STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ADAMS COUNTY NURSING CENTER	587 JOHN R JUNKIN DRIVE NATCHEZ, MS 39120

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI), MS#28189, at the facility from 4/21/25 through 4/24/25. The SA investigated MS #28189 for quality of care and falls and cited M640. During the annual recertification survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and cited M500, M645, M655, M715, M815, and M1570.	M 000		
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	M 500		5/16/25

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M 500	Continued From page 1 nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical 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	M 500		

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M 500	Continued From page 2	M 500		

transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for 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,

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M 500	Continued From page 3 and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to honor a resident's preference related to smoking	M 500	1. On 4/23/2025, The assigned certified nursing assistant took resident #15 to smoke immediately. All resident who smoke are now being given smoke breaks timely. On 4/24/2025, there was no mail to	

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M 500	Continued From page 4 during the scheduled smoking times, in accordance with the facility's designated smoking schedule (Resident #15) and failed to ensure residents receive mail on Saturdays (Resident #26) for 2 (two) of 18 residents reviewed for resident's rights. Findings included: A review of the facility policy titled, "A Matter of RIGHTS," undated, revealed, "A Guide to Your Rights and Responsibilities as a Resident...Dignity and Respect ...You have the right to dignity and respect in the care you receive and the setting you live in. This right includes the right: to be treated as an individual...It also means you have a right to expect care and a residential setting...reflects your individual preferences..." Resident #15 A record review of the "Admission Record" revealed the facility admitted Resident #15 on 7/5/24 with diagnoses including Type 2 Diabetes Mellitus. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/25 revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated he was cognitively intact. A record review of the facility's "Resident Smoking Schedule" revealed 12:30 PM as one of the designated times for resident smoking breaks. On 4/23/25 at 12:30 PM, an observation revealed Resident #15 was waiting to go outside for a	M 500	be delivered to residents 2. All residents who smoke and receive mail have the potential to be affected. 3. On 4/28/2025, a notice was posted by the Activities Director regarding a special resident council meeting in resident common areas. On 5/1/2025, a special resident council meeting was held and conducted by the Activities director to discuss new smoking times that would accommodate both the residents and the facility. A new smoking schedule was agreed upon by the council and the new schedule was implemented on 5/2/2025.On 4/23/2025, The Director of Nursing (DON) in-serviced the Nurses and certified nursing assistants on the smoking policy and resident rights. On 5/2/25, the DON in-serviced nursing staff on the new smoking schedule and the importance of timeliness. On 4/25/2025, the Director of Nursing in-serviced the weekend RN supervisors about mail delivery to the residents on the weekend and implemented a sign in sheet. The mail is delivered to the nurses station by the postal service. The RN supervisor will separate and deliver mail in a timely manner as evidenced by the sign in sheet beginning 4/26/2025. 4. Beginning 4/23/2025, the Director of Nursing will interview two (2) residents per week times four (4) weeks then monthly times two (2) months to monitor compliance with smoke break schedule adherence and resident rights related to smoking. The DON will submit and report	

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M 500	Continued From page 5 smoke break. No staff was present to assist him. During an interview at this time, Resident #15 stated that staff were often late taking him out to smoke or sometimes he did not get to go at all during the scheduled time. He expressed that this was upsetting because he enjoyed both smoking and the opportunity to go outside for fresh air. He stated that the outdoor time helped him feel more relaxed and provided a sense of freedom. He added that since this is his home, he felt he and other residents should be treated with more consideration, stating staff should be more consistent in honoring the outdoor smoking schedule. On 4/23/25 at 12:45 PM, an observation revealed no staff had yet come to take Resident #15 or the other residents outside to smoke. On 4/23/25 at 12:45 PM, during an interview with the Staff Development Licensed Practical Nurse #1 (LPN), she confirmed the "B Hall" staff was scheduled to take the residents out to smoke. When asked if a staff member was currently assigned, she responded that she would find the assigned Certified Nurse Aide (CNA). On 4/23/25 at 12:50 PM, in an interview with CNA #1, she explained she was originally assigned to take the residents out to smoke today, but stated it was not a good time because she needed to change two (2) residents. She further stated that smoking times were frequently delayed because staff were often busy during that time. On 4/23/25 at 3:37 PM, the Director of Nursing (DON) confirmed 12:30 PM was a scheduled smoke time for residents. She explained that the facility needed to adjust the smoking time because staff were usually busy during the 12:30	M 500	findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) Months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25. The Director of Nursing (DON) will interview two (2) residents per week for four (4) weeks then monthly times 2 months to ensure mail is being delivered beginning 4/28/2025. The DON will also monitor the mail delivery sign in sheet weekly times three (3) months beginning 4/28/2025. The Residents will be asked by the Activities Director during the monthly resident council meeting if mail is being delivered on weekends beginning 5/1/2025. The Director of Nursing will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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PM smoke break. The DON confirmed the residents had the right to be taken out for a smoke break by the facility staff at the scheduled times designated by the facility.

