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M 000	Initial Comments The State Agency (SA) conducted a complaint investigation (CI) MS #28029 and CI MS #28085 at the facility from 4/7/25 through 4/8/25. During the survey the SA determined that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm for both CI MS #28085 and CI MS #28029 and cited M500 for resident rights. The SA determined the facility was not in compliance for CI MS #28085 related to staffing and cited M225. The census at the time of the survey was 63 with a bed capacity of 100 licensed beds.	M 000		
M 225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day	M 225		5/20/25

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M 225	Continued From page 1 shift and be responsible for all nursing services in the facility. c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This Statute is not met as evidenced by: Level II Based on staff interviews, record review, and facility policy review, the facility failed to provide the minimum requirements for nursing staff	M 225	On 04/23/2025, the Administrator and Director of Nursing (DON) verified the posting of the DON and Administrator's phone numbers at the nursing stations so	

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M 225	Continued From page 2 based on the ratio of two and eight tenths (2.80) hours of direct nursing care per resident per twenty-four hours for five (5) of 22 days reviewed. 2/21/25, 2/22/25, 3/29/25, 4/4/25, and 4/5/25. Findings include: Record review of facility policy titled, "Staffing", dated 10/22, revealed, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment". Record review of "Facility Assessment" section titled, "Facility Assessment and Staffing Needs", undated, revealed, "a. This facility assessment will be utilized to: b. Guide staffing decisions to ensure there is a sufficient number of staff with the necessary competencies and skill sets to meet residents' needs, as identified through assessments and care plans" . During an interview on 4/9/25 at 2:15 PM, the Administrator acknowledged that they tried to keep the facility well-staffed, but when there were call-ins from work, occasionally they could not find a replacement. She stated the staff would stay late or come in early or come in extra to cover the short shift, but there had been times that they were unable to cover sufficiently and meet the state minimum requirement of 2.80 hours of staffing. The facility advertised open positions and held two job fairs and recruited new staff, but some quit before they completed the orientation process. She felt the staff provided the care needed for each resident's care, but confirmed the staffing ratio fell below the required 2.80 on several occasions.	M 225	staff may contact the DON, Registered Nurse (RN) Supervisor, and/or Administrator when the need arises to report staffing concerns. All residents have the potential to be affected by this practice. On 04/23/25, the Administrator and Corporate personnel scheduled a job fair and will contact local colleges for Career Fair dates until facility staff are in place, hired, and trained. In-service of staffing ratios, poor attendance, and punctuality has begun with clinical staff as of 04/23/2025. Charge nurses are to account for scheduled staff and immediately report absenteeism to the DON to ensure staff are put in place. Beginning 04/21/2025, the Administrator initiated a Sufficient Staff Audit tool to monitor for adequate staffing to provide residents the highest optimal quality of care. Beginning 04/21/2025, the Administrator and/or DON will monitor staffing daily for seven (7) days, weekly for three (3) weeks, and monthly for one (1) month. The Administrator and/or DON will present findings of the audit tool to the Quality Assurance Performance Improvement Committee (QAPI) for three (3) months beginning on 04/24/2025 and three months thereafter for further recommendations. Any identified issues will be addressed immediately.	

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M 225	Continued From page 3 Record review of "Staffing Grid" verified with working schedule revealed five of the 22 dates on the grid with less than 2.8 staffing ratio. These dates were 2/21/25, 2/22/25, 3/29/25, 4/4/25, and 4/5/25.	M 225		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for 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,	M 500		5/20/25

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M 500	Continued From page 4 which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, 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;	M 500		

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M 500	Continued From page 5 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 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);	M 500		

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M 500	Continued From page 6 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available 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 staff interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from misappropriation of a resident's medication for one (1) of five (5) residents reviewed for misappropriation. Resident #1 Findings include:	M 500	Resident #1 continues to receive prn (as needed) narcotic medication per physician's orders, 10-325 milligrams prn every six (6) hours as needed for severe pain. Licensed Practical Nurse (LPN) #1 was in-serviced by the Administrator on 02/19/2025. LPN #1 was suspended on 02/19/2025 and 02/20/25 due to pending investigation results. Resident #1 was assessed by a LPN on 02/19/2025. No abnormal findings was noted. Resident #1	

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M 500	Continued From page 7 Record review of facility policy titled, "Freedom from Abuse, Neglect, and/or Exploitation Prevention Plan Education" dated 8/23/17, revealed, "The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardian, friends, or other individuals. ... Misappropriation of resident property - Deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent." Record review of facility policy titled, "Resident Rights" dated 11/28/16, revealed, "The facility must protect and promote the rights of the resident". Record review of facility policy titled, "Controlled Substances", undated, revealed, " ... 5. Controlled substances are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. 6. All keys to controlled substance containers are on a single key ring that is different from any other keys. 7. The charge nurse on duty maintains the keys to controlled substance containers. The director of nursing services maintains a set of back-up keys for all medication storage areas including keys to controlled substance containers..." During an interview on 4/7/25 at 9:45 AM, the Administrator stated she had reported the incident of missing narcotic medication to the required entities and acknowledged that Licensed	M 500	did not go without prn medications as needed, and the medication was replaced. Beginning 02/19/2025, daily cart audits were initiated and verified by administrative nurses. Medication Administration Records were also reviewed with no missing documentation. On 02/19/2025, Social Services interviewed residents with high Brief Interview for Mental Status (BIMs). Residents did not voice any concerns. Beginning 02/18/2025, the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) began in-servicing nursing staff on resident rights, abuse and neglect, MS Board of Pharmacy regulations regarding drug diversion, safety data sheets, medication cart security, medication labeling and storage, controlled substances, and discarding and destroying medications. Any staff who fail to comply with the points of the in-service will receive further education and/or progressively disciplined as indicated. Beginning 02/18/2025, the DON and/or Designee audited and monitored narcotics daily for seven (7) days and weekly for three (3) weeks, then monthly for two (2) months to ensure compliance for three (3) months. On 02/19/2025, the facility did an ADHOC QAPI. The results of the audits will be presented to the Administrator monthly, and the Administrator will present the results at the monthly Quality Assurance Performance Improvement (QAPI) meeting beginning on 03/21/2025	

