

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04AC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/13/2025
NAME OF PROVIDER OR SUPPLIER ATTALA COUNTY NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 326 HIGHWAY 12 WEST KOSCIUSKO, MS 39090		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) MS # 26990 at the facility on 3/12/25. During the survey the SA determined the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA investigated misappropriation of medications and cited M 500. The facility held a license for 120 beds, with a census of 100.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or	M 500		3/31/25

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/20/25

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M 500	Continued From page 1 nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial	M 500		

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M 500	Continued From page 2 transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care,	M 500		

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M 500	Continued From page 3 and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Pattern Based on staff interview, facility policy review, and record review, the facility failed to ensure a resident's right to be free from misappropriation	M 500	*The Licensed Practical Nurse was terminated on November 5, 2024 by Administrator. Resident #3 is the only resident currently in the facility that was affected and was	

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M 500	Continued From page 4 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 May 2024 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 10/2019 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 11/5/24 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	M 500	assessed with no adverse findings on November 5, 2024 by the Director of Nursing. Reconciliation of meds was performed by Medical Records Nurse on 11-07-24. *All 100 residents have the potential to be affected by this deficient practice. *Beginning 03-13-25 Licensed Practical Nurses and Registered Nurses were in-serviced by the Quality Improvement Nurse on the following policies: Unused Medication Return, revised 06-16; Medication Ordering, Reordering and Receiving, revised 12-19; Destruction of Unused, Expired or Discontinued Medication, revised 10-19 and Employee Corporate Compliance Code of Conduct to include Abuse, Neglect, Misappropriation of Resident Property and Elder Justice Act. In-Servicing will continue until all Licensed Practical Nurses and Registered Nurses have been in-serviced by the Director of Nursing and/or the Staff Development Nurse. A Quality Assurance Committee Meeting was conducted with the Medical Director, Administrator, Director of Nursing, Staff Development/Infection Preventionist, Social Service Designee and the Minimum Data Set Nurse. The Following policies were reviewed: Medication Ordering, Reordering, and Receiving Procedures, revised 12-19; Unused Medication Return, revised 06-16; Destruction of Unused, Expired or Discontinued Medications, revised 10-19 and Employee Corporate Compliance	

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M 500	Continued From page 5 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 3/12/25 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. During an interview on 3/12/25 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.	M 500	Code of Conduct to include Abuse, Neglect, Misappropriation of Resident Property and Elder Justice Act with no changes made. Beginning 3-17-25 the Registered Nurse Supervisor and/or Medical Records Nurse will monitor discontinued medications to ensure they are pulled from the medication cart and cubbies and logged in the discontinued medication binder two times a week for three weeks, weekly for four weeks and monthly for two months. Beginning 3-17-25 the Director of Nursing will monitor that logged in medications are locked in the medication box to be destroyed and to distinguish between what is logged and what is in the box to ensure no discrepancies. Medications will be destroyed every two weeks for one month and monthly thereafter by the Director of Nursing and another nurse at that time. The Registered Nurse Supervisor and/or Medical Records Nurse monitoring will be documented on the discontinued medication list and maintained by the Director of Nursing. The medication destruction will be recorded on the individual medication destruction sheets and maintained by the Director of Nursing. *The Quality Assurance Committee consisting of the Medical Director, Administrator, Director of Nursing, Staff Development Nurse/Infection Preventionist, Minimum Data Set Nurse and Social Service Designee will meet on March 27, 2025 and monthly for three months to discuss findings or make	

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M 500	Continued From page 6 On 3/12/25 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 3/12/25 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	M 500	changes or recommendations as needed to ensure compliance is achieved.	

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M 500	Continued From page 7 ensure that the staff was following the protocol and did not perform any further medication reconciliations on the med carts. During an interview on 3/12/25 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 5/21/24. 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 1/27/22 through 7/5/24, when the medication was discontinued. Record review of the "Face Sheet" revealed the facility admitted Resident #1 on 1/27/22 with a diagnosis of Diabetes Mellitus and the resident discharged on 8/1/24. Resident #2 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 12/15/22. 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	M 500			

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M 500	Continued From page 8 Diltiazem 24 Hour Extended Release 240 mg capsule, and a delivery date of 12/26/22. 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 11/21/22 through 1/3/23 when the medication was discontinued. Record review of the "Face Sheet" revealed the facility admitted Resident #2 on 11/21/22 with a diagnosis of Atrial Fibrillation and Heart Failure. The resident was discharged 1/5/23. 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 10/23/23 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 10/23/23 through 10/25/23 when it was discontinued. Record review of the "Admission Record" revealed the facility admitted Resident #3 on 1/28/19 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	M 500			

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M 500	Continued From page 9 Pravastatin Sodium 40 mg tab with a delivery date of 1/13/24, 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 12/8/23 through 1/15/24 when it was discontinued. Record review of the "Face Sheet" revealed the facility admitted Resident #4 on 12/8/23 with a diagnosis of Hyperlipidemia, and the resident discharged on 1/20/24. On 3/12/25 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.	M 500		