STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

(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 6/16/25 to 6/19/25. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F604, F641, F656, F679, F812 and F880. The facility held a license for 60 beds with a census of 56.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §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 physical . . . 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 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 physical . . . restraints imposed for purposes of discipline or convenience and that are not	F 604		7/26/25

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

Electronically Signed | 07/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

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F 604	Continued From page 1	F 604		

required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical restraints by not identifying and documenting the use of a soft belt as a restraint for one (1) of seventeen (17) sampled residents, Resident #36.

Findings included:

A review of the facility's policy titled "Physical Restraint," dated 2/20/2012, revealed, "
...Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully.
Policy Interpretation and Implementation 1. Restraints will only be used after other alternatives have been tried unsuccessfully, and only with the informed consent from the resident, physician and/or responsible party ...Order of Restraints Least Restrictive to Most Restrictive ...Soft belts are RESTRAINTS under any circumstance ..."

On 6/16/25 at 1:30 PM, during an observation, Resident #36 was observed sitting in a wheelchair with a Velcro soft belt secured across her lap. The resident was unable to remove the belt upon request.

On 6/16/25 at 1:40 PM, during an interview with Certified Nursing Assistant (CNA) #1, she explained that the soft belt was applied to prevent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

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F 604	Continued From page 2	F 604		

the resident from sliding and falling out of the wheelchair. CNA #1 confirmed that Resident #36 could not remove the belt on her own.

On 6/16/25 at 1:55 PM, during an interview with Registered Nurse (RN) #1, she stated that the soft belt was used to keep Resident #36 from sliding out of her high-back wheelchair and was applied each morning, removed at lunch when the resident went to bed for a nap, and then reapplied in the afternoon until bedtime. RN #1 confirmed the soft belt was released every two (2) hours to assist with toileting and peri care.

On 6/17/25 at 11:05 AM, during an interview with the Director of Nursing (DON), she acknowledged that Resident #36 was unable to remove the soft belt upon request and confirmed the device had not been previously identified or documented as a restraint. She stated the facility would begin pre-restraint evaluations, obtain physician's orders and representative consent, ensure documentation, and provide staff in-service training on identifying and documenting restraints.

On 6/19/25 at 10:50 AM, during an interview with the Administrator, she stated the soft belt was used to prevent the resident from sliding out of her wheelchair. The Administrator confirmed the resident could not remove the soft belt on request but stated the facility did not consider it a restraint because the resident lacked the mental capacity to understand or remove it.

A record review of the "Admission Record" revealed the facility admitted Resident #36 on 10/22/23 with current diagnoses including Alzheimer's Disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

(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 604	Continued From page 3 A record review of the "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 6/12/25 revealed Resident #36 had a Brief Interview for Mental Status (BIMS) score of 00 which indicated her cognition was severely impaired. A record review of Resident #36's medical record revealed there was no documentation identifying the soft belt as a restraint or supporting evaluations, orders, consent, or monitoring.	F 604		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is	F 641		7/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

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F 641	Continued From page 4	F 641		

subject to a civil money penalty or not more than $5,000 for each assessment.
§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) regarding an anticoagulant medication for one (1) of 17 sampled residents reviewed for MDS accuracy, Resident #2.

Findings included:

A review of the facility's policy titled "MDS Assessment," dated 5/2006, revealed, " ...It is the policy of this facility to follow the RAI (Resident Assessment Instrument) process as set forth by CMS (Centers for Medicare and Medicaid Services) protocol ...The facility will follow directions per federal and state guidelines for resident assessment protocol and will refer to the MDS RAI manual ..."

A review of the Resident Assessment Instrument (RAI) Manual 3.0, Version 1.19.1, dated October 2024, revealed, " ...N0415: High-Risk Drug Classes ...Do not code antiplatelet medications such as aspirin ...as N0415E, Anticoagulant ..."

A record review of Resident #2's "Admission Record" revealed the facility admitted the resident on 4/7/22 with current diagnoses including Chronic Obstructive Pulmonary Disease and Hypertension.

