Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER COUNTY NH	**15 A SOUTH SIXTH STREET PO BOX 527, BAY SPRINGS, Mississippi, 39422**

(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
M0000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 10/06/2025 through 10/09/2025. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M610, M735, and M1570.	M0000		
M0500	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 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	M0500		

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

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M0500	Continued from page 1 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 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	M0500		

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M0500	Continued from page 2 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 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	M0500		

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M0500	Continued from page 3 decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from unnecessary medications when a resident received an antipsychotic medication without an appropriate diagnosis and without informed consent, which resulted in lethargy, weight loss, and poor meal intake (Resident #79) and failed to ensure a resident's right to privacy and dignity during medication administration when a Licensed Practical Nurse (LPN) administered prescribed eye drops to a resident (Resident #96) in the dining room while other residents were present, for two (2) of 21 sampled residents. Findings include: A review of the facility's policy titled "…Use of Psychotropic Medication(s)," dated 9/17/25, revealed, "…It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated…" A review of the facility's "…Medication Administration Policy," dated 7/30/25, revealed, "…Policy Explanation and Compliance Guidelines…7. Provide privacy…" Resident #79 During observations on 10/6/25 at 12:15 PM, Resident #79 was observed asleep in her wheelchair in the common area, on 10/8/25 at 1:05 PM, she was observed asleep in her wheelchair and remained asleep until 5:15 PM, and on 10/9/25 at 11:04 AM, she was observed asleep in her wheelchair in the dining area. On 10/8/25 at 4:17 PM, during an interview with Certified Nurse Aide (CNA) #1, she explained that Resident #79 had "good days and bad days," often refusing to eat on her bad days. She stated the resident had been refusing meals that day and was uncooperative, often falling asleep during mealtime. She stated that CNAs typically set up the meal tray and later return to check on the resident. On 10/8/25 at 3:00 PM, during an interview with the Nurse Practitioner (NP), she explained that Resident #79 had lost over fifty (50) pounds in the past year.	M0500		

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M0500	Continued from page 4 She stated Resident #79 often refused meals and care. She stated the resident was prescribed Geodon for psychosis related to combative behaviors but acknowledged that the resident did not have a diagnosis of Bipolar Disorder or Schizophrenia. She added that she had intended for the medication to be prescribed as needed (PRN) rather than scheduled daily. She stated that weight loss and lethargy could be side effects of the medication. On 10/8/25 at 3:30 PM, during an interview with the Director of Nursing (DON), she stated that psychosis was listed in the resident's medical history but acknowledged that it was not an approved indication for Geodon use. She confirmed that while the resident had a history of behaviors, the behavior documentation for the past month did not reflect any recorded behaviors. On 10/8/25 at 5:10 PM, during an interview with Licensed Practical Nurse (LPN) #3, she stated that Resident #79 often slept through meals and that it was difficult to get her to eat due to combativeness. She stated that CNAs had reported the resident's sleepiness and that she had reported these observations to her supervisor. She added that Resident #79 sometimes refused medications or slept through medication passes. On 10/9/25 at 10:00 AM, during an interview with Registered Nurse (RN) #2, Medical Records Nurse, she explained that the facility was unable to provide a signed consent for antipsychotic medication for Resident #79. She stated that Geodon was started in June 2024, prior to the facility's implementation of the consent process for antipsychotic use. She further explained that the medication was prescribed for psychosis, which was not an approved indication for use. She confirmed that the facility did not retroactively seek consent from the resident's representative or family after the regulation regarding consents for psychotropic medications went into effect. On 10/9/25 at 10:30 AM, during an interview with the Administrator and the DON, they stated it was their expectation that residents would be free from unnecessary medications and that medications would be administered only for appropriate diagnoses. A record review of Resident #79's "Admission Record" revealed the facility admitted the resident on 10/17/23 with current diagnoses including Dementia. A record review of the "Order Summary Report" revealed Resident #79 had a Physician's Order, dated 1/8/25 for "Ziprasidone (Geodon) HCL Cap (Capsule) 20 MG	M0500		

