STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey, along with two (2) Complaint Investigations (CI MS #27720 and CI MS #27954) at the facility from 3/11/25 through 3/13/25. During the survey, the SA determined the facility was in compliance with the requirements of participation in Medicare and Medicaid. F558, F657, F658, F812, and F880 were cited as a result of the annual recertification survey. CI MS #27720 was investigated for the facility being cold, not clean, and quality of care/life and F584 was cited. CI MS #27954 was a facility reported incident (FRI) investigated regarding verbal abuse and resident not treated with respect and dignity. The facility failed to protect a resident's right to be free from verbal abuse and F600 and F609 were cited related to the FRI. The facility's failure to protect Resident #17 when Certified Nursing Aide (CNA) #1 engaged in an argument with the resident on 2/8/25, using profanity and picked up a spray bottle of chemicals, pointed toward the resident, in response to the resident's agitation. Resident #17 reported feeling "nervous and afraid" at the time of the incident and the facility did not immediately remove the abuser from the facility. Licensed Practical Nurse (LPN) #1 witnessed the abuse and failed to intervene or report the abuse within the required timeframe and the facility did not report the event until 2/12/25. CNA #1 continued to work, delaying the facility's ability to protect this resident from further harm and placing other residents at risk of similar mistreatment.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/02/2025

