STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255343	A. BUILDING B. WING	**01/14/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF PICAYUNE	**2797 COOPER ROAD , PICAYUNE, Mississippi, 39466**

(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 two (2) Complaint Investigations (CI MS #2705336 and CI MS #2709753), at the facility from 1/12/26 through 1/14/26. The complaints were investigated regarding impaired nursing staff and medication administration related to CI MS #2705336, and accidents/hazards related to CI MS #2709753. During the investigation of both CIs, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F600, F609, and F610 related to both MS #2705336 and MS #2709753. Additionally, F689 was cited related to CI MS #2709753 only, and F725, F842, and F838 were cited related to CI MS #2705336 only. The SA identified an Immediate Jeopardy (IJ) that began on 12/31/25 at approximately 3:40 PM related to MS #2709753 when the facility failed to ensure the resident environment remained free of accident hazards after a resident sustained a burn from hot coffee and failed to implement safeguards or supervision to prevent other residents from exposure to the same hazard. The SA also identified an Immediate Jeopardy (IJ) that began on 12/29/25 at 7:00 PM related to MS #2705336 when residents remained under the care of an impaired licensed nurse who was unable to safely perform nursing duties, medication administration could not be verified as accurate and timely, and the facility failed to ensure sufficient licensed supervision and coordination of care due to the absence of a designated charge nurse. The facility's failure to safeguard residents from known burn hazards and for all residents who had access to hot coffee and failure to intervene when an impaired nurse was providing care placed all 29 residents residing on Station B at likelihood for serious injury or illness, serious harm, serious impairment, or death. The IJ and SQC existed at: 42 CFR §483.12 Freedom from Abuse, Neglect, and Exploitation – F600 – Scope/Severity "J" 42 CFR §483.25(d)(2) Accidents/Hazards – F689 – Scope/Severity "J"	F0000		

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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F0000	Continued from page 1 The IJ existed at: 42 CFR §483.12(c) Reporting of Alleged Violations – F609 – Scope/Severity “J” 42 CFR §483.12(c)(3) Investigate/Prevent Further Potential Abuse, Neglect, or Exploitation – F610 – Scope/Severity “J” 42 CFR §483.35 Sufficient Nursing Staff – F725 – Scope/Severity “J” 42 CFR §483.71(c)(2)(3)(5) Facility Assessment – F838 – Scope/Severity “J” The facility Administrator was notified of the IJ and SQC on 1/13/26 at 3:40 PM and provided the IJ templates. The facility provided an acceptable Removal Plan on 1/13/26, in which they alleged all corrective actions to remove the IJ were completed on 1/13/26 and the IJ removed on 1/14/26. The SA validated the Removal Plan on 1/14/26 and determined the IJ was removed on 1/14/26, prior to exit. Therefore, the scope and severity for all cited IJ-level deficiencies were lowered to a scope and severity of “D” while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The census at the time of the survey was 114, and the facility was licensed for 120 beds.	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F0600		

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F0600 SS = SQC-J	Continued from page 2 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide necessary care and services to protect residents from neglect when Resident #1 sustained a burn from hot coffee on 12/31/25 at approximately 3:40 PM and the facility failed to implement safeguards or supervision to protect other residents from exposure to the same hazard. Residents continued to have access to hot coffee in the dining room without supervision, temperature controls, or access restrictions until 1/12/26. Additionally, on the night shift beginning at 7:00 PM on 12/29/25, residents on Station B remained under the care of an impaired licensed nurse who was unable to safely perform nursing duties. Despite staff observations of impairment, the nurse remained responsible for resident care until approximately 3:00 AM on 12/30/25. Review of medication administration records revealed multiple medications were not documented as administered and others were documented late. Staff interviews confirmed medications were pulled by another nurse, but administration was not observed or verified. As a result, the facility could not verify that residents received medications as ordered and to the correct residents for four (4) of (4) sampled residents (Residents #1, #2, #3 #4) and placing all (29) residents residing on Station B at risk. The facility's failure to safeguard residents from known burn hazards and failure to intervene when an impaired nurse was providing care placed all residents who had access to hot coffee and all 29 residents residing on Station B at likelihood for serious injury or illness, serious harm, serious impairment, or death. The situation was determined to be Immediate Jeopardy (IJ) and substandard Quality of Care (SQC) that began on 12/29/25 at 7:00 PM when residents remained under the care of an impaired licensed nurse. The facility Administrator was notified of the IJ on 1/13/26 at 3:40 PM and was presented with the IJ template. The facility provided an acceptable Removal Plan on 1/13/26, in which they alleged all corrective actions to remove the IJ were completed on 1/13/26.	F0600		

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F0600 SS = SQC-J	Continued from page 3 The State Agency (SA) validated the Removal Plan on 1/14/26 and determined that the IJ was removed on 1/14/26, prior to exit. Therefore, the scope and severity for 42 CFR §483.12(a)(1) Freedom from Abuse, Neglect, and Exploitation (F600) was lowered from a “J” to a “D” while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility’s policy “Abuse Prevention Program”, modified 8/2/2022 revealed “…Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation…Policy Interpretation and Implementation…6. Identify and assess all possible incidents of abuse…” A record review of the facility’s incident report, dated 12/31/25 at 3:40 PM, revealed the “Incident Description” included a “Nursing Descriptions” of “Called to resident’s room r/t (related to) resident had coffee spilled on left hip area and blisters noted…Resident alert to person. Stating it hurts, it hurts…” The “Injuries Observed at Time of Incident” revealed a “Burn” to the “Left thigh (front).” “Other Info” included “Resident was given coffee by another resident, and this resident spilled coffee on himself resulting in blisters forming to left hip area.” A record review of the “Progress Notes” revealed Resident #1 had a “Skin Issues” note effective 12/31/25 at 4:40 PM for “…New skin issue…Front left trochanter…Blister…acquired in-house…12/31/2025…Length (cm): 7.06 Width (cm): 7.56 …” A record review of the facility’s “Counseling/Discipline Report”, dated 1/8/26, revealed License Practical Nurse (LPN) #1, was discharged from the facility. The “Date(s) of Violation(s)” was 12/29 through 12/30 (2025). “Policies violated” included “…Sleeping or appearing to be asleep.” The “Employee’s Statement” revealed “I was ill-my temp (temperature) was 101 degrees and blood sugar had dropped to 67… I do not remember this.” In a record review of the facility’s investigation revealed, on 12/30/25 the Director of Nurses (DON) received a call at 1:30 AM from the nurse on station one. (LPN #2). She stated, “the nurse on station 2 isn’t able to complete her med (medication) pass, she keeps falling asleep, I don’t know what’s going on with	F0600		

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F0600 SS = SQC-J	Continued from page 4 her". She advised her to send the nurse to the hospital. She said, "I can't be left here with both sides to do meds for 60 people." The DON advised her to call the scheduler to see if she was able to get a nurse to come in and send the nurse on station 2 home. She was able to get a nurse to come at 3:00 AM. After the DON reviewed the camera footage of the incident that took place, she phoned LPN #1 and did not receive a return call from LPN #1. According to the camera footage, the DON observed the nurse at the nurse's station for about 2 hours. She pushed the cart into the hallway outside of the nurse's station. At this point, she stared at the computer for a long time and swayed around almost falling. LPN #1 appeared to be under the influence of something. She was stumbling around, staring at the med cart fumbling through the cart looking for meds, would pull a med card and just stare at it for minutes. At one point, she fell asleep at the med cart, in the dining room, with her head resting on the cart, the cart started to roll away, and she woke up. There was a resident in the dining room during this time, and he witnessed this incident. The aides came to her several times and woke her up, asking if she was OK. An aide put a chair behind her after she almost fell down, sleeping on the cart. She did not complete her med pass; she only gave meds to 2 residents. A record review of a signed statement by Certified Nurse Assistant (CNA) #1, dated 12/30/25 at 2:30 PM, revealed, "…around 8pm, she started falling asleep standing up. She started crying really loud and moaning. She went back and forth to the bathroom a lot. She fell asleep on the counter in the nurse's station…At one point she fell asleep with the med cart open…Around 11:40 PM, we went and got the nurse from Station 1, and she tried to help with med pass…couldn't stay awake to pull meds or pass them. She almost fell down at the table. Her boyfriend/husband came to pick her up at 3:30 AM…The resident's kept calling us to get their meds, we kept having to wake her up to tell her that residents were needing meds." A record review of a signed statement by CNA #2, dated 12/30/25 at 4:00 PM, revealed, "When came in for our shift (LPN #1) was fine. Then she came up to me in the dining room and said she didn't feel good. Then she started crying and was half out of it. She was at the cart, leaned over with her eyes closed. Her legs were giving out, so I put a chair behind her. No one got their meds, everyone kept calling us for their meds. She kept going to sleep mid conversation. I wondered if she was 'high as hell'. She went to the bathroom a bunch of times for a long time. She kept falling asleep while she was trying to sign the narc (narcotics) book.	F0600		

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F0600 SS = SQC-J	Continued from page 5 …We tried to get her to in an ambulance…but she refused…She was crying so loud I was having a hard time doing my charting…" A record review of the facility's "Medication Admin Audit Report" for "Station B" with "Documentation Type: Missed" for 12/29/25 through 12/30/25 revealed 25 residents had medications with no administration time. A record review of the facility's "Medication Admin Audit Report" for "Station B" with "Documentation Type: Late – 1.0 hours(s)" for 12/29/25 through 12/30/25 revealed 5 residents had medications that were administered late. A record review of the facility's daily staffing schedule for 12/29/25 at Building 1 revealed LPN #1 was assigned to Station 2 for the 7P-7A (7:00 PM to 7:00 AM) shift on 12/29/25. A record review of the facility's "Time Punch Report" revealed on 12/29/25, LPN #1 punched in on 12/29/25 at 7:00 PM and punched out on 12/30/25 at 3:00 AM. LPN #2 punched in on 12/29/25 at 6:30 PM and punched out on 12/30/25 at 7:14 AM. LPN #3 punched in on 12/30/25 at 3:45 AM and punched out on 12/30/25 at 2:45 PM. On 1/12/26 at 7:00 AM, during an interview, the facility's Medical Provider revealed Resident #1 sustained a thermal injury to the left thigh as a result of hot coffee being spilled onto the resident's leg causing a 2nd degree burn. Additionally, the Medical Provider stated he was unaware that an impaired nurse had been responsible for 29 residents on 12/30/25. On 1/12/26 at 7:20 AM, during an observation, there was a coffee machine located in the dining area accessible to residents. The machine was labeled "out of service"; however, the machine remained plugged in and operational. The State Agency obtained coffee from the machine without staff assistance or intervention and the coffee was hot. Residents were present in the dining area at the time of the observation, and no staff were observed supervising or restricting resident access to the coffee machine. No physical barriers were in place to prevent resident use of the machine despite the posted signage. On 1/12/26 at 7:30 AM, during an interview the Director of Nursing (DON), she confirmed that on 12/31/25 at approximately 3:40 PM, a resident provided hot coffee to Resident #1, which spilled onto the resident's left thigh and resulted in blistering to the affected area.	F0600		

