STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68TG	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 an annual recertification survey at the facility from 12/02/24 through 12/04/24. During the 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 deficiencies were cited at M205, M500, M610 and M705. The facility held a license for 98 beds at the time of the survey, and the facility census was 93.	M 000		
M 205	45.2.36 Two-step Testing Two-step Testing. A procedure used for the baseline testing of person who will periodically receive tuberculin skin tests (e.g., health care workers) to reduce the likelihood of mistaking a boosted reaction for a new infection. If the initial tuberculin-test result is classified as negative, a second test is repeated one (1) to three (3) weeks later. If the reaction to the second test is positive, it probably represents a boosted reaction. If the second test is also negative, the person is classified as not infected. A positive reaction to a subsequent test would indicate new infection (i.e., a skin-test conversion) in the person. This Statute is not met as evidenced by: Level II Based on staff interview, record review, and facility policy review, the facility failed to ensure an employee received a two-step tuberculin skin test on hire for one (1) of five (5) new hire personnel files reviewed. Dietary Employee #1 Findings include:	M 205	1. Upon notification of deficient practice, Dietary Employee #1 was advised not to return to work until his two-step test had been restarted. On 12/6/24, the completed two-step skin test was found misfiled and it was noted that the employee did indeed complete the two-step tb skin test on 8/12/24. 2. The facility has determined all	1/8/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68TG	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 205	Continued From page 1 Record review of the facility policy titled "Tuberculosis Testing Healthcare Workers" with a revision date of 2/15/18 revealed under, "Policy: It is the policy of this facility that all healthcare workers be tested for tuberculosis (TB) upon hire and at least annually thereafter using a two-step tuberculin skin test (TST) method or IGRA (blood test that helps diagnose tuberculosis)." Record review of Dietary Employee #1's "New Hire Employee TB (tuberculosis) Skin Test" revealed that the 1st step test was administered on 7/31/24 with no documentation of a 2nd step test. An interview with the Staff Development Nurse on 12/4/24 at 12:34 PM, revealed the hospital and the facility shared a dietary department and that the hospital was responsible for ensuring the dietary staff received the TB skin test on hire. She confirmed Dietary Employee #1 did not have a second step TB test. An interview with the Dietary Manager (DM) on 12/4/24 at 12:51 PM, revealed she did not realize Dietary Employee #1 did not go back to get his 2nd step TB test. She revealed the hospital usually reached out to her to make sure the staff returned, but they did not. An interview with the Director of Nursing on 12/4/24 at 12:56 PM, confirmed Dietary Employee #1 should have had a second step TB (tuberculosis) test on hire.	M 205	residents have a potential to be affected by this deficient practice. 3. Inservice was conducted with the Dietary Manager on 12/6/24 by the Director of Nursing (DON) on the importance of ensuring all new hire employees complete the required two step process and that proper documentation is completed. 4. Beginning 12/9/24, an audit of all new hires will be conducted by the Director of Nursing, Administrator and/or the Staff Development nurse for one month then fifty percent of new hires will be reviewed for two months to ensure proper documentation of the two-step process. Statement of deficiencies and plan of correction were reviewed by the Quality Assurance Committee (QA) on 12/19/24. All findings from audits will be reported to the QA Committee monthly times three months for evaluation of effectiveness and compliance; the QA Committee will make recommendations and/or changes as needed.	
