MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility on 6/9/25 through 6/12/25. During the survey the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M610, and M1570. Census at the time of the survey was 58 and the facility had beds for 60 residents.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		7/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M 500	Continued From page 1 medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M 500	Continued From page 2	M 500		

facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M 500	Continued From page 4 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 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	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M 500	Continued From page 5 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 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.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well	M 610		7/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M 610	Continued From page 6 being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure Activities of 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,	M 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M 610	Continued From page 7	M 610		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M 610	Continued From page 8	M 610		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M 610	Continued From page 9 Status (BIMS) score of 15, which indicated the resident is cognitively intact.	M 610		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II 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)	M1570		7/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M1570	Continued From page 10	M1570		

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...."

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 not have placed the eye drops on the dirty surface.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M1570	Continued From page 11	M1570		

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.

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 #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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52NO	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) COMPLETE DATE
M1570	Continued From page 12 an order dated 06/11/24 for Timolol Ophthalmic 0.5% solution to instill one drop in the right eye daily. 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.	M1570		