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F0600 SS = SQC-J	Continued from page 6 The DON confirmed that nursing staff cleansed the area, measured the wound, applied a dressing, and notified the medical provider. The DON reported she did not become aware of the coffee burn incident until she returned to the facility on 1/2/26. She confirmed that upon becoming aware of the incident, no immediate corrective or preventive measures were implemented to reduce the risk of other residents sustaining burns from hot liquids. The DON explained that the incident was reviewed by facility leadership and determined to be accidental in nature, as staff were aware of how the incident occurred, and therefore leadership did not identify the need for additional interventions at that time. The DON confirmed that following the incident on 12/31/25, the facility continued to allow resident access to the coffee machines and did not restrict access, modify the coffee service process, or implement supervision or temperature-control measures. She acknowledged that no actions were taken between 12/31/25 and 1/6/26 to prevent similar incidents involving other residents. The DON further confirmed that on 1/6/26, the facility removed resident access to the coffee machines and began using coffee carafes as a safety measure. She acknowledged that this intervention was not implemented earlier and confirmed that the delay occurred because leadership did not initially consider the incident to pose an ongoing safety risk to other residents. The DON confirmed that she was aware that LPN #1 was impaired on 12/30/25 at approximately 1:30 AM, when LPN #2 informed her of the situation. She confirmed that she did not feel as if it was neglect because the following day, the residents were not identified as having experienced a change in condition, hospitalization, or medication-related harm. She explained that she did not consider the situation to meet the definition of neglect, as she verbally confirmed that all scheduled medications were administered to residents. The DON agreed she was aware on 12/30/25 at 1:30 AM, LPN #1 was impaired but remained on duty until 3:00 AM, the residents continued to request medications, and LPN #1 remained responsible for the residents care. On 1/12/26 at 10:47 AM, during an interview with LPN #2, she confirmed that on 12/29/25 at approximately 11:30 PM, she was informed by Certified Nurse Aides (CNAs) working on the opposite unit (Station 2) that the nurse assigned to that unit appeared impaired and was requesting assistance because residents were asking for their scheduled medications. LPN #2 explained that she went to Station 2 to provide limited assistance due to concerns about the nurse's condition. She confirmed that she accessed the medication cart and pulled medications for the impaired nurse; however, she did	F0600		

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F0600 SS = SQC-J	Continued from page 7 not administer the medications herself. LPN #2 reported that the impaired nurse remained responsible for administering the medications to the residents on that unit because the impaired nurse was familiar with the residents and their medication routines. LPN #2 acknowledged that she did not document the medications on the Medication Administration Record (MAR) and did not accompany or observe the impaired nurse during medication administration. She confirmed that she did not visually verify that the correct medications were administered to the correct residents and did not perform any checks to ensure medications were given as ordered. She explained that she assumed the medications were administered correctly based on the impaired nurse's familiarity with the residents. LPN #2 further confirmed that she did not take possession of the narcotic keys for Station 2. She explained that she declined to take the keys because she did not want to assume responsibility for both her assigned residents and the residents on the impaired nurse's unit. She acknowledged that as a result, she did not have oversight of controlled medication administration on Station 2 during that time. LPN #2 confirmed that after pulling the medications, she returned to her assigned unit and continued caring for her own residents. She acknowledged that no follow-up verification was completed to confirm that all medications were administered, documented, or administered accurately to the appropriate residents on Station 2 during that medication pass. On 1/12/26 at 11:50 AM, in an interview, the Administrator acknowledged awareness of an incident occurring on the 12/29/25 PM shift involving LPN #1 who was observed falling asleep while assigned to administer medications and was unable to safely complete medication administration duties. The Administrator confirmed he was aware that the nurse remained on duty until a replacement nurse arrived, which was approximately 8 hours later. He was not aware there was no documentation indicating that medications were administered, and he had been told that the residents had received their medications. Additionally, the Administrator confirmed that he was not made aware of the resident coffee burn that occurred on 12/31/25 until the facility stand-up meeting on 1/6/26. He acknowledged that the Director of Nursing did not notify him of the incident prior to that date. When asked why he was not informed earlier, the Administrator explained that no one at the facility brought the incident to his attention and indicated that, due to the holiday period, communication may have been missed. He confirmed that under normal circumstances, incidents involving resident injuries	F0600		

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F0600 SS = SQC-J	Continued from page 8 are communicated to him. The Administrator confirmed that once he became aware of the burn on 1/6/26, leadership discussed modifying the coffee service process; however, he acknowledged that he did not personally verify that corrective measures were implemented or consistently followed after that date. He confirmed there was no documented follow-up or monitoring to ensure resident access to hot coffee had been restricted. The Administrator was informed by the State Agency (SA) that upon arrival to the facility on 1/12/26 at approximately 7:30 AM, the SA was able to obtain hot coffee directly from the coffee machine located in the dining area, despite signage placed on the machine indicating it was out of service. The Administrator acknowledged this information and did not express surprise or provide an explanation as to why the coffee machine remained operational. He confirmed that he was not aware the coffee machine was still accessible to residents on the date of the SA's visit. The facility discussed that after the coffee is prepared for the residents, dietary staff was to unplug the coffee machines, but upon the SA arrival they must not have unplug the coffee machines. The Administrator further acknowledged that the facility did not fully implement or enforce the intervention to remove resident access to the coffee machines until the SA was present in the facility on 1/12/26. He confirmed that between the date of the incident on 12/31/25 and the SA's arrival on 1/12/26, residents continued to have access to hot coffee, and no system was in place to ensure the intervention discussed on 1/6/26 was being followed. On 1/12/26 at 12:15 PM, during an interview with CNA #1, confirmed that she was working on 12/29/25 through 12/30/25 and that she noticed LPN #1 was falling asleep, crying out loud, moaning, and leaning over the medication cart with her eyes closed. She notified the nurse on the opposite unit because residents were complaining that they were not receiving their medications. Resident #1 A record review of the "Admission Record" revealed the facility admitted Resident #1 on 10/20/23 with diagnoses including Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated his cognition was severely impaired.	F0600		

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F0600 SS = SQC-J	Continued from page 9 A record review of the "Emergency Department Encounter", dated 1/6/26 revealed the "Chief Complaint" as "…Patient brought in from (proper name of nursing home), family requesting patient be checked for everything…Patient has burn on left hip area that is being treated with wound care…since 12/31…HPI (History of Present Illness)…presents to the emergency room with complaint of burn…patient was burned at the nursing home from a coffee spill a week ago…" A record review of the "Order Summary Report" with active orders as of 1/13/26, revealed Resident #1 had a Physician's Order, dated 10/20/23, for Donepezil Hydrocholoride (HCL) Tablet 5 mg (milligram) Give 1 tablet by mouth at bedtime. 10/20/23). A record review of the Medication Administration Record (MAR) for December 2025 revealed there was no documentation indicating Resident #1 received the 12/29/25 8:30 PM dose of Donepezil HCL. Resident #2 A record of the "Admission Record" revealed the facility admitted Resident #2 on 9/8/25 with diagnoses including Cerebral Infarction. A record review of the Quarterly MDS with an ARD of 12/10/25 revealed Resident #2 had a BIMS score of 15 which indicated he was cognitively intact. A record review of the "Order Summary Report" with active orders as of 12/31/25, revealed Resident #2 had Physician's Orders for Crestor Oral Tablet 20 MG Give 1 tablet by mouth at bedtime for hyperlipidemia (dated 9/8/25), Latanoprost Ophthalmic Solution 0.005% Instill 1 drop in both eyes at bedtime for glaucoma (dated 9/8/25), Novolog Solution 100 UNIT/ML (milliliter), subcutaneously before meals and at bedtime for Diabetes Mellitus, (dated 9/8/25), and Trazodone HCL Oral Tablet 150 MG Give 1 tablet by mouth at bedtime for insomnia (dated 9/8/25). A record review of the Medication Administration Record (MAR) for December 2025 revealed there was no documentation indicating Resident #2 receiving the scheduled medications for 8:00 PM or 9:30 PM on 12/29/25. On 1/12/26 at 2:00 PM, during an interview with Resident #2, he reported he was awake and seated in the dining room at the time LPN #1 was responsible for medication administration. Resident #2 described observing the nurse appeared impaired, noting she was	F0600		

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F0600 SS = SQC-J	Continued from page 10 unable to safely perform medication administration. Resident #2 reported that he did not receive his scheduled medications on 12/29/25 and that he would have been afraid to accept medications from LPN #1 due to concerns that she may administer the incorrect medications. Resident #3 A record review of the “Admission Record” revealed the facility admitted Resident #3 on 3/21/25 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction. A record review of the Quarterly MDS with an ARD 12/10/25 revealed Resident #3 had a BIMS score of 15, which indicated his cognition was intact. A record review of the “Order Summary Report” with active orders as of 12/31/25, revealed Resident #3 had Physician’s Orders for Accucheck AC (before meals) and HS (at bedtime) for Diabetes (dated 3/21/25), Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for neuropathy, Guaifenesin Oral Tablet 400 MG Give 3 tablets by mouth two times a day for cough to equal 1200 MG, (dated 5/15/25), Keppra Oral Tablet 1000 MG Give 1.5 tablet by mouth two times a day for seizure activity take 1.5 tablets to equal dose of 1500 MG (dated 3/21/25), and Lacosamide Oral Tablet 100 MG by mouth two times a day for seizures (dated 10/9/25). A record review of the Medication Administration Record (MAR) for December 2025 revealed there was no documentation indicating Resident #3 receiving any of his 12/29/25 8:30 PM medications. On 1/12/26 at 2:15 PM, during an interview with Resident #3, the resident reported he was in his room, and the nurse was responsible for medication administration, did not give him his medication nor check is accucheck. Resident #3 asked his CNA for his medications, but she responded something was wrong with the nurse. Resident #4 A record review of the “Admission Record” revealed the facility admitted Resident #4 on 7/1/25 with diagnoses including Senile Degeneration of Brain and Dementia. A record review of the Quarterly MDS with an ARD of 12/24/25 for revealed Resident #4 had a BIMS score of 9, which indicated her cognition was moderately impaired.	F0600		

