STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	**514 BAY STREET , HATTIESBURG, Mississippi, 39401**

(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 recertification survey at the facility from 12/8/25 through 12/11/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F561, F584, F628, and F645. The facility had a census of 145 and was licensed for 184 beds.	F0000		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F0584		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET , HATTIESBURG, Mississippi, 39401

(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
F0584 SS = E	Continued from page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure residents' rights to a comfortable living environment by not ensuring comfortable room and water temperatures for residents across three (3) of four (4) halls in the facility, Halls A, B, and C. Findings include: A review of the facility's policy, "Quality of Life – Homelike Environment", revised 5/2017, revealed, "…Residents are to be provided with a…comfortable and homelike environment…Policy Interpretation and Implementation…2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include…h. Comfortable and safe temperatures (71 degrees Fahrenheit – 81 degrees Fahrenheit)…" A review of the facility's "Resident Rights", undated, revealed, "1) A dignified and comfortable living environment…" On 12/9/25 at 1:35 PM, during a Resident Council meeting, multiple residents reported concerns regarding room temperatures being cold while outside temperatures were in the low 30s. Resident #18 reported he informed maintenance that his room was cold and stated the room temperature did not improve following his request. Residents #138, #36, #93, #54, and #1 also reported that the temperatures in their rooms were cold. The residents also reported concerns that water temperatures in resident rooms and shower rooms were	F0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET , HATTIESBURG, Mississippi, 39401

(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
F0584 SS = E	Continued from page 2 uncomfortable, stating that that the hot water felt cold. On 12/10/25 at 8:10 AM, during an interview, the Social Services Director reported she had received concerns from residents related to room temperatures and water temperatures and submitted work orders through the facility's electronic maintenance request system. On 12/10/25 at 8:33 AM, during an observation and interview, the Maintenance Director assessed room temperatures with an infrared thermometer and water temperatures with a digital thermometer on three halls identified through resident complaints. At 8:36 AM, the temperature in Room A8 (Resident #36) measured 69 degrees Fahrenheit (F) and the water temperature was 68 degrees F. At 8:44 AM, the temperature in Room B22 (Resident #1) measured 65.5 degrees F and the water temperature was 86F. At 8:48 AM, the temperature in Room B2 (Resident #138) measured 70 degrees F and the water temperature was 93 degrees F. At 8:49 AM, the temperature in Room B13 (Resident #54) measured 77 degrees F and the water temperature was 84 degrees F. At 8:55 AM, the temperature in Room B16 (Resident #93) measured 85 degrees F and the water temperature was 99.8 degrees F. At 8:57 AM, the water temperature in Room B11 measured 69.2 degrees F. The Maintenance Director reported that water required several minutes of running before reaching the temperatures measured. On 12/10/25 at 2:00 PM, during observation, the Maintenance Director rechecked room temperatures. Room A8 measured 65 degrees F. Room B2 measured 84 degrees F. Room B13 measured 88 degrees F. Room B16 measured 91 degrees F. On 12/10/25 at 2:08 PM, during an observation in the C-South shower room, the water temperature reached 100 degrees Fahrenheit after four minutes of continuous running. On 12/11/25 at 2:48 PM, during an interview, the Administrator reported the facility operates a tankless hot water system and acknowledged that water must travel through the system before reaching resident rooms. He stated his expectation was for residents to experience a consistent and comfortable living environment.	F0584		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET , HATTIESBURG, Mississippi, 39401

(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
F0628 SS = D	Continued from page 3 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET , HATTIESBURG, Mississippi, 39401

(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
F0628 SS = D	Continued from page 4 (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET , HATTIESBURG, Mississippi, 39401

(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
F0628 SS = D	Continued from page 5 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET , HATTIESBURG, Mississippi, 39401

(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
F0628 SS = D	Continued from page 6 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide complete and timely written transfer notices for six (6) of six (6) residents reviewed for hospitalizations (Residents #1, #9, #10, #12, #14, and #15). The facility did not include a clear, resident-specific reason for why each resident was sent to the hospital. Written notices were provided late for five (5) residents (Residents #1, #10, #12, and #15), and the Responsible Representative for one (1) resident (Resident #14) did not receive a written notification of the transfer at all. Findings include:	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET , HATTIESBURG, Mississippi, 39401