A record review of the "Order Summary Report" with active orders as of 5/1/25 revealed Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

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F 641	Continued From page 5 #2 had a Physician's Order, dated 1/10/2024, for Aspirin EC (Enteric Coated) Tablet Delayed Release 81 milligrams (mg), one tablet by mouth daily for Essential (Primary) Hypertension. There were no active orders for an anticoagulant medication. A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/11/25 revealed Section N0415 was coded to indicate that the resident received an anticoagulant medication. On 6/18/25 at 9:12 AM, during an interview and record review with Registered Nurse (RN) #3, she reviewed the physician's orders and the MDS dated 4/11/25 for Resident #2 and confirmed the resident was not on an anticoagulant medication during the MDS lookback period. RN #3 acknowledged the MDS had been coded in error and explained that the resident was receiving aspirin, which should have been coded as an antiplatelet. On 6/19/25 at 12:15 PM, during an interview with the Administrator and the Director of Nursing (DON), they both confirmed that their expectation was for all MDS assessments to be coded accurately to reflect each resident's condition and treatment.	F 641		
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	F 656		7/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

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F 656	Continued From page 6 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (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-	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

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F 656	Continued From page 7 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and the facility policy review, the facility failed to implement a care plan for enhanced barrier precautions (EBP) by failing to wear the proper Personal Protective Equipment (PPE) while providing care for one (1) of 17 resident care plans reviewed. Resident #2 Findings include: A record review of the facility's policy "Care Plans- Comprehensive" dated 10/2016 revealed " ... An individualized (person centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychological needs is developed for each resident ... Policy Interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his//her family or resident representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level functioning the resident may be expected to attain ..." A record review of Resident #2's Comprehensive Care Plan revealed an individual care plan initiated 4/1/24, "Focus ...has abscess to right buttock and is receiving wound care...Interventions...Use EBP When: Dressing/Bathing, Transferring, Changing Linens, Assisting With Toileting/Incontinence Care, Accessing Indwelling Medical Devices, Providing Wound Care, Any Other High-Contact Resident Care Activities..."	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

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F 656	Continued From page 8	F 656		

A record review of Resident #2's "Admission Record" revealed the facility admitted the resident on 4/7/22 with current diagnoses including Chronic Obstructive Pulmonary Disease.

A record review of the "Order Summary Report" with active orders as of 6/18/25 revealed a Physician's Order, dated 5/20/25, for Enhanced Barrier Precautions (EBP) related to a history of ESBL (Extended Spectrum Beta-Lactamase) resistance infection.

A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/11/25 revealed Section H indicated the resident was always incontinent of bowel and bladder.

During an observation on 06/18/25 at 09:55 AM, Certified Nurse Aide (CNA) #2 provided incontinence care to Resident #2 without wearing a gown as required by EBP.

During an interview on 06/18/25 at 11:50 AM, CNA #2 explained the green sticker by the resident's name on the door indicated she required EBP and she confirmed that she did not wear a gown while providing incontinence care. She stated the PPE that is required for a resident on EBP includes gloves and a gown.

During an interview on 06/19/25 at 10:45 AM, Registered Nurse (RN) #2 explained the purpose of the care plan is for the staff to know how to care for the residents per the physician orders. She expects all staff to follow the care plans while providing care for the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

(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 9 During an interview on 06/19/25 at 11:20 AM, the Director of Nursing (DON) explained she expects all staff to follow EBP as ordered and care planned to protect the resident and the staff members from any spread of infections.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to implement an ongoing resident-centered activities program that incorporated the resident's interests for one (1) of seventeen (17) sampled residents, Resident #22. Findings included: A review of the facility's policy titled "Activity Program," dated 1/21/22, revealed: " ...An ongoing program of activities is designed to meet the needs of each resident ... Policy Interpretation and Implementation 1. Our activity program is designed to encourage restoration to self-care and maintenance of normal activity which is geared to the individual resident's needs. 2.	F 679		7/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

(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 679	Continued From page 10	F 679		

Activities are scheduled daily ... 3. Our activity program consists of individual, and small and large group activities which are designed to meet the needs and interests of each resident ... 7. Residents are encouraged, but not forced, to participate in scheduled activities ..."

A review of the facility's document titled "Resident Behavioral Objectives," undated, revealed: " ...Stimulate resident curiosity and alertness through meaningful activities ..."

