STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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 along with a Complaint Investigation (CI MS #26921) at the facility from 3/3/25 through 3/6/25. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F565, F584, F656, F658, F677, F679, F688, F758, F759, and F761. The SA identified non compliance and cited F584 regarding the physical environment, F656 for not implementing a care plan, and F677 for Activities of Daily Living for CI MS #26921. The census at the time of the survey was 109 and the facility is licensed for 116 beds.	F 000		
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 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.	F 584		4/24/25

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

Electronically Signed | 03/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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 1 §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 observation, resident and staff interviews, record review and facility policy review, the facility failed to provide a safe, clean homelike environment for Residents #6, #11, and #60. This was for one (1) of four (4) hallways. Findings include: A record review of facility policy titled "Safe and Homelike Environment," dated 2024, revealed, "In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment..." A record review of the facility policy titled, "Deep Cleaning Rooms" undated revealed, (6) "Check all room curtains if it needs taking to laundry for	F 584	A. For resident #6 the plywood section behind the headboard was removed and the wall was repaired on 03/07/2025. For resident #60 an odor eliminator was placed on 03/05/2025 in close proximity to the resident's room to help eliminate the odor in the hallway. On 3/06/2025 the housekeeping supervisor put into place twice a day cleaning round to resident #60's room. For #11 the curtain was removed and cleaned on 3/06/2025. A 100% audit was done by the housekeeping supervisor of all curtains in the facility was completed on 3/06/2025. B. All residents in the facility that have a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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 2 washing." Resident #6 During an observation and interview on 03/03/25 at 3:10 PM, Resident #6's room was noted to have a large section of the wall (approximately 3 feet by 3 feet) with scratches and paint missing. Behind the resident's headboard of her bed, a piece of plywood measuring approximately 4 feet by 3 feet was noted to be attached to wall. The plywood had large chunks of wood missing which left uneven and splintered edges on the broken part as well as on the edges of the plywood. Resident #6 stated she would like for it to be repaired. On 3/5/25 at 1:30 PM, during an observation and interview, the Administrator confirmed the paint on the wall was in disrepair and the broken and splintered plywood on the wall behind the resident's bed could cause an injury. She confirmed each resident should have a safe, clean, and homelike environment and the facility failed to provide this for Resident #6. Record review of "Admission Record" revealed the facility admitted Resident #6 on 12/16/2020. Diagnoses included Hemiplegia and Hemiparesis following Cerebral Infarction, Type 2 Diabetes Mellitus, and Dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/24 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.	F 584	plywood wall protector behind their bed has the potential to be affected by the alleged deficient practice. All residents on pink unit hall 2 in close relation to the smell of this room have the potential to be affected by the alleged deficient practice. All residents in facility who have curtains in their room have the potential to be affected by this alleged deficient practice. C. An in service was conducted by the Staff Development Coordinator on 3/18/2025 to all staff to report to supervisor any need for repairs to any rooms in the facility, any curtains that need to be cleaned, and any lingering odors that may be observed throughout the facility. D. Housekeeping supervisor to conduct an audit of four rooms throughout the facility and one room on hall two on the pink unit two times a week for four weeks starting 3/18/2025, then weekly times two weeks, then monthly to ensure solutions are sustained. The Administrator will review the audits two times a week for four weeks starting 3/18/2025, then weekly for two weeks, then monthly times two months to ensure solutions are sustained. The results of the audit will be reported to the quality assurance/performance improvement beginning on 4/24/2025, then quarterly to ensure that consistent substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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 3	F 584		

Resident #60

During an observation on 03/03/25 at 1:06 PM, an overwhelmingly strong and foul-smelling urine odor was noted in the hallway near Resident #60's room with the smell covering approximately 15 - 20 feet of the hallway from the resident's doorway. Upon opening the door to the resident's room, the foul smell was overpowering. Neither of the residents living in that room were in the room at the time.