(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
F0628 SS = D	Continued from page 7 A review of the facility's policy, "Transfer or Discharge Notice" revised November 2023, revealed, "…Policy Interpretation and Implementation…4. Under the following circumstances, the notice is given as soon as it is practical but before the transfer or discharge…d. An immediate transfer or discharge is required by the resident's urgen medical needs…5. The resident and representative will be notified in writing of the following information: a. The specific reason for the transfer or discharge…" Resident #1 A record review of the "Admission Record" revealed the facility initially admitted Resident #1 on 1/12/2024 and she had current diagnoses including Hemiplegia and Hemiparesis. A record review of the "Order Recap Report" revealed Resident #1 had a Physician's Order, dated 10/19/25 to "send to (proper name of acute hospital) er (Emergency Room) for eval (evaluation) and tx (treatment)…" A record review of the "Notice of Resident Transfer or Discharge", dated 10/20/25, for Resident #1 indicated the reason as "The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility." It did not specify the reason for the transfer and was dated one (1) day after the transfer. Resident #9 A record review of the "Admission Record " revealed the facility admitted Resident #9 on 05/24/2025 and she had diagnoses including End Stage Renal Disease. A record review of the "Telephone/Verbal Order Signatures Details" document revealed Resident #9 had a Physician's Order, dated 12/02/25 for "order to send resident to (proper name of acute hospital) ER r/t (related to) respiratory distress…" A record review of the "Notice of Resident Transfer or Discharge", dated 12/2/25 for Resident #9 indicated,	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET , HATTIESBURG, Mississippi, 39401

(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
F0628 SS = D	Continued from page 8 "The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility." It did not specify the reason for the transfer. Resident #10 A record review of the “Admission Record" revealed the facility initially admitted Resident #10 on 4/28/2017 and he had current diagnoses including Hemiplegia and Hemiparesis. A record review of the "Order Recap Report" revealed Resident #10 had a Physician's Order, dated 10/08/25 to "…Send to “(proper name of acute hospital) for evaluation...” A record review of the "Notice of Resident Transfer or Discharge”, dated 10/21/25 for Resident #10 indicated, "The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility." It did not specify the reason for the transfer and was dated 13 days after the resident was transferred to the hospital. Resident #12 A record review of the "Admission Record" revealed the facility initially admitted Resident #12 on 10/10/24 with current diagnoses including Atrial Fibrillation. A record review of the "Telephone/Verbal Order Signature Details” document revealed Resident #12 had a Physician's Order, dated 09/30/25 for "order to send to (proper name of acute hospital) r/t decreased O2 (oxygen) saturations and concern for possible blood clot..." A record review of the "Notice of Resident Transfer or Discharge”, dated 10/6/25, for Resident #12 indicated, "The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility." It did not specify the reason for the transfer and was dated seven (7) days after the resident was transferred to the hospital.	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	**514 BAY STREET , HATTIESBURG, Mississippi, 39401**

(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
F0628 SS = D	Continued from page 9 Resident #14 A record review of the “Admission Record” revealed the facility admitted Resident #14 on 11/9/2025 and he had current diagnoses including Chronic Atrial Fibrillation. A record review of the "Order Recap Report" revealed Resident #14 had a Physician's Order, dated 12/01/25 to "send resident out to “(proper name of acute hospital) ER for critical labs…” A record review of the "Notice of Resident Transfer or Discharge” for Resident #14 indicated, "The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility." It did not specify the reason for the transfer and was dated ten (10) days after the date of the transfer. On 12/11/2025 at 8:01 AM, during a phone interview with the Responsible Representative (RR), he explained that he did not receive written notification of the transfer for Resident #14’s hospitalization on 12/1/2025. He stated the facility had called him to inform him of the transfer, but he did not receive anything in writing. Resident #15 A record review of the "Admission Record" revealed the facility admitted Resident #15 on 06/02/2025 and he had current diagnoses including Personal History of Transient Ischemic Attack. A record review of the "Telephone/Verbal Order Signature Details” document revealed Resident #12 had a Physician's Order, dated 10/25/25 to "send to out to hospital.” A record review of the "Notice of Resident Transfer or Discharge”, dated 10/28/25, for Resident #15 indicated, "The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility." It did not specify the reason for the transfer and was dated three (3) days after the date of the transfer.	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET , HATTIESBURG, Mississippi, 39401