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F0600 SS = SQC-J	Continued from page 11 A record review of the “Order Summary Report” with active orders as of 12/31/25, revealed Resident #4 had Physician’s Orders for Clonidine HCL Oral Tablet 0.2 MG Give 1 tablet by mouth at bedtime for Hypertension (dated 7/1/25), Duloxetine HCL Capsule Delayed Release Particles 60 MG Give 1 capsule by mouth two times a day for depression (dated 7/1/25), and Gabapentin Oral Tablet 600 MG Give 1 tablet by mouth two times a day for Neuropathy (dated 7/1/25). A record review of the Medication Administration Record (MAR) for December 2025 revealed there was no documentation indicating Resident #4 receiving any of her 12/29/25 8:30 PM medications. On 1/13/26 at 9:17 AM, during an interview LPN #3 confirmed that LPN #2 and CNA #1 phoned him many times during 12/30/25 early morning, revealing that LPN #1 was acting strange, impaired, that she was very sick. He confirmed that he reported to work on 12/30/25 clocking in about 3:30 AM. When he relieved the nurse she, was unable to count the narcotics with him and LPN #2 had to perform the count. LPN #1 was very drowsy, unable to give report and stumbling as she walked. The facility submitted the following acceptable Removal Plan on 1/13/26: On 1/13/2026 at 3:55pm the Immediate Jeopardy Templates for F600, F725, F609, F610, F838, F689 were provided to the Administrator. On 12/31/2025, Resident #1 sustained a burn from hot coffee at approximately 3:40pm. The facility failed to implement safeguards or supervision to protect other residents from exposure to the same hazard. Residents continued to have access to hot coffee in the Dining Room without supervision, temperature controls, or access restrictions. The facility failed to implement a thorough investigation and report to the State Agency. On 12/29/25, on the 7:00pm-7:00am shift, the residents on Station 1 remained under the care of an impaired licensed nurse who was unable to safely perform nursing duties. Medication Administration records showed multiple medications were not documented as administered or documented as given late. On 12/29/25, the 7:00pm-7:00am shift, there was no designated Charge Nurse after the scheduled charge nurse called in sick. Therefore, no nurse was designated to assume responsibility to supervise staff, coordinate care, or respond to unsafe conditions. This resulted in the Director of Nursing (DON) not being notified until 1:30 AM which allowed for the impaired nurse to stay in the facility until 3:30 AM. The facility failed to ensure	F0600		

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F0600 SS = SQC-J	Continued from page 12 the facility assessment dated 11/13/24 was updated appropriately and adequately identified staffing and supervisory needs by shift and failed to ensure individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments. The staffing plan did not include contingency planning for absence of supervisory nursing staff and did not ensure onsite licensed supervision when the scheduled charge nurse was absent. 1. On 1/12/26, coffee machines were removed out of service by the Maintenance Director. Individual pots of coffee will be made in the kitchen and temperatures of the pots will be monitored by the Dietary Department to ensure that the coffee served is at or below 140 degrees Fahrenheit. 2.Coffee Temperature logs were created and started on 1/13/2026 that indicate the staff member who tested the temperature of the coffee, the time and date. These logs will be turned into the Administrator daily. 3.Training for ALL staff, prior to their next scheduled shift beginning on 1/13/2026. Beginning on 1/13/26, no staff will be allowed to work until completion of training, provided by the Administrator, DON, and Staff Development Nurse. Accidents and Supervision including implementing immediate interventions. Abuse and Neglect Reporting and Investigation. Hot Liquids Policy. Notification of Administrator and Director of Nursing (DON) of unusual occurrences, High Risk Events and timely notification. Charge Nurse Delegation and Duties to include the assignment of charge nurse by the Scheduling Coordinator and Staff Development Nurse. If assigned charge nurse calls off, the off-going charge nurse will notify the DON for the next assignment. The DON and Administrator's phone numbers are posted on the Facility Assignment Grid. In the event that the charge nurse is impaired, the DON and Administrator will be contacted. Updated Facility Assignment Grid to include assignment for designated charge nurse. Medication Administration Documentation. 1.On 1/12/26, all Residents were evaluated for Safety with Hot Liquids by the DON, Resident Care Coordinators #1 and # 2, Registered Nurses (RN) #1, #2, and #3. 2.Administrator and DON were inserviced on 1/13/26 by the Director of Operations on conducting thorough investigations including root cause analysis and timely reporting to the State Agency.	F0600		

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F0600 SS = SQC-J	Continued from page 13 3.The Facility Assessment was updated on 1/13/2026 by the Administrator to include a contingency plan for absence of supervisory nursing staff and adequately identified staffing needs by shift and building. 4.The facility's Assignment Grid was updated on 1/13/26 to reflect who the Charge Nurse would be each shift. 5.The Scheduler and the Staff Development nurse were inserviced by the DON on 1/13/26 on the new Assignment Grid and Charge Nurse Delegation. The Scheduler and/or Staff Development Nurse will designate on the Assignment Grid who the charge nurse will be. 6.On 1/13/26 all Resident records were reviewed for adverse effects from missed medication by the Corporate RNs with none found. 7.Emergency Quality Assessment and Assurance Committee Meeting held on 1/13/26. Attending the meeting was the Administrator, DON, Infection Preventionist, Minimum Data Set (MDS) Nurse, Social Services Director and Social Services Assistance, Medical Records, Admissions Coordinator, Dietary Manager, Housekeeping Supervisor, Maintenance Supervisor, Human Resources and Central Supply. The Medical Director was present via telephone. The Hot Liquid Policy, Medication Administration Policy, and Sufficient Nursing Policy were reviewed with no changes recommended or made. Summary of incident was discussed with actions taken including training and monitoring. 8.The Attorney General Office and the Mississippi Board of Nursing were notified on 1/12/26 by the Administrator of incident involving LPN #1. LPN #2 was reported to the Agency that she works for and is not allowed to work at this facility. The facility alleges that all corrective actions to remove the immediacy were completed on 1/13/26 and IJ removed on 1/14/26. Validation: The SA validated the removal plan through observations, interviews, and record reviews on 1/13/26 and the immediacy was removed on 1/14/26 prior to exit.	F0600		
F0609 SS = SQC-J	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse,	F0609		

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F0609 SS = SQC-J	Continued from page 14 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to immediately report allegations of neglect to the State Agency for two (2) of (2) events reviewed. The facility's Administrator became aware on 1/6/26 that Resident #1 had sustained a burn from hot coffee on 12/31/25 and residents continued to have access to hot coffee without safeguards in place to prevent additional injuries until 1/12/26. The facility also failed to report to the SA when the Administrator became aware on 12/30/25 that an impaired licensed nurse had remained responsible for resident care from 7:00 PM on 12/29/25 until approximately 3:00 AM on 12/30/25 and medication administration could not be verified as accurate and timely. The facility's failure to report suspected neglect delayed regulatory oversight and corrective intervention, allowing unsafe conditions to continue, placing residents who had access to hot coffee and all (29) residents residing on Station B at likelihood for serious injury or illness, serious harm, serious impairment, or death.	F0609		

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F0609 SS = SQC-J	Continued from page 15 The situation was determined to be Immediate Jeopardy (IJ) that began on 12/29/25 at 7:00 PM when the impaired nurse remained responsible for resident care. The facility Administrator was notified of the IJ on 1/13/26 at 3:40 PM and was presented with the IJ template. The facility provided an acceptable Removal Plan on 1/13/26, in which they alleged all corrective actions to remove the IJ were completed on 1/13/26. The State Agency (SA) validated the Removal Plan on 1/14/26 and determined that the IJ was removed on 1/14/26, prior to exit. Therefore, the scope and severity for 42 CFR §483.12(c)(1) Reporting of Alleged Violations (F609) was lowered from a “J” to a “D” while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility’s policy “Abuse Investigation and Reporting” revised 8/2/22 revealed “…All reports of resident…neglect…shall be promptly reported to local, state and federal agencies (as defined by current regulation) and thoroughly investigated by facility management…Reporting 1. All alleged violations involving…neglect…will be reported by the facility Administrator, or his/her designee…2. An alleged violation of…neglect…will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse..” A record review of the facility’s incident report, dated 12/31/25 at 3:40 PM, revealed the “Incident Description” included a “Nursing Descriptions” of “Called to resident’s room r/t (related to) resident had coffee spilled on left hip area and blisters noted…Resident alert to person. Stating it hurts, it hurts…” The “Injuries Observed at Time of Incident” revealed a “Burn” to the “Left thigh (front).” “Other Info” included “Resident was given coffee by another resident, and this resident spilled coffee on himself resulting in blisters forming to left hip area.” There was no documentation indicating interventions to prevent re-occurrence being initiated. A record review of the “Progress Notes” revealed Resident #1 had a “Skin Issues” note effective 12/31/25 at 4:40 PM for “…New skin issue…Front left trochanter…Blister…acquired in-house…12/31/2025…Length (cm): 7.06 Width (cm): 7.56 …”	F0609		

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F0609 SS = SQC-J	Continued from page 16 A record review of the facility's "Counseling/Discipline Report", dated 1/8/26, revealed License Practical Nurse (LPN) #1, was discharged from the facility. The "Date(s) of Violation(s)" was 12/29 through 12/30 (2025). "Policies violated" included "…Sleeping or appearing to be asleep." The "Employee's Statement" revealed "I was ill-my temp (temperature) was 101 degrees and blood sugar had dropped to 67… I do not remember this." In record review of the facility's investigation revealed, on 12/30/25 the Director of Nurses (DON) received a call at 1:30 AM from the nurse on station one. (LPN #2). She stated "the nurse on station 2 isn't able to complete her med (medication) pass, she keeps falling asleep, I don't know what's going on with her". She advised her to send the nurse to the hospital. She said "I can't be left here with both sides to do meds for 60 people" the DON advised her to call the scheduler to see if she was able to get a nurse to come in and send the nurse on station 2 home. She was able to get a nurse to come at 3:00 AM. After the DON reviewed the camera footage of the incident that took place, she phoned LPN #1 and did not receive a return call from LPN #1. According to the camera footage, the DON observed the nurse at the nurse's station for about 2 hours. She pushed the cart into the hallway outside of the nurse's station. At this point, she stared at the computer for a long time and swayed around almost falling. LPN #1 appeared to be under the influence of something. She was stumbling around, staring at the med cart fumbling through the cart looking for meds, would pull a med card and just stare at it for minutes. At one point, she fell asleep at themed cart, in the dining room, with her head resting on the cart, the cart started to roll away, and she woke up. There was a resident in the dining room during this time, and he witnessed this incident. The aides came to her several times and woke her up, asking if she was OK. An aide put a chair behind her after she almost fell down, sleeping on the cart. She did not complete her med pass, she only gave meds to 2 residents. The DON A record review of a signed statement by Certified Nurse Assistant (CNA) #1, dated 12/30/25 at 2:30 PM, revealed, "…around 8pm, she started falling asleep standing up. She started crying really loud and moaning. She went back and forth to the bathroom a lot. She fell asleep on the counter in the nurse's station…At one point she fell asleep with the med cart open…Around 11:40 we went and got the nurse from Station 1, and she tried to help with med pass…couldn't stay awake to pull meds or pass them. She almost fell down at the table. Her boyfriend/husband came to pick	F0609		

