STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A190	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST , CHARLESTON, Mississippi, 38921

(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 10/27/25 through 10/29/25. During the survey, the SA determined that the facility was not in compliance with the Medicare and Medicaid regulations for participation and cited regulatory deficiencies F558, F697, and F880. The SA also investigated complaint investigations (CI) 2653611 and CI 2601612 with no deficiencies cited in regard to the allegations in the complaints. Census at the time of survey was 91 and the facility is licensed for 98.	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure the call light was within reach for one (1) of 24 sampled residents reviewed (Resident #10). This deficient practice resulted in the resident not having access to staff assistance when needed. Findings Include: Review of the facility policy titled “Call Light” with a revision date of 9/08 revealed, “...Be sure call light is within reach at all times." On 10/27/25 at 12:30 PM, the surveyor observed the call light hanging behind the bed and out of the resident's reach. The resident stated, "It doesn't work half the time." During an observation of resident's room and an interview with Licensed Practical Nurse (LPN) #2 on	F0558		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0558 SS = D	Continued from page 1 10/28/25 at 1:15 PM, an observation was made of Resident #10's call light, behind her bed and out of reach. LPN #1 stated, " Yes, I know it is out of reach. It is intentional because if we give her the call light, she will push it repeatedly. She usually just yells loud, and we can all hear her and we come in and check on her." An interview with the Director of Nursing (DON) on 10/28/25 at 1:50 PM revealed that the call light should always be in reach of the resident. The DON stated, "At all times, the call light should be in reach of the resident." Record review of the "Admission Record" revealed the facility admitted Resident #10 on 3/11/2013 with a diagnosis of Crohn's Disease. Record review of Resident #10's Admission Minimum Data Set (MDS), Section C, dated 7/18/25, revealed a Brief Interview for Mental Status (BIMS) score of 7 which indicates moderate cognitive impairment.	F0558		
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure an active order for an as needed pain medication for a resident with pain management needs was available when medication was needed for one (1) of 20 sampled residents. Resident #96 Findings include: Record review of facility policy titled, "Pain Assessment and Management" with effective date of 7/13 revealed, "The purpose of this procedure is to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying cause of pain. ... The pain management program is based on a facility-wide commitment to resident comfort. 'Pain management' is defined as the process of alleviating the resident's pain to a level	F0697		

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F0697 SS = D	Continued from page 2	F0697		

that is acceptable to the resident and is based on his/her clinical condition and established treatment goals. ... 6. Implement the medication regimen as ordered, carefully documenting the results of the interventions..." An interview with Resident #96 on 10/27/25 at 2:55 PM, revealed there were times he did not receive his pain medicine because the prescription expired and the Nurse Practitioner (NP) had to reorder this medication. He stated he had generalized pain which was most frequent in his legs and knees. He revealed his pain level scores were usually four to five and at times it was six to seven on a scale of 1-10 with 10 being the worst pain it could be. He revealed there was an incident recently when he asked for his pain medicine and was told that it had expired and they would contact the NP. He stated he got angry and knocked filing cabinets over and knocked things off of the carts and he told the staff he would continue this behavior until he received his medicine. He revealed he was sent to Behavioral Health for an evaluation and treatment. He stated he hated he acted that way, but there were only so many times that he could hear that the provider had to be notified for a new prescription for him to receive the medication for his pain relief. He revealed it was the staff's responsibility to ensure the medications and prescriptions were available when he needed his medications and this did not occur. During interviews on 10/27/25 at 3:45 PM and 10/28/25 at 9:45 AM, the Director of Nursing (DON) revealed that as needed (PRN) pain medication had to be renewed every 30 days in order to meet the federal regulations related to psychotropic and pain medication use. When the provider gave an order for an as needed pain medication, the facility staff put a 30-day stop date into the computer system. She revealed in the facility's computer charting system, there was not a way to trigger a notification for a medication that would be expiring. The charge nurses and the NP review orders to ensure the orders were reordered prior to expiration, but this one slipped through. She acknowledged that even though the medication was available in the medication cart, it could not be administered to the resident due to the order being expired. She revealed the incident occurred when Resident #96 asked for his pain medication and was told the prescription had expired and staff would notify the provider. He became angry and knocked over filing cabinet, pushed items off the medication cart, and tried to turn over the linen cart and the medication cart. She acknowledged the staff notified the NP and received the order and the resident received his medication within approximately 20 - 30 minutes. She acknowledged it was her expectation that each resident's right to receive the PRN pain medication as