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident	M 500		1/8/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68TG	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 500	Continued From page 2 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68TG	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 500	Continued From page 3	M 500		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68TG	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 500	Continued From page 4	M 500		

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, 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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68TG	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 500	Continued From page 5 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 Based on observation, staff interview, record review and facility policy review, the facility failed to ensure resident information was not accessible to the public during medication administration for one (1) of four (4) residents observed. Resident #82. Findings Include: Record review of the facility policy, "Administration of Drugs" with revised date of 09/08 revealed, ".....Medication Administration Records should be kept covered to ensure privacy of information...." An observation on 12/03/24 at 9:00 AM, of a medication cart on the A-Hall, revealed an open computer screen with Resident #82's Electronic Medication Administration Record (EMAR)	M 500	1. Upon notification of deficient practice on 12/03/24, the privacy screen was applied by the Staff Development RN to protect resident #82□s personal health information. 2. The facility has determined that all residents have the potential to be affected by the failure to properly use privacy screens to protect personal health information. 3. An in-service was conducted with Licensed Practical Nurse (LPN) #1 on 12/3/24 by the Staff Development nurse regarding the Residents right to privacy and the proper use of privacy screens. Beginning 12/3/24, LPN□s and Registered Nurses (RN)□s were in-serviced by the Director of Nursing (DON) and Staff Development nurse on the Residents right to privacy and the proper use of privacy screens.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68TG	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 500	Continued From page 6 information visible to anyone passing by the medication cart. The visible information included Resident # 82's name, medications, and room number. An interview on 12/03/24 at 9:10 AM, with Licensed Practical Nurse (LPN) #1 revealed that she was assigned to the medication cart on A-Hall. She confirmed that the EMAR for Resident #82 was visible on the computer screen and that she should have clicked the privacy screen on before she walked away from the cart. LPN #1 agreed that this was a privacy issue and that the resident's information in the medical record should be kept confidential. An interview on 12/03/24 at 9:55 AM, with LPN Supervisor revealed that the nurses were supposed to lock the computer screen prior to leaving the medication cart unattended. She revealed that the purpose of the locked screen was to prevent anyone who might be walking by from seeing a resident's personal health information. LPN Supervisor stated, "It's always a given to lock the cart and have the privacy screen on while administering medicine." An interview on 12/03/24 at 10:05 AM, with Director of Nursing (DON) revealed that a resident's personal information should never be left up on the computer screen while the medication cart is unattended. She revealed that there was a privacy button that was supposed to be pushed before the nurse stepped away from the computer. The DON confirmed that this was a privacy issue and that residents information should be kept confidential. Record review of Resident #82's "Admission Record" revealed an admission date of 01/26/23.	M 500	4. Beginning 12/09/24, the Administrator, DON, Medical Records nurse, Minimum Data Set (MDS) nurses and/or Charge Nurses will conduct audits daily times one week then three times weekly times one week then twice weekly times two weeks then weekly times two months to ensure the proper use of computer privacy screens. The Consultant Pharmacist conducted an audit to ensure proper use of privacy screens on 12/18/24. Statement of deficiencies and plan of correction were reviewed by the Quality Assurance Committee (QA) on 12/19/24. All findings from audits will be reported to the QA Committee on 01/2/25 then monthly times three months for evaluation of effectiveness and compliance; the QA Committee will make recommendations and/or changes as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68TG	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 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: Level II Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide care to maintain personal hygiene, as evidenced by the failure to provide nail care for two (2) of nineteen sampled residents. Resident #38 and Resident #147 Findings include: A review of the facility policy titled "Fingernails/Toenails, Care Of" revised 09/08 revealed "Purpose: ... To clean the nail bed, to keep nails trimmed, and to prevent infections...Nail care cleaning should be done daily." Resident #38 An observation on 12/02/24 at 2:10 PM of Resident #38's nails revealed bilateral fingernails were approximately one-half (1/2) inch long and	M 610	1. Upon notification of deficient practice on 12/3/24, the Certified Nurse Aides (CNAs) responsible for Resident # 38 and 147s care immediately provided them with proper hand hygiene and nail care. 2. The facility has determined that all residents who require assistance with hygiene and/or grooming have the potential to be affected. 3. An in-service was conducted with CNA□s, Licensed Practical Nurses (LPN) and Registered Nurses (RN) on 12/5/24 by the Director of Nursing regarding proper hygiene and grooming. All residents requiring assistance with grooming/hygiene were assessed on 12/3/24 and 12/4/24 for proper nail care by the Director of Nursing, Charge nurses, floor nurses and Staff Development nurse. 