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F0609 SS = SQC-J	Continued from page 17 her up at 3:30…The resident's kept calling us to get their meds, we kept having to wake her up to tell her that residents were needing meds." A record review of a signed statement by CNA #2, dated 12/30/25 at 4:00 PM, revealed, "When came in for our shift (LPN #1) was fine. Then she came up to me in the dining room and said she didn't feel good. Then she started crying and was half out of it. She was at the cart, leaned over with her eyes closed. Her legs were giving out, so I put a chair behind her. No one got their meds, everyone kept calling us for their meds. She kept going to sleep mid conversation. I wondered if she was 'high as hell'. She went to the bathroom a bunch of times for a long time. She kept falling asleep while she was trying to sign the narc (narcotics) book. …We tried to get her to in an ambulance…but she refused…She was crying so loud I was having a hard time doing my charting…" A record review of the facility's "Medication Admin Audit Report" for "Station B" with "Documentation Type: Missed" for 12/29/25 through 12/30/25 revealed 25 residents had medications with no administration time. A record review of the facility's "Medication Admin Audit Report" for "Station B" with "Documentation Type: Late – 1.0 hours(s)" for 12/29/25 through 12/30/25 revealed 5 residents had medications that were administered late. During an observation on 1/12/26 at 7:20 AM, there was a coffee machine located in the dining area accessible to residents. The machine was labeled "out of service"; however, the machine remained plugged in and operational. The State Agency obtained coffee from the machine without staff assistance or intervention and the coffee was hot. Residents were present in the dining area at the time of the observation, and no staff were observed supervising or restricting resident access to the coffee machine. No physical barriers were in place to prevent resident use of the machine despite the posted signage. During an interview on 1/12/26 at 7:30 AM, the Director of Nursing (DON) confirmed that on 12/31/25 at approximately 3:40 PM, a resident gave a cup of hot coffee to Resident #1, at which time the coffee spilled onto the resident's left thigh, resulting in blistering to the affected area. The DON reported that following the incident, nursing staff cleansed the affected area, measured the wound, applied a dressing, and notified the medical provider. She stated she was not aware of the coffee burn until she returned to the facility on	F0609		

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F0609 SS = SQC-J	Continued from page 18 1/2/26 and confirmed there were no immediate interventions put in place to safeguard other residents who drink coffee. The DON reported the facility did not remove the coffee machines, but instead added signs on 1/6/26 (6 days after the burn) to not use the coffee machines, at which point they began using coffee carafes (a container, usually made of glass or stainless steel that holds and serves coffee). She was unaware that the coffee machines were still operational and being used as of 1/12/26 (13 days after the burn), despite the signage on the machines. Additionally, the DON confirmed that she was aware that LPN #1 was impaired on 12/30/25 at approximately 1:30 AM, when LPN #2 informed her of the situation. She verbally confirmed with LPN #2 that the residents received their medications but did not verify administration by interviewing residents or reviewing the Medication Audit Report for Missed or Late medications. The DON confirmed she was aware that although LPN #1 was impaired, she remained on duty for approximately eight (8) hours in which she was responsible for resident care and medication administration. During an interview on 1/12/26 at 11:50 AM, the Administrator acknowledged awareness of an incident occurring on the 12/29/25 PM shift involving LPN #1 who was observed falling asleep while assigned to administer medications and was unable to safely complete medication administration duties. The Administrator confirmed he was aware that the nurse remained on duty until a replacement nurse arrived, which was approximately 8 hours later. He was not aware there was no documentation indicating that medications were administered, and he had been told that the residents had received their medications. The Administrator also acknowledged awareness that Resident #1 sustained a burn injury after hot coffee spilled onto the resident's leg while at the facility. He explained that although the incident occurred on 12/31/25, he was not aware of it until 1/6/26, which was six (6) days after the incident occurred. He reported that signs were placed on the coffee machine on 1/6/26 indicating not to use and he was unaware that the machines were still being as of 1/12/26, despite there being signage. The Administrator confirmed there were no immediate interventions put into place to safeguard other residents who drink coffee. He explained that he believed both incidents to not be reportable events because he did not consider either issue to be neglect. On 1/13/26 at 9:17 AM, during an interview with LPN #3, he confirmed that LPN #2 and CNA #1 phoned him many times during 12/30/25 early morning, revealing that LPN	F0609		

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(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
F0609 SS = SQC-J	Continued from page 19 #1 was acting strange, impaired, and that she was very sick. He confirmed that he reported to work on 12/30/25 and had clocked in at approximately 3:30 AM. When he relieved LPN #1, she was unable to count the narcotics with him and LPN #2 had to perform the count. LPN #1 was very drowsy, unable to give report and stumbling as she walked. The facility submitted the following acceptable Removal Plan on 1/13/26: On 1/13/2026 at 3:55pm the Immediate Jeopardy Templates for F600, F725, F609, F610, F838, F689 were provided to the Administrator. On 12/31/2025, Resident #1 sustained a burn from hot coffee at approximately 3:40pm. The facility failed to implement safeguards or supervision to protect other residents from exposure to the same hazard. Residents continued to have access to hot coffee in the Dining Room without supervision, temperature controls, or access restrictions. The facility failed to implement a thorough investigation and report to the State Agency. On 12/29/25, on the 7:00pm-7:00am shift, the residents on Station 1 remained under the care of an impaired licensed nurse who was unable to safely perform nursing duties. Medication Administration records showed multiple medications were not documented as administered or documented as given late. On 12/29/25, the 7:00pm-7:00am shift, there was no designated Charge Nurse after the scheduled charge nurse called in sick. Therefore, no nurse was designated to assume responsibility to supervise staff, coordinate care, or respond to unsafe conditions. This resulted in the Director of Nursing (DON) not being notified until 1:30am which allowed for the impaired nurse to stay in the facility until 3:30am. The facility failed to ensure the facility assessment dated 11/13/24 was updated appropriately and adequately identified staffing and supervisory needs by shift and failed to ensure individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments. The staffing plan did not include contingency planning for absence of supervisory nursing staff and did not ensure onsite licensed supervision when the scheduled charge nurse was absent. 1. On 1/12/26, coffee machines were removed out of service by the Maintenance Director. Individual pots of coffee will be made in the kitchen and temperatures of the pots will be monitored by the Dietary Department to ensure that the coffee served is at or below 140 degrees Fahrenheit.	F0609		

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F0609 SS = SQC-J	Continued from page 20 2.Coffee Temperature logs were created and started on 1/13/2026 that indicate the staff member who tested the temperature of the coffee, the time and date. These logs will be turned into the Administrator daily. 3.Training for ALL staff, prior to their next scheduled shift beginning on 1/13/2026. Beginning on 1/13/26, no staff will be allowed to work until completion of training, provided by the Administrator, DON, and Staff Development Nurse. Accidents and Supervision including implementing immediate interventions. Abuse and Neglect Reporting and Investigation. Hot Liquids Policy. Notification of Administrator and Director of Nursing (DON) of unusual occurrences, High Risk Events and timely notification. Charge Nurse Delegation and Duties to include the assignment of charge nurse by the Scheduling Coordinator and Staff Development Nurse. If assigned charge nurse calls off, the off-going charge nurse will notify the DON for the next assignment. The DON and Administrator's phone numbers are posted on the Facility Assignment Grid. In the event that the charge nurse is impaired, the DON and Administrator will be contacted. Updated Facility Assignment Grid to include assignment for designated charge nurse. Medication Administration Documentation. 1.On 1/12/26, all Residents were evaluated for Safety with Hot Liquids by the DON, Resident Care Coordinators #1 and # 2, Registered Nurses (RN) #1, 2, and 3. 2.Administrator and DON were inserviced on 1/13/26 by the Director of Operations on conducting thorough investigations including root cause analysis and timely reporting to the State Agency. 3.The Facility Assessment was updated on 1/13/2026 by the Administrator to include a contingency plan for absence of supervisory nursing staff and adequately identified staffing needs by shift and building. 4.The facility's Assignment Grid was updated on 1/13/26 to reflect who the Charge Nurse would be each shift. 5.The Scheduler and the Staff Development nurse were inserviced by the DON on 1/13/26 on the new Assignment Grid and Charge Nurse Delegation. The Scheduler and/or Staff Development Nurse will designate on the Assignment Grid who the charge nurse will be. 6.On 1/13/26 all Resident records were reviewed for adverse effects from missed medication by the Corporate RNs with none found.	F0609		

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F0609 SS = SQC-J	Continued from page 21 7.Emergency Quality Assessment and Assurance Committee Meeting held on 1/13/26. Attending the meeting was the Administrator, DON, Infection Preventionist, Minimum Data Set (MDS) Nurse, Social Services Director and Social Services Assistance, Medical Records, Admissions Coordinator, Dietary Manager, Housekeeping Supervisor, Maintenance Supervisor, Human Resources and Central Supply. The Medical Director was present via telephone. The Hot Liquid Policy, Medication Administration Policy, and Sufficient Nursing Policy were reviewed with no changes recommended or made. Summary of incident was discussed with actions taken including training and monitoring. 8.The Attorney General Office and the Mississippi Board of Nursing were notified on 1/12/26 by the Administrator of incident involving LPN #1. LPN #2 was reported to the Agency that she works for and is not allowed to work at this facility. The facility alleges that all corrective actions to remove the immediacy were completed on 1/13/26 and IJ removed on 1/14/26. Validation: The SA validated the removal plan through observations, interviews, and record reviews on 1/13/26 and the immediacy was removed on 1/14/26 prior to exit.	F0609		
F0610 SS = SQC-J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the	F0610		

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F0610 SS = SQC-J	Continued from page 22 alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to conduct thorough and timely investigations and failed to implement corrective actions to prevent further neglect for two (2) of (2) events reviewed. Resident #1 sustained a burn on 12/31/25 at approximately 3:40 PM; however, the facility failed to determine the root cause of the injury or implement safeguards to prevent additional residents from exposure to the same hazard, and residents continued to have access to hot coffee without supervision, temperature controls, or access restrictions until 1/12/26. Additionally, residents remained under the care of an impaired licensed nurse from 7:00 PM on 12/29/25 until approximately 3:00 AM on 12/30/25. Medication administration could not be verified as accurate and timely. However, the facility failed to immediately investigate how long the nurse had been impaired, whether medications were administered correctly, or what system failures allowed unsafe care to continue without supervision. The facility's failure to conduct thorough investigations and implement corrective actions to prevent recurrence allowed unsafe conditions to continue and placed residents who had access to hot coffee and all (29) residents residing on Station B at likelihood for serious injury or illness, serious harm, serious impairment, or death. The situation was determined to be Immediate Jeopardy (IJ) that began on 12/29/25 at 7:00 PM when the impaired nurse remained responsible for resident care. The facility Administrator was notified of the IJ on 1/13/26 at 3:40 PM and was presented with the IJ template. The facility provided an acceptable Removal Plan on 1/13/26, in which they alleged all corrective actions to remove the IJ were completed on 1/13/26. The State Agency (SA) validated the Removal Plan on 1/14/26 and determined that the IJ was removed on 1/14/26, prior to exit. Therefore, the scope and severity for 42 CFR §483.12(c)(3) Investigate/Prevent Further Potential Abuse, Neglect, or Exploitation (F610) was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.	F0610		