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M0500	Continued from page 5 (Milligrams) Give 1 capsule by mouth at bedtime related to Unsp (Unspecified) psychosis not due to a substance or known physiological cond (condition)…." A record review of Quarterly Minimum Data Set (MDS) with an Annual Assessment Reference Date (ARD) of 8/19/25 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated her cognition was moderately impaired. A record review of the "Amount Eaten" from 9/11/25 through 10/8/25 revealed the staff documented that Resident #79 refused her meal 38 times during the month. A record review of the "Behavior Monitoring and Interventions Report" Log" from 9/8/25 through 10/8/25 revealed there were no documented behaviors for Resident #79. A record review of the "Vital: Weight" log for Resident #79 revealed that she weighed 214.2 pounds on 10/1/24 and 159.2 pounds on 10/1/25, which was a total of 55 pounds and 25.7 percent total weight loss in twelve (12) months. A record review of the "RD (Registered Dietician) Assessment Summary," dated 10/7/25 revealed Resident #79 the "Reason for Assessment" was "SWLX30/90/180 (Significant Weight Loss times 30/90/180 days) and included "Observations/statements from chart/staff/resident. Assessment due to weight loss…Needs cueing r/t (related to) falling asleep while eating…" A record review of the "Psych (Psychiatric) Progress Note" dated 9/25/25 revealed Resident #79's medication included Geodon 20 mg and the "Case Conceptualization" revealed, "Chart indicates poor appetite and ongoing wt (weight) loss…" Resident #96 On 10/7/25 at 8:37 AM, during an observation, LPN #1 administered eye drops to Resident #96 while the resident was in the dining room. At the time of the observation, nine (9) other residents were also present in the dining room. On 10/7/25 at 8:45 AM, during an interview, LPN #1 stated she normally administered medications in the dining room for residents who were present there during the morning medication pass. She reported that Resident #96 had not expressed a problem with receiving eye	M0500		

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M0500	Continued from page 6 drops while in the dining room but acknowledged that privacy could be an issue when given in the presence of other residents. On 10/7/25 at 10:15 AM, during an interview, the Director of Nursing (DON) stated eye drops should not be administered in the dining room in front of other residents. She stated her expectation was that medications such as eye drops be administered in a private setting to ensure resident dignity and privacy. A record review of the “Admission Record” revealed the facility admitted Resident #96 on 3/11/24 with current diagnoses including Pulmonary Fibrosis. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/26/25 revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident’s cognition was moderately impaired. A record review of the “Order Summary Report” revealed Resident #96 had a physician’s order, dated 8/27/24, for Artificial Tears eye drops.	M0500		
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, interviews, record review, and facility policy review, the facility failed to provide shaving for residents who were dependent on staff for Activities of Daily Living (ADLs) for two (2) of (21) sampled residents, Residents #6 and #11. Findings include:	M0610		

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M0610	Continued from page 7 A review of the facility's "Shaving Policy," (undated) revealed, "It is the policy of this facility that male residents will be shaved as follows: – Encouraged to be shaved daily and as needed …" Resident #6 A record review of the "Admission Record" revealed the facility admitted Resident #6 on 2/13/23 with diagnoses including Alzheimer's Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/9/25 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident's cognition was moderately impaired. Section GG revealed Resident #6 had limitations in range of motion in both lower extremities and was dependent on staff for bathing and personal hygiene. A record review of the facility's "Bath Schedule – Group C" revealed Resident #6 received a pan bath daily on the night shift. On 10/6/25 at 10:44 AM, during an observation and interview, Resident #6 was lying in bed with long facial hair. He stated that staff were responsible for shaving him, but he had not been shaved in a long time and wished to be shaved. On 10/7/25 at 12:32 PM, during an observation, Resident #6 was observed sitting in his wheelchair with long facial hair. On 10/7/25 at 3:00 PM, during an interview with Certified Nurse Aide (CNA) #2, she stated that Resident #6 received a bed bath daily on the evening shift (7:00 PM–7:00 AM) and required total assistance for all ADLs except feeding. She stated the resident was cooperative and never refused care, including baths. CNA #2 stated that shaving was part of the bath or shower routine and should occur daily or at least every other day. She confirmed Resident #6 had long facial hair that appeared not to have been shaved in several days, possibly a week. She reported that Resident #6 preferred to be clean-shaven and that she had shaved him approximately two (2) weeks ago when his facial hair was also long. On 10/7/25 at 3:30 PM, during an interview with Licensed Practical Nurse (LPN) #4, she stated that Resident #6 was cooperative and dependent on staff for all ADLs except feeding. She confirmed the resident received a bed bath nightly, which included shaving.	M0610		