4. Beginning 12/6/24, at least five different residents will be checked per day by the Director of Nurses, Staff Development Nurse, Charge Nurses, Medical Records Nurse and/or Minimum	1/8/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68TG	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 610	Continued From page 8 jagged with a brown substance under the nails. An observation on 12/03/24 at 9:03 AM and again at 10:30 AM revealed Resident #38's fingernails on bilateral hands remained long and jagged with a brown substance under the nails. An observation and interview on 12/03/24 at 10:45 AM, Certified Nurse Aide (CNA) #1 revealed the CNAs are responsible for doing Resident #38's nail care. She revealed we do the nail care when we see that it needs to be done and confirmed that the resident's fingernails were long and had a brown substance under them, revealing they needed to be cleaned and trimmed. An observation and interview on 12/03/24 at 11:05 AM, the Director of Nurses (DON) confirmed that Resident #38's fingernails needed cleaning and trimming and revealed that this could cause skin concerns for the resident. Record review of Resident #38's "Admission Record" revealed the resident was admitted to the facility on 06/01/2021 with medical diagnoses that included Vascular Dementia, Depressive disorders, and Hemiplegia and Hemiparesis following Cerebral infarction affecting right dominant side. Resident #147 During an observation and interview on 12/02/24 at 10:25 AM, Resident #147 revealed she would like her nails to be trimmed. She stated she had never had long nails and she preferred her nails to be kept short. Observation of her nails revealed seven (7) of her 10 nails were long with thumb nails approximately 3/4 inch long and	M 610	Data Set (MDS) nurse□s daily times one week then three times weekly times one week then twice weekly times two weeks then weekly times two months to ensure proper hygiene and grooming has been provided to residents. Statement of deficiencies and plan of correction were reviewed by the Quality Assurance Committee (QA) on 12/19/24. All findings from audits will be reported to the QA Committee on 01/2/25 then monthly times three months for evaluation of effectiveness and compliance; the QA Committee will make recommendations and/or changes as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68TG	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 610	Continued From page 9 some of her nails were jagged and rough. An interview with Registered Nurse (RN) #1 with an observation of Resident #147's nails on 12/3/24 at 10:25 AM, revealed the resident's long and rough nails. The resident informed RN #1 that she preferred to have short nails. During an interview on 12/3/24 at 11:20 AM, the DON revealed each resident's nails should be maintained as the resident preferred and since this resident preferred short nails, the staff should ensure they are kept clean and short. Record review of Resident #147's "Admission Record" revealed the facility admitted the resident on 11/12/24 with a diagnosis of Stress Fracture to right ankle. Record review of Resident #147's "Minimum Data Set" (MDS) with Assessment Reference Date (ARD) of 11/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had a moderate cognitive impairment.	M 610		
M 705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following: 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and	M 705		1/8/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68TG	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 705	Continued From page 10 5. Administration of all drugs and biologicals. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to properly secure medications as evidenced by leaving a medication cart unlocked for one (1) of four (4) medication administration observations. Findings include: Record review of the facility policy, "Storage of Medications" with revision date of 09/08 revealed, "Purpose: Is to ensure that medications are stored in a safe, secure, and orderly manner...Compartments containing medications are locked when not in use. Carts used to transport such items are not left unattended. (Compartments include...drawers, cabinets, rooms, refrigerators, carts..." An observation on 12/03/24 at 9:45 AM, with Licensed Practical Nurse (LPN) #1 revealed an unlocked medication cart left unattended on A-Hall during administration of a resident's medications. At 9:48 AM, LPN #1 revealed that she was assigned to the medication cart on A-Hall and confirmed that she did not lock the medication cart and stated, "I don't usually lock it." LPN #1 confirmed that she should have locked the medication cart prior to walking away to prevent others from taking medications out of the cart. An interview on 12/03/24 at 9:53 AM, with LPN Supervisor, revealed that the medication carts should always be locked when unattended to prevent others from opening the drawers and taking the medications. She stated, "It's always a	M 705	1. Upon notification of deficient practice on 12/03/24, the medication cart was locked by the Staff Development nurse. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. 3. Licensed Practice Nurses and Registered Nurses were in-serviced on the importance of never leaving an unattended medication cart unlocked beginning 12/3/24 by Staff Development Nurse. 4. Beginning 12/09/24, the Administrator, DON and/or Charge Nurses will conduct audits daily times one week then three times weekly times one week then twice weekly times two weeks then weekly times two months to ensure the medication carts are locked properly. The Consultant Pharmacist conducted an audit to ensure medication carts were properly secured on 12/18/24. Statement of deficiencies and plan of correction were reviewed by the Quality Assurance Committee (QA) on 12/19/24. All findings from audits will be reported to the QA Committee on 01/2/25 then monthly times three months for evaluation of effectiveness and compliance; the QA Committee will make recommendations and/or changes as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68TG	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

(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 705	Continued From page 11 given to lock the carts...and they all know this." An interview on 12/03/24 at 10:03 AM, with Director of Nursing (DON), revealed that the medication carts should always be locked when unattended to keep the medications secure and for safety reasons. She revealed that LPN #1 should have locked the medication cart before she walked away from it to keep the medications secure.	M 705		