Resident #26

On 4/23/25 at 10:30 AM, during a resident council meeting, Resident #26, the council president, reported that residents did not consistently receive mail on Saturdays. She stated that this concern had been brought up at every council meeting and confirmed that although some nurses would deliver the mail in the past, it was not received every Saturday. All residents in attendance confirmed they did not receive mail consistently on Saturdays and would like to receive it regularly.

On 4/23/25 at 11:20 AM, during an interview with the Director of Nursing (DON), she explained that residents not receiving mail on Saturdays had been a concern. She stated that it was the Registered Nurse (RN) Supervisor's responsibility to ensure mail was distributed and reported that she had addressed the issue and had disciplined staff for failure to distribute mail. The DON stated it was important that residents receive their mail on Saturdays.

On 4/23/25 at 2:47 PM, during an interview with the Activities Director, she stated that the mail issue had been ongoing and that she mentioned it during the morning meeting. She confirmed the residents should receive their mail on Saturdays and was unsure why the issue persisted.

On 4/24/25 at 9:09 AM, in a follow-up interview with Resident #26, she stated that recently, residents had not been receiving their mail on

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M 500	Continued From page 7 Saturdays at all. A record review of the "Admission Record" revealed the facility admitted Resident #26 on 2/2/18 and she had current diagnoses including Iron Deficiency Anemia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/25 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated she was cognitively intact A record review of the Resident Council meeting minutes, dated 2/14/25, revealed residents had concerns of not consistently receiving mail on Saturdays.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review and facility policy review, the facility failed to investigate or determine root causes for Resident #38 for three (3) of seven (7) falls. (1/12/25, 2/13/25, and 2/25/25) Findings included:	M 640	1.On 4/13/2025, the RN supervisor completed a fall assessment. Resident #38 remains a high risk for falls. 2.All residents with incidents have potential to be affected. 3.On 4/21/2025, the Director of Nursing immediately began in-servicing nursing	5/16/25

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M 640	Continued From page 8 A review of the facility's "Responsibility for Accident/Incident Reports Policy," dated 07/2016, revealed, "It is the policy of this facility for all Incident and Accidents involving resident's to be investigated immediately upon knowledge of the incident. Procedure. Staff are to be trained how to investigate and document assessment of possible causes for the accident/incident. They are to obtain written statements from staff on duty and an possible witnesses to the incident. They are to document on the proper forms ..." A record review of the "Admission Record" revealed the facility initially admitted Resident #38 on 01/09/25 with diagnoses including Cardiac Arrest. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/7/25, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 12, which indicates moderate cognitive impairment. A record review of the "Progress Notes," for Resident #38, dated 1/12/2025 at 9:26 AM, revealed, " ...This nurse was called to resident room by unit CNA (Certified Nurse Aide) R/T (related to) witnessed fall without injury. CNA stated 'resident slid to the floor and sat down when trying to get on the stand lift ..." The author was LPN #4. A record review of the "Progress Notes," for Resident #38, dated 2/13/25 at 11:18 AM, revealed, " ...This nurse was called to Therapy, when entering the room noted resident laying on the floor on her left side ...immediately started c/o (complaining of) being dizzy ...Resident left the	M 640	staff on completion of incident reporting and implementing interventions. When a resident has a fall, the nurse will complete fall assessment, investigation as to root cause, interventions, and updating care plan. The Director of Nursing will review the incident report, nurses notes and complete an investigation beginning 4/22/2025 and ongoing. 4.On 4/22/2025, and ongoing, the Director of Nursing will begin reviewing all incident reports within 72 hours, ensure that fall assessments are completed if indicated, and interventions are implemented. The Director of Nursing will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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M 640	Continued From page 9	M 640		

facility at approx (approximately) 10:10 AM ...Nurse called report to (Proper Name of Acute Care Hospital_..."

