STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 000	Initial Comments The State Agency (SA) conducted an annual licensure survey at the facility on 9/22/25 through 9/24/25 and found that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and deficiencies were cited at M500, M610, and M640. At the time of the survey, the facility had a census of 122 and held a license for 125 beds.	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 medical record), is afforded the opportunity to	M 500		

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M 500	Continued From page 1	M 500		

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 facility accept his written delegation of this

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M 500	Continued From page 2 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 unopened, unless medically contraindicated (as	M 500		

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M 500	Continued From page 3 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, record reviews, and facility policy review, the facility failed to ensure that residents had coffee served with their breakfast meal for three (3) of the twenty-four sampled residents. Resident #7, Resident #8 and Resident #9	M 500		

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M 500	Continued From page 4 Findings include Review of facility policy titled "Resident Rights" with a review date of May 13, 2022, revealed, "The resident has the right to exercise his or her rights as a resident of the facility ...under Purpose: ...It is the responsibility of the Proper name of the facility Affairs board to protect and promote the rights of each resident." RESIDENT #7 During an interview on 9/22/25 at 11:50 AM, Resident #7 revealed he doesn't get coffee on his breakfast tray when he eats in his room. He revealed that he had asked for coffee with his breakfast every morning when he came to the facility and stated, "I may have gotten a cup once, so I just quit asking about it and started going to the dining room in the morning and having coffee." He revealed I sometimes eat breakfast in my room, but we don't get coffee on our breakfast tray, because they have to pass the trays first and they don't put coffee on the trays. Record review of "Resident Face Sheet" revealed Resident #7 was admitted to the facility on 1/10/2024 with diagnoses that included a Personal history of Transient Ischemic Attack (TIA) and Cerebral Infarction without residual deficits. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/15/2025, Section C revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #7 is cognitively intact. RESIDENT #8	M 500		

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M 500	Continued From page 5 An interview on 9/23/25 at 8:30 AM, with Resident #8 he stated, "Ma'am, could you please get me a cup of coffee, cream, and sugar?" He revealed that he doesn't get coffee with his breakfast, so I guess I have to ask someone for it. The resident was observed sitting in his room eating his breakfast. An interview on 9/23/25 at 8:33 AM, with Licensed Practical Nurse (LPN) #2, revealed that coffee does not come on the breakfast trays, the shower team usually comes around after the breakfast trays are already passed out, and then passes out the coffee. She revealed they hadn't gotten around to it yet this morning, I guess. During an interview on 9/23/25 at 8:38 AM, Certified Nurse Aide (CNA) #1 confirmed that the coffee is not sent out with the breakfast meal, the kitchen will send out a separate gray cart that has a carafe of coffee, and the cups will be on the cart as well. CNA #1 revealed we then go down the hall and pass out the coffee and stated, "I think they have just been busy in the kitchen, and it is probably just human error that they have been forgetting to send the cart out." In an interview on 9/23/25 at 8:55 AM, the Dietary Manager revealed the kitchen staff do not take coffee out to the residents on the hall, nor do we send a cart. She revealed that it is up to the nursing staff, I'm not sure if it is nurses or CNAs who come and get the coffee for the residents on their individual halls. She revealed she is unsure why coffee is not sent out with breakfast meals, but that is how it has always been done since she started working over a year ago. Record review of "Resident Face Sheet" revealed	M 500		

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M 500	Continued From page 6	M 500		

Resident #8 was admitted to the facility on 9/18/2025 with Diagnoses that included abnormal weight loss and anxiety disorder.

RESIDENT #9

Interview on 9/22/25 at 11:10 AM, Resident #9 stated, "I don't get coffee with my breakfast, they bring me my breakfast tray, and it will have orange juice and milk on the tray, but no coffee. I'm a coffee drinker and I want coffee each morning. When I ask for a cup of coffee, the aide says we have to pass the breakfast trays first, and then I'll get you some coffee. I still haven't had any coffee yet today."

