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 **10/29/2025**

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
M0000	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 Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited regulatory deficiency M500 and M1570. The SA also conducted complaint investigations (CI) for 2653611 and CI 2601612 with no deficiencies related to the complaints. Census at the time of survey was 91 and the facility is licensed for 98 beds.	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	M0500		

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

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M0500	Continued from page 1 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 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	M0500		

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M0500	Continued from page 2 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 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	M0500		

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M0500	Continued from page 3 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 LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on resident and staff interview, record review, and facility policy review, the facility failed to ensure a resident's right to receive timely pain management care was honored as evidenced by not having an active order for an as needed pain medication 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 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..." Record review of facility policy titled, "Resident's Rights and Responsibilities", undated, revealed, "As a resident, you have the ... right to always be treated with the respect and dignity they deserve". 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 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. 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 Nurse Practitioner (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	M0500		

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M0500	Continued from page 4 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 Nurse Practitioner 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 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. An interview by phone with Licensed	M0500		

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M0500	Continued from page 5 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 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	M0500		

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M0500	Continued from page 6 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 #96 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.	M0500		
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 transmission of infections and communicable diseases.	M1570		

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M1570	Continued from page 7 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: Level II 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 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.	M1570		

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M1570	Continued from page 8 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 #77During 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. 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.	M1570		