STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 at the facility from 6/9/25 through 6/12/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F584, F585, F605, F656, F677, F757, F761, and F880. The census at the time of the survey was 58 and the facility is licensed for 60 beds.	F 000		
F 584 SS=D	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	F 584		7/23/25

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

Electronically Signed | 06/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 1	F 584		

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

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility policy review the facility failed to maintain a clean and homelike environment as evidenced by a dirty air conditioning unit in one (1) of 30 rooms observed. Room #123.

Findings Include:

Review of the facility policy, "Routine Cleaning and Disinfection" with revision date of February 2023, revealed, "It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible..."

An observation on 06/09/25 at 11:23 AM and on 06/11/25 at 2:55 PM, in Room #123, revealed a dirty air conditioning unit that had a damp, black substance scattered on the plastic slats on the front panel. There were also scattered food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

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F 584	Continued From page 2	F 584		

particles and dried crumbs on the front lower part of the thermostat section of the air conditioner unit.

An observation in Room #123 and interview with Licensed Practical Nurse (LPN #2) on 06/11/25 at 3:00 PM, confirmed that there was a black substance scattered throughout the front slats of the air conditioner unit. She revealed that the black substance looked like mildew, and this could cause respiratory issues for the resident if not taken care of and cleaned. She also confirmed that scattered food particles and crumbs were on the front lower part of the thermostat section and stated, "It needs to be cleaned."

During an observation in Room #123 and interview with Director of Nurses (DON) on 06/11/25 at 3:10 PM, he confirmed the damp, black substance on the front panel of the air conditioner and the food particles and crumbs on the anterior right section under the thermostat control. The DON revealed that the black substance on the air conditioner looked like mildew and that this could cause respiratory problems. He also confirmed that by leaving the air conditioner dirty, they failed to ensure that they maintained a clean homelike environment for the residents.

On 06/11/25 at 4:55 PM, an interview with the Maintenance Director, revealed that sometimes the residents eat their meals near the air conditioning units and would drop food in the units. He revealed that they removed the front panels of the air conditioner units three times a year and as needed, and cleaned them out good. He confirmed that the air conditioner unit in Room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 3 #123, was left dirty and needed to be cleaned.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance	F 585		7/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

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F 585	Continued From page 4	F 585		

can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

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F 585	Continued From page 5	F 585		

regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interviews, and facility policy review, the facility failed to address a grievance regarding answering a call light and providing Activities of Daily Living (ADL) care in a timely manner for one (1) of the 17 sampled residents. Resident #45

Findings include:

A review of the facility policy titled "Policy Statement Filing Grievances/Complaints" with a revision date of 3/17/17 revealed, "...Staff will assist in completing and filing a grievance or complaint when such requests are made. Grievances include, but are not limited to, resident care, treatment, abuse, neglect...2. Grievances can be filed orally, in writing, or anonymously...4. Grievances will be responded to within 5 working days of the date the grievance was filed. Immediate action will be taken on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

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F 585	Continued From page 6	F 585		

grievances where alleged violations of any resident rights are reported to prevent further potential violations..."

An observation and interview on 6/09/25 at 10:20 AM, revealed Resident #45 lying in her bed and she was visibly upset. Resident #45 stated, "It has been almost three hours that I have been sitting in a poopy diaper. The last time my diaper was changed was on the night shift." Resident #45 further revealed, "I have put my call light on several times this morning. They come in and ask me what I need, and I tell them I need my diaper changed because I have had a bowel movement, then they turn the call light off and say they will get my aide." She revealed they need to take care of me instead of turning my light out and leaving. Resident #45 revealed that she had previously spoken with the Director of Nursing (DON) about this issue, and he is aware. She stated, "I tried to talk with the DON last week, but he never got back with me." She became tearful and stated, "I feel so useless. I'm not able to do anything for myself, and I'm at the mercy of everyone else. I haven't spoken to the Administrator because she has a lot on her plate to deal with."

During an interview on 06/09/25 at 11:10 AM, the DON revealed that Resident #45 had some complaints about her call light not being answered on time in the past and having to wait to be changed. He confirmed that he had not formally written up a grievance to ensure the problem was addressed and a follow-up had not been conducted to see if her grievance was corrected.