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F0697 SS = D	Continued from page 3 needed and as ordered was honored. She confirmed that even though it was only a brief time frame before the medication was administered, the facility failed to have the active orders in place that would allow the pain medicine to be given when needed by the resident. A phone interview with the Nurse Practitioner on 10/28/25 at 4:05 PM, revealed she was notified of the incident with Resident #96 and responded back within 20-30 minutes with an active order. He had requested his pain medication, but the PRN (as needed) pain medication had "fallen off" the active order list and could not be administered until renewed. The resident got angry and threatened the nurse, knocked filing cabinets over, pushed things off medicine cart, tried to overturn linen cart and medication cart. She acknowledged she viewed the video footage and the resident waited around 20-30 minutes for the medication and was acting out during that time. She stated this had "been an issue" and this was the 2nd or 3rd time it had occurred with the resident needing his pain medication and that it had expired in the system and could not be given until the NP was notified. An interview by phone with Licensed Practical Nurse (LPN) #3 on 10/29/25 at 9:30 AM, revealed she was the charge nurse when the incident with Resident #96 occurred. The floor nurse informed her that Resident #96's pain medication had "dropped off" and was no longer available to be administered to the resident. She stated the floor nurse informed the resident that they were getting in touch with the provider but he "was not hearing it". He became extremely angry and knocked over filing cabinets, pushed items off of the med cart, tried to overturn carts, and stated he was going to continue this behavior until he received his medication. She stated he "tore up the nurses' station". She notified the NP who renewed the order and the medication was administered in less than 30 minutes from the start of the incident. She revealed that once the medication was administered, the resident was immediately better. Record review of "Order Recap Report" revealed an order dated 6/2/25 with end date of 7/2/25 for Tramadol 50 milligrams (mg) every six hours as needed for pain for 30 days. Record review of "Progress Note" dated 7/8/25 at 3:07 AM revealed resident received Tylenol 325 mg tablets two tablets for 650 mg for complaints of pain. Review of "Progress Note dated 7/8/25 at 5:50 AM revealed a follow-up pain scale of three and the administration of the Tylenol was ineffective. Review of "Progress Note" dated 7/9/25 for 7/8/25 revealed Tramadol was restarted. Record review of "Order Recap Report" revealed an order dated 7/8/25 with end date of 8/7/25 for Tramadol 50 mg every six hours as needed for pain for 30 days. Record review of "Progress Note" dated 8/9/25 revealed, "Resident	F0697		

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F0697 SS = D	Continued from page 4 angry and states he is moving out Monday b/c (because) he was unable to get his pain meds. Advised resident PRN (as needed) orders expire and have to be renewed/reordered. Resident was advised that this nurse had already got his tramadol ordered for him". Record review of "Order Recap Report" revealed an order dated 8/9/25 with end date of 8/12/25 for Tramadol 50 mg every six hours as needed for pain. Record review of "Order Recap Report" revealed an order dated 8/12/25 with end date of 9/8/25 for Tramadol 50 mg every six hours as needed for pain for 30 days and give one tablet by mouth one time a day for pain. Record review of "Progress Note" dated 9/8/25 revealed, "Resident requested to see NP (Nurse Practitioner) regarding pain meds. NP did see resident who states that the tramadol does not work very long or very well anymore and that he needs something stronger. Stated he saw ortho and they recommend knee replacement, and he states he is not quite ready for that. New order received for Norco 5-325 every 6 hours as needed for pain". Record review of "Order Recap Report" revealed an order dated 9/8/25 with end date of 10/8/25 for Hydrocodone-Acetaminophen Oral Tablet 5-325 mg one tablet every 6 hours as needed for pain for 30 days. Record review of "Progress Note" dated 10/12/25 revealed, "Resident yelling and cursing at staff due to PRN medication Norco not being available for administration at the time. Medication was showing completed on EMAR. Resident was informed that NP (Proper name removed) was being contacted on behalf of medication to get new order Norco. Resident was offered PRN Tylenol at the time until order was approved by NP. Resident proceed to flip bend and attempt to flip med cart. Resident stated that he would continue behavior until he could get his pain medication. No injuries noted." Record review of "Order Recap Report" revealed an order dated 10/12/25 for Hydrocodone-Acetaminophen Oral Tablet 5-325 one tablet by mouth every 6 hours as needed for pain. Record review of Nurse Practitioner note dated 10/13/25 revealed the reason for visit, "This is a follow up visit for NH (Nursing Home) resident date of service 10/13/25. On 10/12/25, resident became combative, cursing at staff, and trying to flip med cart over after not being able to receive pain medication due to order expiring on MAR (Medication Administration Record). Pain medication reordered and administered." Record review of Resident #96's "Admission Record" revealed the facility admitted the resident on 3/27/25. Resident had a diagnosis of pain. Record review of Resident #96's "Minimum Data Set" (MDS) with Assessment Reference Date (ARD) of 10/2/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was intact cognitively.	F0697		