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 000	Continued From page 1 During the investigation of the FRI, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 2/8/25 and existed at: 42 CFR(s): 483.12 Freedom from Abuse, Neglect, Exploitation (F600) - Scope and Severity of "J" 42 CFR(s): 483.12(c)(1) Reporting of Alleged Violations - (F609) Scope and Severity of "J" The abuser was not immediately removed from the facility which left Resident #17 and other residents in a situation that was likely to result in ongoing serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 3/12/25 at 2:15 PM and provided the Administrator with the IJ templates. Based on the facility's implementation of corrective actions on 2/12/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 2/13/25, prior to the SA's entrance on 3/11/25. At the time of survey, the facility was licensed for 120 beds and had a census of 99 residents.	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or	F 558		4/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 558	Continued From page 2 other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure the resident's right to reasonable accommodation as evidenced by a call light that was not within reach for one (1) of twenty-one (21) sampled residents, Resident #39. Findings included: A review of the facility's policy titled "Resident Call System," dated 3/28/23, revealed, " ... Residents are provided with a means to call staff for assistance... Policy Interpretation and Implementation 1. Each resident is provided with a means to call staff directly for assistance..." On 03/11/2025 at 11:38 AM, during an observation, Resident #39's call light was observed draped over a shelf and out of reach. Certified Nurse Aide (CNA) #1 confirmed the call light was not within reach of Resident #39. On 03/12/2025 at 10:08 AM, during an interview, Licensed Practical Nurse (LPN) #1 stated that call lights are supposed to be left within reach of the resident after each visit, and that CNAs are expected to make rounds every two (2) hours. On 03/13/2025 at 8:51 AM, during an interview, CNA #2 stated that on every visit to a resident's room, CNAs are trained to ensure the resident is comfortable, the call light is within reach, and that the resident does not need anything else. CNA #2 further explained the importance of answering call lights quickly to ensure residents receive the help they need.	F 558	Preparation and submission of the plan of correction by Picayune Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement of state and federal law. F558 1. On 3/11/2025 Resident #39 call light was placed within reach by certified nurse's aide #1 (CNA). On 3/11/25 the Director of Nursing (DON) assessed Resident # 39 for any abnormalities with no negative findings. On 03/11/2025 the Director of Nursing (DON) audited all resident rooms to ensure resident call light was within reach of resident. No further concerns were noted. On 03/11/2025 CNA#1 was in serviced by the Staff Development Coordinator on the call light policy along with Resident Rights. 2. All residents have the potential to be affected. 3. On 4/1/25 an in-service was initiated and ongoing by the Staff Development Coordinator with all staff on the call light policy and Resident Rights. On 03/14/25 observation rounds were completed on all resident rooms by the DON to check placement of call lights and ensure call lights were within reach. No issues were identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 558	Continued From page 3 On 03/13/2025 at 2:40 PM, during an interview, the Administrator stated that staff are expected to have the call light within reach and to answer call lights in a timely manner. On 03/13/2025 at 2:45 PM, during an interview, the CNA Supervisor stated that staff completed in-services in February 2025 and that call light procedures are reviewed at orientation, quarterly, and as needed. The CNA Supervisor confirmed that CNAs are expected to leave call lights within reach of residents before exiting the room. On 03/13/2025 at 3:21 PM, during an interview, the Director of Nursing (DON) stated that CNAs are expected to leave call lights within reach of residents upon exiting the room and to answer call lights in a timely manner. A record review of the "Admission Record" revealed the facility admitted Resident #39 on 12/12/2021 and he had current diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. A record review of Resident #39's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/2024 revealed the resident required a staff interview to assess cognition and his cognition was severely impaired. A review of the facility's "In-service Training" with a subject of "answering call lights in a timely manner, dated 02/27/2025 revealed the facility staff received education to " ... Make sure call lights are always within reach of your Residents every time you enter and exit the room ..."	F 558	4. Beginning 3/17/25 the Director of Nursing will conduct observations rounds on ten resident room weekly for four (4) weeks and then monthly for three (3) months and quarterly thereafter to ensure the call light policy and procedures are being followed and call lights remain within reach of residents. A report will be submitted to the Quality Assurance Performance Improvement on 04/01/2025 for review and recommendations then and monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		4/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 584	Continued From page 5 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure the residents' right to a comfortable, homelike environment related to the facility being an uncomfortably cold temperature for five (5) of 21 sampled residents, with the potential to affect all 99 residents in the facility. Residents #82, Resident #43, Resident #45, Resident #5, and Resident # 34. Findings included: A review of the facility's policy titled "Resident Rights," revised April 2017, revealed, "...Residents shall...r. Live in a physical environment which ensures their physical and emotional security and well-being ..." Resident #82 On 03/11/2025 at 9:30 AM, during an interview and observation, the room was cold and Resident #82 stated that it is always cold in her room. She was observed wearing long sleeves, a blouse, a jacket, and was covered with a blanket. A record review of the "Admission Record" revealed the facility admitted Resident #82 on 06/07/2024 with current diagnoses including Alzheimer's Disease with Late Onset. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/13/2025 revealed Resident #82 had a Brief Interview for Mental Status (BIMS) score	F 584	F584 Safe/Homelike Environment 1. On 03/14/2025 the Maintenance Director verified temperatures in Resident #82, 43, 45, 5, and 34. Resident #82, 43, 45, 5, and 34 all had temperatures that were within the required temperature setting of 71-81 degrees Fahrenheit by state and federal regulations. 2. All residents have the potential to be affected. 3. On 03/13/2025 the Maintenance Director and the Assistant Maintenance Director was in serviced by the Administrator on ensuring that temperature levels are maintained with in the federal temperature requirements but are also checked in various locations to ensure that desired temperature levels are achieved with consideration of humidity and air movement in the building. On 04/01/2025an in-service was initiated and ongoing by the Staff Development Coordinator with all staff on the importance of ensuring resident rights are followed by maintaining air temperatures and reporting any resident concerns. 4. Beginning the week of 03/17/2025 the Maintenance Director will audit resident rooms to check on temperatures in a variety of high air flow resident care areas (5) five rooms weekly times (4) four weeks and monthly for (3) three months and quarterly thereafter. A report will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 584	Continued From page 6 of 15, which indicated the resident was cognitively intact. Resident #43 On 03/11/2025 at 10:48 AM, during an observation and interview, Resident #43 complained about the cold temperature in his room. The resident had two blankets on his bed, while two additional blankets were folded on his roommate's bed. Resident #43 stated it was always too cold in his room. On 03/11/2025 at 2:35 PM, Resident #43's family member confirmed that his father consistently complains about being cold, and that both his father and the roommate have jackets and extra blankets. A record review of the "Admission Record" revealed the facility admitted Resident #43 on 06/10/2024 with current diagnoses including Chronic Diastolic (Congestive) Heart Failure. A record review of the Quarterly MDS with an ARD of 12/18/2024 revealed Resident #43 had a BIMS score of 3, which indicated severe cognitive impairment. Resident #45 On 03/11/2025 at 9:41 AM, Resident #45 was observed sitting in the hallway wearing a jacket. Resident #45 reported that his room is always too cold, which is why he wears his jacket and stays in the hallway. A record review of the "Admission Record" revealed the facility admitted Resident #45 on	F 584	submitted to the Quality Assurance Performance Improvement on 04/01/2025 for review and recommendations then and monthly for three (3) months. The Administrator and Maintenance Director is responsible for monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 584	Continued From page 7	F 584		

11/18/2021 with current diagnoses including Peripheral Vascular Disease.