An observation and interview on 9/23/25 at 8:20 AM revealed Resident #9 sitting on the side of the bed and revealed he did not get a cup of coffee with his breakfast tray this morning.

Record review of "Resident Face Sheet" revealed Resident #9 was admitted to the facility on 2/20/2025 with diagnoses that included Type 2 Diabetes Mellitus and Parkinsonism.

Record review of the MDS with an ARD of 8/13/2025 Section C revealed a BIMS score of 13, which indicated Resident #9 is cognitively intact.

In an interview on 9/23/25 at 9:50 AM, the Director of Nurses (DON) revealed that if coffee is on their breakfast meal ticket, they should receive it with that meal. She confirmed it's the residents' right to have coffee with their breakfast without having to ask for it continually, and it should be available and given to them with their meal.

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M 610	Continued From page 7	M 610		
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 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: Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to ensure residents received assistance with Activities of Daily Living (ADL) to maintain their highest practicable well-being as evidenced by dirty, long, and jagged fingernails for four (4) of 24 sampled residents. Residents #9, #10, #11, and #24 Findings include: Review of the facility policy titled, "Bath, Bed" undated, revealed, "Care of fingernails and toenails is part of the bath. Be certain nails are clean." ..." Check care plan for specifics regarding nail care, i.e., podiatrist or licensed nurse may need to do this." RESIDENT #9 An observation and interview on 9/22/25 at 11:05 AM, revealed Resident #9's fingernails to be approximately ½ (one-half) inches long and	M 610		

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M 610	Continued From page 8	M 610		

jagged past the tips of the fingers. Resident #9 stated, "My nails need to be clipped. When I got a shower the last time, the girl said I needed my nails clipped because they were getting long, but they haven't been trimmed yet."

During an interview on 9/23/25 at 1:35 PM, Registered Nurse (RN) #1 revealed that any nurse can trim the non-diabetic residents' fingernails, but only the RN's can do the diabetic residents' nail care. RN #1 confirmed Resident #9's fingernails were long and had some jagged areas and it could put him at risk for a skin tear.

In an interview on 9/24/25 at 10:50 AM, the nursing consultant revealed that the RN's are responsible for doing nail care for diabetic residents monthly and as needed. She revealed each resident is to be adequately groomed, which includes having clean and trimmed nails.

Record review of Resident #9's Care Plan revealed, under skin, that the resident "is at risk for impaired skin integrity related to (r/t) decreased mobility, fair skin turgor, and other risk factors. Under Approach, Keep fingernails/toenails clean, neat and trimmed. RN to trim fingernails and toenails monthly and PRN (as needed) may perform on any day of the month."

Record review of "Resident Face Sheet" revealed Resident #9 was admitted to the facility on 2/20/2025 with diagnoses that included Type 2 Diabetes Mellitus and Parkinsonism.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/2025 Section C revealed a Brief Interview for Mental Status (BIMS) score of 13, which

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M 610	Continued From page 9 indicated Resident #9 is cognitively intact. RESIDENT #10 On 9/22/25 at 11:55 AM and again on 9/23/25 at 1:00 PM, an observation revealed that Resident 10's fingernails on both hands were approximately ½ inches long and jagged, with a dark brown substance underneath them. On 9/23/25 at 1:20 PM, an interview was conducted with Licensed Practical Nurse (LPN) #1, who was assigned to the resident on this date. LPN #1 stated that nursing staff are responsible for providing the resident's nail care. She acknowledged the resident's fingernails were dirty and required cleaning and trimming. LPN #1 further stated that with the resident's fingernails being jagged and unclean, there is an increased risk of the resident sustaining a skin tear and developing an infection. Record review of Resident #10's Care Plan revealed, under skin, the resident "is at risk for impaired skin integrity r/t decreased mobility, fair skin turgor, and other risk factors. Under Approach, Keep fingernails/toenails clean, neat and trimmed. Record review of "Resident Face Sheet" revealed Resident #10 was admitted to the facility on 3/25/2025 with diagnoses that included Hypertensive heart and chronic kidney disease with heart failure, and Chronic Obstructive Pulmonary Disease. Record review of the MDS with an ARD of 9/10/2025 Section C revealed a BIMS score of 10, which indicated Resident #10 had a moderate cognitive impairment.	M 610		