On 6/16/25 at 1:32 PM, during an observation on the 200 Hall, Resident #22 was observed sitting in her room with her chair facing the window. She was confused and unable to speak but attempted to smile and express words. There were no organized activities occurring at the time.

On 6/16/25 at 1:38 PM, during an observation, a daily activity schedule was posted, listing "rest and digest" at 1:00 PM and "group activity and snacks" at 2:00 PM. However, there was another activity calendar, a monthly calendar for June 2025 that indicated "ball toss" was scheduled at 10:00 AM and "bowling" at 2:00 PM. These calendars were located at the station on the hall.

On 6/17/25 at 2:01 PM, during an observation in the main dining room, several residents were participating in a bowling activity. The monthly calendar for June that was posted indicated "movie and popcorn" at 10:00 AM and "Bingo" at 2:00 PM.

On 6/17/25 at 2:16 PM, during an observation, Resident #22 was observed sitting in her chair in her room, almost asleep, and smiled when spoken to.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

(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 679	Continued From page 11	F 679		

On 6/17/25 at 2:30 PM, during an observation on the 200 Hall, three (3) staff were sitting with residents in the common area. A snack tray with lemonade and water and boxed snack cakes was observed at the nurse's station. No activities were occurring.

On 6/17/25 at 2:40 PM, during an interview with Certified Nurse Aide (CNA) #3, she stated there was no set activity schedule on the hall. She explained the three (3) CNAs "just wing" activities and Resident #22 rarely comes out of her room or participates. CNA #3 added that when the resident's family visits, they may take her outside, but this is not often, and no daily routine is followed.

On 6/17/25 at 2:50 PM, during an interview with CNA #4, she stated she had done puzzles and coloring activities earlier and had taken some residents to the theater room for popcorn. She confirmed that Resident #22 did not participate in those activities.

On 6/17/25 at 2:55 PM, during an interview with CNA #5, she stated that although most staff on the unit were consistent and tried to provide activities daily, there was no consistent activity schedule followed. She stated some residents participate in facility-wide activities, but Resident #22 does not, unless accompanied by family.

On 6/18/25 at 7:30 AM, during an observation, Resident #22 was observed dressed and sitting in a bedside chair facing the window.

On 6/18/25 at 10:00 AM, during an observation, Resident #22 remained in her room, with no staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

(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 679	Continued From page 12	F 679		

interaction observed. Six (6) residents were in the common area. At 10:06 AM, CNA #3 initiated ring toss with residents. Another CNA was giving a shower, and the third CNA was off the unit. Resident #22 remained in her room, uninvolved. The posted schedule listed "group activity/devotion" at 10:00 AM, while the main activity schedule listed "card games."

On 6/18/25 at 11:05 AM, during an observation, six (6) residents were watching TV with CNA #3. Licensed Practical Nurse (LPN) #2 entered to perform a blood sugar check. Resident #22 remained in her room with no staff interaction observed. During an interview, LPN #2 stated she did not stay on the unit and rarely saw Resident #22 involved in activities.

On 6/18/25 at 11:55 AM, during an observation, Resident #22 was assisted to the dining room. At the nurse's station, three different activity schedules were observed. CNA #3 stated she was unsure why there were multiple colors and thought they were just for decoration. She said the schedules were for ideas and were not followed or updated.

On 6/18/25 at 2:20 PM, during an observation, Resident #22 remained in her room while three (3) CNAs were in the common area with other residents.

On 6/18/25 at 3:15 PM, during an interview with CNA #6, she stated she worked the 200 Hall evening shift with three (3) CNAs. She said the nurse checks in periodically. Resident #22 comes out occasionally but mostly stays in her room watching TV. CNA #6 stated there was no set evening activity schedule.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255340	A. BUILDING _____ B. WING _____	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	211 WINDMILL DRIVE MERIDIAN, MS 39305

(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 679	Continued From page 13	F 679		

On 6/19/25 at 10:23 AM, during an interview with the Director of Nursing (DON), she stated Resident #22 had experienced a decline and was less active. She acknowledged not being aware that Resident #22 had no activity interaction and stated staff were expected to encourage interactions. The DON acknowledged that residents with dementia need consistency and confirmed that several daily schedules were available on the unit and expected to be followed to promote interaction.