A record review of the Quarterly MDS with an ARD of 11/29/24 revealed Resident #45 had a BIMS score of 15, which indicated the resident was cognitively intact.

Resident #5

On 03/11/2025 at 2:25 PM, in an observation and interview, Resident #5 reported that her room is cold. She was observed wearing a gown and a thick robe near the window and the room was cold.

A record review of the "Admission Record" revealed the facility admitted Resident #5 on 05/11/2022 with current diagnoses including Unspecified Dementia.

A record review of the Quarterly MDS, with an ARD of 12/16/2024 revealed Resident #5 had a BIMS score of 9, which indicated moderate cognitive impairment.

Resident #34

On 03/11/2025 at 11:18 AM, during an observation and interview, Resident #34's room was cold. The resident had placed a sheet in the window to block the draft and reported that his room is normally cold, especially after showers. The resident stated that staff informed him the facility has to remain cold.

A record review of the "Admission Record" revealed the facility admitted Resident #34 on 10/18/2024 with current diagnoses including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 584	Continued From page 8	F 584		

Acute and Chronic Respiratory Failure with Hypoxia.

A record review of the Quarterly MDS with an ARD of 1/17/2025 revealed Resident #34 had a BIMS score of 15, which indicated the resident was cognitively intact.

On 03/11/2025 at 3:12 PM, temperatures were checked in multiple rooms after residents complained about feeling cold. The following temperatures were observed: Resident #5's room at 3:15 PM measured 67.5 degrees (°) Fahrenheit (F); Resident #82's room at 3:20 PM measured 69°F; Resident #34's room at 3:23 PM measured 65°F; Resident #43 and Resident #45's room at 3:26 PM measured 65.5°F. The Maintenance Director confirmed that thermostats were set at 72°F on the cool setting.

On 03/11/2025 3:30 PM, during an interview, the Maintenance Director stated that he typically keeps the thermostats set at 72°F, but adjustments are made based on resident complaints. He explained that maintaining consistent temperatures is difficult due to varying preferences, building layout, and vent placement. He also mentioned that an igniter malfunctioned in January 2025 on one of the halls and took three days to repair.

On 03/12/2025 10:50 AM, during an interview the Administrator stated that she believed the facility usually meets the federal requirement of 71°F but acknowledged that the building's age, traffic patterns, and vent placements can affect room temperatures.

On 03/12/2025 at 3:00 PM, during an interview,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 584	Continued From page 9	F 584		

Certified Nurse Aide (CNA) #10 stated that rooms 34, 35, 36, and 37 are always cold and that blankets are placed in the windows to block the cold air. CNA #10 confirmed that residents frequently complain about the cold and that staff provide extra blankets.

On 03/12/2025 at 3:45 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated that rooms near doors throughout the facility have always been colder than other rooms. LPN #1 confirmed that residents frequently complain, and that staff provide extra blankets and block window drafts with blankets. She confirmed that maintenance and management have been informed of the issue.

On 03/12/2025 at 3:50 PM, during an interview with LPN #2 revealed that about one (1) or two (2) residents on each hall occasionally complain about the cold, but staff typically notify maintenance and provide residents with extra blankets or jackets.

On 03/12/2025, at 3:55 PM, during an interview with CNA #9 revealed that some residents occasionally complain about cold rooms, but maintenance usually addresses complaints within approximately 30 minutes, and staff provide extra blankets as needed.

