STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PONTOTOC NURSING HOME	**176 SOUTH MAIN STREET , PONTOTOC, Mississippi, 38863**

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M0000	Initial Comments The State Agency (SA) conducted an annual re-certification survey with one (1) complaint investigation (CI) MS # 505265, at the facility from 7/21/25-7/24/25. During the survey, the SA determined the facility was not in compliance with Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M610 and M615. There were no deficiencies cited for CI MS# 29409 related to resident-on-resident abuse. The census at the time of the survey was 42 and the facility is licensed for 44 beds.	M0000		08/07/2025
M0610	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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review the facility failed to provide Activities of Daily Living (ADL) care for three (3) of 42 residents observed during the initial tour related to nail care for Resident #17 and failed to shave Residents #1 and #30. Findings Include:	M0610	Corrective action: Resident #1 was shaved on 7/23/2025 at 08:01 am leaving his mustache per his request. Nail care including cleaning, trimming and filing was performed for Resident #17 per her request on 07/23/2025. Resident #30 was shaved on 7/23/2025 by the CLPN upon his request leaving a mustache and goatee. All residents were assessed by the Director of Nursing (DON), Administrator and Administrative Assistant for shaving and nail care on 7/23/2025. Identifying other residents: All other dependent residents were found to have the potential to be affected. Measures put into place: All residents were assessed by the Director of Nursing (DON), Administrator and Administrative Assistant for shaving and nail care on 7/23/2025. The Director of Nursing (DON), Administrator and Administrative Assistant provided shaving education and	08/12/2025

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

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M0610	Continued from page 1 The facility provided a statement on letterhead signed by the Director of Nursing that revealed, “(Proper name) of the facility does not have a personal hygiene policy.” Review of the facility policy titled, "Nails, Care of," last revised 08/06/24, revealed: “Policy: It is the policy of 'Proper Name' Nursing Home that nails should be properly cared for..." Resident #1 On 7/21/2025 at 11:18 AM, an observation and interview with Resident #1 revealed he had black and gray facial hair approximately 1/4 (one-fourth) inch in length and stated he wanted to be shaved but preferred to keep his mustache. An interview with Certified Nurse Aide (CNA) #5 on 7/22/2025 at 10:36 AM revealed Resident #1 should be shaved every time he received a bath. She stated it was the shower aide’s responsibility to ensure this was done and confirmed the resident needed shaving. An interview with the Director of Nursing (DON) on 7/22/2025 at 10:40 AM revealed that male residents were to be shaved once weekly or as requested. She confirmed that Resident #1 was unshaven and acknowledged that this gave him an untidy appearance. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/18/25 revealed Resident #1 required substantial/maximal assistance with personal hygiene, including shaving. Record review of the “Demographics” revealed the facility admitted Resident #1 on 4/14/25 with a medical diagnoses including Unspecified Dementia. Record review of Resident #1’s “Flowsheet History” dated 7/18/25 revealed a Brief Interview for Mental Status (BIMS) summary score of 3, indicating the resident was severely cognitively impaired. Resident #17 An observation on 7/21/25 at 10:30 AM revealed Resident #17's nails were approximately 1/2 inch long and jagged in appearance. Resident #17 stated she could not remember the last time her nails were trimmed but stated she would like them trimmed. An observation of Resident #17's nails with CNA #1 on 7/22/25 at 10:28 AM revealed the resident's nails were	M0610	Continued from page 1 communicated documentation instructions and responsibilities to all direct care staff. The shaving education and documentation communication included the following: Resident’s ADL needs are included in their plan of care. Each resident’s plan of care can be found at the nurses’ desk available to all caregivers. Each resident’s plan of care is individualized. During resident’s Bath times, male residents should be offered shaving. This usually occurs three times weekly as communicated by each resident and care planned accordingly. It is important and your responsibility to document bathing and shaving in a resident’s medical recorded especially if a resident refuses care. If a resident does have a preference which differs from their plan of care the nurse should be notified for care plan updates. For instance: If Mr X is scheduled a bath three times a week and usually only wants to be shaved on Wednesdays, you should still offer shaving on all bath days and document “refused” as it applies. Shaving documentation should occur on the resident’s flowsheet. Access the Daily Cares flowsheet Open Hygiene tab Shower needs- click in the time column space giving you a shaving selection. Upon selecting shaving, click the comments icon and type refused in the comments section. All Education was completed by 8/12/2025. Signatures were required for proof of attendance. Attachment 1: ADL performance and documentation education (pg. 2-4) The Director of Nursing (DON), Administrator and	

