STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 The State Agency (SA) conducted an annual recertification and three (3) complaint investigations (CI MS #25105, CI MS #27402, and CI MS #27528), at the facility, from 2/24/25 through 2/27/25. CI MS #25105 was investigated for Administration/Personnel, CI MS #27402 for resident assessment after change in condition, neglect, and quality of life, and CI MS #27528 for injury of unknown surgery and resident safety. There were no citations related to the CIs. During the recertification survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F558, F584, F809, F812, and F868. The facility held a license for 110 beds with a census of 87.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation,interviews, facility policy review and record review, the facility failed to ensure residents had access to a call light while in bed for two (2) of 18 residents sampled (Residents #1 and #12). Findings include:	F 558	Preparation and submission of this plan of correction by Pearl River County Nursing Home does not constitute an admission or agreement by the provider of truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted	4/11/25

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

Electronically Signed | 03/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 558	Continued From page 1 A review of the facility's policy, "Call Light, Use Of", revised on 05/22/2012, revealed: "...position the call light conveniently for the resident to use... Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand..." A review of the facility's Resident Rights revealed "The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside ...the facility." Resident #1 On 02/24/2025 at 03:49 PM, an observation of Resident #1 revealed the resident calling for help from his room. The resident's call light was observed to be draped over the call light box located on the wall. The resident was observed to have an amputated leg. The resident stated he was unable to get out of bed to reach the call light from the call light box on the wall. The resident stated the call light was normally on his bed. On 02/24/2025 at 03:50 PM, an interview with Certified Nursing Assistant (CNA) #1 acknowledged the call light was draped over the call light box and was out of the resident's reach. CNA#1 noted that residents' call lights should always be accessible for their safety and stated "everyone is responsible for making sure residents have their call lights within reach." A record review of the facility's "Admission Record" revealed the facility admitted Resident #1 on 07/16/2021, with diagnoses including Acquired Absence of Left Leg Below the Knee. A record review of the annual Minimum Data Set	F 558	solely pursuant to the requirement under the state and federal laws. F558 1. Call lights were immediately placed back within reach of the resident for Residents #1 and #12 on February 24, 2025. Clips were added to the call lights for Residents #1 and #12 to help them remain within reach at all times. Education was conducted by the Education Nurse Licensed Practical Nurse (LPN), with the Certified Nursing Assistants assigned to Residents #1 and #12 on the importance of call lights remaining within reach on February 25, 2025. 2. Each resident who uses a call light within the facility has the potential to be affected. 3. Education was provided to all staff by the Education Nurse LPN beginning on March 18, 2025 on the importance of call lights remaining within reach. 4. Each hall Nurse shall monitor 2 call lights on a weekly basis on his or her respective hall for 4 weeks beginning March 24, 2025; then monthly for 3 months thereafter. Findings will be brought forth to the Quality Assurance (QA) Committee for analysis and compliance for four months, beginning April 9, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 558	Continued From page 2	F 558		

(MDS) with an Assessment Reference Date (ARD) of 02/07/2025 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.

Resident #12

On 02/24/2025 at 03:45 PM, observed Resident #12 calling out for help while in her room. The resident stated she was not able to use her call light because she could not see it. The resident explained that she "cannot see very well." The resident's call light was observed on the floor under the head of her bed. The resident stated the call light is usually located on her bed within reach.

On 02/24/2025 at 03:47 PM, an interview with Licensed Practical Nurse (LPN) #1, Charge Nurse, acknowledged that Resident #12's call light was out of reach and on the floor. LPN #1 noted that not only CNAs but floor nurses as well should assist in making checks to ensure residents' call lights are within reach. LPN #1 stated her expectation would be that residents' call lights should be within reach at all times.

A record review of the Admission Record revealed that the facility admitted Resident #12 on 10/31/2024, with diagnoses including Unspecified Visual Loss.

A record review of the quarterly MDS with an ARD of 12/20/2024 revealed Resident #12 had a BIMS score of 06, indicating severe cognitive decline.