On 03/13/2025 at 10:47 AM, the Maintenance Director verified room temperatures again. The temperatures were as follows: Resident #5's room was measured at 70.5°F; Resident #82's room at 71°F; Resident #43 and Resident #45's room at 70°F; Resident #34's room measured 70.5°F by the door and 67.5°F by the window; Room 61 measured 69.5°F. Thermostats were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 584	Continued From page 10 set at 74°F on the cool setting.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to revise the comprehensive care plan to include the use of zinc oxide, as per a physician's order for one (1) of 21 care plans reviewed. (Resident	F 657	F657 CarePlan Timing and Revision 1. On 03/21/2025 Registered Nurse (RN) #1 reviewed and revised the comprehensive care plan to include the	4/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 657	Continued From page 11 #22) Findings included: A review of the facility's "Care Plans, Comprehensive Person-Centered" dated 2/24/25, revealed, " ...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation ...13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change..." On 03/11/2025 at 12:56 PM, during an observation of incontinence care, Certified Nursing Assistant (CNA) #8 applied zinc oxide to the resident's buttocks after providing perineal care. A record review of Resident #22's "Comprehensive Care Plan" revealed, "I have potential for impairment of my skin integrity related to weakness, decreased mobility, bowel and bladder incontinence, severe protein-calorie malnutrition..." There were no interventions in place to address applying zinc oxide. A record review of the "Order Summary Report" with active orders as of 3/13/25 revealed Resident #22 had a physician's order, dated 02/15/2025 for "Redness: Apply zinc barrier cream to sacrum every day shift." On 03/13/2025 at 12:56 PM, during an interview, the Director of Nursing (DON) explained that the Care Plan Nurse is responsible for updating the	F 657	use of zinc oxide as per physician orders for resident #22. On 03/14/2025 the Director of Nursing completed an Inservice RN #1 on ensuring that the Comprehensive resident centered care plan is developed and revised per facility policy. 2. All residents have the potential to be affected. 3. On 03/14/2025 a quality review of current resident's care plans was conducted by the Director of Nursing to ensure comprehensive care plan interventions were revised to include physician orders within the prior seven days of 03/7/2025-.03/14/2025. No issues were identified. On 04/01/2025 the Director of Nursing (DON) initiated an all-Interdisciplinary Care Plan Team in-service on developing Comprehensive Person-Centered Care Plans including rev. new hires training and education will be conducted in orientation. 4. Beginning week of 03/17/2025 the Director of Nursing will monitor Comprehensive Care plan for the timeliness of revisions for five (5) residents weekly for 4 weeks, then monthly for three (3) months then and quarterly thereafter. A report will be submitted to the Quality Assurance Performance Improvement on 04/01/2025 for review and recommendations then and monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 657	Continued From page 12 care plan daily by reviewing the physician's orders. The DON confirmed the care plan was not updated to include the application of zinc oxide to Resident #22's buttocks. On 03/13/2025 at 1:07 PM, during an interview, the Administrator stated that she expects staff to follow the facility's policies and standards of practice. The Administrator further stated she expects staff to update residents' care plans according to facility policy. On 03/13/2025 at 1:11 PM, during an interview, Registered Nurse (RN) #1 confirmed that the care plan was not updated to reflect the use of zinc oxide. RN #1 stated that she had not yet had a chance to update the care plan and that care plans are updated according to physicians' orders. RN #1 explained that the care plan is used to direct the care of the resident and to assign responsibilities according to staff job descriptions and training. A record review of the "Admission Record" revealed the facility admitted Resident #22 on 09/10/2024 with diagnoses including Acute and Chronic Respiratory Failure with Hypoxia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/2024 revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section GG revealed Resident #22 was incontinent of bowel and bladder and required partial to moderate assistance for bathing, toileting, and personal hygiene.