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 **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUNICA COUNTY HEALTH & REHAB, LLC	**1024 HIGHWAY 61 SOUTH , TUNICA, Mississippi, 38676**

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M0000	Initial Comments The State Agency (SA) conducted an annual re-certification survey at the facility from 09/29/25 through 10/01/25. During the survey, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for Aged or Infirm, state licensure requirements and cited M610, M625, M690 and M815.	M0000		
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 ensure fingernail care was provided for one (1) of (53) residents reviewed for activities of daily living (ADLs). (Resident #33). Findings include: Review of the facility policy titled, “Care of Fingernails/Toenails,” last revised October 2020, revealed: “Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.”	M0610		

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

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M0610	Continued from page 1 On 9/29/25 at 10:45 AM, Resident #33's fingernails were observed to be long and dirty. They were approximately ½ inch long past the tips of his finger and had a thick, dark brown substance under the nail beds. During an interview at this time, the resident stated he felt his nails were too long and dirty and reported he had not received any nail care since admission. An observation and interview on 9/30/25 at 1:06 PM with Licensed Practical Nurse (LPN) #1 confirmed Resident #33's fingernails were long with a dark buildup under the beds. She confirmed the nails required attention and stated failure to provide nail care could cause the resident to scratch himself and develop a skin infection. During an interview on 9/30/25 at 1:15 PM, the Director of Nursing (DON) confirmed Resident #33 is a diabetic and his nails should be assessed at least every two weeks by a registered nurse and trimmed as needed. She stated that failure to provide nail care places residents at risk of skin injury and infection. Record review of the "Admission Record" for Resident #33 revealed the facility admitted the resident on 8/26/25 with a diagnosis of Type 2 Diabetes Mellitus. Review of Resident #33's Admission Minimum Data Set (MDS), Assessment Reference Date 9/18/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact, and Section GG0130 (Self-Care) coded 2, partial/moderate assistance.	M0610		
M0625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review the facility failed to ensure that a resident received adequate services to prevent an avoidable decline and the development of a contracture for one (1) of three (3) residents reviewed for range of motion (ROM). Resident #6. Findings included:	M0625		

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M0625	Continued from page 2 Review of the facility policy "Functional Impairment-Clinical Protocol", revised April 2013, revealed "Assessment and Recognition...2.The staff will identify individuals with a significant decline in function, including ability to perform activities of daily living...Treatment/Management...2.In conjunction with the physician and staff, therapist will propose a rehabilitation or restorative care plan that provides an appropriate intensity, frequency and duration of interventions to help achieve anticipated goals and expected outcomes efficiently using available resources..." Review of the facility policy "Range of Motion Exercises", undated, revealed "The purpose of this procedure is to exercise the resident's joints and muscles..." On 9/29/25 at 1:30 PM, Resident #6 was observed lying in bed with her left leg bent at an approximate 90-degree angle at the knee. The resident stated she was unable to straighten her leg and that it was “stuck” in that position. She denied receiving ROM exercises or splinting of her left leg. Record review of the “Physical Therapy Evaluation and Plan of Treatment” dated 10/13/24 documented no contractures to the left lower extremity. A subsequent “Physical Therapy Evaluation and Plan of Treatment” dated 7/31/25 revealed the presence of a 100-degree flexion contracture at the left knee and abduction at the hip joint. A record review of the “Progress Notes” dated 7/28/25 revealed that Resident #6’s left knee was “swelling…LT (left) extremity appears to be contracting..." An interview with Licensed Practical Nurse (LPN #1) on 10/1/25 at 9:00 AM, confirmed that Resident #6’s left leg had been in the contracted position since July 2025. She stated she was unaware of the resident receiving therapy and had not witnessed Certified Nursing Assistants (CNA) performing ROM exercises. During an interview on 10/1/25 at 10:15 AM, the Rehabilitation Director (RD) confirmed that the delay in evaluation and lack of documented ROM services could have contributed to worsening of the resident’s contracture. The RD stated the facility did not have a Restorative Program and that he assumed CNAs were providing ROM during care but was unable to provide documentation. An interview with the Administrator on 10/1/25 at 12:15	M0625		

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M0625	Continued from page 3 PM confirmed that no documentation was available to show that CNAs or therapy staff had performed ROM exercises to prevent the contracture. She stated it was her expectation that therapy would evaluate residents within 24 to 48 hours of referral and that CNAs would provide ROM exercises during care. Record review of the "Admission Record" revealed that the facility admitted Resident #6 on 10/11/24 with diagnoses that included Cerebral Infarction. Record review of the Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/17/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that Resident #6 was cognitively intact. Section GG indicated Resident #6 had functional limitation in range of motion on one side.	M0625		
M0690	45.23.1 Rehabilitative services Rehabilitative services. Residents shall be provided rehabilitative services as needed upon the written orders of an attending physician or nurse practitioner/physician assistant. 1. The therapies shall be provided by a qualified therapist. 2. Appropriate equipment and supplies shall be provided. 3. Each resident ' s medical record shall contain written evidence that services are provided in accordance with the written orders of an attending physician or nurse practitioner/physician assistant. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interview, record review and facility policy review the facility failed to ensure timely provision of therapy services for one (1) of three (3) resident reviewed for contractures (Resident #6). Findings included: Review of the facility policy titled “Scheduling Therapy Services" revised July 2013, revealed "Policy Statement, Therapy Services shall be scheduled in accordance with the resident's treatment plan..."	M0690		