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M0610	Continued from page 8 She stated the resident had long facial hair and that she had not been informed of any refusals. Resident #11 A record review of the “Admission Record” revealed the facility admitted Resident #11 on 12/13/18 with diagnoses including Alzheimer’s Disease. A record review of the Quarterly MDS with an ARD of 8/13/25 revealed a BIMS score of 3, which indicated the resident’s cognition was severely impaired. Section GG revealed Resident #11 had limitations in range of motion in both lower extremities and was dependent on staff for bathing and personal hygiene. A record review of the facility’s “Bath Schedule – Group A” revealed Resident #11 received a pan bath daily on the day shift. On 10/6/25 at 12:11 PM, during an observation, Resident #11 was sitting in her wheelchair with multiple long hairs several inches in length noted on her chin. On 10/6/25 at 12:15 PM, during an interview and observation with CNA #3, she confirmed Resident #11 had long chin hair and that shaving should be completed during showers. She stated the resident received her showers on the evening shift. On 10/7/25 at 12:31 PM, during an observation, Resident #11 was sitting in the dining room with long chin hair visible. On 10/7/25 at 12:35 PM, during an interview and observation with CNA #4, she stated that she worked restorative care and also assisted on the floor as needed. She confirmed that ADL care included bathing, brushing teeth, dressing, and shaving as needed on shower days. She stated Resident #11 had long chin hair that appeared to have been there for some time. On 10/7/25 at 2:20 PM, during an interview and observation with CNA #5, she stated that Resident #11 was totally dependent for all ADLs and was scheduled for showers on the evening shift, which included shaving. She stated the resident was usually cooperative with care, though occasionally confused. She confirmed the resident had long chin hair that appeared to have not been recently shaved. On 10/7/25 at 3:25 PM, during an interview with LPN #4, she stated that Resident #11 received showers on the evening shift and that she had not been informed of any	M0610		

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M0610	Continued from page 9 refusals of care. She stated the resident was confused but easily redirected and cooperative. On 10/8/25 at 8:35 AM, during an observation, Resident #11 was lying in bed and continued to have long chin hair. On 10/8/25 at 9:00 AM, during an observation and interview with the Director of Nursing (DON), Resident #6 was sitting in the dining room eating breakfast. The DON stated that both men and women were expected to be shaved as part of bathing or shower care. She stated that, as a woman, she would not want to have long chin hair and expected staff to shave or pluck such hairs as needed. She confirmed that Resident #6 had long facial hair and stated she would follow up on Resident #11. On 10/9/25 at 1:01 PM, during a follow-up interview with the DON, she confirmed Resident #11 had numerous chin hair and stated she expected staff to provide shaving for all residents as needed to meet each resident's individual needs and ensure quality care.	M0610		
M0735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary,	M0735		

