STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	A. BUILDING _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMPHREYS CO NURSING CENTER	500 CCC ROAD BELZONI, MS 39038

(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) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/15/25 the State Agency (SA) conducted an onsite complaint investigation (CI MS #27393, which alleged that a resident had been improperly discharged. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F623. The census at the time of the survey was 47 and the facility is licensed for 60 beds.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		2/10/25

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

Electronically Signed | 01/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	A. BUILDING _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMPHREYS CO NURSING CENTER	500 CCC ROAD BELZONI, MS 39038

(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) COMPLETION DATE
F 623	Continued From page 1	F 623		

before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	A. BUILDING _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMPHREYS CO NURSING CENTER	500 CCC ROAD BELZONI, MS 39038

(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) COMPLETION DATE
F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on resident representative (RR), Ombudsman, and staff interview, record review, and facility policy review the facility failed to communicate with a resident representative regarding discharge of a resident as evidenced by no notification of discharge provided to the resident/resident representative for (1) one of (3) three residents reviewed for transfer/discharge	F 623	F623 Transfer and Discharge Requirements: 1. Administrator re-mailed Discharge letter dated 12/11/2024 certified return receipt requested that had been signed by Administrator on 1/22/2025 and sent by previous Accounts Manager but unable to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	A. BUILDING _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMPHREYS CO NURSING CENTER	500 CCC ROAD BELZONI, MS 39038

(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) COMPLETION DATE
F 623	Continued From page 3 notice. (Resident #1) Findings include: Review of the facility policy titled, "Discharge," revised 12/24, revealed. If a discharge is sought out by the facility, the resident and the resident representative will be given written notice. ... All discharges require documentation in the clinical record by the interdisciplinary ream indicating the reason for the discharge that is consistent with the resident's assessment of discharge potential and change of condition, either physical or financial..." In a phone interview with Resident #1's RR on 1/15/24 at 9:00 AM, she revealed that she was told on 12/09/24 by the previous Business Office Manager (BOM) that her dad would be allowed to come back to the facility. She then stated the very next day that the facility called the hospital and told them that Resident #1 was discharged. She stated then, "I just don't see how they could discharge my dad from the facility without even discussing it with his family." The RR then stated that she nor her brother received any form of plans to discharge him in writing or verbally. She stated his Medicaid was pending, and she was making payments to the facility, and they should have taken him back. Review of a progress note for Resident #1 dated 12/10/24 by the Director of Nursing revealed contacted by TB (tuberculosis) nurse, she reported the MD (Medical Doctor) had cleared the resident to return to the nursing home all his tests were negative. In an interview with the Administrator on 1/15/24	F 623	verify in facility and resident representative stated they had not received according to surveyor during complaint survey. Administrator in-serviced the new Accounts Manager on Discharge Policy regarding 30-day notification and communication with Resident Representative on January 15, 2025. 2. All forty-seven (47) residents currently residing in the facility have the potential to be affected by this deficient practice. 3. Administrator in-serviced the new Accounts Manager and Social Services Director on policy and procedure for 30-day discharge notices on January 21, 2025. 4. Administrator will monitor/audit facility Discharge letters beginning on 1/20/2025 weekly for three (3) weeks and then monthly for three (3) months to ensure Discharge documentation is sufficient and notification to Responsible Representatives are mailed certified return receipt requested, and documented in the medical record. Any inaccurate findings will result in immediate notification to Responsible Representative, Ombudsman, and Quality Assurance Committee. A Quality Assurance Committee meeting was conducted on 1/21/2025 with Administrator, Director of Nursing Infection Control Nurse, Medical Director, Nurse Case Manager, Accounts Manager, Medical Records, Social Services Director, Assessment Nurse and Activity Director. A follow-up Quality Assurance Committee Meeting will be conducted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	A. BUILDING _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMPHREYS CO NURSING CENTER	500 CCC ROAD BELZONI, MS 39038

(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) COMPLETION DATE
F 623	Continued From page 4 at 12:00 PM, he revealed that Resident #1 went to a doctor's appointment on 11/25/24 and was admitted to the hospital from the appointment. He stated the facility did not allow the resident to return to the facility related to nonpayment of financial responsibilities. He then revealed he was unable to find where a discharge notice was ever provided to the resident/resident's representative. Furthermore, he also revealed that he was also unable to find any documentation in the residents' record that discharge for nonpayment was ever discussed with the Ombudsman or the resident's representative. The Administrator then stated the importance of notifying the residents/resident representative of notification of discharge is to allow the individuals the right to appeal the decision and have the guidance of the Ombudsman. In a continued interview, the Administrator revealed that the previous BOM would have been responsible for communicating with the resident/ resident representative and providing them with the discharge notice and confirmed she was no longer employed at the facility. Record review of the "Ombudsman Discharge" list for 11/2024 revealed Resident #1 was being discharged due to max bed hold. In a phone interview with the Ombudsman for the facility on 1/15/24 at 2:00 PM, she confirmed that she was not aware of the facility's plans to discharge Resident #1. Record review of the "Admission Record" revealed Resident #1 was admitted by the facility on 9/26/24 with a diagnosis of Chronic Combined Systolic and Diastolic Heart Failure, End Stage Renal Disease and Dependence on Renal	F 623	again on 2/09/2025 and quarterly thereafter if no new findings. Administrator will take necessary corrective action such as: Individual in-service, employee disciplinary actions or terminations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	A. BUILDING _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMPHREYS CO NURSING CENTER	500 CCC ROAD BELZONI, MS 39038

(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) COMPLETION DATE
F 623	Continued From page 5 Dialysis. He was discharged on 12/10/24. Record review of Resident #1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/03/24, revealed in Section C a Brief Interview for Mental Status (BIMS) was scored as 11 indicating the resident was moderately cognitively impaired. Record review of Resident #1's Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/25/24, revealed, Section A0310: Entry /discharge reporting coded 11-discharge assessment -return anticipated.	F 623		