(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
F0628 SS = D	Continued from page 10 On 12/10/2025 at 2:42 PM, in an interview with the Director of Social Services (DSS), she confirmed that she was responsible for filling in the Notice of Resident Transfer or Discharge form and mailing it to the RR when a resident is transferred to the hospital. The Director of Social Services stated she does not list a reason for the transfer to hospital because the nurse will explain the reason over the phone. The DSS acknowledged that this leaves the RR without clear information regarding the transfer. The DSS stated she will begin writing the reason that the resident was sent to the hospital from now on. On 12/11/2025 at 1:02 PM, in an interview with the Director of Nursing (DON), she acknowledged the facility's hospital transfer form did not include a reason for hospitalization for Resident #14 and that the notice was not mailed to the RR. She stated the purpose of including this information is to ensure the RR is informed. The DON explained she expected the Social Services Director to complete the area with the symptoms charted and ensure the information was sent to the family and mailed to every RR. She stated she will suggest to the Administrator that staff follow up by phone a few days after mailing the notices to confirm they were received. On 12/11/2025 at 1:18 PM, in an interview with the Administrator, he acknowledged there was no reason for hospitalization documented on the transfer forms, including Resident #14's form that was not provided to the RR. He stated the reason for the RR to receive written notification with the reason for hospitalization is to support transparency. The Administrator stated his expectation was that the Social Services Director provide a specific reason for hospitalization and mail the forms in a timely manner.	F0628		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F0645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	**514 BAY STREET , HATTIESBURG, Mississippi, 39401**

(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
F0645 SS = D	Continued from page 11 (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility	F0645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET , HATTIESBURG, Mississippi, 39401

(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
F0645 SS = D	Continued from page 12 services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure that a resident's diagnosis of a major mental illness was accurately identified on the Pre-Admission Screening and Resident Review (PASRR) at the time of admission for one (1) of twenty-nine (29) sampled residents, Resident #11. Findings include: A review of the facility's policy "Admission Criteria" revised December 2016, revealed "… Our facility will admit only those residents whose medical and nursing care needs can be met. Policy Interpretation and Implementation 1. The objectives of our admission criteria policy are to: … e. assure that the facility receives appropriate medical … records … 8. Nursing and medical needs of individuals with mental disorders … will be determined by coordination with the Medicaid Pre-Admission Screening and Resident Review Program (PASARR) to the extent practicable…" A record review of the facility's "PASRR Completion Policy" , undated, revealed "The Center will a make sure that all admissions have the appropriate Patient Assessment and Resident Review (PASRR) completed. PRACTICE GUIDELINES: 1. Center Administrator will designate either the Admissions Director or Social Worker to make sure that the PASSRR and/or Level of Care (LOC) is done on all potential residents. If the referral indicates anything which might constitute an SMI (Serious Mental Illness) or ID (Intellectual Disability), the PASRR must be completed prior to admission. If the resident is deemed "hospital exempted" that must be clearly documented in the transfer documents prior to admission from the acute care facility…"	F0645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255321	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET , HATTIESBURG, Mississippi, 39401

(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
F0645 SS = D	Continued from page 13 A record review of the “Admission Record” revealed the facility admitted Resident #11 on 6/30/22 with diagnoses including Bipolar Disorder, with an onset date of 2/26/25. A record review of the “Pre-Admission Screening,” dated 6/30/22, revealed Resident #11 had no diagnosis of Alzheimer’s Disease, Dementia, or major mental illness identified at the time of admission. Further review revealed documentation that the resident was taking or had a history of taking psychotropic medications. A record review of electronic hospital records revealed Resident #11 had a “Problem” of “Bipolar disorder” that was “Noted” on 12/25/2014 and “Updated” on 4/23/25. A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/28/2025 revealed Resident #11 had a Brief Interview for Mental Status (BIMS) summary score of 13, which indicated he was cognitively intact. A review of Section I revealed he had no diagnoses of Dementia or Alzheimer's, however, the MDS indicated he had diagnoses including Psychiatric/Mood Disorders of Anxiety, Depression, and Bipolar Disorder. On 12/11/25 at 11:10 AM, during an interview with the Director of Nursing (DON) and a concurrent record review of Resident #11’s “Problem List” with last review dated 9/25/25, she explained that the resident had a diagnosis of Bipolar Disorder, with a documented onset date of 12/25/14. She confirmed there was no diagnosis of Dementia or Alzheimer’s Disease that would qualify the resident for a Level II PASRR exemption and that the PAS screening was completed inaccurately on admission dated 6/30/22. She reported that the staff member responsible for completing the PAS screening at that time was from Social Services but was no longer employed at the facility. On 12/11/25 at 2:00 PM, during an interview with Social Services, she confirmed she completes PAS screenings for all new admissions. She explained she gathers information from referral packets, electronic medical records, verbal information from the referring facility, and information obtained from families. On 12/11/25 at 3:48 PM, during an interview with the Administrator, he reported that he expects the staff member completing PAS screenings to complete them accurately and to identify any concerns to assure the facility can meet the resident’s care needs.	F0645		