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M0610	Continued from page 2 long and jagged. CNA #1 confirmed the nails needed to be trimmed. An observation on 7/22/25 at 10:30 AM with Registered Charge Nurse #1 revealed Resident #17's nails were long and jagged and needed to be trimmed. She stated it was her responsibility to trim the nails but confirmed she had not gotten around to it. She stated a concern with the resident's nails not being trimmed was that the resident could scratch herself. Record review of the "Demographics" for Resident #17 revealed the facility admitted the resident on 1/15/22 with a diagnosis of hemiplegia affecting the left side as a late effect of cerebrovascular accident. Record review of Resident #17's BIMS, dated 7/11/25, revealed a score of 15, indicating the resident was cognitively intact. Review of Section GG of the MDS – Functional Abilities, dated 7/11/25, revealed a code of 03 which indicated Resident #17 required partial/moderate assistance for personal hygiene. Resident #30 During an observation and interview on 7/21/2025 at 12:23 PM with Resident #30 revealed that he had facial hair measuring one-half to one inch on his cheeks, chin, upper lip, and neck. During the interview, Resident #30 stated, "I cannot shave myself and I would like to be shaved, but (Proper Name of CNA#3) doesn't work here anymore, and she was the one who always shaved me." When asked if he would allow someone else to shave him, he agreed that he would. During an interview with CNA#2 on 7/22/25 at 10:43 AM concerning Resident #30, she confirmed that residents are typically shaved on their designated shower days, which for Resident #30 are Tuesday, Thursday, and Saturday nights. However, when the medical record was reviewed with CNA #2, it was noted that there was no documentation regarding personal hygiene, specifically shaving, for Resident #30. During an interview on 7/22/25 at 11:00 AM with the DON, she validated that it is standard practice for residents to be shaved during shower days. An interview with the MDS Coordinator at 12:41 PM on 7/22/25 confirmed that while Resident #30 was capable of taking showers independently with supervision, he has not been shaved in quite some time. The MDS	M0610	Continued from page 2 Administrative Assistant provided education and communicated documentation responsibilities to all licensed staff referencing the facility's Nail Care Policy (Attachment 3) The education and communication included the following: Nail Care policy and procedure (Attachment# 3) reviewed for licensed staff responsibilities. Nail Trimming, Nail filing should be scheduled in the electronic medical record in the Worklist Tasks tab. The responsible licensed staff member should complete the task then document the task accurately. If a resident should refuse nail care or a family member provides nail care this should be documented in a nurse's note. All measures put into place and education completed 8/12/2025. Attachment 3: Nail Care Policy Attachment 5: Nail Care Responsibilities Monitoring for sustained solutions: The Director of Nursing or Charge Nurse will perform monthly audits for completion of shaving and nail care to ensure solutions are sustained. The audits will occur monthly for year 2025 then quarterly for year 2026 will include the following: Visualization of 10 random residents monthly auditing for: Shaving completed during bathing Shaving documentation accuracy Nail care performance including cleaning, trimming, and filing Accuracy of nail care performance All residents were assessed by the Director of Nursing	