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M0690	Continued from page 4 Record review of the “Nursing/Therapy Communication Form” dated 7/16/25 documented a request for physical and occupational therapy for Resident #6 due to complaints of left leg stiffness. Further review of the “Physical Therapy (PT) Evaluation and Plan of Treatment” revealed that therapy did not evaluate the resident until 7/31/25, which was (15) days after the consultation was initiated. An interview with the Administrator (ADM) on 10/1/25 at 9:45 AM, confirmed that therapy was consulted on 7/16/25 when the resident was complaining of leg stiffness. She verified that at the time of the referral; the resident’s knee was slightly bent but not contracted. An interview with the Rehabilitation Director (RD) on 10/1/25 at 10:15 AM, revealed that the referral was delayed because a physical therapist was not available to complete the evaluation. The RD stated that physical therapy does not work full time at the facility and that therapy assistants are not permitted to perform the initial evaluation. The RD agreed that the delay in evaluation and treatment could have contributed to the worsening of Resident #6’s contracture. A follow-up interview with the ADM on 10/1/25 at 12:15 PM, confirmed that it was her expectation that physical therapy evaluations would be completed within 24 to 48 hours after receiving a referral. She stated that the delay in Resident #6’s evaluation did not meet this expectation. Record review of the "Admission Record" revealed that the facility admitted Resident #6 on 10/11/24 with diagnoses that included Cerebral Infarction. Record review of the Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/17/25, revealed in Section GG that Resident #6 had functional limitation in range of motion on one side.	M0690		
M0815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, and facility policy review, the facility failed to ensure food was prepared and served under sanitary conditions and failed to label and store food properly for one (1) of	M0815		

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M0815	Continued from page 5 three (3) kitchen tours. Findings include: Review of the facility policy titled, "005 Food Preparation Service" revised October 2017, revealed, "Policy Statement: Food and nutrition services employees shall prepare and serve food in a manner that complies with safe food handling practices...Food Service Distribution...23. Food and nutrition services staff shall wear hair restraints (hair net, bat, beard restraint, etc.) so that hair does not contact food..." Review of the facility policy titled, "006 Food Receiving Storage" revised October 2017, revealed, "Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation...8. All food stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date). Review of the facility policy titled, "Food Storage Labeling" reviewed: 3/24, revealed, "Policy: The facility will ensure the safety and quality of food by following good storage and labeling procedures... Procedure...3. Foods that are prepared and stored for later service must be labeled and dated...10. Product Placement: Food is stored in containers intended for food that are durable, leak proof and can be tightly sealed or covered and labeled." On 9/29/25 at 10:10 AM, during the initial observation, Dietary Aides #1, #2, and #3 were observed in the kitchen area without wearing a hair restraint. An interview on 9/29/25 at 10:11 AM with Dietary Aide #1 revealed that the facility had ran out of hair nets and did not have any available at that time. She confirmed that breakfast had been prepared and served without any of the dietary staff wearing a hair restraint. An observation during the initial tour on 9/29/25 at 10:20 AM, with Dietary Aide #1, revealed in Refrigerator #1 a tray of 15 individual cups of pineapple, which were found without any covering or date. The walk-in cooler included enchilada sauce, Thousand Island dressing, shredded parmesan cheese, lettuce, shredded coconut, sliced cheese, sliced ham, sliced bologna, and chicken, all of which were present without dates indicating when they were opened or when they expired.	M0815		

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M0815	Continued from page 6 During an observation and interview with the Dietary Manager (DM) on 9/29/25 at 10:35 AM, confirmed that the facility did not have hair nets available for the dietary staff. Observation of the dry goods storage area with the DM, revealed multiple items were noted without open dates and were not stored in sealed containers. These items included corn meal, basil leaves, poultry seasoning, cake mix, and graham cracker crumbs. The DM confirmed that no open food items should be stored without an open date and emphasized that this practice is unacceptable as it could lead to foodborne illnesses. An interview with the Administrator on 9/29/25 at 10:50 AM, confirmed that hair restraints should always be worn in the kitchen and that open food items should always be stored in sealed containers with an open date. She further stated that her expectations were for the dietary staff to constantly follow food safety guidelines as they were trained to do.	M0815		