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M0735	Continued from page 10 including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and facility policy review, the facility failed to maintain an accurate resident clinical record related to a physician's order for a resident who was transferred to the hospital for one (1) of 21 sampled residents. Resident #7 Findings include: A review of the facility's "Physician's Orders Policy," revised 8/29/17 revealed "…Reminders…The nurse noting the order is responsible for…Transcribing the orders to the appropriate place…" A record review of the facility's "Admission Record" revealed the facility admitted Resident #7 on 4/23/2019 with current diagnoses including Type 2 Diabetes Mellitus. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/25/25	M0735		

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M0735	Continued from page 11 revealed Resident #7 was transferred from the facility due to a Unplanned discharge to a Short-Term General Hospital on 7/25/2025. A record review of “Progress Notes” revealed Resident #7 had a “Transfer to Hospital Summary” note, dated 7/25/2025, which indicated she had been sent to an acute hospital for further evaluation. A review of the clinical record for Resident #7 revealed there was no Physician’s Order documented related to the 7/25/25 transfer to the hospital. On 10/08/2025 at 11:56 AM, during an interview with the Assistant Director of Nursing (ADON), she acknowledged there was no physician order in the medical record related to Resident #7’s transfer to an acute hospital on 7/25/25. She stated it was the responsibility of the nurse that receives the order to transcribe it and follow it through. On 10/08/2025 at 1:21 PM, during an interview the Director of Nursing (DON), confirmed there was not a physician order in the clinical record for Resident #7 when she was transferred to the hospital on 7/25/25. The DON stated that when a verbal order is received from the physician the nurse must put that information in the computer immediately or as quickly as possible.	M0735		
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	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M1570	Continued from page 12 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow infection prevention and control practices, as evidenced by failure to wear gloves during the administration of eye drops and by placing medication containers on contaminated surfaces without cleaning or using a barrier for two (2) of three (3) residents observed for medication administration (Residents #14 and #96). Findings include: A review of the facility's "…Medication Administration Policy, dated 7/30/25, revealed, "… "Medications are administered by licensed nurses…as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection..." Resident #14 A record review of the "Admission Record" revealed the facility admitted Resident #14 on 11/14/22 with current diagnoses including Unspecified Glaucoma. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/28/25 revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact. A record review of the "Order Summary Report" revealed Resident #14 had a Physician's Order for Combigan Opthalmic Solution 0.2-0.5%, dated 11/14/2022. On 10/7/25 at 8:18 AM, during an observation, Licensed Practical Nurse (LPN) #2 was observed administering medications to Resident #14 during the morning medication pass. LPN #2 administered one (1) drop of eye drops to each of the resident's eyes without wearing gloves. She then placed the plastic medication bag on the resident's bed, retrieved it, and returned it to the medication cart without sanitizing the container.	M1570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/09/2025**

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M1570	Continued from page 13 On 10/7/25 at 8:21 AM, during an interview, LPN #2 stated that gloves should have been worn during eye drop administration to prevent the spread of infection through bodily fluids or potential eye infections such as conjunctivitis (pink eye). She further stated medication containers should not be placed on the resident's bed or returned to the cart without sanitizing. She stated that a barrier, such as a paper towel, should be used between items and contaminated surfaces to prevent infection transmission. Resident #96 A record review of the "Admission Record" revealed the facility admitted Resident #96 on 3/11/24 with current diagnoses including Pulmonary Fibrosis. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/26/25 revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident's cognition was moderately impaired. A record review of the "Order Summary Report" revealed Resident #96 had a physician's order, dated 8/27/24, for Artificial Tears eye drops. On 10/7/25 at 8:37 AM, during an observation, LPN #1 administered eye drops to Resident #96 without wearing gloves. On 10/7/25 at 8:45 AM, during an interview, LPN #1 stated she should have worn gloves while administering eye dops to Resident #96. On 10/7/25 at 10:15 AM, during an interview with the Director of Nursing (DON), she stated that any items placed on a resident's bed or bedside table must have a clean barrier and should be sanitized before being returned to the medication cart. She further stated that gloves should always be worn for procedures involving the eyes to prevent the spread of infection.	M1570		