STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 000	Initial Comments The State Agency (SA) conducted an Annual Licensure Survey and Complaint Investigations (CIs), MS #25833, CI MS #25749, CI MS #26048, CI MS #26075, and CI MS #26383, at the facility from 9/17/24 through 9/19/24. CI MS #25749 was investigated related to pest control and CI MS #26075 was investigated related to abuse. There were no deficiencies cited related to those complaints. CI MS #25833, CI MS #26383, and CI MS# 26048 were investigated related to resident rights and M500 was cited. During the licensure survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M610, M1010, and M1570 The facility had a census of 141 and was licensed for 150 beds.	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	M 500		

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M 500	Continued From page 1 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 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,	M 500		

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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 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;

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M 500	Continued From page 3 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, 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	M 500		

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choice. The facility shall encourage and assist in the fullest exercise of these rights.

This Statute is not met as evidenced by:
Based on interviews, record review, and facility policy review, the facility failed to ensure residents funds were protected from misappropriation. This affected 135 residents who had monies deposited in trust fund accounts. The facility also failed to protect a resident from exploitation (Resident # 1) for one (1) of 30 sampled residents and failed to ensure residents had uninterrupted services in the designated "Chapel" room. This had the potential to affect all residents who use the Chapel.

Findings include:

A review of the facility's policy, "Resident Rights", Review Date: May 13, 2022, revealed, " ...The resident has the right to be free from interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights ...If he/she wishes, have the facility manage his/her personal funds...Voice grievances and have the facility respond to those grievances ..."

A review of the facility's document, "Vulnerable Adults in Mississippi", revealed, " ...The illegal or improper use of a vulnerable adult or his resources for another's profit or advantage with or without the consent of the vulnerable adult ..."

Misappropriation of Resident Funds:

A record review of a letter from the Chief Financial Officer dated July 10, 2024 revealed there was an allegation of embezzlement of an employee at the facility and an investigation was being conducted and the Administrator was

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advised to lock up all receipt books and documents until a formal investigation was completed by the State Auditor Office.

On 9/17/24 at 10:40 AM, during an interview with Administrator, Administrator in Training (AIT), and Director of Nursing (DON), they advised the Attorney General's Office (AGO), the Chief Financial Officer (CFO) of the State of Mississippi, and the State Auditor has been investigating regarding misappropriation of resident funds. The Department of Veterans Affairs had also investigated the facility and found the facility to be out of compliance regarding protecting resident funds.

A record review of the "Department of Veterans Affairs State Veterans Home Survey Report" revealed survey dates 7/30/24 through 8/2/24, the facility was cited for Protection of resident funds and Accounting of records.

A record review of the "Face Sheet" revealed the facility admitted Resident #1 on 8/9/22 with current diagnoses of Diabetes Mellitus and Major Depressive Disorder.

A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/21/24 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact.

A record review of the Facility Reportable revealed on 9/4/24, the facility submitted a facility-reported complaint to the State Agency and Attorney General that Resident #1 had loaned a former security guard about $6,000.00 over six (6) months and had only re-paid the resident $600.00. Resident #1 gave the former

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M 500	Continued From page 6 security guard his personal debit card with the pin number and gave permission to the security guard to use his debit card for different transactions. Resident #1 reported the incident to the AIT on 9/4/24, that the resident loaned the former security guard $6000.00 over a 6-month period. The security card was terminated earlier in the year for not following the facility's policy and procedure. The resident was briefed on not loaning any employee money and that only the Social Workers and or Activities staff were allowed to receive money from residents for resident purposes. The facility was waiting for the AGO to investigate. The facility did not report to the local police dept. On 9/17/24 at 10:55 AM, an interview with Resident #1 confirmed that he gave a security guard at the facility his debit card with his pin number many times to give him money for loans for different reasons. He trusted the security guard as if it was his son. The resident confirmed that he only notified the AIT recently because he thought he would have been paid back. Resident #1 stated he was aware that he gave the security guard his debit card with pin number on his own behalf, but he felt since the security guard worked at the facility the facility should return his money. On 9/17/24 at 11:45 AM, during an interview with the AIT, he confirmed that the facility reported the allegation that Resident #1 gave the security guard his debit card with his pin number from his personal bank account. The facility had no permission to access the resident's personal bank accounts to review the charges. The security guard worked with a private contractor and was terminated due to the allegations and the facility had no obligation for resident personal bank accounts.	M 500		