A record review of the "Progress Notes," for Resident #38, dated 2/25/25 at 15:30 (3:30 PM), revealed, "This nurse was called to residents room by CNA upon entering the room resident was sitting on bed. Noted knot to left side of forehead noted bleeding ..." Another note dated 2/25/25 at 14:14 (2:14 PM) revealed, "This nurse assisted floor nurse ...with sending resident to ER (Emergency Room) DT (due to) unwitnessed fall with head injury ..."

A record review of the medical record for Resident #38 revealed there was no facility fall investigation (Fall Evaluation Tool) completed related to the falls that occurred on 1/12/25, 2/13/25, and 2/25/25. There was a "Fall Evaluation Tool," for falls that occurred on 1/17/2025, 1/25/25, 1/28/25, and 2/27/25.

On 04/21/25 at 10:11 AM, during an observation and interview with Resident #38, she was sitting in her wheelchair at the bedside. Resident #38 stated that she had fallen three (3) different times.

On 04/23/25 at 10:55 AM, during an interview with the facility's Director of Nursing (DON), she explained that an investigation should be completed each time a resident falls, even when a resident experiences more than one fall in the same day. The DON stated that each incident should be reviewed separately to determine the cause and to implement interventions to prevent recurrence.
On 04/24/25 at 10:17 AM, during a follow up interview with the DON, she stated she was not

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M 640	Continued From page 10 aware that Resident #38 had experienced a fall on 01/12/25. She acknowledged there should have been an incident report completed for that fall, explaining that incident reports help identify the circumstances of a fall and guide the implementation of preventive interventions. The DON stated she was also unaware of the fall that occurred on 02/13/25. She confirmed she had knowledge of the fall on 02/25/25 but admitted she failed to complete the incident report, stating she became sidetracked and forgot. She confirmed that all falls should be documented and investigated.	M 640		
M 645	45.21.9 Nutrition Nutrition. Residents shall maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless residents ' clinical condition indicates that this is unavoidable. All residents shall receive diets as orders by their physician or nurse practitioner/physician assistant. Residents identified with significant nutritional problems shall receive appropriate medical nutrition therapy based on current professional standards. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to follow the physician's order to provide a nutritional supplement with meals to support nutritional status for one (1) of eighteen (18) sampled residents, Resident #27. Findings included:	M 645	1.On 4/22/2025, resident #18 was immediately given boost supplement with her meal by dietary staff per physicians order. On 4/22/2025 an audit of all residents for supplement orders by the Director of Nursing and all residents with orders for supplements are receiving supplements. 2.All residents who have orders for supplements have the potential to be	5/16/25