During an interview on 3/4/25 at 12:20 PM, Certified Nursing Assistant (CNA) #1 revealed Resident #60 frequently urinated on the floor while he attempted to use the toilet. She stated they have tried to mop the floor every hour or two and replaced the flooring in his bathroom, but the smell is still overwhelming. An observation during the interview confirmed that the urine smell in the hallway of Resident #60's room was still foul and overpowering.

An interview on 3/4/25 at 12:25 PM, with CNA #3 confirmed that Resident #60's room and hallway near the resident's room had a strong smell of urine present. She stated she felt that the resident attempted to urinate in the toilet but would frequently miss and urinate on the floor. Her interview revealed that housekeeping mopped the floor every hour or two, but there was still a strong and very unpleasant smell, and she had several residents complain about the bad smell.

During an interview on 3/4/25 at 12:30 PM, Licensed Practical Nurse (LPN) #3 confirmed that the urine smell in and near Resident #60's room had been an ongoing problem. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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	F 584		

acknowledged that the resident "pees on the floor", and even though unintentional, it still smelled terrible and "it is not fair to other residents. This is their home, and they should not have to live in a stinky home." She stated she did not know what else could be done to improve the situation, but they have had residents and family members complain about the awful smell.

During an interview with the Director of Nursing (DON) on 3/5/25 at 10:30 AM, he revealed he and the staff had worked with Resident #60 to try to improve this concern. They had assisted him with voiding in the toilet and even tried to encourage him to sit down while toileting. The resident was unwilling to try that and was unwilling to be prompted by staff to toilet more often. The DON stated the resident would go into the bathroom but before he was positioned properly, he would urinate on the floor. The DON confirmed that he was aware of the terrible smell in the resident's room as well as in the hallway surrounding the resident's room and had tried multiple things to help improve the smell. The floor was replaced which helped for a while, but he confirmed there was a foul odor in that area of the facility which had not been successfully resolved.

During an interview on 3/5/25 at 10:35 AM, the Administrator stated she was aware of the foul urine odor in and near Resident #60's room. She stated multiple options had been tried such as replacement of the floor and wall in bathroom, resealing the toilet, mopping frequently, education and encouragement of resident with different techniques of voiding, but none of these led to a permanent solution to the problem. She confirmed this concern had continued to occur

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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	F 584		

and an acceptable and permanent solution had not been established. She also confirmed it was not fair for the other residents to have to accept this strong, foul urine smell in their home. She confirmed that each resident had the right to a clean, comfortable, homelike environment and the facility failed to provide this for the residents in that area.

Record review of Resident #60's "Admission Record" revealed the facility admitted him on 3/25/2019. Diagnoses included Chronic Obstructive Pulmonary Disease and Borderline Intellectual Functioning.

Record review of the MDS with an ARD of 1/10/25 revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated that Resident #60 had a moderate cognitive impairment.
Resident #11

An observation and interview on 3/03/25 at 12:05 PM, revealed multiple large splotched discolored areas to the privacy curtain visible upon entering Resident #11's room. Resident #11 revealed that "This curtain needs cleaning; they don't ever clean it."

An observation on 3/04/25 at 10:10 AM and again on 3/5/25 at 8:20 AM revealed the privacy curtain remained dirty with multiple large, discolored splotches throughout the fabric on the curtain.