In an interview on 6/11/25 at 9:10 AM, the Administrator revealed that she is the grievance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

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F 585	Continued From page 7 officer and confirmed that no formal grievance had been written regarding the resident's concerns and complaints. She revealed the residents' complaint should have been written up as a grievance so that we could have addressed it and followed up to ensure it was resolved. Record review of the "Revenue Cycle" Face sheet revealed the facility admitted Resident #45 on 10/09/2023 with medical diagnoses that included acute Kidney Failure, Heart Failure, and Depression. Record review of Resident #45's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/3/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.	F 585		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is	F 605		7/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

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F 605	Continued From page 8	F 605		

not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.
§483.12(a) The facility must-. . .
§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.
. . . .
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-
(1) In excessive dose (including duplicate drug therapy); or
(2) For excessive duration; or
(3) Without adequate monitoring; or
(4) Without adequate indications for its use; or
(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

§483.45(e) Psychotropic Drugs. Based on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 605	Continued From page 9	F 605		

comprehensive assessment of a resident, the facility must ensure that--

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to ensure an as needed (PRN)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 605	Continued From page 10	F 605		

psychotropic hypnotic medication for insomnia was limited to 14 days or to an appropriate time frame approved by the provider for one (1) of five (5) medication reviews. Resident #20

Findings include:

Record review of facility letterhead signed by the Administrator and dated 6/12/25 revealed, "(Proper name of facility) does not have a policy on stop dates for psychotropic drugs".

Record review of Resident #20's "Orders" revealed an order dated 4/17/25 for "Zolpidem 5 milligram oral tablet...every night at bedtime PRN for insomnia".

Record review of "Consultant Pharmacist Recommendation to Physician" dated 4/23/25, revealed, "Ambien 5 mg (milligrams) qhs (every night at bedtime) PRN (as needed) for insomnia. May we extend the above order for 6 months?" The physician's response was, "Agree...Cont (continue) it 6 months".

During an interview on 6/11/25 at 10:10 AM, Registered Nurse/Minimum Data Set Coordinator (RN/MDS) revealed Resident #20 had a psychotropic hypnotic medication ordered as needed (PRN) for insomnia and this order did not have the required stop date. She stated any PRN psychotropic medication should have a 14 day stop date or another date approved by the physician. She stated the pharmacist recommended the medication be extended for six months and the provider approved this recommendation, but it was overlooked by the facility staff and was not entered into the resident's orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 605	Continued From page 11 An interview with the Director of Nursing (DON) on 6/11/25 at 12:05 PM, revealed any PRN psychotropic medication should have a stop date of 14 days or longer if approved by the physician to ensure psychotropic PRN medication use is monitored and not extended if unnecessary. He stated Resident #20 was on a psychotropic hypnotic medication at bedtime as needed. He acknowledged the pharmacist made a recommendation for a six month stop date which was approved by the provider and the facility failed to enter this date into the resident's orders. He confirmed the facility failed to have the required stop date for a resident receiving a PRN hypnotic psychotropic medication. Record review of Resident #20's "Revenue Cycle" face sheet revealed the resident was admitted to the facility on 4/17/25 with diagnoses that included insomnia.	F 605		
F 656 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	F 656		7/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 656	Continued From page 12	F 656		

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.
(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, resident and staff interviews, record review, and facility policy review, the facility failed to implement a person-centered care plan for providing incontinent care for one (1) of the 18 care plans reviewed. Resident #45

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 656	Continued From page 13	F 656		

Findings include:

Record review of facility policy titled "Quality of Care" undated revealed, "Each resident shall receive optimal care to attain and/or maintain the highest mental and physical functional status as defined by the comprehensive assessment and plan of care. Additionally, the resident will receive the appropriate interventions to maintain or to improve his/her abilities."

Record review of Resident #45's care plan, updated 4/9/25 revealed "Plan Comments: I am incontinent of bowels... Outcomes...I will be kept clean & dry of incontinent bowel...Interventions...Provide incontinence/pericare after each incontinent episode..."

Record review of Resident #45's care plan, updated 4/9/25 revealed "Plan Comments: I have a potential for complications associated with urinary incontinence...Outcomes...I will be kept clean, dry, & comfortable daily...Interventions... Provide peri-care after each incontinent episode...Assess me every 2 to 3 hrs (hours) and PRN (as needed) for incontinent episodes..."