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M 500	Continued From page 7 On 9/18/24 at 10:05 AM, an interview with the AIT confirmed that the facility had a Banker responsible for the resident's personal funds. He stated there was a discrepancy in an audit and an investigation had begun when it was identified. On 9/18/24 at 2:13 PM, during an interview with the Administrator, he confirmed that Resident #1 had a BIMS score of 14 and that he was oriented and alert. He stated that Resident #1 knew what he was doing and trusted a lousy person. The facility was unable to help him with his personal account. Uninterrupted Services in the Chapel: On 9/17/24 at 10:50 AM, the State Agency (SA) observed the facility's Chapel, which was marked outside of the room as "Chapel." There was a large conference room table with twelve (12) chairs around the table that was located between the pews and the pulpit. Inside of the Chapel, there was an office that was marked as "In-Service". On 9/17/24 at 11:15 AM, during both an interview and observation with the AIT, he confirmed that the Chapel was being used as a multi-function room. The AIT revealed that the residents use the chapel several days a week for services, but it was also used for new employee orientation, resident admissions, in-service training for the staff, and for meetings. He stated the "In-Service" office that was located inside of the chapel was the In-Service Coordinator's office. He stated the facility also provided "Quiet Rooms" on each unit. On 9/17/24 at 12:15 PM, an interview with	M 500		

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Resident #2 confirmed the facility used the Chapel for many things including a conference room and there was an office inside of the Chapel. He stated it was for church services several days a week. He explained that during church services, the staff would enter and exit as often as they wanted, which would disrupt their church services. The resident stated he had informed the Administrator and the AIT, but there had been no changes; they continued to use the chapel as a multi-function room. He expressed that the residents should not be disturbed in the Chapel, and they should be able to use the chapel at any time for quiet time and reflection. He also stated that no one informed the residents the facility was going to use the Chapel for other purposes.

On 9/18/24 at 10:06 AM, during an interview with the facility's Chaplin, he confirmed the chapel was used at least two times a week as a chapel for the veterans to worship. The Chaplin confirmed that several times while giving services, facility staff entered and exited, which interrupted services, and the residents have complained about the interruptions.

On 9/18/24 at 1:00 PM, in an interview with the Ombudsman, she confirmed the residents had complained that the designated Chapel for the residents was being used by the facility for other purposes. She explained there had been up to eleven (11) interruptions in one service and the residents were upset about it. She said the facility's chapel was not used for other purposes until approximately three (3) months ago.

On 9/18/24 at 2:13 PM, during an interview with the Administrator, he confirmed that the Chapel served as a multi-purpose room. The

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M 500	Continued From page 9 Administrator revealed the Chapel was blocked off from the staff several times a week so the residents can hold church services. During the interview, the Administrator stated if they were in their own home, they would not have a chapel at their house. On 9/19/24 at 8:20 AM, during an interview with License Practical Nurse (LPN) #1, she confirmed her office was in the Chapel and she was the in-service coordinator. She revealed that the chapel was a dual-purpose room for new employees, in-services for staff, and new admissions. The chapel was blocked off when church services were performed several times weekly.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure a resident who was dependent on staff for care had toe nails that were trimmed and comfortable for one (1) of 30 sampled residents. Resident #29	M 610		