During an observation and interview on 3/05/25 at 8:30 AM, LPN #2 confirmed the privacy curtain in Resident #11's room was dirty and stained and needed to be pulled down and cleaned. She revealed it is not a home-like environment and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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 wasn't sure when it was last cleaned. During an observation and interview on 3/05/25 at 9:45 AM, the Administrator confirmed the privacy curtain in Resident #11's room was extremely dirty and stated, "I was just in this room yesterday and didn't even notice it." Resident #11 revealed "It's been dirty like this for a long time." A record review of Resident #11's "Admission Record" revealed the facility admitted the resident on 02/24/2012 with diagnoses that included Major Depressive Disorder, Unspecified Kidney Failure, and Anxiety Disorder. A record review of Resident #11's MDS Section C with an ARD of 1/23/2025 revealed a BIMS score of 15, indicating that the resident is cognitively intact.	F 584		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		4/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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 656	Continued From page 7 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for nail care, oral hygiene, and hand rolls for one (1) of 25 sampled residents. Resident #74 Findings Include:	F 656	A. For resident #74 nail care and oral care was performed on 3/06/2025 to ensure nails were trimmed and cleaned and mouth was cleaned. For resident #74 hand rolls were applied on 3/06/2025 to prevent skin breakdown and prevent further contraction of hand. The charge nurse will check daily to see if resident has hand rolls are in place and if oral care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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 656	Continued From page 8 Review of the facility policy titled "Comprehensive Care Plans" unrevised, revealed under," Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality." Review of Resident #74's "Care Plan Report" revealed under, "Focus: I require total assistance with my ADL's (activities of daily living) r/t (related to) CVA (cerebrovascular accident) with left hemiplegia and bilateral hand contractures." Also revealed under, "Interventions: Caregiver to don (apply) bilateral hand rolls to bilateral hands to decrease risk of skin breakdown and decrease risk of further contracture formation with skin checks/cleanse at the end of each shift to ensure no adverse effects x(times) 7 days a week ... Mouth care: Brush teeth twice daily in the morning and night. X (times) 1 staff to assist with oral care ... Nail care: clean and file PRN (as needed), trim my nails weekly." On 3/03/25 at 12:00 PM, an observation of Resident #74, revealed he was lying in bed with long brown discolored nails on the left hand measuring approximately 1 inch (in.) in length. One of his nails was broken off and hanging inside his palm. The residents' upper and lower teeth and lower gum line were covered in a thick white substance. Contractures observed to both hands/fingers with no device in place for contracture management.	F 656	has been completed according to the care plan. The charge nurses on each unit will ensure activities of daily living are being performed according to the residents specific care plan daily. Charge nurses will be required to attend weekly care plan meeting to ensure they are aware of residents specific activities of daily living to ensure that the problem does not recur. B. Any dependent residents that require assistance with activities of daily living care could be affected by this alleged deficient practice. Any residents with limited range of motion could be affected by this alleged deficient practice. C. An in-service was conducted by the Staff Development Coordinator on 3/18/2025 with all licensed employees on the requirement of following the care plan on completing activities of daily living care with dependent residents, also if dependent residents refuse activities of daily living care the importance of documenting refusal and notifying physician of refusal. She also in serviced all licensed employees on 3/18/2025 on the requirement of following the care plan on ensuring hand rolls are in place as resident allows, if residents refuse hand rolls to be put in to place it is vital to document refusal and notify the physician of refusal. D. Charge Nurses or Unit Manager will conduct audits on five different care plans are being followed for correct activities of daily living care starting 3/18/2025 two	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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 656	Continued From page 9 An observation of Resident #74 on 3/04/25 at 10:15 AM revealed he was lying in bed without hand rolls in place. On 3/05/25 at 7:50 AM, an observation with interview revealed Resident #74 lying in bed with long brown, discolored nails on the left hand and a thick white substance on the upper and lower teeth and the lower gum line. He revealed he asked the staff to brush his teeth. Contractures observed to both hands/fingers with no device in place for contracture management. The resident voiced that sometimes the staff applied a hand towel inside his hands, and stated they were not in his hands now. On 3/05/25 at 8:00 AM an observation and interview with Registered Nurse (RN) #1 confirmed Resident #74 did not have his hand rolls in place, had long nails, and described the residents' teeth as, "They need brushing." An interview with the Minimum Data Set (MDS) Nurse on 3/06/25 at 8:20 AM revealed staff should follow Resident #74's care plan. She revealed the purpose of having a care plan was to make staff aware of how to care for the resident. The MDS Nurse confirmed staff did not follow his care plan. Record review of the "Admission Record" revealed the facility admitted Resident #74 on 2/02/22 with medical diagnoses that included Cerebral Infarction and Hemiplegia Unspecified Affecting the Left Nondominant Side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/25 revealed, under section C, a Brief	F 656	times a week for four weeks, then weekly for two weeks, then monthly times two months to ensure the care plan is being followed to ensure activities of daily living care is being performed for dependent residents and hand rolls are being put into place on residents that require them. Director of Nursing or Assistant Director of Nursing will review weekly audits starting 3/18/2025 two times a week for four weeks, then weekly for two weeks, then monthly for two months to validate accuracy of audits. The results of the audit will be reported to the quality assurance/performance improvement committee on 4/24/2025, then quarterly until such time consistent substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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 656	Continued From page 10 Interview for Mental Status (BIMS) summary score of 15, which indicated the Resident #74 was cognitively intact.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure a resident dependent on staff for Activities of Daily Living (ADLs) received oral care and nail care for one (1) of 25 sampled residents. Resident #74 Findings Include: Review of the facility policy titled "Activities of Daily Living Policy" with a revision date of 7/2014, revealed under, "Policy Statement: Based on previous evaluations and current date, the nursing staff, in conjunction with Attending Physician, Consultant Pharmacist, therapy staff, and others, will seek to identify the level of care a resident requires for ADLs." An observation of Resident #74, on 3/03/25 at 12:00 PM, revealed he was lying in bed with fingernails that were approximately 1 inch (in.) in length on the left hand with a brown substance on each nail and one nail that was broken off and hanging inside his palm. The residents' upper and lower teeth and lower gum line were covered in a thick white substance.	F 677	A. For resident #74 nail care and oral care was performed on 3/06/2025 to ensure nails were trimmed and cleaned and mouth was cleaned. An audit was done by the unit manager on 3/07/2025 on all dependent residents requiring activities of daily living care, with no issues being found. The unit manager will now update activity of daily living kardex at weekly care plan meeting. B. Any dependent residents that require assistance with activities of daily living care could be affected by this alleged deficient practice. C. An in-service was conducted by the Staff Development Coordinator on 3/18/2025 with all licensed employees on the requirement of completing activities of daily living care with dependent residents, also if dependent residents refuse activities of daily living care the importance of documenting refusal and notifying physician of refusal.	4/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