During an observation and interview on 6/09/25 at 10:20 AM, revealed Resident #45 lying in her bed visibly upset and stated, "It has been almost three hours that I have been sitting in a poopy diaper the last time my diaper was changed was on the night shift." Resident #45 further revealed, "I have put my call light on several times this morning. They come in and ask me what I need, and I tell them I need my diaper changed because I have had a bowel movement. They turn the call light off and say they will get my aide but they never come

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 656	Continued From page 14 back." During an interview on 6/10/25 at 2:30 PM, the Registered Nurse (RN) Minimum Data Set (MDS) Coordinator revealed she is responsible for developing the care plans. She revealed that the care plans are developed individually for each resident, so the staff will know how to care for that resident's specific needs. She confirmed Resident #45's care plan was not being followed regarding her incontinence care, and it should have been. Record review of the "Revenue Cycle" Face sheet revealed the facility admitted Resident #45 on 10/09/2023 with medical diagnoses that included acute Kidney Failure, Heart Failure, and Depression. Record review of Resident #45's MDS with an Assessment Reference Date (ARD) of 4/3/2025 Section H: Resident is always incontinent of urinary and bowel continence. Section C revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure Activities of	F 677		7/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 677	Continued From page 15	F 677		

Daily Living (ADLs) with incontinent care was provided for one (1) of 17 sampled residents. Resident #45

Findings include:

Record review of facility policy titled "Quality of Care" undated revealed, "...The policy of the facility is to establish a minimum acceptable level of daily care, which shall include and involve the maximum utilization of the resident's capabilities, while providing the necessary assistance to accomplish the following: ... Toileting ...Staff is to check and change incontinent residents every 2 hours and prn (as needed)..."

On 6/09/25 at 10:20 AM, during an observation and interview revealed Resident #45 lying in her bed visibly upset and stated, "It has been almost three hours that I have been sitting in a poopy diaper the last time my diaper was changed was on the night shift." Resident #45 further revealed, "I have put my call light on several times this morning. They come in and ask me what I need, and I tell them I need my diaper changed because I have had a bowel movement and they turn the call light off and say they will get my aide."

An observation from the hallway on 6/9/25 at 10:32 AM ,revealed Resident #45's call light was pressed and came on and Certified Nurse Aide (CNA) #1 entered the room, the call light was turned off, and CNA #1 exited the room within approximately fifteen (15) seconds. CNA #1 went down the hall and around a corner, then returned to the hall and began to pass ice and water to other rooms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 677	Continued From page 16	F 677		

An interview on 6/9/25 at 10:36 AM, Resident #45 revealed "I turned on my call light, and the aide came in and asked me what I needed. I told her that I needed to be changed because I had a bowel movement. She told me, 'Okay,' and then turned off the call light, telling me she would let my aide know."

During an interview on 6/9/25 at 10:45 AM, CNA #2 revealed she is assigned to the resident today and confirmed she started her shift at 6:45 AM and did her rounds on the resident this morning but the resident didn't say if she was wet or needed to be changed, she will usually let us know when she needs changing so I didn't change her. So, I moved on to the other hall and was giving a bed bath, and two aides came and told me that Resident #45 needed to be changed. She confirmed that she had not provided incontinent care to Resident #45 this morning because she was not wet when she initially made her rounds this morning.

During an interview on 6/09/25 at 10:50 AM, CNA #3 revealed she went into Resident #45's room about 9:00 AM to see if she was ready for her whirlpool bath. The resident said she had to have a brief change first because she had a bowel movement. CNA #3 revealed, "I then went and told her assigned aide, (Proper name of CNA #2), that the resident needed to be changed." CNA #3 revealed "I am also able to provide incontinent care and I should have changed her brief instead of making her wait longer."

