STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255214	(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
F0000	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 requirements for participation in Medicare and Medicaid and cited F656, F686 and F880. The facility held a license for 60 beds, with a census of 56.	F0000		
F0656 SS = D	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 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.	F0656		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0656 SS = D	Continued from page 1 (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, interview, record review, and facility policy review, the facility failed to implement care plan interventions during wound care for two (2) of (2) wound care observations (Residents #2 and #3). Findings include: A review of the facility's policy, "Care Plan Process," with a review date of 12/24, revealed, "…The comprehensive care plan is an interdisciplinary communication tool…The facility staff shall follow the care plan…" Resident #2 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…" A record review of the "Care Plan Report" revealed a	F0656		

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F0656 SS = D	Continued from page 2 Resident #2 had "Interventions" including "…Cleanse Stage 3 Pressure Ulcer to Sacrum with Wound Cleanser, Pat Dry…" and "Cleanse excoriated area to the Rt (Right) hip with wound cleanser, pat dry…" On 9/4/25 at 9:50 AM, during an observation of wound care provided to Resident #2, Licensed Practical Nurse (LPN) #1 did not pat the wound on the right hip dry before applying Santyl, gentamicin, nystatin powder, calcium alginate, and foam dressing. LPN #1 also did not dry the sacral wound before applying calcium alginate and foam dressing, contrary to the physician's orders and the resident's care plan. 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. Resident #3 A record review of the "Care Plan Report" revealed Resident #3 had "Interventions" including "Cleanse Stage 2 to sacrum with wound cleanser, pat dry…" 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 10:35 AM, during an observation of wound care for Resident #3, LPN #1 cleansed the sacral wound with gauze soaked in wound cleanser, inserted gauze into the wound bed with a cotton swab and applied calcium alginate without patting the wound dry as ordered and care planned. On 9/4/25 at 11:04 AM, during an interview, LPN #1 acknowledged that she did not pat dry the wounds prior to applying the dressings and confirmed she did not follow the physician's orders or the care plan. On 9/4/25 at 3:25 PM, during an interview, the Director of Nursing (DON) stated LPN #1 did not follow the care plan during wound care for Residents #2 and #3. She stated her expectation is that all staff follow the care plan when providing care to residents.	F0656		

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F0656 SS = D	Continued from page 3 On 9/4/25 at 4:34 PM, during an interview, Registered Nurse (RN) #1, the MDS/Case Manager, stated that staff should follow the care plan, which is developed to direct resident care. She confirmed LPN #1 did not follow the care plan and explained that the care plan is designed to inform staff of the resident's care needs. A record review of the "Admission Record" revealed the facility admitted Resident #3 on 3/18/19 with 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.	F0656		
F0686 SS = E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This 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:	F0686		

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F0686 SS = E	Continued from page 4 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 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	F0686		

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F0686 SS = E	Continued from page 5 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. 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.	F0686		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880		

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F0880 SS = D	Continued from page 6 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or	F0880		

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F0880 SS = D	Continued from page 7 infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This 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	F0880		

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F0880 SS = D	Continued from page 8 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 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…"	F0880		