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M 610	Continued From page 10 Findings Include: On 9/17/24 at 9:30 AM, during an interview with Resident #29, was sitting up in a wheelchair and stated that his toenails were very long and uncomfortable. He commented that he would like to have them trimmed. On 9/17/24 at 9:45 AM, during an interview and observation, Certified Nurse Aide (CNA) #3 was assisting Resident #29 to the shower. She removed the resident's right shoe and his toenails were long and jagged. CNA #3 confirmed that his nails were long and stated the Registered Nurses (RNs) were responsible for trimming and completing nail care for the residents. On 9/18/24 at 3:16 PM, in an interview with Resident #29, he stated that his toenails were still long and that no one had come to cut them for him. He complained that the toenails were so long that they were uncomfortable when he puts on his slippers. On 9/18/24 at 3:20 PM, in an interview with Licensed Practical Nurse (LPN) #2, she stated that unless the resident was a diabetic, the CNA should complete toenail care on the residents. She also stated that if the resident had long, hard nails, the facility had a podiatrist that saw the residents if they were on the list. LPN #2 said the CNAs usually provided toenail care on the resident's shower days, but they may do it anytime. She confirmed the LPNs complete weekly skin assessments that included a head-to-toe assessment of the resident's skin. On 9/18/24 at 3:30 PM, in an interview with the Director of Nursing, she stated that the facility provided a list of residents for the podiatrist to see	M 610		

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M 610	Continued From page 11 monthly. She explained the RN unit managers and the wound care nurse work together to provide nail care for the residents and expressed that she would have the wound care nurse to cut his nails. She also explained the facility did not have a policy regarding nail care. A record review of the "Face Sheet" revealed the facility admitted Resident #29 on 7/29/24 and he had current diagnoses including Glaucoma.	M 610		
M1010	45.35.1 Housekeeping Facilities and Services Housekeeping Facilities and Services. 1. The physical plant shall be kept in good repair, neat, and attractive. The safety and comfort of the resident shall be the first consideration. 2. Janitor closets shall be provided with a mop-cleaning sink and be large enough in area to store house cleaning supplies and equipment. A separate janitor closet area and equipment should be provided for the food service area. This Statute is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure a safe and homelike environment for three (3) of six (6) sampled resident rooms on the D Hall. Findings Include: Room 129 An observation of Room 129 B, on the D left hall on 09/17/2024 at 9:45 AM revealed an overwhelming urine smell. The wall behind the head of the B bed had an area approximately	M1010		

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M1010	Continued From page 12 three (3) feet by four (4) feet that was discolored compared to the rest of the wall. An overbed table beside the B bed had three (3) water bottles-one empty, one half full of clear liquid, and one containing yellow liquid. A subsequent observation on 09/17/2024 at 12:15 PM of Room 129 B revealed the continued presence of the urine smell. The B bed had a sheet bunched up in the center of the mattress, which appeared soaked. A urinal with yellow liquid was observed on top of the dresser. Room 132 An observation and interview on 09/17/2024 at 9:55 AM in Room 132 C, on the D left hall revealed a three (3) by four (4) foot area on the wall behind Resident #10's bed that was discolored compared to the rest of the room. A strip of vinyl baseboard behind the bed was stripped from the wall and hanging onto the floor for approximately four (4) to five (5) feet. Resident #10 stated that the baseboard had been like that since he was admitted in May 2024. He reported telling several staff members, but no repairs had been made. The resident was unable to recall whom he told but believed he had informed nursing staff and possibly a maintenance worker. A record review of Resident #10's most recent quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/08/2024, revealed that the resident was admitted to the facility on 05/02/2024 and had a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating that the resident was cognitively intact.	M1010		

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M1010	Continued From page 13 Room 141 P On 09/17/2024 at 10:30 AM, an observation of Room 141 P, on the D left hall revealed an overbed table with crumbs and spilled liquid on the surface. The edges of the table were missing lining, revealing rough and splintery pressed wood. Observation on 09/17/2024 at 12:20 PM, during lunch service, revealed the resident's meal tray was placed on the same overbed table, which still had crumbs and spilled liquid on it. Observation on 09/17/20224 at 2:30 PM, the lunch tray had been removed, but the table remained dirty. On 09/18/2024 at 9:00 AM, an observation of Room 141 P revealed that the overbed table was no longer in the room. The bathroom in the room contained three stained overbed tables. The bathtub had been removed, and the inner wall was exposed, with broken and missing tiles. Two safety rails were stacked in the corner where the tub had been, and a clear trash bag filled with used briefs was present. The bathroom smelled strongly of urine, particularly near the trash bag. On 09/18/2024 at 11:30 AM, Certified Nursing Assistants (CNAs) #1 and #2 stated that when a CNA notices something in a resident's room that requires repair, they are to inform a nurse, who then notifies maintenance. Both CNAs worked the D left hall regularly. Neither recalled seeing anything in need of repair in Rooms 129 or 132, but CNA #2 mentioned that the bathroom in Room 141 had needed repair "for a while." When asked whether the bathroom was being used for storage, CNA #1 did not answer, and CNA #2	M1010		