In an interview on 6/9/25 at 11:10 AM, the Director of Nurses (DON) revealed the resident has had some complaints about her call light not being answered in a timely manner. He revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 677	Continued From page 17 that it is his expectation that residents receive incontinent care at least every 2 hours or more and for Resident #45 to be left soiled without being cleaned up for that amount of time is unacceptable. In an interview on 6/11/25 at 3:25 PM, the Administrator revealed that residents are supposed to receive incontinent care every two hours and as needed. She revealed that the CNAs should have made their rounds every two hours and provided care and should have changed the resident instead of turning the light off and not providing the care she needed. Record review of the "Revenue Cycle" Face sheet revealed the facility admitted Resident #45 on 10/09/2023 with medical diagnoses that included Acute kidney failure, Heart failure, and Depression. Record review of Resident #45's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/3/2025 Section H: Resident is always incontinent of urinary and bowel continence. Section C revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.	F 677		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		7/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 757	Continued From page 18 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility letterhead review, the facility failed to monitor residents for side effects of anticoagulant medication use for two (2) of five (5) medication reviews. Resident #27 and Resident #56 Findings include: Record review of facility letterhead signed by the Administrator and dated 6/12/25 revealed, "(Proper name of nursing home) does not have a policy on anticoagulant monitoring". Resident #27 Record review of Resident #27's "Orders" revealed an order dated 8/26/24 for "Apixaban (Eliquis) 5 milligram oral tablet)...BID (two times daily)". During an interview on 6/10/25 at 3:40 PM,	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 757	Continued From page 19	F 757		

Licensed Practical Nurse (LPN) #3 revealed Resident #27 received an anticoagulant medication and acknowledged awareness of the risk of anticoagulant medication use and the need to observe for bruising or bleeding. She revealed there was not an area in the computer documentation to prompt the nurses to monitor or to document that the resident was monitored for bleeding or bruising.

During an interview on 6/11/25 at 10:10 AM, the Registered Nurse/Minimum Data Set (RN/MDS) acknowledged Resident #27 received an anticoagulant medication and monitoring for side effects had not been documented. She revealed the nurses should observe for bleeding and bruising and report if noted, but there was no documentation to prompt the nurses to monitor this routinely or verify this was done. She confirmed that residents receiving an anticoagulant medication should be monitored due to their risk for bleeding and this was not done.

An interview with the Director of Nursing (DON) on 6/11/25 at 12:05 PM, revealed Resident #27 received an anticoagulant medication that could cause excessive bleeding and needed to be monitored for bleeding and bruising. He revealed that monitoring would help ensure the resident was evaluated and treated promptly to prevent complications. He confirmed the facility failed to monitor a resident on an anticoagulant medication for bleeding and/or bruising and document their observations.

Record review of Resident #27's "Revenue Cycle" Face sheet revealed an original admission date of 8/26/24 with the most recent admit date of 5/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 757	Continued From page 20	F 757		

and diagnoses that included Venous thrombosis and Embolism.

Resident #56

An interview and observation on 06/11/25 at 9:50 AM, with LPN #2 revealed that they were supposed to pay close attention to the residents on anticoagulants. She revealed that they looked at labs, monitored for bleeding or bruising throughout the shift to make sure they didn't have any side effects of taking the blood thinners. An observation revealed LPN #2 pull Resident #56's information up on the computer screen on the medication cart and she confirmed that there was no documentation of monitoring for anticoagulant side effects for him and stated, "I don't know why it's not getting done."

An interview with RN #1, revealed that there was not a monitoring section for anticoagulants in their system. She revealed that the nurses were supposed to monitor for side effects of anticoagulants and if they noticed anything abnormal, they were to document it. RN #1 confirmed that Resident #56 was on an anticoagulant and there was no documentation found where the nurses monitored for side effects and also confirmed that inadequate monitoring placed the resident at risk for bleeding.

Record review of Resident #56's "Revenue Cycle" Face Sheet revealed an admission date of 05/16/25 and that he had diagnoses that included Peripheral Vascular Disease and Atrial Fibrillation.

Record review of Resident #56's "Orders" revealed an order dated 05/16/25 for Apixaban 5 mg (milligrams) by mouth twice a day and there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 757	Continued From page 21 was no order to monitor for bruising or bleeding. Record review of Resident #56's Medication Administration Record (MAR) for June 2025 revealed that he received Apixaban 5 mg (milligrams) orally bid (two times a day) and there was no monitoring tool in place for staff to monitor for signs of bleeding or bruising with the anticoagulant.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		7/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 761	Continued From page 22	F 761		

by:
Based on observation, interview, and facility policy review, the facility failed to ensure medications were stored properly in a secure manner in the medication cart for one (1) of five (5) medication administration observations.

Findings Include:

Review of the facility policy titled "Medication Storage", undated, revealed "...1. General Guidelines:..c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart..."

An observation on 06/11/25 at 9:05 AM, revealed a medication card of Lasix tablets on top of an unattended medication cart. An observation revealed Licensed Practical Nurse (LPN) #1 walked away from the medication cart down to the end of the hall in the sitting area and assisted a resident in a wheelchair to her room to receive her medications.