(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 677	Continued From page 11 An observation with interview on 3/05/25 at 7:50 AM with Resident #74 revealed no change in the resident's appearance and he stated that he had asked the staff in the past to brush his teeth. An observation and interview with Registered Nurse (RN) #1 on 3/05/25 at 8:00 AM confirmed Resident #74 had long nails on the left fingers that could cause skin breakdown due to his contracted fingers, which were turned inward toward the palm. She revealed the nurses, or the aides, could trim his nails. RN #1 described the residents' teeth as, "They need brushing." She confirmed that staff failing to do this could cause gingivitis and tooth decay. She revealed the aides were responsible for brushing his teeth daily. An interview with the Administrator (ADM) on 3/05/25 at 2:00 PM revealed her expectations were for staff to perform the care tasks listed and document accordingly. Record review of the March 2025 "Documentation Survey Report" for Resident #74 revealed the resident requires total dependence for personal hygiene with the assist of 1- two (2) staff. Record review of the "Admission Record" revealed the facility admitted Resident #74 on 2/02/22 with medical diagnoses that included Cerebral Infarction and Hemiplegia Unspecified Affecting the Left Nondominant Side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary	F 677	D. Charge Nurses or Unit Manager will conduct audits on five dependent residents activities of daily living care is being performed starting 3/18/2025 two times a week for four weeks, then weekly for two weeks, then monthly times two months to ensure activities of daily living care is being performed for dependent residents. Director of Nursing or Assistant Director of Nursing will review weekly audits starting 3/18/2025 two times a week for four weeks, then weekly for two weeks, then monthly times two months to validate accuracy of audits. The results of the audit will be reported to the quality assurance/performance improvement committee on 4/24/2025, then quarterly until such time consistent substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	**135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350**

(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 677	Continued From page 12 score of 15, which indicated that Resident #74 was cognitively intact.	F 677		