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M 645	Continued From page 11 A review of the facility's policy titled "Initiation of Order Changes and Discontinuation of Medications," dated 2/2012, revealed, "...Procedure ...The nurse will assure that the order is complete with date, time, drug, dose, route, and how often to be administered ..." A record review of the "Admission Record" revealed the facility admitted Resident #27 on 12/22/21 and she had current diagnoses including Unspecified Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/22/25 revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated her cognition was severely impaired. A record review of the "Order Summary Report" revealed Resident #27 had a Physician's Order, dated 8/29/24 for "Regular diet ...Add boast (Boost, a type of nutritional drink) supplement to all meals ..." A record review of the meal tray card, dated 4/22/25, for Resident #27 revealed there was no supplement listed under the "Diet" portion of the card to reflect the Physician's Order. On 4/21/25 at 11:46 AM, during a dining observation, Resident #27 was observed without a meal supplement beverage on her tray. On 4/22/25 at 12:00 PM, during a second dining observation, Resident #27 again was not served a meal supplement beverage on her tray. On 4/22/25 at 12:10 PM, during an interview with Resident #27, she stated that she only liked	M 645	affected. 3.On 4/22/2025, nursing staff and dietary staff were in-serviced by the Dietary Supervisor and the Director of Nursing on following physicians orders for supplements and communication to the dietary staff by use of dietary communication forms. 4.Starting on 4/22/2025, The Dietary Supervisor will print an order listing report daily, during tour of duty, on an ongoing basis to check for new dietary orders. The Director of Nursing (DON) will review new orders during the clinical morning meeting Monday- Friday and Saturday and Sunday will be reviewed on the following Monday beginning 4/22/2025 times four (4) weeks then monthly times two (2) months. Beginning 4/22/2025 the DON or Registered Nurse (RN) Supervisor will observe three (3) resident trays to assure supplements are given on meal tray three (3) times weekly times four (4) weeks, then monthly times two (2) months. The DON will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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M 645	Continued From page 12 sweets and mashed potatoes with no gravy. She confirmed that she would drink a nutritional supplement shake if she had one. On 4/22/25 at 12:45 PM, during an interview with the Dietary Supervisor (DS), she stated that Resident #27 was not served a nutritional supplement with her meals because there was no order written to provide supplements with meals. She added that the only additional nutrition the resident received was snacks delivered to the floor. On 4/23/25 at 7:33 AM, during an interview with the Director of Nursing (DON), she confirmed the resident had a physician's order dated 9/3/24 for a nutritional supplement shake with all meals. She explained that orders are reviewed during morning meetings and should have been communicated to the dietary department. She acknowledged the failure in communication and emphasized that physician orders are intended to direct resident care. On 4/23/25 at 7:44 AM, during an interview with the Administrator, she acknowledged that the facility failed to follow the physician's order dated 9/3/24 to provide a nutritional supplement with all meals for Resident #27. She emphasized the importance of staff following physician orders and stated the facility would ensure reviews are used to cross-check physician orders.	M 645		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids;	M 655		5/16/25

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M 655	Continued From page 13 colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, interview, record review, and policy review, the facility failed to ensure oxygen-in-use signage was posted on the door for one (1) of one (1) resident reviewed for oxygen safety, Resident #39. Findings included: A review of the facility's policy, "Oxygen Safety" (undated), revealed: " ...General Guidelines ...5. 'No Smoking' signs must be clearly visible in areas where oxygen is stored or in use." On 4/21/25 at 11:00 AM, Resident #39 was observed lying in bed with oxygen flowing at three (3) liters per minute. There was no oxygen caution signage posted on the resident's door. On 4/21/25 at 1:42 PM, during an observation and interview with Licensed Practical Nurse (LPN) #2, she confirmed there was no oxygen caution signage on Resident #39's door. She stated there should be one since oxygen was in use. On 4/22/25 at 11:15 AM, during an interview with the Director of Nursing (DON), she stated, there had been signage on the doors and explained there is a resident who is a known wanderer and likely removed the signs. She stated they had run out of signage for a couple of days while searching for replacements. She confirmed	M 655	1. On 4/21/2025, the Staff Development nurse immediately posted Oxygen in Use signs for all residents who are currently using oxygen. 2. All residents who use oxygen have the potential to be affected. 3. On 4/21/2025, the Director of Nursing began conducting in-services regarding oxygen use and oxygen safety. 4. Starting 4/22/2025, the Director of Nursing will conduct an audit three (3) times weekly for thirty (30) days and then weekly times two (2) months with department head rounds to ensure that oxygen signs are in place. The Director of Nursing will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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M 655	Continued From page 14 signage should be posted on the door and acknowledged that its absence represented a safety hazard. A record review of the "Admission Record" revealed the facility admitted Resident #39 on 11/3/21 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/27/25 revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. A record review of the "Order Review History Report" revealed a physician's order dated 8/27/24 for "Oxygen at 3 L (liters) per nasal cannula continuously ..."	M 655		
M 715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This Statute is not met as evidenced by: Level II Based on observation, interview, and record review, the facility failed to ensure medications were stored securely for two (2) of five (5) residents reviewed for medication storage and administration, Resident #37 and Resident #50. Findings included:	M 715	1. On 4/22/2025, medications were immediately removed from resident #37 and #50 room and placed on medication cart and nurses were in-serviced on medication storage by the Director of Nursing. 2. All residents have the potential to be affected.	5/16/25