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F0697 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 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.	F0697 F0880		

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F0880 SS = D	Continued from page 6 (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. §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 observations, staff interviews, record review and facility policy review, the facility failed to ensure infection control practices were maintained for two (2) of 24 residents reviewed. (Resident #20 and #77) Findings include: A review of the policy titled, “Infection Control" effective 9/2016 revealed, "7. All resident specific equipment such as…suction supplies...will be stored in a covered container such as a clean bag in the resident's room and changed as appropriate…" Record review of facility policy titled, "Guidelines for Isolation Precautions" with revision date 1/27/23, revealed, "Enhanced Barrier Precautions (EBP) require the use of gown and gloves only for high-contact resident care activities (i.e....indwelling medical device care and use...)" Resident #20 On 10/27/25 at 2:00 PM, and again on 10/28/25 at 12:54 PM, a yanker suction catheter was observed out of its	F0880		

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F0880 SS = D	Continued from page 7 protective packaging on the bedside table in Resident #20's room. A suction canister was observed approximately one-fourth full of white liquid. During an interview and observation on 10/28/25, Licensed Practical Nurse (LPN) #2 confirmed the yanker was out of the packaging and the canister contained liquid. She stated, "The yanker should be in its packaging because of infection control. The fluid in the canister could be an infection control issue and should have been disposed of." An interview with the Director of Nursing (DON) on 10/28/25 at 1:45 PM, confirmed that the yanker should have been stored in a plastic container when not in use and that the canister should have been disposed of or emptied and disinfected per facility policy. Review of the “Admission Record” revealed the facility admitted Resident #20 on 11/02/2016 with diagnosis of Dementia. Record Review of Resident #20's Admission Minimum Data Set (MDS), Section C, dated 8/11/25, revealed a Brief Interview for Mental Status (BIMS) score of 3 which indicates severe cognitive impairment. Resident #77 During an observation of medication administration on 10/28/2025 at 9:00 AM for Resident #77 with Licensed Practical Nurse (LPN) #1, it was observed that the nurse failed to use Enhanced Barrier Precautions (EBP) while administering Percutaneous Endoscopic Gastrostomy (PEG) medications. Record review of the Order Summary Report revealed an order dated 5/2/24 for Enhanced Barrier Precautions due to PEG two times a day. During an interview on 10/28/2025 at 9:15 AM with LPN #1, she confirmed that EBP should have been used during medication administration for residents with PEG tubes. She further stated that EBP was ordered to help prevent the spread of infection. During an interview on 10/28/2025 at 9:54 AM with the Director of Nursing (DON), she stated EBP should be used with any tubes or wounds to prevent possible cross contamination. She further stated that her expectations were for staff to follow EBP with all care provided for residents with a tube or wound.	F0880		

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F0880 SS = D	Continued from page 8 Record review of the Admission Record that Resident #77 was admitted to the facility on 4/7/13, with medical diagnoses that included spastic quadriplegic cerebral palsy and gastrostomy status. Record review of the quarterly MDS with an Assessment Reference Date (ARD) of 7/29/25 revealed, under Section C, a BIMS score of 0 indicated that an interview should not be conducted because the resident was rarely/never understood.	F0880		