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M0610	Continued from page 3 Coordinator acknowledged that CNA#3 typically performed the shaving tasks but is currently on educational leave. She stated that the CNA's responsible for showering residents should have offered to shave Resident #30 during those times. She further confirmed there was no documentation indicating that Resident #30 had refused to be shaved. A record review of Resident #30's Demographics revealed that the resident was admitted to the facility on 6/9/23, with diagnoses that included Parkinson's Disease. A record review of Resident #30's Flowsheet History revealed a BIMS Summary Score of 13 dated 5/30/25, which indicated that the resident was cognitively intact.	M0610	Continued from page 3 (DON), Administrator and Administrative Assistant for shaving and nail care on 7/23/2025. The Director of Nursing (DON) will complete the next audit on 8/8/2025. The completed monthly audit will be reported to the QA Attachment 4: Nail Care/Shaving Audit PI committee starting on 8/12/2025 continuing to be reported monthly to the committee throughout 2025 and 2026.	
M0615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to assess and implement timely interventions to address skin integrity concerns, resulting in progression of a pressure injury and delayed wound healing for one (1) of three (3) residents reviewed for pressure ulcers. Resident #6 Findings include: Review of the facility policy titled "Assessment and Reassessment of Patients" with a revision date of 5/12/25 revealed under, "Policy: It is the policy of (proper name of facility) that patients should be properly assessed and reassessed." Also revealed under, "Procedure: … 6. Wound assessments and measurements should be performed at start of care, resumption of care, and recommended weekly. Reassessment should be performed any time there is a significant change noted..." Record review of Resident #6's hospital "Integumentary Flowsheet History" revealed documentation on 3/7/25 of deep tissue injury (DTI) left heel.	M0615	Corrective action: The facility was unable to accomplish a corrective action for Resident #6 as the finding occurred in the past. On 7/24/2025 the Administrator, the Director of Nursing, the Charge Nurse, and MDS Coordinator completed a skin Audit for each resident assessing for the presence of skin breakdown, previous identification of skin breakdown, accurate documentation, wound treatment intervention, and care planning. Identifying other residents: Dependent bed-bound residents were identified as having the potential to be affected upon hospital return. Measures put into place: Measure 1: Review of Facility Policy On 7/24/2025, the Administrator and Director of Nursing reviewed the following facility policies and determined the facility does have assessment, intervention, and documentation policies consistent with professional standards of practice to prevent pressure ulcers: Assessment and Reassessment Documentation: Resident Care	08/12/2025

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M0615	Continued from page 4 An interview with the Director of Nursing (DON) on 7/24/25 at 9:20 AM revealed Resident #6 transferred to the hospital on 3/1/25 and returned on 3/9/25. Record review of the "Nursing Note" for Resident #6, dated 3/9/25 revealed, "Resident returned from "proper name" of hospital around 10 AM." There was no documentation regarding any skin concerns. Record review of Resident #6's body audits conducted on 3/9/25, 3/10/25, 3/13/25, 3/14/25, 3/15/25 revealed scattered bruising, no abrasion, no blister, no excoriation. There was no documentation on the left heel. Record review of Resident #6's body audit conducted on 3/16/25 revealed, "Unstageable pressure injury to left posterior heel, dark purple, dry, hard, closed, without pain. Measures 4.5 x 2.2 x 0." Record review of Resident #6's wound care "Work List Task Details" revealed an order dated 3/16/25, "Unstageable pressure injury to left, posterior heel. Clean with betadine and leave OTA (open to air) daily at 10:00 AM." Record review of Resident #6's "Integumentary Flowsheet History" dated 7/15/25 revealed, "Redness to buttocks." Record review of Resident #6's "Wound History" dated 7/17/25 revealed, "Sacrum stage III pressure wound, red, slightly moist measuring 1.8 cm (centimeters) x 0.5 cm (centimeters) x 0.1 cm (centimeters) full thickness tissue loss with slough. Record review of Resident #6's wound care "Work List Task Details" revealed an order dated 7/17/25, "Cleanse stage III pressure ulcer to sacral area with NS (normal saline) or DWC (dermal wound cleanser), pat dry with 4 x 4 gauze, apply collagen with silver, cover with dry dressing. Change T (Tuesday)/Th (Thursday)/Sat (Saturday) and prn (as needed)." An interview with the Director of Nursing (DON) on 7/23/25 at 11:12 AM confirmed Resident #6 developed a pressure injury on her left heel while in the hospital, and the wound was not identified in the facility until eight days later, at which point it had progressed to an unstageable pressure injury. She revealed it would have been the charge nurse's responsibility to assess the resident's skin on readmission and then weekly thereafter. She confirmed there were no interventions implemented when the resident returned to address the skin concern. The DON explained that after the body	M0615	Continued from page 4 Pressure Ulcer Prevention and Intervention. Measure 2: Staff Education: The following policies included in staff education: Assessment and Reassessment (Attachment 6) Documentation: Resident Care (Attachment 7) Pressure Ulcer Prevention and Intervention. (Attachment 8) Licensed staff education provided by the Director of Nursing started on 8/8/2025 to be completed by 8/12/2025. Measure 3: Staff Education: Professional standards of practice Licensed staff education addressing professional standards of practice assessment and documentation responsibilities. Licensed staff education provided by the Director of Nursing starting on 8/8/2025 to be completed by 8/12/2025. Brief Description of Education: American Nurses Association (ANA) Principles for Nursing Documentation ANA Scope and Standards of Practice Legalities of Nursing Documentation Attachment 10: Nursing Assessment and Documentation Responsibilities Education Monitoring for sustained solutions: The Director of Nursing or Charge Nurse will monitor upon hospital return nurse assessment and documentation compliance within 1 day of return/readmission to ensure the skin assessment, identification of skin breakdown, accurate documentation, intervention, and treatment planning are complete starting 7/25/2025. If not completed by the Director of Nursing, the charge nurse	