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards	F 658		4/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 658	Continued From page 13 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and the facility's Certified Nurse Assistant (CNA) job description review, the facility failed to ensure professional standards practices were maintained when a CNA applied a medicated cream to a resident during one (1) of two (2) incontinent resident care observations. (Resident #22) Findings Include: A record review of the facility's Certified Nursing Assistant (CNA) "Job Description" dated March 2017, revealed, " ...Function: Cares for Residents under the direction and supervision of a registered nurse or a licensed practical/vocational nurse ..." A record review of a letter from the State Board of Nursing, dated 7/15/2005, revealed, " ...medication administration may only be delegated to another registered nurse or licensed practical nurse and not an unlicensed person. This would include medicated ointments, lotions and protective barriers, regardless of skin integrity ..." In an observation of incontinence care on 3/11/25 at 12:56 PM, Licensed Practical Nurse (LPN) #7/MDS Nurse gave CNA #8 zinc oxide cream to	F 658	F 658- D Services provided meet professional standards 1. On 03/11/2025 Resident #22 was assessed by the Registered Nurse Supervisor for any adverse reactions due to failure to follow facilities policy and procedure for Administering Topical Skin Application containing zinc oxide. No adverse reactions were found. On 3/13/2025 an Inservice was completed with Certified Nursing Assistant (CNA) #8 and Licensed Practical Nurse (LPN) #7 by the Director of Nurses on Delegation Skills Considerations- the skill of administering topical medications containing zinc oxide cannot be delegated to nursing assistant personnel. 2. All residents have the potential to be affected. 3. Beginning 4/1/2025 and ongoing, all licensed nursing staff and certified nursing assistants were in serviced by Staff Development Coordinator and Director of Nursing on proper policy and procedures for Administering Topical Skin Applications containing zinc oxide. 4. Beginning 03/17/2025, The Director of Nursing will conduct audits/interviews on three (3) nurses and (3) certified nursing assistants three (3) times weekly for four	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 658	Continued From page 14 put on the resident's buttocks. CNA #8 applied the zinc oxide to the resident's sacrum after completing incontinence care. A record review of the "Order Summary Report" with active orders as of 3/13/25, revealed Resident #22 had Physician's Order, dated 02/15/2025, for "Redness: Apply zinc barrier cream to sacrum every day shift." On 03/13/25 at 12:32 PM, in an interview, LPN #7 confirmed she gave CNA #8 the cream to apply to Resident #22's buttocks. She acknowledged that the facility does not allow CNA's to apply medicated creams such as zinc oxide to the residents because CNA's cannot administer medications. During an interview on 03/13/25 at 12:56 PM, with the Director of Nursing (DON), he stated the facility does not allow the CNAs to apply zinc oxide to the residents and that CNA's do not administer medications. The DON also said both the nurse and CNA have been trained that CNA's cannot administer medications. During an interview on 03/13/25 01:07 PM, the Administrator stated she expects the staff to follow the facility policies and standards of practice and confirmed the facility does not allow CNAs to administer medications. A record review of the "Admission Record" revealed the facility admitted Resident #22 on 09/10/2024 with diagnoses including Acute and Chronic Respiratory Failure with Hypoxia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date	F 658	(4) weeks, then monthly for three (3) months then and quarterly thereafter. A report will be submitted to the Quality Assurance Performance Improvement on 04/01/2025 for review and recommendations then and monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 658	Continued From page 15 (ARD) of 12/18/2024 revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section GG revealed Resident #22 was incontinent of bowel and bladder and required partial to moderate assistance for bathing, toileting, and personal hygiene.	F 658		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure food items in the cooler and freezer were wrapped, covered, and dated and ensure serving bowls were cleaned appropriately for one (1) of three (3) days of survey.	F 812	F-812 1. On 3/11/2025 Dietary Staff #4 was immediately in-serviced by the Dietary Manager on infection control, sanitation, and food borne illness. Based on tracking and trending conducted by the Infection Control Preventionist observations, no	4/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 812	Continued From page 16 Findings included: A review of the facility's policy titled "Food Storage: Cold Foods" dated 02/2023 revealed, " ...All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored ... Procedures ... 5. All foods will be stored wrapped or covered in containers, labeled and dated..." A review of the facility's policy titled "Ware Washing," dated 02/2023 revealed, " ...All dishware, serviceware, and utensils will be cleaned and sanitized after each use..." On 03/11/2025 at 8:43 AM, during an observation of the kitchen and interview with Dietary Manager (DM) #1 revealed: Walk-In Cooler #1, there was an opened cheesecake box, which did not indicate the date opened, and the cheesecake was not fully wrapped or covered in the container. In Freezer #1, an opened frozen mixed vegetables container and an opened box of beef patties were not fully wrapped or covered in the containers and were exposed. Dried and stuck-on food residue was observed on serving bowls that were considered washed. The DM stated that these dishes were washed and stacked by the night shift. On 03/12/2025 at 12:35 PM, during an interview, Dietary Aide (DA) #4 confirmed the importance of ensuring plates and dishes are cleaned and sanitized to prevent residents from becoming sick. On 03/13/2025 at 2:40 PM, during an interview, the Administrator stated that her expectation is that kitchen staff prepare, store, label, and date	F 812	resident has become ill. 2. All residents have the potential to be affected. 