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 **11/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER B CROOK NURSING FACILITY	**840 NORTH OAK AVENUE , RULEVILLE, Mississippi, 38771**

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M0000	Initial Comments The State Agency (SA) conducted an annual re-certification survey with one (1) complaint investigation (CI) MS # 2666740 at the facility from 11/11/25-11/13/25. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm. The SA identified non-compliance and cited M0610 related to Activity of Daily Living (ADL), M0615 related to Pressure Sores, M0620 related to Urinary Incontinence, and M1570 related to Infection Control. There were no deficiencies cited for CI MS# 2666740. The census at the time of the survey was 55 and the facility is licensed for 60 beds.	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: Level II Based on observation, interview, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care related to nail care for three (3) of 16 sampled residents. (Resident	M0610		

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

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M0610	Continued from page 1 #8, Resident #46). Findings Include: Record review of the facility policy titled “Activities of Daily Living, Supporting” revised March 2018, revealed “…Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene…” Review of the facility policy titled "Activities of Daily Living" revealed under "Fingernails/Toenails, Care of” with a revision date of February 2018 states, “The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.” Resident #8 During an observation and interview with Resident #8 on 11/11/2025 at 11:46 AM and again on 11/12/25 at 10:15 AM, revealed the resident had approximately three-fourths (3/4") inch long, jagged fingernails with brown substance underneath and she stated she would like to have her nails cut shorter. During an observation and interview on 11/12/2025 at 10:21 AM, Certified Nursing Assistant (CNA) #1, she confirmed Resident #8 had long jagged fingernails. She stated nail care was the responsibility of the treatment nurse. She further stated that long, jagged fingernails could cause skin tears. During an observation and interview on 11/12/2025 at 10:28 AM, with the Treatment Nurse, she confirmed that Resident #8's fingernails were approximately 3/4" in length and had jagged edges. She stated that nail care could be provided by nurses and CNAs unless the resident was a diabetic, then only a nurse could cut their nails. She further stated that when a resident had long, jagged fingernails that puts them at risk for scratches, skin tears, and infections and that proper nail care was just part of hygiene. During an interview on 11/12/2025 at 10:30 AM, with the Administrator, she confirmed that nail care could be provided by all nursing staff, except for diabetic residents, and it should be performed at least weekly. During an interview on 11/12/2025 at 10:34 AM, with the Director of Nursing (DON), she confirmed that CNA's and nurses can perform nail care on residents unless they are diabetic, then it is to be done by nurses only.	M0610		

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M0610	Continued from page 2 Record review of Resident #8's Admission Record revealed that the resident was admitted to the facility on 4/16/2025 with a medical diagnosis that included Cerebral Infarction, Unspecified. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/19/2025 revealed under Section C that Resident #8's Brief Interview for Mental Status (BIMS) score was 7, indicating that the resident was severely impaired. Resident #46 An observation on 11/11/25 at 11:35 AM and again on 11/12/25 at 10:00 AM of Resident #46 revealed the resident lying in bed with long nails, approximately one-fourth (1/4) inches in length on the left hand and approximately one-half (1/2) inches in length on the right hand with a brown substance underneath. The right hand was observed as contracted and in a clenched fist. An observation and interview on 11/12/25 at 10:24 AM at Resident #46's bedside with Registered Nurse (RN) #2 confirmed the resident's nails were long and dirty. She opened her hand and revealed that all the fingernails were long with a brown substance underneath. No broken skin was observed on either hand. She stated, "If his nails are not kept trimmed and clean, he could easily get a break in his skin and develop an infection." On 11/12/25 at 11:41 AM the DON was interviewed regarding the facility's expectations for fingernail care. The DON stated, " Staff are expected to keep residents' fingernails trimmed and clean. Long or dirty nails could cause a break in the skin and lead to infection." Record review of Resident #46 's Admission Record revealed that the facility admitted resident on 7/19/2019 with a medical diagnosis that included Cerebral Infarction, Unspecified. Record review of the MDS with an ARD of 8/29/2025 revealed under Section C that Resident #46's BIMS was 6 and the cognitive skills for daily decision making were severely impaired.	M0610		
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	M0615		