An interview on 06/11/25 at 9:15 AM with LPN #1 revealed that medications were supposed to be locked up in the the medication carts when unattended. She confirmed that she left the Lasix 40 milligram (mg) medication card face down on the medication cart while she walked down the hall to get a resident to come to her room. LPN #1 confirmed that medications should never be left on top of the cart and by doing so could allow someone to come up to the cart, grab the medicine and possibly take something they were not supposed to have.

An interview on 06/11/25 at 9:54 AM, with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 761	Continued From page 23 Director of Nursing (DON), revealed that leaving medications unattended on top of the medication cart was unacceptable practice and was a safety issue. He revealed that a resident could walk by and take the medications and could possibly take something they were not supposed to take. He confirmed that medications were supposed to be within sight of the person administering the medications or be locked in the medication cart.	F 761		
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:	F 880		7/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 24 (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 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:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 25	F 880		

Based on observation, interview, and facility policy review the facility failed to utilize protective barriers to prevent possible contamination and spread of bacteria during two (2) of five (5) resident medication administration observations. Resident #1 and Resident #43.

Findings Include:

Review of the facility policy, "Administration of Eye Drops or Ointments Policy" with revision date of 04/24/23 revealed, "Eye medications are administered as ordered by the physician and in accordance with professional standards of practice...5. Administration: a. Remove medication cap and place on clean, dry surface (i.e. tissue or paper towel) to prevent contamination...."

Resident #1
An observation on 06/11/25 at 8:20 AM, during Resident #1's medication pass revealed Licensed Practical Nurse (LPN) #1, removed Timolol eye drop bottle from the box and placed it on the overbed table with no barrier in use and had not sanitized the overbed table prior to placing the eye drop bottle on the table. LPN #1 administered the eye drops, placed the eye drop bottle back on the overbed table and then returned it to the medication cart.

An interview on 06/11/25 at 8:30 AM, with LPN #1 confirmed that she did not place the eye drop bottle on a barrier and that she had placed it directly on the overbed table while she administered Resident #1's other medications. LPN #1 revealed that not utilizing a barrier with the bottle of eye drops could cause spread of germs and cross contamination and she should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 26	F 880		

not have placed the eye drops on the dirty surface.

Record review of Resident #1's "Revenue Cycle" Face Sheet revealed an admission date of 10/15/1991 and that she had diagnoses that included Cerebral Palsy, Ocular Hypertension of the Right Eye, and Unspecified Keratoconus of the Right Eye.

Record review of Resident #1's "Orders" revealed an order dated 06/11/24 for Timolol Ophthalmic 0.5% solution to instill one drop in the right eye daily.

Resident #43
An observation on 06/11/25 at 8:50 AM, during Resident #43's medication pass, revealed LPN #1 removed the Systane eye drop bottle from the box, she administered the eye drops and then placed the eye drop bottle on the overbed table with no barrier in use and had not sanitized the table prior to placing the medication there. LPN #1 administered Resident #43's other medications, picked up the eye drop bottle from the overbed table and returned it to the medication cart.

An interview on 06/11/25 at 8:58 AM, LPN #1 revealed that she did not clean the overbed table prior to setting the eye drop bottle down and confirmed that she should have placed it on a barrier. She stated, "I forgot." LPN #1 revealed that not using a protective barrier and by placing the eye drops directly on the overbed table, could cause the spread of germs and cross contamination. She revealed that she would make sure she used a protective barrier going forward.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

(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 27 An interview on 06/11/25 at 9:54 AM, with the Director of Nursing (DON), revealed that the nurses were supposed to use protective barriers when providing care including during medication administration. He confirmed that LPN #1 placing Resident #1 and Resident #43's eye drop bottles on the overbed table during medication administration without a barrier was an infection control issue and it could cause the spread of germs and bacteria. Record review of Resident #43's "Revenue Cycle" Face Sheet revealed an admission date of 06/28/23 and that she had diagnoses that included Alzheimer's Disease and Major Depressive Disorder. Record review of Resident #43's "Orders" revealed an order dated 10/30/24 for Systane Complete Optimal Dry Eye Relief ophthalmic solution (ocular lubricant) to instill one drop both eyes two times a day.	F 880		