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M 715	Continued From page 15 A review of the facility's policy titled, "Medication Storage in the Facility," revised January 2018, revealed, " ...Medications and biologicals are stored safely, securely, and properly ...The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications ...Procedures ...B ...Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access ..." Resident #37 During an observation and interview on 4/22/25 at 7:25 AM, Licensed Practical Nurse (LPN) #3 retrieved an inhaler from Resident #37's bedside drawer, where it had been stored. LPN #3 stated the resident always kept it in the drawer in case she needed it and stated the medication should probably be kept locked up in the medication cart when not in use. A record review of the "Admission Record" revealed the facility admitted Resident #37 on 11/15/24 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of Resident #37's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident's cognition was moderately impaired. A record review of the "Order Review History Report" revealed Resident #37 had a Physician's Order dated 11/15/24 for "Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base)	M 715	3. On 4/23/2025, the Director of Nursing began in-servicing nursing staff on medication storage. All rooms were checked by the facility nursing department heads for medications with no other issues identified. 4. On 4/23/2025, the facility department heads began to monitor all resident rooms weekly times four (4) weeks then monthly times two (2) months, to ensure there are no medications present with no new issues identified. The interdisciplinary team will assess residents for capability of self-administration as needed. If resident is identified as safe to administer their own medications, this will be noted, care planned and re-assessed quarterly for safety. The Director of Nursing will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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M 715	Continued From page 16 MCG/ACT, 2 puffs inhale orally every four (4) hours as needed." Resident #50 During an observation and interview on 4/22/25 at 7:41 AM, Resident #50 was given a Budesonide nebulizer vial that was left at the bedside by LPN #3. LPN #3 stated she leaves it with him each morning. A record review of the "Admission Record" revealed the facility admitted Resident #50 on 5/12/23 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of Resident #50's MDS with an ARD of 3/6/25 revealed a BIMS score of 12, which indicated the resident's cognition was moderately impaired. A record review of the "Order Review History Report" revealed Resident #50 had a Physician's Order dated 3/5/25 for "Budesonide Inhalation Suspension 0.5 milligrams (mg)/2 milliliters (ml), one (1) vial orally two (2) times a day." On 4/22/25 at 7:55 AM, during an interview with the Director of Nursing (DON), she stated that medications should not be left in resident rooms because there are wandering, confused residents in the building who could ingest the medications. She further stated another risk would be residents giving themselves the wrong dose. She confirmed her expectation is that nurses administer medications appropriately and ensure secure storage.	M 715		

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M 815	Continued From page 17	M 815		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, interview, and facility policy review, the facility failed to store food in accordance with professional standards for food safety by not discarding expired items, failing to refrigerate opened perishable items, and improperly storing dry goods, for one (1) of two (2) kitchen observations. Findings included: A review of the facility's policy, "Food Safety Requirements," dated 02/2023 revealed, "Policy ...Food will be stored... in accordance with professional standards for food service safety... Policy Explanation and Compliance Guidelines: 1. Food safety practices shall be followed throughout the facility's entire food handling process ...b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms... 3. Facility shall inspect all food ...for safe transport and quality upon delivery/receipt and ensure timely and proper storage ...c. Refrigerated storage - foods that require refrigeration shall be refrigerated immediately upon receipt or placed in freezer ...Practices to maintain safe refrigerated storage include ...iv. Labeling, dating, and monitoring refrigerated food... so it is used by its use-by	M 815	1. On 4/21/2025, the expired items were immediately disposed of by the Dietary Supervisor. The dietary supervisor was immediately in-serviced by the administrator on food storage and expiration. 2. All residents have the potential to be affected. 3. On 4/22/2025, the dietary staff was in-serviced on food storage and expiration by the Dietary Supervisor. 4. Starting 4/22/2025, the Dietary Supervisor began monitoring expiration dates daily for two (2) weeks and then monthly for two (2) months. The Dietary Supervisor will submit and report findings to the Quality Assurance Performance Improvement (QAPI) committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	5/16/25