On 02/26/2025 at 01:50 PM, an interview with the Director of Nursing (DON) acknowledged that the call lights for Residents #1 and #12 were out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 558	Continued From page 3 reach. The DON stated that call lights should always be within reach for every resident. She further stated that the entire nursing staff is responsible for ensuring residents have access to their call lights. The DON emphasized the importance of residents being able to access their call lights to call for assistance and stated the facility's expectation is that all call lights should be clipped to the bed and within reach. The DON noted that she plans to conduct rounds to ensure residents' call lights remain within reach. On 02/27/2025 at 02:13 PM, an interview with the Administrator acknowledged that the call lights for Residents #1 and #12 were out of reach. The Administrator emphasized the importance of residents having call lights within reach so they can call for help. The Administrator stated that he expects nursing staff to assist residents by ensuring their call lights remain accessible at all times.	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		4/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 584	Continued From page 4 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and facility policy review, the facility failed to ensure Resident #74 had a safe, clean, and homelike environment for two (2) of four (4) days of facility observations. Findings include: A record review of the "Resident Rights", in Section H revealed "...1. The facility must provide a safe, clean, comfortable, and homelike environment...2. Housekeeping and maintenance	F 584	F584 1. Resident number 74's room was immediately deep cleaned on February 25, 2025, and the stained privacy curtain was removed and replaced. 2. All residents in the facility have the potential to be affected by the deficient practice. 3. Education was provided to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 584	Continued From page 5 services necessary to maintain a sanitary, orderly, and comfortable interior..." record review of the "Seven-Step Deep Cleaning", revised 2/04/14 revealed that cleaning steps include: "Disinfecting all surfaces... disinfecting all furniture... inspection of room..." On 02/25/2025 at 02:41 PM, an observation of Resident #74 in bed revealed the bed frame, walls, curtains, and bed rails were stained. Resident #74's room had an odor. The resident stated that his room is cleaned daily. On 02/25/2025 at 02:45 PM, an interview with Certified Nurse Aide (CNA) #3 revealed that Environmental Services is responsible for keeping rooms clean, including wiping walls and bed frames. On 02/25/2025 at 02:50 PM, an interview with Environmental Services (EVS) Worker #1 revealed that staff clean rooms daily. Routine cleaning includes dusting furniture, cleaning the bathroom, taking out the trash, and wiping off bed frames when dirt and debris are visible. On 02/26/2025 at 08:42 AM, a phone interview with the EVS Manager revealed that resident rooms receive detailed cleaning three (3) times per week. Detailed cleaning includes walls cleaned, bed frames wiped off, mattresses wiped (if wipeable), furniture dusted, trash removed, bathrooms cleaned, and bed rails sanitized. The EVS Manager stated that deep or detailed cleaning can occur when residents are out of the room. On 02/26/2025 at 08:48 AM, an observation	F 584	Environmental Services Staff to include cleaning of walls, bed frames, and privacy curtains - by the Environmental Services Director on February 27, 2025 and March 19, 2025. An audit was performed facility-wide on all privacy curtains on March 20, 2025 by the Regional Environment Services Director. Education was provided to direct care staff by the Education Nurse Licensed Practical Nurse (LPN) on removing soiled linens, and the tidiness of rooms and expectations on March 20, 2025. 4. Monitoring by the Infection Preventionist Registered Nurse (RN) will be completed on 5 rooms from Station 1 and Station 2, once per week for 4 weeks beginning on March 24, 2025; then monthly for 3 months thereafter. Findings will be brought forth to the Quality Assurance (QA) Committee for analysis and compliance for four months, beginning on April 9, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 584	Continued From page 6 revealed Resident #74 was in bed. The bed frame, walls, curtains, and bed rails remained stained. On 02/26/2025 at 09:10 AM, an observation of Resident #74's room was made by the State Agency and the EVS Manager. This observation revealed a stained bed frame, walls, curtains, and bed rails. The EVS Manager acknowledged the brown stains on the bed frame, curtains, walls, and bed rails. The EVS Manager stated that she would contact laundering services to remove the curtains and clean them. On 02/27/2025 at 08:14 AM, a phone interview with the EVS Manager revealed that her expectation of EVS staff is to clean rooms according to policy. She stated that nursing staff should inform EVS staff when a resident's room is not clean or needs a deeper cleaning. The EVS Manager acknowledged the stains on the walls, bed rails, bed frame, and curtains and stated that she believed the stains were dried food on the walls, bed frame, curtains, and bed rails. On 02/27/2025 at 01:33 PM, an interview with the Director of Nursing (DON) revealed that EVS staff are expected to clean resident rooms daily. The DON stated that if CNAs observe stains on residents' walls, bed frames, or bed rails, they should clean them between EVS daily cleanings.	F 584		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in	F 809		4/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 809	Continued From page 7 the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to serve meals within the 14-hour timeframe without providing a substantial snack for one (1) of four (4) days of survey. Findings included: A review of the facility's policy titled "Resident Nutrition Services," revised in July 2017, revealed, "Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident...7. Nourishing snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snacks may be scheduled between meals to accommodate the resident's typical eating patterns..."	F 809	F809 1. On March 18, 2024, new meal times were proposed in a meeting held with the Administrator, Director of Nursing, Quality Assurance Registered Nurse (RN), Infection Preventionist Registered Nurse (RN), Restorative Licensed Practical Nurse (LPN), Dietary Manager, Education Nurse Licensed Practical Nurse (LPN), Dietary Liaison and Regional Dietary Director. The proposed meal times would change the breakfast and evening meal serving times to only 14 hours in between, as follows: Station 2 breakfast – from 7:15am to 6:45am; Station 1 breakfast from 7:35am to 7:05am; Station 2 evening meal from 4:00pm to 5:15pm; and Station 1 evening meal from 4:20pm to 5:35pm. On March 19, 2024, a special Resident Council meeting was held in which the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 809	Continued From page 8 A record review of the facility's "Meal Serving Schedule," updated on 04/04/2023, revealed that dinner for Station Two (2) starts at 4:00 PM to 4:20 PM, and breakfast is served at 7:15 AM to 7:35 AM, resulting in 15 hours and 15 minutes between dinner and breakfast. The schedule also revealed that dinner for Station One starts at 4:20 PM to 4:40 PM, and breakfast is served at 7:35 AM to 7:55 AM, resulting in 15 hours and 10 minutes between dinner and breakfast. A record review of the facility's "Cart Delivery Log," dated 02/25/2025 to 02/26/2025, revealed that Station Two received the dinner meal cart on the floor at 4:06 PM on 02/25/2025 and received the breakfast meal cart on 02/26/2025 at 7:28 AM, resulting in a 15-hour and 22-minute lapse between dinner and breakfast. The log also revealed that Station One received their dinner cart at 4:30 PM on 02/25/2025 and their breakfast meal cart at 7:55 AM on 02/26/2025, resulting in a 15-hour and 20-minute lapse between dinner and breakfast. ON 02/25/25 at 4:00 PM, in an observation, the dinner meal trays on 200 Hall at 4:04 PM. The first tray was served at 4:09 PM. The second dinner cart arrived at 4:16 PM and the diabetic nigh snacks were served in brown bags with resident room numbers on the front. Residents in the Dining Hall received their meal tray at 4:22 PM to residents in Dining Hall. On 02/25/2025 at 4:49 PM, during an interview, Dietary Staff #1 stated that the previous Administrator and Director of Nursing (DON) decided approximately six (6) to seven (7) months ago to stop the snack cart due to residents wanting snack options, such as soup,	F 809	new, proposed meal times were approved. Substantial snacks are available 24 hours per day, and 7 days per week, on each nursing station in the respective nourishment room. 2. Each resident who eats meals within the facility has the potential to be affected. 3. Education was initiated to dietary staff on meal time changes by the Dietary Manager on March 19, 2025. Education was initiated to facility staff on meal time changes and the availability of substantial snacks by the Education Nurse LPN on March 19, 2025. 4. Daily meal cart delivery times will be monitored for compliance by the Dietary Manager daily for 4 weeks beginning March 24, 2025, then weekly for 4 weeks, and monthly for 3 months. Findings will be brought forth to the Quality Assurance (QA) Committee for analysis and compliance for five months, beginning April 9, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 809	Continued From page 9	F 809		