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M0615	Continued from page 3 condition indicates they were unavoidable. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to accurately assess, document, and implement treatment for a pressure injury for one (1) of 55 residents. This failure resulted in an avoidable full-thickness tissue loss wound that went ten (10) days without implementation of the physician's orders. Resident #5 Findings Include: Review of the facility policy titled “Wound Care Policy and Protocol” dated 1/24/25, revealed under, “2. Policy Statement: Proper name of the facility is committed to 1. Proactive wound prevention through comprehensive assessments. 2. Prompt identification and treatment of wounds. 3. Use of advanced wound care techniques. 4. Minimizing infection risks through proper dressing techniques. 5. Educating staff and residents on wound prevention and care.” The documented practice did not reflect the policy requirements for proactive identification and timely intervention. An observation and interview with Resident #5 on 11/11/25 at 1:16PM revealed he was lying in bed and stated he had a sore on his bottom that he developed after coming to the facility. Record review of the “Progress Notes” dated 11/05/25 revealed Resident #5 had a sacral Stage 3 pressure ulcer measuring 2.4 centimeters in length x (by) 1.3 centimeters in width x (by) 0.2 cm in depth with 100% granulation tissue, confirming advanced tissue loss. An observation of wound care on 11/12/25 at 9:05 AM with the Wound Nurse revealed Resident #5 had the sacral wound for a while. She stated the resident was seen weekly by wound care and the wound had been debrided several times. The wound was circular over the sacral region, edges well-defined, and the wound bed contained 80% (percent) red granulation tissue and 20% yellow adherent slough. Record review of Resident #5’s hospital “Discharge	M0615		

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M0615	Continued from page 4 Summary" dated 3/18/25 revealed documentation that the "Sacrum and bilateral buttocks were clear of wound" on admission to the facility. Record review of Resident #5's "Skin/Wound Note" dated 4/04/25 revealed, "Nurse called to room regarding resident's sacral area. Nurse noted a stage III pressure ulcer measuring 1.9 centimeters (CM) x 3.0 CM x 0.1 CM. 50% epithelial tissue, 25% slough, 25% eschar noted," confirming full-thickness skin breakdown on this date. Record review of "Weekly Skin Audits" dated 3/22/25 for Resident #5 revealed, "No new skin issues noted." Record review of "Weekly Skin Audits" dated 3/29/25 revealed documentation of "No new skin issues noted at this time per CNA (Certified Nurse Aide)" indicating assessments were inaccurately completed or concerns were not correctly documented. Record review of the April 2025 "Treatment Administration Record (TAR)" revealed an order dated 10/08/24, "Apply lantiseptic ointment to coccyx area every shift related to (R/T) excoriation until resolved," was initialed as completed on 4/1, 4/2, 4/3, with no accompanying documentation indicating a change in skin condition. No evidence was found to show the skin issue was identified or escalated prior to being staged as a Stage III on 4/4/25. An interview with the Wound Nurse on 11/12/25 at 2:20 PM revealed aides were required to complete body map forms for new skin concerns and submit them to the Director of Nursing (DON). The wound nurse stated weekly skin audits were to be completed by the medication cart nurses each week. She acknowledged the wound should have been identified earlier and confirmed the wound was avoidable. An interview with Staff Development Nurse on 11/13/25 at 9:12 AM with the DON present, revealed they had discovered that a night shift CNA found the open area to Resident #5's sacrum on 3/26/25, and she had completed a body audit form and notified the night shift nurse. The night shift nurse received treatment orders from the Emergency room (ER) doctor, but she failed to carry out the order or enter it into the computer system. She explained the nurse left the information in a binder at the nurse's desk for the incoming Registered Nurse (RN) charge nurse, which then	M0615		