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F0610 SS = SQC-J	Continued from page 23 Findings include: A review of the facility's policy "Abuse Investigation and Reporting" revised 8/2/22 revealed "…All reports of resident…neglect…shall be…thoroughly investigated by facility management…Role of the Administrator: 1. If an incident or suspected incident of resident…neglect…is reported, the Administrator or designee will lead the investigation. 4. The Administrator or designee will ensure that any further potential…neglect…is prevented…Investigative Process: 1. The individual conducting the investigation will…a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident…d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate)…g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident…i. Interview other residents to whom the accused employee provides care or services; and j. Review all events leading up to the alleged incident..2. The following guidelines will be used when conducting interviews…3. Upon conclusion of the investigation, the Administrator or designee will document the results f the investigation…" A record review of the facility's incident report, dated 12/31/25 at 3:40 PM, revealed the "Incident Description" included a "Nursing Descriptions" of "Called to resident's room r/t (related to) resident had coffee spilled on left hip area and blisters noted…Resident alert to person. Stating it hurts, it hurts…" The "Injuries Observed at Time of Incident" revealed a "Burn" to the "Left thigh (front)." "Other Info" included "Resident was given coffee by another resident, and this resident spilled coffee on himself resulting in blisters forming to left hip area." There was no documentation indicating interventions to prevent re-occurrence being initiated. A record review of the "Progress Notes" revealed Resident #1 had a "Skin Issues" note effective 12/31/25 at 4:40 PM for "…New skin issue…Front left trochanter…Blister…acquired in-house…12/31/2025…Length (cm): 7.06 Width (cm): 7.56 …" A record review of the facility's "Counseling/Discipline Report", dated 1/8/26, revealed License Practical Nurse (LPN) #1, was discharged from the facility. The "Date(s) of Violation(s)" was 12/29 through 12/30 (2025). "Policies violated" included "…Sleeping or appearing to be asleep." The "Employee's Statement" revealed "I was ill-my temp (temperature) was 101 degrees and blood sugar had dropped to 67… I do	F0610		

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F0610 SS = SQC-J	Continued from page 24 not remember this." In record review of the facility's investigation revealed, on 12/30/25 the Director of Nurses (DON) received a call at 1:30 AM from the nurse on station one. (LPN #2). She stated "the nurse on station 2 isn't able to complete her med (medication) pass, she keeps falling asleep, I don't know what's going on with her". She advised her to send the nurse to the hospital. She said "I can't be left here with both sides to do meds for 60 people" the DON advised her to call the scheduler to see if she was able to get a nurse to come in and send the nurse on station 2 home. She was able to get a nurse to come at 3:00 AM. After the DON reviewed the camera footage of the incident that took place, she phoned LPN #1 and did not receive a return call from LPN #1. According to the camera footage, the DON observed the nurse at the nurse's station for about 2 hours. She pushed the cart into the hallway outside of the nurse's station. At this point, she stared at the computer for a long time and swayed around almost falling. LPN #1 appeared to be under the influence of something. She was stumbling around, staring at the med cart fumbling through the cart looking for meds, would pull a med card and just stare at it for minutes. At one point, she fell asleep at themed cart, in the dining room, with her head resting on the cart, the cart started to roll away, and she woke up. There was a resident in the dining room during this time, and he witnessed this incident. The aides came to her several times and woke her up, asking if she was OK. An aide put a chair behind her after she almost fell down, sleeping on the cart. She did not complete her med pass, she only gave meds to 2 residents. The DON A record review of a signed statement by Certified Nurse Assistant (CNA) #1, dated 12/30/25 at 2:30 PM, revealed, "…around 8pm, she started falling asleep standing up. She started crying really loud and moaning. She went back and forth to the bathroom a lot. She fell asleep on the counter in the nurse's station…At one point she fell asleep with the med cart open…Around 11:40 we went and got the nurse from Station 1, and she tried to help with med pass…couldn't stay awake to pull meds or pass them. She almost fell down at the table. Her boyfriend/husband came to pick her up at 3:30…The resident's kept calling us to get their meds, we kept having to wake her up to tell her that residents were needing meds." A record review of a signed statement by CNA #2, dated 12/30/25 at 4:00 PM, revealed, "When came in for our shift (LPN #1) was fine. Then she came up to me in the dining room and said she didn't feel good. Then she	F0610		

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F0610 SS = SQC-J	Continued from page 25 started crying and was half out of it. She was at the cart, leaned over with her eyes closed. Her legs were giving out, so I put a chair behind her. No one got their meds, everyone kept calling us for their meds. She kept going to sleep mid conversation. I wondered if she was 'high as hell'. She went to the bathroom a bunch of times for a long time. She kept falling asleep while she was trying to sign the narc (narcotics) book. …We tried to get her to in an ambulance…but she refused…She was crying so loud I was having a hard time doing my charting…" A record review of the facility's "Medication Admin Audit Report" for "Station B" with "Documentation Type: Missed" for 12/29/25 through 12/30/25 revealed 25 residents had medications with no administration time. A record review of the facility's "Medication Admin Audit Report" for "Station B" with "Documentation Type: Late – 1.0 hours(s)" for 12/29/25 through 12/30/25 revealed 5 residents had medications that were administered late. During an observation on 1/12/26 at 7:20 AM, there was a coffee machine located in the dining area accessible to residents. The machine was labeled "out of service"; however, the machine remained plugged in and operational. The State Agency obtained coffee from the machine without staff assistance or intervention and the coffee was hot. Residents were present in the dining area at the time of the observation, and no staff were observed supervising or restricting resident access to the coffee machine. No physical barriers were in place to prevent resident use of the machine despite the posted signage. In an interview on 1/12/26 at 7:30 AM, the Director of Nursing (DON) confirmed that on 12/31/25 at approximately 3:40 PM, a resident gave a cup of hot coffee to Resident #1 and Resident #1 then spilled it onto his left thigh, resulting in blistering. She reported nursing staff cleansed the affected area, measured the wound, applied a dressing, and notified the medical provider. The DON stated she was not aware of the coffee burn until she returned to the facility on 1/2/26 and confirmed there were no immediate interventions implemented to safeguard other residents who drink coffee until 1/6/26. She reported that the facility did not remove the coffee machines but added signs on 1/6/26 instructing staff and residents not to use the coffee machines, and began using coffee carafes instead. She stated she was not aware the coffee machines remained operational and were still being used as of 1/12/26, despite the signage instructing not to	F0610		

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F0610 SS = SQC-J	Continued from page 26 use them. The DON did not describe completing interviews with residents who drink coffee, review of the procedure to check coffee temperatures or environmental risks related to access to hot liquids to prevent recurrence. The DON also confirmed she was notified on 12/30/25 at approximately 1:30 AM by LPN #2 that LPN #1 appeared impaired while on duty and responsible for resident care and medication administration. She reported she verbally confirmed with LPN #2 that residents had received their medications but did not verify medication administration by reviewing Medication Administration Records, reviewing the Medication Audit Report for missed or late medications, or interviewing residents. She also did not describe reviewing all events leading up to and following the incident to determine root cause or to prevent recurrence. The DON confirmed she was aware that although LPN #1 was impaired, the nurse remained on duty and responsible for resident care until approximately 3:00 AM. In an interview on 1/12/26 at 11:50 AM, the Administrator acknowledged awareness of the incident occurring on the 12/29/25 evening shift involving LPN #1 who was observed falling asleep while assigned to administer medications and was unable to safely complete medication administration duties. He confirmed the nurse remained on duty until a replacement nurse arrived approximately eight (8) hours later. However, he stated he was told residents had received their medications and did not review Medication Administration Records, Medication Audit Reports, or other documentation to verify whether medications were administered accurately and timely. The Administrator also acknowledged awareness that Resident #1 sustained a burn injury after hot coffee spilled onto the resident's leg, stating the incident occurred on 12/31/25 but he was not aware of it until 1/6/26, six (6) days after the incident occurred. He reported signs were placed on the coffee machines on 1/6/26 instructing not to use the machines and stated he was not aware the coffee machines remained operational and were still being used as of 1/12/26, despite the signage. He confirmed there were no immediate interventions implemented to safeguard other residents who drink coffee or to assess environmental risks related to access to hot liquids immediately following the incident on 12/31/25. The Administrator did not describe initiating a formal investigation that included interviewing residents who drink coffee, interviewing residents who were under the care of the impaired nurse, reviewing documentation related to medication administration, or identifying root causes and corrective actions to prevent recurrence for either	F0610		

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F0610 SS = SQC-J	Continued from page 27 incident. The facility submitted the following acceptable Removal Plan on 1/13/26: On 1/13/2026 at 3:55pm the Immediate Jeopardy Templates for F600, F725, F609, F610, F838, F689 were provided to the Administrator. On 12/31/2025, Resident #1 sustained a burn from hot coffee at approximately 3:40pm. The facility failed to implement safeguards or supervision to protect other residents from exposure to the same hazard. Residents continued to have access to hot coffee in the Dining Room without supervision, temperature controls, or access restrictions. The facility failed to implement a thorough investigation and report to the State Agency. On 12/29/25, on the 7:00pm-7:00am shift, the residents on Station 1 remained under the care of an impaired licensed nurse who was unable to safely perform nursing duties. Medication Administration records showed multiple medications were not documented as administered or documented as given late. On 12/29/25, the 7:00pm-7:00am shift, there was no designated Charge Nurse after the scheduled charge nurse called in sick. Therefore, no nurse was designated to assume responsibility to supervise staff, coordinate care, or respond to unsafe conditions. This resulted in the Director of Nursing (DON) not being notified until 1:30am which allowed for the impaired nurse to stay in the facility until 3:30am. The facility failed to ensure the facility assessment dated 11/13/24 was updated appropriately and adequately identified staffing and supervisory needs by shift and failed to ensure individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments. The staffing plan did not include contingency planning for absence of supervisory nursing staff and did not ensure onsite licensed supervision when the scheduled charge nurse was absent. 1. On 1/12/26, coffee machines were removed out of service by the Maintenance Director. Individual pots of coffee will be made in the kitchen and temperatures of the pots will be monitored by the Dietary Department to ensure that the coffee served is at or below 140 degrees Fahrenheit. 2.Coffee Temperature logs were created and started on 1/13/2026 that indicate the staff member who tested the temperature of the coffee, the time and date. These logs will be turned into the Administrator daily. 3.Training for ALL staff, prior to their next scheduled	F0610		