cereal, and sandwich, instead of chips, crackers, and snack cakes. Now the kitchen supplies the nurses' station with snacks, sandwiches with meat and bread, and residents can request these items. Dietary Staff #1 explained that diabetic residents receive snacks automatically with their dinner trays. Dietary Staff #1 defined a suitable snack as juice, a sandwich, graham crackers, a beverage, or soup.

On 02/26/2025 at 7:38 AM, during an interview, Licensed Practical Nurse (LPN) #2 confirmed that there is no documentation indicating who receives a snack. LPN #2 explained that each non-diabetic resident must request a snack, whereas diabetic residents receive snacks automatically with their dinner meal.

On 02/27/2025 at 1:23 PM, during an interview, Dietary Staff #2, the newly appointed Dietary Manager, stated that she did not know who set the mealtimes and was unaware that there were more than fourteen (14) hours between the dinner meal and the breakfast meal. She stated that she believed snacks were offered to all residents between 7:00 PM and 9:00 PM but was unaware that residents were not receiving a substantial snack.

On 02/27/2025 at 1:31 PM, during an interview, Dietary Staff #3 stated that she was unaware that the meal schedule exceeded fourteen (14) hours between dinner and breakfast. She stated that the three meals served daily met residents' nutritional needs but was unaware that residents were not offered snacks at night.