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M0615	Continued from page 5 called in the following morning, resulting in the order not being completed or carried out. The DON and the Staff Development Nurse confirmed this failure allowed the wound to remain unrecognized and untreated until 4/4/25, when it had progressed to full-thickness tissue loss. The nurse that was responsible was an agency staff nurse and she was no longer allowed to work at the facility. The facility provided documentation for Resident #5 that was left in a binder at the nurse's station dated 3/26/25 and read, “Small open area to coxy area.” There was a written note attached that read, “Emergency room (ER) doctors said clean with wound cleanser (WC) and apply Duoderm. Stage 2. Turn every (Q) two (2) hours and notify wound care. I didn’t put order in yet,” confirming staff acknowledgment of a wound. There was no documentation in the Electronic Medical Record (EMR) regarding new skin concerns, and no orders were carried out. Wound was later re-identified on 4/4/25 as a Stage III. Record review of the “Admission Record” revealed the facility admitted Resident #5 on 3/19/25 with a medical diagnosis including Multiple Sclerosis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/22/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 14, indicating Resident #5 was cognitively intact.	M0615		
M0620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on staff interviews and record review the facility failed to provide bowel and bladder training services to reduce incontinence for one (1) of 16 sampled residents. (Resident #10) Findings include: Review of "Facility Statement	M0620		

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M0620	Continued from page 6 Regarding Bowel and Bladder Policy" with no date revealed the facility did not have a policy for Bowel and Bladder. Record review of Resident #10's Bowel/Bladder Screenings dated 8/15/24 and 11/8/24 revealed Resident #10 was a good candidate for retraining. The Bowel/Bladder Screenings dated 2/3/25, 4/29/25, and 7/23/25, revealed Resident #10 was a candidate for schedule toileting. An interview on 11/12/2025 at 4:00 PM, with the Administrator and Director of Nursing (DON), revealed the facility did not currently have a bowel/bladder toileting program. They stated that after the screenings are completed that a Registered Nurse (RN) reviews the screening and makes a decision or recommendation accordingly. Record review of Resident #10's plan of care, "I sometimes have trouble getting to the bathroom in time. Staff are helping me retrain my bladder and bowel so I can stay dry and comfortable as much as possible" developed 10/10/25, revealed the following goals, "I will improve or maintain my bladder and bowel control by participating in my individualized toileting program..." with the following interventions noted, "Adjust schedule based on identified bladder pattern or resident feedback...Interdisciplinary team reviews during quarterly and significant change assessments to determine continued appropriateness of retraining program...Nurse reviews weekly for progress or modification needs..." During an interview on 11/13/2025 at 8:27 AM, with the DON and the RN #1, Care Plan Coordinator, confirmed that Resident #10 has incontinent episodes and is not on a toileting program because they don't currently have a toileting program. Both nurses confirmed that there was no documentation following each B/B screening by a RN assessing the need for the program. RN #1, Care Plan Coordinator, stated, "There is a note in for October only." The DON stated they do remind her to toilet every few hours but there is not documentation for that. She confirmed that Resident #10 should be on a toileting program to help maintain her current level of independence. Record review of progress note dated 10/10/2025 revealed, "Care plan review and update performed regarding bowel and bladder program screener. Resident scored as a candidate for scheduled toileting or timed voiding. Staff are providing regular, scheduled toileting assistance with the goal of helping the resident stay dry and maintain skin integrity. Resident is cooperative with toileting efforts. Progress and response to the toileting schedule will be monitored and documented, and care plan will be updated as needed."Record review of Resident #10's Admission Record revealed that the resident was admitted to the facility on 2/23/2024 with a medical diagnosis that included Multiple Sclerosis and Epilepsy.	M0620		

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M0620	Continued from page 7 Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/17/2025 revealed under Section C that Resident #10's Brief Interview for Mental Status (BIMS) score was 15, indicating that the resident was cognitively intact.	M0620		
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. 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 one (1) of three (3) care opportunities. (Resident #13) Findings include: A review of the policy titled, "ENHANCED BARRIER PRECAUTIONS (EBP)" effective 4/1/24 revealed, "For residents whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Device care of use: Central line, urinary catheter, feeding tube, etc."	M1570		

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M1570	Continued from page 8 During an observation of medication administration on 11/12/2025 at 9:08 AM for Resident #13 with Licensed Practical Nurse (LPN) #3, it was observed that the nurse failed to use EBP while administering Percutaneous Endoscopic Gastrostomy (PEG) medications. During an interview on 11/12/25 at 9:25 AM with LPN #3, 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 and she forgot to put the gown on herself prior to administering the medications. During an interview on 11/12/25 at 9:38 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 #13 was admitted to the facility on 12/24/2013 with medical diagnoses that included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/10/2025 revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 0 indicated that an interview should not be conducted because the resident was rarely/never understood.	M1570		