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M0615	Continued from page 5 audit conducted on 7/15/25 identified redness to the resident's buttocks, no treatment was initiated. She confirmed interventions should have been implemented. She stated, "I thought we were better than that." She acknowledged that the lack of assessment and follow-through with treatment could have caused both wounds to progress and worsen. An interview with Registered Nurse (RN) #2 on 7/24/25 at 8:30 AM revealed she was the charge nurse working on 3/9/25 when Resident #6 returned from the hospital. She confirmed she did not perform a body audit on readmission and stated, "I don't remember doing one." She explained that on 7/15/25, she assessed the resident's skin and noted redness to the buttocks. She revealed that she applied "pink" cream and a bandage to the area but did not document it or initiate wound care orders. She stated, "As far as why I didn't, I get busy, and it just fell through the cracks." An observation on 7/24/25 at 9:50 AM with Resident #6 during wound care revealed the left heel (unstageable due to eschar) revealed a round eschar covered wound. The wound bed was black; peri wound intact with no redness or irritation. Edges were well defined. The sacral wound (stage III) was oval shaped, yellow adherent slough covered, edges well defined, peri wound without redness or irritation. Record review of the "Demographics" revealed the facility admitted Resident #6 on 2/13/25 with diagnoses including Dementia with Anxiety. Record review of the "Flowsheet Data" dated 5/16/25 revealed a Brief Interview for Mental Status (BIMS) summary score of 6, indicating Resident #6 was severely cognitively impaired.	M0615	Continued from page 5 will provide this monitoring in writing to the Director of Nursing immediately upon completion. The Director of Nursing will provide this monitoring to the QAPI committee monthly throughout 2025 and 2026 to ensure nursing assessment, treatment and documentation compliance has been sustained. The Director of Nursing will perform monitoring of the licensed staff weekly body audits to ensure treatments have been initiated as needed and upon each resident's hospital return for the presence of: Skin assessment completed Skin assessment documented accurately If wound identified: wound description, treatment initiation, Care Plan revision all documented accurately. Each audit completed upon every hospital return starting 7/25/2025 will be reported monthly to the facility's Quality Assurance Performance Improvement committee monthly starting on 8/12/2025 to ensure sustained compliance. Weekly body audits will be monitored to ensure treatment is initiated starting on 7/25/2025 and will continue weekly for 2025 and then by auditing 100% of weekly audits identifying a wound monthly for year 2026. The Director of Nursing performed the first skin assessment, wound identification, and documentation audit on 7/30/2025 after a resident's hospital return on 7/29/2025.	