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M 815	Continued From page 18 date... or discarded..." On 4/21/25 at 10:27 AM, during an observation of the kitchen and interview with the Dietary Supervisor (DS), Refrigerator #1 contained one (1) opened bag of coleslaw mix with a manufacturer's use-by date of 3/7/25. The contents of the bag were grayish in appearance. An observation of the pantry revealed a scoop sitting inside the bin of sugar, two (2) opened 48-ounce bottles of lemon juice sitting on the shelf with instructions to refrigerate after opening, and three (3) soft potatoes with shriveled skin. The DS acknowledged the expired coleslaw, the improperly stored juice, the scoop left in the sugar, and the overly ripe potatoes. She stated she was new to the job but took responsibility for the deficiencies and intended to discard the expired items and bring the kitchen up to standard. She stated in-services are held weekly. On 4/21/25 at 10:45 AM, during an interview with the Cook, she stated that the previous supervisor checked expiration dates but that is no longer happening due to the new DS. She explained that if she notices expired or undated items in the refrigerator, she throws them away. She reported that staff are in-serviced monthly on food safety. On 4/24/25 at 8:37 AM, during an interview with the Corporate Nurse (CN), she acknowledged the outdated coleslaw mix, improperly stored lemon juice, scoop left in the sugar, and overly ripe produce. The CN stated the DS is responsible for ensuring food quality and hygiene and affirmed the expectation that the DS ensures food is dated, stored correctly, and discarded before expiration.	M 815		

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M1570	Continued From page 19	M1570		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to follow infection prevention practices by not ensuring respiratory equipment was properly stored when not in use for one (1) of two (2) residents reviewed for respiratory services. (Resident #37)	M1570	1. On 4/22/2025, the Director of Nursing immediately replaced resident #37 oxygen tubing and nebulizer tubing in labeled bags. 2. All residents who use respiratory equipment have the potential to be affected. 3. On 4/22/2025, the Director of Nursing	5/16/25

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M1570	Continued From page 20 Findings Included: A review of the facility's "Nebulizer and Oxygen Tubing Storage Policy," dated April 2007, revealed, " ...It is the policy of this facility to decrease the risk of potential and/or direct exposure to infectious disease, air contaminants and bacterial exposure. We will provide our residents with the proper storage and cleaning of respiratory equipment. Procedure ...These tubings will be ...stored in a dated plastic bag when not in use ..." On 4/22/25 at 7:37 AM, during an observation, Resident #37's oxygen and nebulizer tubing were observed unbagged, lying on each piece of equipment. No clean storage method was in place. A record review of the "Admission Record" revealed the facility admitted Resident #37 on 11/15/24 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of Resident #37's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident's cognition was moderately impaired. On 4/22/25 at 8:00 AM, during an interview with the Director of Nursing (DON) at Resident #37's bedside, she confirmed the oxygen cannula and nebulizer tubing/masks were not bagged and stated they should be kept in a bag when not in use to prevent the spread of respiratory infection. She explained that it is the Sunday night cart nurse's responsibility to bag and change out tubing for each resident.	M1570	in-serviced nursing staff on the appropriate storage and labeling of respiratory tubing. All nebulizer and oxygen tubing was replaced in labeled bags and secured to side of oxygen concentrator with tape on 4/22/2025 4. On 4/22/2025, the Director of Nursing began checking the appropriate storage and labeling of all respiratory tubing twice weekly for two (2 weeks) monthly for two (2) months. The Director of Nursing will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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M1570	Continued From page 21 On 4/23/25 at 2:47 PM, during an interview with Licensed Practical Nurse (LPN) #1, the Infection Preventionist (IP) Nurse, she stated that nasal cannula, oxygen, nebulizer tubing, and masks should be kept in a bag to prevent respiratory infections. She further stated they should be changed weekly by the Sunday night nursing staff and confirmed that this task appears on the Medication Administration Record (MAR).	M1570		