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F0610 SS = SQC-J	Continued from page 28 shift beginning on 1/13/2026. Beginning on 1/13/26, no staff will be allowed to work until completion of training, provided by the Administrator, DON, and Staff Development Nurse. Accidents and Supervision including implementing immediate interventions. Abuse and Neglect Reporting and Investigation. Hot Liquids Policy. Notification of Administrator and Director of Nursing (DON) of unusual occurrences, High Risk Events and timely notification. Charge Nurse Delegation and Duties to include the assignment of charge nurse by the Scheduling Coordinator and Staff Development Nurse. If assigned charge nurse calls off, the off-going charge nurse will notify the DON for the next assignment. The DON and Administrator's phone numbers are posted on the Facility Assignment Grid. In the event that the charge nurse is impaired, the DON and Administrator will be contacted. Updated Facility Assignment Grid to include assignment for designated charge nurse. Medication Administration Documentation. 1.On 1/12/26, all Residents were evaluated for Safety with Hot Liquids by the DON, Resident Care Coordinators #1 and # 2, Registered Nurses (RN) #1, 2, and 3. 2.Administrator and DON were inserviced on 1/13/26 by the Director of Operations on conducting thorough investigations including root cause analysis and timely reporting to the State Agency. 3.The Facility Assessment was updated on 1/13/2026 by the Administrator to include a contingency plan for absence of supervisory nursing staff and adequately identified staffing needs by shift and building. 4.The facility's Assignment Grid was updated on 1/13/26 to reflect who the Charge Nurse would be each shift. 5.The Scheduler and the Staff Development nurse were inserviced by the DON on 1/13/26 on the new Assignment Grid and Charge Nurse Delegation. The Scheduler and/or Staff Development Nurse will designate on the Assignment Grid who the charge nurse will be. 6.On 1/13/26 all Resident records were reviewed for adverse effects from missed medication by the Corporate RNs with none found. 7.Emergency Quality Assessment and Assurance Committee Meeting held on 1/13/26. Attending the meeting was the Administrator, DON, Infection Preventionist, Minimum Data Set (MDS) Nurse, Social Services Director and Social Services Assistance, Medical Records, Admissions	F0610		

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F0610 SS = SQC-J	Continued from page 29 Coordinator, Dietary Manager, Housekeeping Supervisor, Maintenance Supervisor, Human Resources and Central Supply. The Medical Director was present via telephone. The Hot Liquid Policy, Medication Administration Policy, and Sufficient Nursing Policy were reviewed with no changes recommended or made. Summary of incident was discussed with actions taken including training and monitoring. 8.The Attorney General Office and the Mississippi Board of Nursing were notified on 1/12/26 by the Administrator of incident involving LPN #1. LPN #2 was reported to the Agency that she works for and is not allowed to work at this facility. The facility alleges that all corrective actions to remove the immediacy were completed on 1/13/26 and IJ removed on 1/14/26. Validation: The SA validated the removal plan through observations, interviews, and record reviews on 1/13/26 and the immediacy was removed on 1/14/26 prior to exit.	F0610		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure the resident environment remained free of accident hazards when Resident #1 sustained a burn with blisters from hot coffee on 12/31/25 at approximately 3:40 PM and the facility failed to implement environmental controls or supervision to prevent other residents from exposure to the same hazard. Despite staff knowledge that hot coffee posed a burn risk, coffee pots remained accessible to residents in the dining room without supervision, temperature controls, or access	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255343	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = SQC-J	Continued from page 30 restrictions until 1/12/26. This deficient practice affected one (1) of four (4) sampled residents (Resident #1) with the potential to affect all residents who drink hot coffee. The facility's failure to provide adequate supervision resulted in Resident #1 sustaining a burn with blisters and placed all residents who had access to hot coffee at likelihood for serious injury, serious harm, serious impairment, or death. The situation was determined to be Immediate Jeopardy (IJ) that began on 12/31/25 when Resident #1 sustained a burn from hot coffee. The facility Administrator was notified of the IJ on 1/13/26 at 3:40 PM and was presented with the IJ template. The facility provided an acceptable Removal Plan on 1/13/26, in which they alleged all corrective actions to remove the IJ were completed on 1/13/26. The State Agency (SA) validated the Removal Plan on 1/14/26 and determined that the IJ was removed on 1/14/26, prior to exit. Therefore, the scope and severity for 42 CFR §483.25(d)(2) Accidents/Hazards (F689) was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility's policy "Safety of Hot Liquids" created 7/25/22 revealed "…Hot liquids are to be served at proper (safe and appetizing) temperatures using appropriate safety precautions…Policy Interpretation and Implementation…3. Appropriate interventions will be implemented to minimize the risk from burns. Such interventions may include: a. maintaining a hot liquids serving temperature of not more than 140 degrees Fahrenheit…f. staff supervision or assistance with hot beverages…4. General safety precautions when serving hot liquids include, but are not limited to…d. Regulate temperature of hot liquids to which residents have direct access…" A record review of the facility's policy "Safety and Supervision of Residents" revised 8/2/22 revealed, "Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation…1. Our facility-oriented approach to safety addresses risks for groups of residents. 2.	F0689		

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F0689 SS = SQC-J	Continued from page 31 Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes…3. When accident hazards are identified, The Quality Assurance Performance Improvement (QAPI)/Safety Committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible…Individualized, Resident-Centered Approach to Safety…2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision…4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary; d. Ensuring that interventions are implemented; and e. Documenting interventions.." A record review of the facility's incident report, dated 12/31/25 at 3:40 PM, revealed the "Incident Description" included a "Nursing Descriptions" of "Called to resident's room r/t (related to) resident had coffee spilled on left hip area and blisters noted…Resident alert to person. Stating it hurts, it hurts…" The "Injuries Observed at Time of Incident" revealed a "Burn" to the "Left thigh (front)." "Other Info" included "Resident was given coffee by another resident, and this resident spilled coffee on himself resulting in blisters forming to left hip area." A record review of a handwritten statement signed by Certified Nurse Aide (CNA) #3 on 1/7/26 revealed that on 12/31/25 after 3:00 PM, revealed she and two (2) other CNAs were in the dining room and Resident #1 was sitting by the Christmas tree asleep. Another resident walked past Resident #1 and approximately 15 seconds she heard Resident #1 yelling, "hey help me this hot". CNA #3, along with the other 2 CNAs, took the resident to his room and noticed that his left side was red. The wound care nurse was notified and came to check on the resident because he had spilled coffee on himself. A record review of the "Progress Notes" revealed Resident #1 had a "Skin Issues" note effective 12/31/25 at 4:40 PM for "…New skin issue…Front left trochanter…Blister…acquired in-house…12/31/2025…Length (cm): 7.06 Width (cm): 7.56 …" A record review of the facility's "Hot/Cold Holding	F0689		

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F0689 SS = SQC-J	Continued from page 32 Temperature Log" which was identified as "Coffee logs" revealed there were no coffee temperatures recorded prior to 1/6/26. The facility's Medical Director revealed on 1/12/26 at 7:00 AM, during an interview, that Resident #1 sustained a thermal injury to the left thigh as a result of hot coffee being spilled onto the resident's leg causing a 2nd degree burn. An observation on 1/12/26 at 7:20 AM, revealed there was a coffee machine located in the dining area accessible to residents. The machine was labeled "out of service"; however, the machine remained plugged in and operational. The State Agency obtained coffee from the machine without staff assistance or intervention and the coffee was hot. Residents were present in the dining area at the time of the observation, and no staff were observed supervising or restricting resident access to the coffee machine. No physical barriers were in place to prevent resident use of the machine despite the posted signage. The Director of Nursing (DON) revealed on 1/12/26 at 7:30 AM during an interview, that on 12/31/25 at approximately 3:40 PM, a resident provided hot coffee to Resident #1, which spilled onto the resident's left thigh and resulted in blistering to the affected area. The DON confirmed that nursing staff cleansed the area, measured the wound, applied a dressing, and notified the medical provider. The DON reported she did not become aware of the coffee burn incident until she returned to the facility on 1/2/26. She confirmed that upon becoming aware of the incident, no immediate corrective or preventive measures were implemented to reduce the risk of other residents sustaining burns from hot liquids. The DON explained that the incident was reviewed by facility leadership and determined to be accidental in nature, as staff were aware of how the incident occurred, and therefore leadership did not identify the need for additional interventions at that time. The DON confirmed that following the incident on 12/31/25, the facility continued to allow resident access to the coffee machines and did not restrict access, modify the coffee service process, or implement supervision or temperature-control measures. She acknowledged that no actions were taken between 12/31/25 and 1/6/26 to prevent similar incidents involving other residents. The DON further confirmed that on 1/6/26, the facility placed signs on the machines and began pouring the coffee into carafes as a safety measure. She acknowledged that this intervention was not implemented earlier and confirmed that the delay occurred because leadership did not initially	F0689		

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F0689 SS = SQC-J	Continued from page 33 consider the incident to pose an ongoing safety risk to other residents. The Administrator revealed on 1/12/26 at 11:50 AM, in an interview, that he was not made aware of the resident coffee burn that occurred on 12/31/25 until the facility stand-up meeting on 1/6/26. He acknowledged that the Director of Nursing did not notify him of the incident prior to that date. When asked why he was not informed earlier, the Administrator explained that no one at the facility brought the incident to his attention and indicated that, due to the holiday period, communication may have been missed. He confirmed that under normal circumstances, incidents involving resident injuries are communicated to him. The Administrator confirmed that once he became aware of the burn on 1/6/26, leadership discussed modifying the coffee service process by using the coffee machines to make the coffee and then pouring the coffee into coffee carafes. He acknowledged that he did not personally verify that corrective measures were implemented or consistently followed after that date. He confirmed there was no documented follow-up or monitoring to ensure resident access to hot coffee had been restricted. The Administrator was informed by the State Agency (SA) that upon arrival to the facility on 1/12/26 at approximately 7:30 AM, the SA was able to obtain hot coffee directly from the coffee machine located in the dining area, despite signage placed on the machine indicating it was out of service. The Administrator acknowledged this information and did not provide an explanation as to why the coffee machine remained operational. The facility discussed that after the coffee is prepared for the residents, dietary staff was to unplug the coffee machines, but upon the SA arrival they must not have unplugged the coffee machines. The Administrator further acknowledged that the facility did not fully implement or enforce the intervention to remove resident access to the coffee machines until the SA was present in the facility on 1/12/26. He confirmed that between the date of the incident on 12/31/25 and the SA's arrival on 1/12/26, residents continued to have access to hot coffee, and no system was in place to ensure the intervention discussed on 1/6/26 was being followed. On 1/12/26 at 2:00 PM, during an interview with Resident #2, he reported that residents continued to receive coffee from the coffee machines until the SA entered the facility. He explained that around the 1st of January, after the holidays, staff were expected to unplug the machines throughout the day; however, he observed that this did not consistently occur. Resident	F0689		

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F0689 SS = SQC-J	Continued from page 34 #2 reported that residents were still able to obtain coffee from the machines because they remained plugged in and usable. On 1/12/26 at 3:00 PM, the SA observed a sign on back of the dietary door revealing, “Attention!!!! Every 2 hours whom ever the Aide is. Are to refill the coffee kettle pots on each side! Plug coffee machine in let it heat up and refill the kettle pot every 2 hours and then un plug the coffee machines! The coffee is to hot in the machine for the residents. Signed by: Dietary Manager.” There was no date indicating when the sign was placed. On 1/13/26 at 11:00 PM, during an interview with the Dietary Manager, she confirmed that following the coffee-related burn injury on 12/31/25, the facility continued to use the coffee machines until 1/6/26. She confirmed that on 1/6/26, the facility still used the coffee machines to make the coffee but then transitioned the coffee to a coffee dispensary device. She explained there were “Do Not Use” signage on the coffee machines and provided in-services to dietary staff regarding testing coffee temperatures. She further confirmed that the coffee machines were not shut down and removed from the building until 1/12/26, after the SA entry. Resident #1 A record review of the “Admission Record” revealed the facility admitted Resident #1 on 10/20/23 with diagnoses including Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated his cognition was severely impaired. A record review of the “Emergency Department Encounter”, dated 1/6/26 revealed the “Chief Complaint” as “…Patient brought in from (proper name of nursing home), family requesting patient be checked for everything…Patient has burn on left hip area that is being treated with wound care…since 12/31…HPI (History of Present Illness)…presents to the emergency room with complaint of burn…patient was burned at the nursing home from a coffee spill a week ago…” Resident #2 A record of the “Admission Record” revealed the	F0689		

