told her that CNA #1 had hit Resident #1. She revealed that she realized this was a serious allegation and that she should have reported it immediately. She revealed that she tried to report it to the DON, but she was gone for the day and confirmed that she did not report this to anyone else. LPN #1 revealed that she reported it to the DON the next

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day. LPN #1 revealed that she was suspended because she reported the incident too late and she had decided not to return to the facility after that and she quit.

On 02/03/25 at 12:42 PM, an interview with CNA #2, revealed that on 10/10/24, she was in the dining room helping with the lunch meal. She stated that she asked Resident #1 if she was done eating and she told her, "No" but there wasn't anything left on her tray. CNA #2 revealed that she tried to take Resident #1's tray, and the resident slung the tray across the table and turned her cup over as well. CNA #2 revealed that CNA #1 was sitting across the room in a chair and she got up from her seat, walked over to Resident #1 and she punched Resident #1 in the face with her fist. CNA #2 revealed that Resident #1 stated, "You hit me. You hit me." CNA #2 revealed that LPN #1 was in the hall on the medication cart and came into the dining room. She revealed that LPN #1 came over and got CNA #1 away from the resident and made sure she was okay. CNA #2 revealed that she and LPN #1 looked at Resident #1 and there was no redness, no type of bruise or injury to her face.

An interview with ADM on 02/03/25 at 4:08 PM revealed that an allegation of abuse should be reported within 24 hours if there was no injury and within two hours if it was abuse with injury. She confirmed that they were "still out of that window" and that it should have been reported immediately. ADM revealed that she found out during the investigation that the alleged abuse occurred on 10/10/24 and she didn't find out until 11/07/24 and that's when she reported it.

Record review of the "Facility Investigation"

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revealed that on November 07, 2024, CNA #3 reported to ADM that she overheard a conversation involving CNA #1 who allegedly abused Resident #1. CNA #3 did not know when it happened or know any further details. CNA #2 told ADM that she witnessed CNA #1 hit Resident #1 in the nose with a closed fist. CNA #2 revealed that she got LPN #1 involved and intervened by addressing CNA #1. CNA #2 revealed that she took over Resident #1's care while CNA #1 moved on to picking up trays. LPN #1 looked for the DON to report it and couldn't find her. LPN #1 revealed that she returned to her hall, addressed call lights and finished up the shift that was about to end. LPN #1 reported that she reported the incident to the DON the following day. Education provided to LPN #1 and CNA #2 on 11/07/24 on the importance of timely reporting. LPN was suspended effective 11/07/24 due to late reporting. DON and CNA #1 were suspended immediately and both resigned immediately during the pending investigation.

Record review of CNA #2's "Written Statement" dated 11/08/24 revealed that on October 10, 2024 around lunch time she asked Resident #1 if she was done with her lunch and Resident #1 said, "No I'm not finish with it." CNA # 2 proceeded to pick up her tray and Resident #1 threw her tray across the table and threw her cup. CNA #2 stated that CNA #1 got up from her seat and hit the resident (proper name) Resident #1 with her fist. CNA #2 responded to CNA #1 and LPN #1 also witnessed what she did and it was reported to DON. The statement was signed by CNA #2.

Record review of LPN #1's "Statement" revealed, she was getting medicine ready to pass out to a resident, heard a commotion which caused her to

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turn around to see what was going on. She stated as she turned around, she noticed CNA #1 standing over the resident holding her wrists. She intervened by pushing CNA #1 away from the resident. After the incident, CNA #1 passed out trays and LPN #1 went down the hall to look for DON. DON was not in her office, LPN #1 got sidetracked by call light to help out with another resident. LPN #1 notified DON on October 11/2024 by text message.

Interview on 02/03/25 at 2:10 PM by phone with the former DON stated that she had nothing to say because she did not know anything about the situation because it wasn't reported to her and that she was not made aware of an allegation of abuse.

Record review of Resident #1's "Admission Record" revealed an admission date of 08/06/24 and that she had diagnoses that included Dementia, Schizophrenia, Restlessness and Agitation.

Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/13/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 04 which indicated that she had severe cognitive deficits.

Validation of Past Non-Compliance
The SA validated through interview and record review the facility began investigation into the incident on 11/07/24 and reported the allegation of abuse on 11/07/24. In-services regarding abuse/neglect and reporting began on 11/07/24. 100 percent body audits were conducted on all residents on 11/8/24. Residents with a BIMS of 12

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F 609	Continued From page 6 or higher were interviewed to ensure they all felt safe and free of abuse. The SA, Attorney General 's Office, local law enforcement, Medical Director and Resident Representative were notified. The DON and CNA#1 were suspended and resigned from the facility on 11/7/24. The facility held a Quality Assurance meeting on 11/08/24 and continued to monitor abuse/neglect and reporting concerns throughout the next thirty days. Based on the implementation of the facility's corrective actions on 11/08/2024, the deficient practice was determined to be Past Non-Compliance, and the facility had put measures in place to correct the deficient practice prior to the State Agency's (SA) entrance into the facility on 02/03/25.	F 609		