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M 610	Continued From page 10 RESIDENT #11 On 9/22/25 at 11:10 AM and again on 9/23/25 at 11:00 AM an observation and interview of Resident #11 revealed his fingernails were one-eighth (1/8) inch in length, jagged with a brown substance underneath and Resident #11 stated he would like his nails to be trimmed. An interview with LPN # 2, she confirmed that Resident #11 had a brown substance under his long nails. LPN #2 confirmed his nails needed cleaning and cut and indicated the nurses were responsible for trimming his nails because he was a diabetic. An observation of Resident #11's nails and interview with the Director of Nursing (DON) on 9/24/25 at 8:40 AM, she confirmed his long and dirty nails and stated it could cause a break in his skin, and it could lead to infection. The DON stated that her expectation is for staff to keep resident nails trimmed and clean. Review of the "Resident Face Sheet" revealed that the facility admitted Resident #11 on 11/25/24 with a medical diagnosis that included type 2 diabetes mellitus with hyperglycemia. Record review of the MDS with an ARD of 9/18/25 revealed under Section C, a BIMS summary score of 13 which indicated Resident #11 was cognitively intact. RESIDENT #24 During an observation and interview on 9/22/25, at 11:26 AM with Resident #24 revealed, fingernails were approximately one (1) inch in length. Resident #24 expressed a preference for shorter nails and indicated a willingness to have	M 610		

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M 610	Continued From page 11 staff assist in trimming them. During an observation and interview on 9/23/25, at 12:38 PM with LPN #3, she confirmed that Resident #24's fingernails were indeed very long and required trimming. LPN #3 noted the potential risk for the resident to scratch himself, which could lead to open areas on the skin and increase the risk of infection. Record review of the "Resident Face Sheet" revealed Resident #24 was admitted to the facility on 4/2/25 with medical diagnoses that included Parkinsonism. Record review of the quarterly MDS with an ARD of 8/6/25 revealed, under Section C a BIMS score of 14, which indicated the resident was cognitively intact.	M 610		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to ensure chemicals were securely stored on a housekeeping cart on B Unit for one (1) of five (5) halls observed during the survey. Findings Include:	M 640		

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M 640	Continued From page 12 Review of the facility policy titled "Housekeeping Department" revised 3/18/22 revealed under, "2. General: The (proper name of the facility) has a housekeeping department designated to maintain a safe and clean environment for the residents and staff of the facility." An observation on Unit B on 9/22/25 at 10:55 AM revealed a housekeeping cart that was unlocked and contained multiple bottles of cleaning solutions. Housekeeping Staff #1 was inside a resident's room mopping the floor, out of sight of the cart. Further observation revealed the unlocked cart contained liquid Clorox Clean-Up disinfectant, Profect HP disinfectant, liquid glass cleaner, liquid Clorox disinfectant spray, liquid toilet bowl cleaner, Liquid Enzyme II, liquid Pine-Sol, and Caviwipes. An observation and interview with Registered Nurse (RN) #2 on 9/22/25 at 10:59 AM confirmed the housekeeping cart with chemicals was unlocked. She stated for the safety of all residents, the cart should always be locked so residents cannot access items that could be hazardous to them. An interview with Housekeeping Staff #1 on 9/22/25 at 11:08 AM revealed she had been employed at the facility for about two (2) months. She stated she had been trained to keep the housekeeping cart locked so residents would not have access to the chemicals and that she just failed to do that while she was in a room cleaning.	M 640		