On 6/19/25 at 12:20 PM, during an interview with the Administrator, she stated her expectation was for all residents to have the opportunity and encouragement to participate in scheduled activities.

A record review of the "Admission Record" revealed the facility admitted Resident #22 on 3/4/25 with diagnoses including Unspecified Dementia.

A record review of the "Admission Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 3/11/25 revealed Section B0700 indicated the resident rarely or never had the ability to express ideas or wants and only sometimes understood others. Section C revealed a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident's cognition was severely impaired. Section F noted that very important activities included having books, newspapers, and magazines to read, listening to music, and going outside for fresh air when weather permitted. Other somewhat important preferences included being involved in group activities and doing favorite pastimes.

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	255340	A. BUILDING _____ B. WING _____	06/19/2025

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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 and staff interview, and facility policy review the facility failed to ensure a dietary staff member wore a hair restraint (beard) while checking food temperatures and preparing meal trays in the food service area, during one (1) of two (2) kitchen observations. Findings included: A review of the facility's document titled "Personal Hygiene," dated 2010, revealed, "Hair Care. Hair completely restrained including beard restraints..." On 6/17/25 at 10:50 AM, during an observation and interview in the kitchen, the Certified Dietary	F 812		7/26/25

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F 812	Continued From page 15 Manager (CDM), who had a beard and mustache, was observed checking food temperatures and preparing resident trays in the food service area without wearing a beard restraint. The CDM acknowledged he was not wearing a hair restraint for his facial hair while handling the food. He confirmed that failing to cover facial hair could result in physical contamination of food. He stated he would begin wearing his beard restraint whenever handling food. On 6/19/25 at 7:50 AM, during an interview with the Administrator, she acknowledged the CDM had not been wearing a beard restraint while in the food service area. The Administrator stated she was aware that the CDM did not wear a hair restraint when checking the food temperature and preparing meal trays and she expected all dietary to wear hair restraints as required.	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	F 880		7/26/25

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F 880	Continued From page 16	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or 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.

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F 880	Continued From page 17	F 880		

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility policy review, the facility failed to follow Enhanced Barrier Precautions (EBP) when a Certified Nurse Aide (CNA) did not wear a gown while providing incontinent care for one (1) of two (2) residents reviewed for care, Resident #2.

Findings included:

A review of the facility's policy titled "Enhanced Barrier Precautions," revised 8/7/24, revealed, " ...It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). Definitions: 'Enhanced barrier precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and gloves use during high contact resident care activities ...Policy Explanation and Compliance Guidelines ... 2. Initiation of Enhanced Barrier Precautions: a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC (Centers for Disease Control) ...4. High-contact resident care activities include: ...d. Providing

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F 880	Continued From page 18	F 880		

hygiene ...f. Changing briefs or assisting with toileting ..."

On 6/18/25 at 9:55 AM, during an observation, CNA #2 provided incontinent care to Resident #2, who was incontinent of bowel and bladder. CNA #2 did not wear a gown during the care.

On 6/18/25 at 11:50 AM, during an interview with CNA #2, she confirmed that the green sticker by the resident's name indicated EBP. She acknowledged that she did not wear a gown or gloves during the care and confirmed that Personal Protective Equipment (PPE) was required to protect the resident from infection.

On 6/18/25 at 12:05 PM, during an interview with Licensed Practical Nurse (LPN) #1, she explained that the facility continued EBP for Resident #2 due to a history of frequent urinary tract infections with ESBL (Extended Spectrum Beta-Lactamase). She reported that staff had been educated and had completed incontinence care check-offs. She stated staff were expected to follow EBP at all times when providing care.

On 6/19/25 at 11:20 AM, during an interview with the Director of Nursing (DON), she stated she expected all staff to follow EBP as ordered to protect both the resident and staff from the spread of infection.

A record review of Resident #2's "Admission Record" revealed the facility admitted the resident on 4/7/22 with current diagnoses including Chronic Obstructive Pulmonary Disease.

A record review of the "Order Summary Report" with active orders as of 6/18/25 revealed a

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F 880	Continued From page 19 Physician's Order, dated 5/20/25, for Enhanced Barrier Precautions (EBP) related to a history of ESBL resistance infection. A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/11/25 revealed Section H indicated the resident was always incontinent of bowel and bladder.	F 880		