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M 500	Continued From page 8 Practical Nurse (LPN) #1 had left the medication keys unattended at the nurses station while she went outside for a break and also left the keys on the medication cart unattended while the corporate nurse checked the medication cart. When LPN #1 returned from her break she went to the medication cart to obtain a PRN (as needed) medication for Resident #1 and realized that a medication card for a 30 count Norco Oral Tablet 10-325 milligram was missing, and she reported it and an investigation was initiated immediately. During an interview on 4/7/25 at 4:00 PM, the Registered Nurse (RN) Supervisor revealed that around 2:30 PM - 3:00 PM on 02/18/25, LPN #1 informed her that one of Resident #1's pain medication cards was missing. They immediately searched for this card but were unable to locate it. An investigation began, and drug screens and statements were obtained on each staff member that worked that day. The RN Supervisor determined that LPN #1 had gone outside for a break earlier that day and left the narcotic keys unattended on the desk in the nurses' station. She had also left these keys on the medication cart while the corporate nurse checked her cart for expired and unlabeled medications. She acknowledged the medication keys were to remain with the nurse on their person at all times to prevent an unauthorized person having access to the residents' medications and confirmed that LPN #1 had failed to prevent the misappropriation of a resident's medication by leaving her narcotic keys unattended. A phone interview with LPN #1 on 4/7/25 at 5:30 PM, revealed she had worked in the facility from around 7:00 AM until 11:00 PM on 2/18/25, the day the medications went missing. She stated on	M 500	and three (3) months thereafter. Any concerns will be addressed, and an action plan will be written by the QAPI committee if needed. The action plan will be monitored by the Administrator weekly until resolved.	

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M 500	Continued From page 9	M 500		

that morning she made a "careless mistake" and when she went outside to take a break that she left the medication cart and narcotic box keys on the nurses' desk. When she returned, the keys were where she left them, and she was unaware of any concern. She stated around 2:00 PM - 2:20 PM, she opened the medication cart for the corporate nurse to check her cart and left her keys on top of the cart and she was nearby, but the corporate nurse did not go into the controlled medication locked box on the cart. Then around 2:30 PM - 3:00 PM, she unlocked the medication cart to get Resident #1's medication and noticed that one of the narcotic medication cards was missing for that resident. She reported this to the nurse supervisor, and they began searching for the medication which they did not locate. LPN #1 confirmed that she was tested for drugs, which was negative, and wrote a statement about what occurred. She confirmed she left the keys unsecured at the desk and on the medication cart and a resident's narcotic medication was missing. She confirmed she had been in-serviced on this and knew not to leave the keys unattended and "it was a careless mistake that I won't do again". She stated this occurred around 3:00 PM and she was told to finish her shift which was a shift from 7:00 AM - 11:00 PM and then she was off for two days after that. She completed her assignment for that evening which included the medication pass for the evening shift. She stated she was not told to turn in her keys or leave the facility immediately and she returned to work after her two days off. She acknowledged that she had been in-serviced on abuse/neglect/misappropriation, resident rights, and medication administration which included keeping keys in her possession and locking the medication cart.

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M 500	Continued From page 10 During an interview on 4/9/25 at 2:15 PM, the Administrator confirmed that Resident #1 had narcotic medication that was missing and had not been located, and LPN #1 was the nurse responsible for that medication cart. She acknowledged LPN #1 left her keys on the desk while she went outside and on the medication cart while the corporate nurse was checking the cart for expired medication. She acknowledged the medication keys were to remain with the nurse on their person at all times to prevent an unauthorized person having access to the residents' medications. She confirmed the facility failed to prevent the misappropriation of a resident's medication by not ensuring that the keys remained in a nurse's possession and not left unattended. Record review of "Order Summary Report" revealed an order dated 12/13/23 for Norco (Hydrocodone) Oral Tablet 10-325 milligram; give one tablet by mouth every six (6) hours as needed for severe pain. Record review of "Controlled Drug Receipt/Record/Disposition Form" revealed two cards of 30 count Hydrocodone/APAP tablets each were delivered to the facility on 1/13/25 and two more cards with 30 tablets each was delivered to the facility on 02/17/25. One of these cards was the one that was missing, and the other of these medication cards was completed being used by the resident. Record review of "Controlled Drugs Count Record" for February 2025 revealed on 2/18/25, LPN #1 signed that the narcotic medication count was correct when she came in at 7:00 AM and signed again when she was leaving at 11:00 PM that the narcotic medication count was correct.	M 500		

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M 500	Continued From page 11 Record review of LPN #1's "Employee Time Cards" revealed on 2/18/25, she clocked in at 6:37 AM and clocked out at 11:36 PM, and she did not return to work until 2/21/25. Record review of in-service signature sheets revealed that LPN #1 had been trained on "Medication Administration, Compliance Requirements (Abuse/Neglect), Resident Rights, Code of Conduct, Medication Administration, Five Rights, and Documentation. Record review of Resident #1's "Admission Record" revealed she was originally admitted to the facility on 4/19/22 with the most recent admission being 5/10/23, with diagnoses that included displaced midcervical fracture of left femur, aftercare following joint replacement surgery, and dementia. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/21/25 revealed a Brief Interview for Mental Status (BIMS) of 11 which indicated this resident had a moderate cognitive impairment.	M 500		