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	16CO	A. BUILDING: _____ B. WING _____	C 09/19/2024

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M1010	Continued From page 14 nodded in agreement. An interview and record review on 09/18/2024 at 11:40 AM, with Registered Nurse (RN) #1 revealed that the facility had a system called TELS (a type of maintenance management software) to track needed repairs. RN #1 explained that any staff could log in and enter the room number and repair needed. A review of the TELS system showed an entry for Room 141P, completed in April 2024, but no entries for Rooms 129 or 132. RN #1 was aware of the repairs needed in Room 141 but not for Rooms 129 or 132. An interview with the Maintenance Director on 09/18/2024 at 12:15 PM, confirmed that the facility used the TELS system to track repairs. He stated that paint had been ordered for Rooms 129 and 132, but he was unaware of the baseboard issue. He explained that damage to walls and baseboards often occurs when beds are placed too close to the walls. The Maintenance Director also acknowledged that the bathtub in Room 141 had been removed about a month prior, and the plan was to replace it with a shower due to concerns from the resident's family about fall risks. The work had been delayed due to the facility undergoing a Veteran's Administration survey. He confirmed that the kitchen dish room repairs had been prioritized over the bathroom. On 09/18/2024 at 1:00 PM, during an interview and observation with the Administrator-in-Training (AIT), he stated that while he had been making environmental rounds, his involvement was inconsistent due to his training schedule. The AIT confirmed the needed repairs in Rooms 129, 132, and 141 on the D left hall.	M1010		

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M1010	Continued From page 15 On 09/18/2024 at 2:00 PM, during an interview and review of TELS forms with the Maintenance Director, a work order was found for Room 132 B, created on 03/05/2024 for "wall needs repair behind bed," with a completion date of 06/29/2024. However, there was no mention of the baseboard needing repair. Resident #10 was in the C bed in Room 132, and there was no work order for his bed. A work order for Room 129 was created on 03/18/2024 for "wall behind bed repair," with a completion date of 06/29/2024, but the walls had not been painted. A work order for Room 141, created on 04/15/2024, for "take out old tub and replace with new shower," was marked as in progress but had no completion date.	M1010		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources	M1570		

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M1570	Continued From page 16 and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure staff washed or sanitized their hands before and after direct resident contact when passing and setting up meal trays on the hall for one (1) of three (3) dining observations. Findings include: A review of the facility's policy, "Hand Hygiene Guidance", dated 8/15/23, revealed, " ...2. General: It is imperative that all employees ...follow safe and effective hand hygiene procedures to prevent the spread of infection ...Hand hygiene means cleaning your hands by using either handwashing ...or antiseptic hand wash, antiseptic hand rub (i.e., alcohol-based hand sanitizer including foam or gel" ...4. Procedure: A. All employees should use an alcohol-based hand rub or wash with soap and water for the following examples of resident care ...4. After touching a resident or resident's immediate environment ..." On 9/17/24 at 11:53 AM, during an observation, Certified Nurse Aide (CNA) #3 did not wash or sanitize her hands at any time before and after direct contact with multiple residents, before or after entering the residents' rooms and passing and setting up the resident's meal trays.	M1570		

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M1570	Continued From page 17 On 9/17/24 at 12:10 PM, during an interview with CNA #3, she confirmed she did not wash or sanitize her hands when serving the meals trays. She stated the facility had in-service training regarding infection control and using hand hygiene, and she was aware that she should have used hand hygiene when serving meals trays. On 9/19/24 at 10:30 AM, in an interview with the Director of Nursing (DON), she stated she expected the staff to use hand sanitizer before each meal tray was served to the residents. She explained there was hand sanitizer available on top of the meal tray cart as well as in the hallways.	M1570		