On 02/27/2025 at 1:44 PM, during an interview, the Director of Nursing (DON) stated that she did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 809	Continued From page 10 not know who set the mealtimes, but they had been in place since she started working at the facility. The DON stated she was unaware that residents waited longer than fourteen (14) hours between meals and that snacks were not routinely offered. She confirmed awareness of the resident council's decision to remove the snack cart but was unsure why the decision was made. On 02/27/2025 at 2:05 PM, during an interview, the Administrator stated that he was unaware that residents waited longer than fourteen (14) hours between dinner and breakfast and that residents were not offered snacks at night. The Administrator stated that he expected residents to be offered a substantial snack between meals.	F 809		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		4/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 812	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to label and date food items in the refrigerator, freezer, and dry good rooms for one (1) of four (4) observations. Findings included: A review of the facility's "Food Preparation" policy", undated, revealed, "...Discard foods that are not date marked ..., TCS (Time/Temperature Control for Safety) foods that was opened or prepared seven (7) days prior..." A review of the facility's "Labeling" policy", undated, revealed "...Ensure all food items are labeled. Be especially cautious to label all food items that are not kept in their original containers ... Ready -to-Eat TCS food ..." On 02/24/25 at 09:45 AM, during an observation and interview with the Dietary Manager (DM), there was (1) clear plastic bag of boiled eggs unlabeled without a used by or prepared date. In the freezer, there was an unlabeled box of assorted mini cheesecakes, (1) bag of hushpuppies opened, without product opened date. During tour of dry goods room, there was an opened, exposed, an unlabeled box of graham cracker crumbs, and two (2) sweet potatoes that shows deterioration. The DM confirmed the unlabeled items in the refrigerator, freezer, and dry goods room. On 2/27/25 at 2:56 PM, in an interview with the Administrator, confirmed he was had been informed of the findings in the kitchen.	F 812	F812 1. Unlabeled food and spoiled dry goods were immediately disposed of upon discovery of non-compliance by Dietary Staff on February 24, 2025. 2. Each resident who eats meals within the facility has the potential to be affected. 3. Education was provided to dietary staff by the Dietary Manager on proper storage and labeling of food on February 27, 2025. 4. Daily inspection of food storage areas will be completed by the Dietary Manager, daily for 4 weeks beginning on March 24, 2025, weekly by the Administrator for 4 weeks beginning March 24, 2025, and monthly for three months by the Administrator and Dietary Manager thereafter. Findings will be brought forth to the Quality Assurance (QA) Committee for analysis and compliance for five months, beginning April 9, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:	F 868		4/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 868	Continued From page 13 Based on record review and facility policy review, the facility failed to have mandatory members of the Quality Assurance Performance Improvement (QAPI) Committee present for (4) four of 12 months reviewed. Findings include: A record review of the facility's QAPI sign in logs revealed the Infection Preventionist (IP) was not present for the meeting on 3/20/24, 5/15/24, 6/19/24, and 7/17/24. On 02/27/25 at 02:37 PM, an interview with Registered Nurse #1/Quality Assurance (QA) nurse revealed the IP was not present for four (4) QAPI meetings in 2024. The QA nurse revealed the purpose of having all required disciplines present is that all ideas can be heard and that the department that is affected by a topic can provide input or receive information. The QA nurse stated the nursing home has had a lot of turnover of staff and going forward she expects all required disciplines to be present. On 02/27/25 at 02:59 PM, during an interview with the Administrator, he acknowledged the IP nurse was not present for four (4) QAPI meetings in 2024. The Administrator revealed the purpose of having all required disciplines present is to provide correct communication between the disciplines regarding patient care issues. The Administrator stated that going forward he expects all required disciplines to be present at the QAPI meetings.	F 868	F868 1. Education was provided to the Infection Preventionist Registered Nurse (RN) on the importance of being present for all QA meetings by the Administrator on February 27, 2025. 2. All residents have the potential to be affected related to the deficient practice. 3. Quality Assurance Performance Improvement (QAPI) attendance form was updated by the Quality Assurance Registered Nurse (RN) to list the required members of the committee. A second certified staff member was identified to serve in place for Infection Prevention should the need arise. 4. Quality Assurance Registered Nurse (RN) will be responsible for ensuring participation and record of attendance for all applicable Quality Assurance (QA) committee members by scheduling and sending out meeting invites to members at least two weeks prior to the meeting date. The Administrator will verify meeting attendance for 3 months for analysis and compliance beginning on March 19, 2025.	