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F0689 SS = SQC-J	Continued from page 35 facility admitted Resident #2 on 9/8/25 with diagnoses including Cerebral Infarction. A record review of the Quarterly MDS with an ARD of 12/10/25 revealed Resident #2 had a BIMS score of 15 which indicated he was cognitively intact. The facility submitted the following acceptable Removal Plan on 1/13/26: On 1/13/2026 at 3:55pm the Immediate Jeopardy Templates for F600, F725, F609, F610, F838, F689 were provided to the Administrator. On 12/31/2025, Resident #1 sustained a burn from hot coffee at approximately 3:40pm. The facility failed to implement safeguards or supervision to protect other residents from exposure to the same hazard. Residents continued to have access to hot coffee in the Dining Room without supervision, temperature controls, or access restrictions. The facility failed to implement a thorough investigation and report to the State Agency. On 12/29/25, on the 7:00pm-7:00am shift, the residents on Station 1 remained under the care of an impaired licensed nurse who was unable to safely perform nursing duties. Medication Administration records showed multiple medications were not documented as administered or documented as given late. On 12/29/25, the 7:00pm-7:00am shift, there was no designated Charge Nurse after the scheduled charge nurse called in sick. Therefore, no nurse was designated to assume responsibility to supervise staff, coordinate care, or respond to unsafe conditions. This resulted in the Director of Nursing (DON) not being notified until 1:30am which allowed for the impaired nurse to stay in the facility until 3:30am. The facility failed to ensure the facility assessment dated 11/13/24 was updated appropriately and adequately identified staffing and supervisory needs by shift and failed to ensure individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments. The staffing plan did not include contingency planning for absence of supervisory nursing staff and did not ensure onsite licensed supervision when the scheduled charge nurse was absent. 1. On 1/12/26, coffee machines were removed out of service by the Maintenance Director. Individual pots of coffee will be made in the kitchen and temperatures of the pots will be monitored by the Dietary Department to ensure that the coffee served is at or below 140 degrees Fahrenheit. 2.Coffee Temperature logs were created and started on	F0689		

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F0689 SS = SQC-J	Continued from page 36 1/13/2026 that indicate the staff member who tested the temperature of the coffee, the time and date. These logs will be turned into the Administrator daily. 3.Training for ALL staff, prior to their next scheduled shift beginning on 1/13/2026. Beginning on 1/13/26, no staff will be allowed to work until completion of training, provided by the Administrator, DON, and Staff Development Nurse. Accidents and Supervision including implementing immediate interventions. Abuse and Neglect Reporting and Investigation. Hot Liquids Policy. Notification of Administrator and Director of Nursing (DON) of unusual occurrences, High Risk Events and timely notification. Charge Nurse Delegation and Duties to include the assignment of charge nurse by the Scheduling Coordinator and Staff Development Nurse. If assigned charge nurse calls off, the off-going charge nurse will notify the DON for the next assignment. The DON and Administrator's phone numbers are posted on the Facility Assignment Grid. In the event that the charge nurse is impaired, the DON and Administrator will be contacted. Updated Facility Assignment Grid to include assignment for designated charge nurse. Medication Administration Documentation. 1.On 1/12/26, all Residents were evaluated for Safety with Hot Liquids by the DON, Resident Care Coordinators #1 and # 2, Registered Nurses (RN) #1, 2, and 3. 2.Administrator and DON were inserviced on 1/13/26 by the Director of Operations on conducting thorough investigations including root cause analysis and timely reporting to the State Agency. 3.The Facility Assessment was updated on 1/13/2026 by the Administrator to include a contingency plan for absence of supervisory nursing staff and adequately identified staffing needs by shift and building. 4.The facility's Assignment Grid was updated on 1/13/26 to reflect who the Charge Nurse would be each shift. 5.The Scheduler and the Staff Development nurse were inserviced by the DON on 1/13/26 on the new Assignment Grid and Charge Nurse Delegation. The Scheduler and/or Staff Development Nurse will designate on the Assignment Grid who the charge nurse will be. 6.On 1/13/26 all Resident records were reviewed for adverse effects from missed medication by the Corporate RNs with none found.	F0689		

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F0689 SS = SQC-J	Continued from page 37 7.Emergency Quality Assessment and Assurance Committee Meeting held on 1/13/26. Attending the meeting was the Administrator, DON, Infection Preventionist, Minimum Data Set (MDS) Nurse, Social Services Director and Social Services Assistance, Medical Records, Admissions Coordinator, Dietary Manager, Housekeeping Supervisor, Maintenance Supervisor, Human Resources and Central Supply. The Medical Director was present via telephone. The Hot Liquid Policy, Medication Administration Policy, and Sufficient Nursing Policy were reviewed with no changes recommended or made. Summary of incident was discussed with actions taken including training and monitoring. 8.The Attorney General Office and the Mississippi Board of Nursing were notified on 1/12/26 by the Administrator of incident involving LPN #1. LPN #2 was reported to the Agency that she works for and is not allowed to work at this facility. The facility alleges that all corrective actions to remove the immediacy were completed on 1/13/26 and IJ removed on 1/14/26. Validation: The SA validated the removal plan through observations, interviews, and record reviews on 1/13/26 and the immediacy was removed on 1/14/26 prior to exit.	F0689		
F0725 SS = J	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to	F0725		

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F0725 SS = J	Continued from page 38 all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure sufficient licensed nursing supervision and coordination of care when no licensed nurse was designated to serve as charge nurse for the night shift beginning at 7:00 PM on 12/29/25. The scheduled charge nurse called in sick, and no replacement charge nurse was designated. As a result, no licensed nurse was assigned responsibility to supervise staff, coordinate care, or respond to unsafe conditions. During this shift, residents on Station B remained under the care of an impaired licensed nurse who was unable to safely perform nursing duties, and leadership was not notified until approximately 1:30 AM on 12/30/25, with the impaired nurse not replaced until approximately 3:00 AM for one (1) of seven (7) shifts reviewed. The facility's failure to ensure a designated licensed charge nurse was present to supervise staff and coordinate resident care resulted in unsafe nursing care continuing for over eight (8) hours, including inability to verify timely and accurate medication administration, and placed all (29) residents residing on Station B at likelihood for serious injury, serious harm, serious impairment, or death. The situation was determined to be Immediate Jeopardy (IJ) that began on 12/29/25 at 7:00 PM when no charge nurse was designated and residents remained under the care of an impaired licensed nurse. The facility Administrator was notified of the IJ on 1/13/26 at 3:40 PM and was presented with the IJ template. The facility provided an acceptable Removal Plan on 1/13/26, in which they alleged all corrective actions to remove the IJ were completed on 1/13/26. The State Agency (SA) validated the Removal Plan on 1/14/26 and determined that the IJ was removed on 1/14/26, prior to exit. Therefore, the scope and	F0725		

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F0725 SS = J	Continued from page 39 severity for 42 CFR §483.35 Sufficient Nursing Staff (F725) was lowered from a “J” to a “D” while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility’s policy “Nursing Services and Sufficient Staff” created 8/2/24 revealed “…It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident…Policy Explanation and Compliance Guidelines…3. The facility must designate a licensed nurse to serve as a charge nurse on each tour of duty…” A record review of the facility’s “Counseling/Discipline Report”, dated 1/8/26, revealed License Practical Nurse (LPN) #1, was discharged from the facility. The “Date(s) of Violation(s)” was 12/29 through 12/30 (2025). “Policies violated” included “…Sleeping or appearing to be asleep.” The “Employee’s Statement” revealed “I was ill-my temp (temperature) was 101 degrees and blood sugar had dropped to 67… I do not remember this.” In record review of the facility’s investigation revealed, on 12/30/25 the Director of Nurses (DON) received a call at 1:30 AM from the nurse on station one. (LPN #2). She stated “the nurse on station 2 isn’t able to complete her med (medication) pass, she keeps falling asleep, I don’t know what’s going on with her”. She advised her to send the nurse to the hospital. She said “I can’t be left here with both sides to do meds for 60 people” the DON advised her to call the scheduler to see if she was able to get a nurse to come in and send the nurse on station 2 home. She was able to get a nurse to come at 3:00 AM. After the DON reviewed the camera footage of the incident that took place, she phoned LPN #1 and did not receive a return call from LPN #1. According to the camera footage, the DON observed the nurse at the nurse’s station for about 2 hours. She pushed the cart into the hallway outside of the nurse’s station. At this point, she stared at the computer for a long time and swayed around almost falling. LPN #1 appeared to be under the influence of something. She was stumbling around, staring at the med cart fumbling through the cart looking for meds, would pull a med card and just stare at it for minutes. At one point, she fell asleep at themed cart, in the	F0725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255343	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/14/2026

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F0725 SS = J	Continued from page 40 dining room, with her head resting on the cart, the cart started to roll away, and she woke up. There was a resident in the dining room during this time, and he witnessed this incident. The aides came to her several times and woke her up, asking if she was OK. An aide put a chair behind her after she almost fell down, sleeping on the cart. She did not complete her med pass, she only gave meds to 2 residents. A record review of a signed statement by Certified Nurse Assistant (CNA) #1, dated 12/30/25 at 2:30 PM, revealed, "…around 8pm, she started falling asleep standing up. She started crying really loud and moaning. She went back and forth to the bathroom a lot. She fell asleep on the counter in the nurse's station…At one point she fell asleep with the med cart open…Around 11:40 we went and got the nurse from Station 1, and she tried to help with med pass…couldn't stay awake to pull meds or pass them. She almost fell down at the table. Her boyfriend/husband came to pick her up at 3:30…The resident's kept calling us to get their meds, we kept having to wake her up to tell her that residents were needing meds." A record review of a signed statement by CNA #2, dated 12/30/25 at 4:00 PM, revealed, "When came in for our shift (LPN #1) was fine. Then she came up to me in the dining room and said she didn't feel good. Then she started crying and was half out of it. She was at the cart, leaned over with her eyes closed. Her legs were giving out, so I put a chair behind her. No one got their meds, everyone kept calling us for their meds. She kept going to sleep mid conversation. I wondered if she was 'high as hell'. She went to the bathroom a bunch of times for a long time. She kept falling asleep while she was trying to sign the narc (narcotics) book. …We tried to get her to in an ambulance…but she refused…She was crying so loud I was having a hard time doing my charting…" A record review of the facility's "Medication Admin Audit Report" for "Station B" with "Documentation Type: Missed" for 12/29/25 through 12/30/25 revealed 25 residents had medications with no administration time. A record review of the facility's "Medication Admin Audit Report" for "Station B" with "Documentation Type: Late – 1.0 hours(s)" for 12/29/25 through 12/30/25 revealed 5 residents had medications that were administered late. A record review of the facility's daily staffing schedule for 12/29/25 at Building 1 revealed LPN #1 was assigned to Station 2 for the 7P-7A (7:00 PM to 7:00	F0725		

