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 **09/04/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE CO NURSING CENTER	**700 JEFFERSON STREET SOUTH PO BOX 398, MONTICELLO, Mississippi, 39654**

(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
M0000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI) MS #489925, at the facility, from 9/3/25 through 9/4/25. CI MS #489925 was investigated related to wound care, neglect, and Quality of care. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and M615 and M1570 were cited.	M0000		
M0615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide wound care in accordance with professional standards of practice and physician's orders, specifically failing to cleanse wounds with proper technique and dry wounds prior to dressing application, and placing a resident (Resident #2) in two (2) briefs, which increased the risk for skin breakdown and infection for (2) of three (3) sampled residents reviewed for wound care (Residents #2 and #3). Findings include: A record review of the facility's "Dressing Change Policy and Procedure" with a review date of 8/21 revealed, "…Steps in the Procedure…14. Dry the skin surrounding the area by patting with a soft 4 X (by) 4…" Resident #2 On 9/4/25 at 9:50 AM, an observation of Licensed Practical Nurse (LPN) #1 providing wound care revealed	M0615		

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

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M0615	Continued from page 1 Resident #2 was wearing two briefs. LPN #1 removed the soiled dressing and cleansed the hip wound by wiping back and forth across the wound bed multiple times with the same gauze rather than discarding it after a single pass. A second gauze was used in the same manner. LPN #1 did not pat the wound dry prior to applying Santyl, gentamicin, nystatin powder, calcium alginate, and foam dressing as ordered. LPN #1 repeated the same technique when cleansing the sacral wound, wiping back and forth with gauze, and again did not dry the wound before applying calcium alginate and foam dressing. A record review of the “Admission Record” revealed the facility admitted Resident #2 on 12/24/20 with diagnoses including a Pressure Ulcer. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/16/25 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident was severely cognitively impaired A record review of the “Order Summary Report” revealed Resident #2 had a Physician’s Order, dated 7/4/25 to “Cleanse excoriated area to the right hip with wound cleanser, pat dry, apply Santyl ointment…and Hydrofera blue classic daily to the wound. Secure with adhesive foam until healed…” There was also an order dated 8/22/25 to “Cleanse stage 3 pressure ulcer to sacrum with wound cleanser, pat dry, apply santyl, gentamicin 0.1%, nystatin powder calcium alginate and cover with border foam dressing daily…” Resident #3 On 9/4/25 at 10:35 AM, an observation of Resident #3 receiving wound care revealed LPN #1 cleansed the sacral wound using gauze soaked in wound cleanser, then inserted gauze into the wound bed with a cotton swab, and applied calcium alginate without patting the wound dry as ordered. A record review of the “Order Summary Report” revealed Resident #3 had a Physician’s Order, dated 6/20/25, to “Cleanse Stage 2 pressure wound to the sacrum with wound cleanser, pat dry, lightly pack calcium alginate to the wound and secure with adhesive foam until healed…” On 9/4/25 at 10:23 AM, during an interview with Certified Nursing Assistant (CNA) #1, she stated that placing two briefs on a resident was against her training and could contribute to skin breakdown or rash.	M0615		

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M0615	Continued from page 2 On 9/4/25 at 11:04 AM, during an interview with Licensed Practical Nurse (LPN) #1, she acknowledged that she did not pat dry the wounds prior to applying the dressings and confirmed that she did not follow the physician's orders. She stated she did not clean Resident #2's wound correctly and thought she had folded or flipped the gauze. She explained that a wound should be dried before covering to reduce the risk of further breakdown and infection. She acknowledged that her actions placed the residents at risk for infection. She also stated that no resident should be double briefed, as doing so can irritate the skin. On 9/4/25 at 12:11 PM, during an interview, the Director of Nursing (DON) stated that residents should never be double briefed because it can contribute to skin breakdown. She further explained that wounds should be cleaned using either a top-to-bottom or circular motion, discarding gauze after each use. She stated wounds must always be dried before dressing application, and that failure to do so could result in moisture contributing to skin breakdown or infection. On 9/4/25 at 2:00 PM, during an interview, CNA #2 stated she had provided perineal care for Resident #3 earlier that morning and acknowledged that she had placed two briefs on the resident. CNA #2 stated she had previously received in-service training on the risks of double briefing. A record review of the "Admission Record" revealed the facility admitted Resident #3 on 3/18/19 with current diagnoses including a Pressure Ulcer. A record review of the Quarterly MDS with an ARD of 7/7/25 revealed Resident #3 had a BIMS score of 4, which indicated the resident was severely cognitively impaired.	M0615		
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,	M1570		

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M1570	Continued from page 3 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to follow infection prevention and control practices by placing wound care supplies on an undisinfected bedside table during treatment, creating the potential for cross-contamination and infection, for one (1) of two (2) wound care observations (Resident #3). Findings include: A review of the facility's policy, "Infection Control," revised 4/21, revealed "The facility will maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment with minimal exposure to the transmission of disease and infection…" On 9/4/25 at 10:35 AM, during an observation of wound care provided to Resident #3's sacral wound, Licensed Practical Nurse (LPN) #1 entered the resident's room with supplies carried on a white disposable barrier. She placed the barrier on the foot of the resident's bed, then placed a bottle of hand sanitizer and clean gloves directly on the resident's bedside table without disinfecting the surface. LPN #1 donned (put on) gloves, then removed the resident's soiled dressing and placed it in a biohazard bag. She then removed her gloves, sanitized her hands, and reapplied gloves obtained from the bedside table. LPN #1 repeated this process four times, each time retrieving gloves and sanitizer from the undisinfected bedside table before continuing wound care. On 9/4/25 at 11:04 AM, during an interview, LPN #1 confirmed she did not disinfect the bedside table before placing wound care supplies on it. She stated she should have cleaned the table before and after wound care and acknowledged her actions placed the	M1570		

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M1570	Continued from page 4 resident at risk for infection. On 9/4/25 at 12:24 PM, during an interview, the Director of Nursing (DON) stated LPN #1 should have disinfected the bedside table and used a barrier before placing supplies on it. She explained that failure to follow this practice could lead to infection. On 9/4/25 at 2:23 PM, during an interview, LPN #2, the facility's Infection Preventionist (IP) nurse, confirmed that no items should be placed on a bedside table without first disinfecting it. She stated that germs present on the surface could be transferred to the gloves and sanitizer bottle, then carried to the resident's wound during care, creating a risk of infection. A record review of the "Admission Record" revealed the facility admitted Resident #3 on 3/18/19 with current diagnoses including a Pressure Ulcer of sacral region, stage 2. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/7/25 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident was severely cognitively impaired. A record review of the "Order Summary Report" revealed Resident #3 had a physician's order, dated 6/20/25, to "Cleanse Stage 2 pressure wound to the sacrum with wound cleanser, pat dry, lightly pack calcium alginate to the wound and secure with adhesive foam until healed…"	M1570		