3. On 03/25/2025 An in-service was conducted by the Dietary Manager with Healthcare Services Group on food preparation and servicing in relation to infection control and sanitation with all dietary staff. 4. Beginning on 03/14/25 the dietary manager will conduct rounds to monitor the sanitation and storage including labeling within dietary department three times a week for four (4) weeks, then monthly for three (3) months then and quarterly thereafter. A report will be submitted to the Quality Assurance Performance Improvement on 04/01/2025 for review and recommendations then and monthly for three (3) months. The Dietary Manager is responsible for monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 812	Continued From page 17 foods according to facility policy.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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	F 880		4/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 880	Continued From page 18 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 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, interviews, record review, and facility policy review, the facility failed to maintain proper infection control practices by failing to prevent cross-contamination of perineal wipes during perineal care for one (1) of four (4) residents observed. Resident #58. Findings included:	F 880	F 880 1. On 3/13/2025 Resident #58 was reviewed and assessed by the Director of Nursing for any adverse reactions due to failure to prevent the possibility of infections by failing to maintain proper infection control practices during a direct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 880	Continued From page 19 A review of the facility's policy titled "Perineal Care," revised 04/16/2024, revealed, " ...The purposes of this procedure are to provide cleanliness and comfort to the resident... to prevent infections and skin irritation ..." On 03/13/2025 at 9:18 AM, during an observation of perineal care of Resident #58, Certified Nursing Assistant (CNA)#3, assisted by CNA #5, gathered supplies, sanitized her hands, and donned gloves. CNA #3 removed six (6) premoistened wipes from the pack and used the wipes to clean the front area of the resident. The resident was assisted to her left side and then CNA #3 pulled six (6) additional wipes from the pack, touching the package with contaminated gloves, and then continued perineal care in the buttocks area. Resident #58 had a bowel movement during care and CNA #3's gloves were visibly soiled with feces. CNA #3 pulled six (6) more wipes from the pack, touching the package with visibly soiled gloves. CNA #3 then removed her soiled gloves, sanitized hands, applied clean gloves, and then pulled more wipes from the pack to continue cleaning the resident. On 03/13/2025 at 9:33 AM, during an interview, CNA #3 stated she improperly removed wipes during care. She confirmed she contaminated the wipes container by pulling more wipes from the pack with soiled gloves. On 03/13/2025 at 11:36 AM, during an interview, the Risk Manager (RM)/Infection Preventionist (IP) stated that CNA #3 contaminated the wipes each time she pulled them from the pack with dirty gloves on.	F 880	care observation on 3/13/2025 by state surveyor. No adverse reactions were found. On 03/13/2025 Certified Nursing Assistant (CNA) #3 was educated by the Director of Nursing on Infection Control policies and procedures and completed a peri care check off. No issues were found. On 03/13/2025 CNA# 3 provided proper peri care following infection control policies and procedures on Resident #58 under observation of the Director of Nursing. No issues were found. 2. All residents have the potential to be affected. 3. On 04/1/2025 and ongoing the Director of Nurses in-serviced nursing staff on following the infection control policy with all direct resident care including peri care practices. 4. On 3/14/2025 the Infection Preventionist will make observation rounds on three (3) resident peri care observations to ensure that accurate infection control practices were followed during direct care. These observations will occur weekly times four (4) weeks and then monthly for three (3) months and quarterly thereafter. A report will be submitted to the Quality Assurance Performance Improvement on 04/01/2025 for review and recommendations then and monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
F 880	Continued From page 20 On 03/13/2025 at 1:57 PM, during an interview, the Director of Nursing (DON) stated CNA #3 should have pulled enough wipes from the container before beginning care. The DON confirmed there was potential for contamination and possible infection. A record review of the "Admission Record" revealed the facility admitted Resident #58 on 11/02/2021 with diagnoses including Unspecified Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/28/2025 revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section GG revealed the resident requires partial to moderate assistance with toileting. A record review of the facility's "Perineal Care Check List", dated 8/22/24, revealed CNA #3 received training and performed a return demonstration regarding perineal care.	F 880		