Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	**402 GETWELL DR , SENATOBIA, Mississippi, 38668**

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M0000	Initial Comments The State Agency (SA) conducted an annual recertification survey along with two (2) Complaint Investigations (CI), CI #477262 and a facility reported incident CI MS #477259 at the facility from 8/4/25-8/7/25. During the survey, the SA determined the facility was in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm. The SA investigated CI #477262 related to activities of daily living, pest control and staffing with no deficiencies cited. The facility was found not in compliance with CI MS #477259 related to narcotic diversion and significant medication errors and cited M500. Based on implementation of the facility's corrective actions beginning on 6/25/25 through 7/2/25, the deficient practice was determined to be past noncompliance, and the facility was determined to be in compliance effective 7/3/25 prior to the SA entrance on 8/4/25. The facility held a license for 106 beds, with a census of 88 residents.	M0000		
M0500	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	M0500	"Past Noncompliance - no plan of correction required"	

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

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M0500	Continued from page 1 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, 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;	M0500		

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M0500	Continued from page 2 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); 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	M0500		

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M0500	Continued from page 3 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on staff interview, record review, and facility policy review, the facility failed to ensure residents were free from misappropriation of medications for two (2) of eight (8) residents reviewed for drug diversion (Residents #14 and #42). Findings include: Review of the facility policy titled, “Drug Diversion,” undated, revealed: “Policy: This facility recognizes the risks associated with diversion of controlled medications and monitors staff with access to controlled substances to prevent diversion...” During an interview with the Administrator on 8/5/25 at 12:30 PM regarding the facility-reported incident MS #477259, he stated that during the investigation, it was discovered that on 6/21/25 at 1:45 AM, agency Licensed Practical Nurse (LPN) #2 signed out an oxycodone for Resident #14 on the controlled substance log, but the medication was not documented on the Medication Administration Record (MAR) as given. He stated video from that date and time showed LPN #2 preparing and taking routine medications to Resident #14’s room but not accessing the narcotic lock box. The Administrator stated that during the investigation of another concern, Resident #42 reported he received only one pain pill from the agency nurse working the evening shift on 6/24/25. He stated the resident reported requesting his pain medication later in the shift, but the nurse never returned. The Administrator stated he reviewed video footage from 6/24/25 (3:00 PM to 11:00	M0500		

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M0500	Continued from page 4 PM) and found that LPN #2 did not enter Resident #42's room at any time after approximately 4:00 PM, when she had administered earlier medications. He stated that at 10:50 PM, LPN #2 signed out one hydrocodone for Resident #42 on the controlled substance log and signed that it was administered; however, the video showed she never entered the resident's room. The Administrator stated the facility attempted to have LPN #2 return for an interview and drug screen, but she did not report back. He further stated that at the end of her shift, LPN #2 stated she did not have a ride home and slept for several hours on a couch in the day room before leaving the facility. He confirmed that LPN #2 was made a "Do Not Work" status with the contracted agency. He confirmed that the incident and investigation results were presented to the Quality Assurance (QAPI) committee during the committee meeting on 6/26/25 and again on 7/31/25 in which the Medical Director attended, the facility policy was reviewed with no revisions made. LPN # 2 was not allowed to work at the facility after 6/24/25 and all the required agencies were notified. Resident #14 Record review of the Controlled Substance Record for Resident #14 revealed Oxycodone 5 mg (milligrams) tablet, one tablet, signed out by LPN #2 on 6/21/25 at 1:45 AM. Record review of the June 2025 MAR for Resident #14 revealed no documentation that the medication was administered on 6/21/25. Record review of the "Admission Record" revealed Resident #14 was admitted on 3/16/25 with a diagnosis of Femur Fracture. Resident #42 Record review of the Controlled Substance Record for Resident #42 revealed Hydrocodone 10/325 mg, one tablet, signed out by LPN #2 on 6/24/25 at 10:50 PM. Record review of the June 2025 MAR revealed the medication was documented as administered. Record review of the "Admission Record" revealed Resident #42 was admitted on 6/13/25 with a diagnosis of osteomyelitis. During an interview with the Director of Nurses (DON) on 8/5/25 at 1:00 PM, she stated LPN #2 worked agency shifts on 6/18/25, 6/19/25, 6/20/25, and 6/24/25. She	M0500		

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M0500	Continued from page 5 stated she audited the narcotic records for residents assigned to agency LPN #2 and confirmed that oxycodone had been signed out for Resident #14 on the Controlled Medication form without documentation on the MAR as administered. She stated the nurse was also not observed to access the narcotic box during that time per facility video monitoring. The DON stated diversion of narcotics poses a risk because the medication may be taken by the individual, can lead to adverse consequences for residents, and is not the staff's property to take. In a continued interview with the DON on 8/6/25 at 12:00 PM, she stated she interviewed Resident #42, who was cognitively intact, on 6/25/25. The resident reported he did not receive his night medications on 6/24/25, including pain medication, and that the nurse never returned after an early evening visit. The DON revealed immediate in-services on diversion and misappropriation was initiated on 6/26/25 and continued until 7/2/25 when all nurses had been educated. She also confirmed narcotic reconciliation audits were completed on five (5) residents weekly for four weeks as well with no concerns. In an interview with LPN #1 on 8/5/25 at 1:30 PM, she stated that on the morning of 6/25/25, Resident #42 complained that the agency nurse had not given him his medication the previous night. LPN #1 stated she immediately informed the DON and the charge nurse. In an interview with Registered Charge Nurse #1 on 8/6/25 at 2:00 PM, she stated that during follow-up assessments of all residents assigned to the agency LPN #2 on 6/24/25 (3:00 PM to 11:00 PM), Resident #42 again reported the nurse only came into his room once early in the shift and never returned to provide pain medication or other evening medications. She stated she assessed the resident to have no adverse findings related to not receiving his medications. She also confirmed that the provider and resident representative was notified for every possible affected resident. Based on the implementation of the facility's corrective actions on 6/25/25, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 7/3/25. Validation: The SA validated on 8/5/2025, through interview and record review that all corrective actions had been implemented as of 7/3/25, and the facility was in compliance as of 7/3/25, prior to the SA's entrance on	M0500		

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