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F0725 SS = J	Continued from page 41 AM) shift on 12/29/25. Further review revealed the "Supervisor 7P-7A" name was marked through with "vacation" written in. There was no indication there was a charge nurse assigned to replace the staff member that was marked through on the schedule. A record review of the facility's "Time Punch Report" revealed on 12/29/25, LPN #1 punched in on 12/29/25 at 7:00 PM and punched out on 12/30/25 at 3:00 AM. LPN #2 punched in on 12/29/25 at 6:30 PM and punched out on 12/30/25 at 7:14 AM. LPN #3 punched in on 12/30/25 at 3:45 AM and punched out on 12/30/25 at 2:45 PM. On 1/12/26 at 7:30 AM, during an interview with the Director of Nursing (DON), she confirmed awareness that on 12/29/25 during the PM shift, LPN #1 was observed to be impaired and falling asleep while assigned to administer medications and provide resident care. The DON confirmed that at the time of the incident, there was no designated charge nurse providing direct supervision on the unit or responding to the unsafe conditions caused by the impaired nurse. She acknowledged that despite concerns regarding the nurse's ability to safely perform assigned duties, the nurse remained responsible for resident care and medication administration until a replacement nurse arrived, which was approximately eight (8) hours later. The DON confirmed the facility did not immediately remove the nurse from duty and acknowledged the absence of active supervisory oversight during the period the nurse remained impaired and responsible for resident care. On 1/12/26 at 11:50 AM, during an interview with the Administrator, he acknowledged awareness of an incident occurring on the 12/29/25 PM shift involving a licensed nurse who was observed falling asleep while assigned to administer medications and was unable to safely complete medication administration duties. The Administrator confirmed the nurse remained on duty until a replacement nurse arrived, which was approximately eight (8) hours later. The Administrator also acknowledged that the facility did not have a supervisor scheduled for the shift to oversee staff supervision, resident care, and unsafe conditions. On 1/13/26 at 10:00 AM, an interview with CNA #1 confirmed that during the incident involving an impaired nurse on 12/29/25, medications were not administered as ordered and staff relied on informally notifying the nurse on the other unit as there was no defined supervisor on duty to address the unsafe conditions.	F0725		

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F0725 SS = J	Continued from page 42 On 1/13/26 at 10:40 AM, during an interview with Registered Nurse (RN) #1, she confirmed she was not aware that the facility did not have a designated charge nurse assigned during the shift in which LPN #1 was observed to be impaired. She confirmed she could not identify a staff member assigned to provide charge nurse oversight or supervision at that time. The facility submitted the following acceptable Removal Plan on 1/13/26: On 1/13/2026 at 3:55pm the Immediate Jeopardy Templates for F600, F725, F609, F610, F838, F689 were provided to the Administrator. On 12/31/2025, Resident #1 sustained a burn from hot coffee at approximately 3:40pm. The facility failed to implement safeguards or supervision to protect other residents from exposure to the same hazard. Residents continued to have access to hot coffee in the Dining Room without supervision, temperature controls, or access restrictions. The facility failed to implement a thorough investigation and report to the State Agency. On 12/29/25, on the 7:00pm-7:00am shift, the residents on Station B remained under the care of an impaired licensed nurse who was unable to safely perform nursing duties. Medication Administration records showed multiple medications were not documented as administered or documented as given late. On 12/29/25, the 7:00pm-7:00am shift, there was no designated Charge Nurse after the scheduled charge nurse called in sick. Therefore, no nurse was designated to assume responsibility to supervise staff, coordinate care, or respond to unsafe conditions. This resulted in the Director of Nursing (DON) not being notified until 1:30am which allowed for the impaired nurse to stay in the facility until 3:30am. The facility failed to ensure the facility assessment dated 11/13/24 was updated appropriately and adequately identified staffing and supervisory needs by shift and failed to ensure individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments. The staffing plan did not include contingency planning for absence of supervisory nursing staff and did not ensure onsite licensed supervision when the scheduled charge nurse was absent. 1. On 1/12/26, coffee machines were removed out of service by the Maintenance Director. Individual pots of coffee will be made in the kitchen and temperatures of the pots will be monitored by the Dietary Department to ensure that the coffee served is at or below 140 degrees Fahrenheit.	F0725		

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F0725 SS = J	Continued from page 43 2.Coffee Temperature logs were created and started on 1/13/2026 that indicate the staff member who tested the temperature of the coffee, the time and date. These logs will be turned into the Administrator daily. 3.Training for ALL staff, prior to their next scheduled shift beginning on 1/13/2026. Beginning on 1/13/26, no staff will be allowed to work until completion of training, provided by the Administrator, DON, and Staff Development Nurse. Accidents and Supervision including implementing immediate interventions. Abuse and Neglect Reporting and Investigation. Hot Liquids Policy. Notification of Administrator and Director of Nursing (DON) of unusual occurrences, High Risk Events and timely notification. Charge Nurse Delegation and Duties to include the assignment of charge nurse by the Scheduling Coordinator and Staff Development Nurse. If assigned charge nurse calls off, the off-going charge nurse will notify the DON for the next assignment. The DON and Administrator's phone numbers are posted on the Facility Assignment Grid. In the event that the charge nurse is impaired, the DON and Administrator will be contacted. Updated Facility Assignment Grid to include assignment for designated charge nurse. Medication Administration Documentation. 1.On 1/12/26, all Residents were evaluated for Safety with Hot Liquids by the DON, Resident Care Coordinators #1 and # 2, Registered Nurses (RN) #1, 2, and 3. 2.Administrator and DON were inserviced on 1/13/26 by the Director of Operations on conducting thorough investigations including root cause analysis and timely reporting to the State Agency. 3.The Facility Assessment was updated on 1/13/2026 by the Administrator to include a contingency plan for absence of supervisory nursing staff and adequately identified staffing needs by shift and building. 4.The facility's Assignment Grid was updated on 1/13/26 to reflect who the Charge Nurse would be each shift. 5.The Scheduler and the Staff Development nurse were inserviced by the DON on 1/13/26 on the new Assignment Grid and Charge Nurse Delegation. The Scheduler and/or Staff Development Nurse will designate on the Assignment Grid who the charge nurse will be. 6.On 1/13/26 all Resident records were reviewed for adverse effects from missed medication by the Corporate RNs with none found.	F0725		

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F0725 SS = J	Continued from page 44 7.Emergency Quality Assessment and Assurance Committee Meeting held on 1/13/26. Attending the meeting was the Administrator, DON, Infection Preventionist, Minimum Data Set (MDS) Nurse, Social Services Director and Social Services Assistance, Medical Records, Admissions Coordinator, Dietary Manager, Housekeeping Supervisor, Maintenance Supervisor, Human Resources and Central Supply. The Medical Director was present via telephone. The Hot Liquid Policy, Medication Administration Policy, and Sufficient Nursing Policy were reviewed with no changes recommended or made. Summary of incident was discussed with actions taken including training and monitoring. 8.The Attorney General Office and the Mississippi Board of Nursing were notified on 1/12/26 by the Administrator of incident involving LPN #1. LPN #2 was reported to the Agency that she works for and is not allowed to work at this facility. The facility alleges that all corrective actions to remove the immediacy were completed on 1/13/26 and IJ removed on 1/14/26. Validation: The SA validated the removal plan on 1/13/26 and the immediacy was removed on 1/14/26 prior to exit.	F0725		
F0838 SS = J	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to:	F0838		

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F0838 SS = J	Continued from page 45 (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.	F0838		

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F0838 SS = J	Continued from page 46 §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's	F0838		

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F0838 SS = J	Continued from page 47 emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review the facility failed to ensure the facility assessment dated 11/13/24 was updated appropriately and failed to identify staffing and supervisory needs by shift and failed to ensure individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments. The facility assessment did not include contingency planning for absence of supervisory nursing staff and did not ensure onsite licensed supervision when the scheduled charge nurse was absent. On the night shift beginning at 7:00 PM on 12/29/25, the scheduled charge nurse called in sick, and no replacement charge nurse was designated. As a result, there was not a licensed nurse assigned the responsibility to supervise staff, coordinate care, or respond to unsafe conditions. Residents on Station B remained under the care of an impaired licensed nurse who was unable to safely perform nursing duties until approximately 3:00 AM on 12/30/25. This deficient practice affected four (4) of (4) sampled residents (Residents #1, #2, #3, and #4). The facility's failure to ensure the facility assessment accurately identified staffing, supervisory, and coordination of care needs by shift resulted in unsafe nursing care continuing without supervisory intervention, inability to verify timely and accurate medication administration, and placed all residents residing on Station B at likelihood for serious injury, serious harm, serious impairment, or death. The situation was determined to be Immediate Jeopardy (IJ) that began on 12/29/25 at 7:00 PM when no supervisory licensed nurse was designated and residents remained under the care of an impaired licensed nurse. The facility Administrator was notified of the IJ on 1/13/26 at 3:40 PM and was presented with the IJ template. The facility provided an acceptable Removal Plan on 1/13/26, in which they alleged all corrective actions to remove the IJ were completed on 1/13/26. The State Agency (SA) validated the Removal Plan on 1/14/26 and determined that the IJ was removed on 1/14/26, prior to exit. Therefore, the scope and severity for 42 CFR §483.71(c)(2)(3)(5) Facility Assessment (F838) was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor	F0838		

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F0838 SS = J	Continued from page 48 the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Record review of a typed statement on facility letterhead dated January 19, 2026, revealed “To Whom it May Concern, (Proper name of facility) does not have a Facility Assessment Policy.” A review of the facility’s policy “Nursing Services and Sufficient Staff” created 8/2/24 revealed “…It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident…Policy Explanation and Compliance Guidelines…3. The facility must designate a licensed nurse to serve as a charge nurse on each tour of duty…” A record review of the facility’s policy “Staffing”, revised 7/21/22 revealed, “…Our facility provides adequate staffing to meet needed care and services for our resident population…Our facility maintains adequate staffing on each shift to ensure that our resident’s needs and services are met…” A review of the facility assessment, dated 11/21/2024, revealed the assessment identified residents requiring medication administration, supervision, and safety monitoring. The assessment was not updated annually as required. It also did not identify staffing and supervisory needs by shift and did not include safeguards or contingency planning for absence of required nursing staff, including supervisory staff. A record review of the facility’s “Counseling/Discipline Report”, dated 1/8/26, revealed License Practical Nurse (LPN) #1, was discharged from the facility. The “Date(s) of Violation(s)” was 12/29 through 12/30 (2025). “Policies violated” included “…Sleeping or appearing to be asleep.” The “Employee’s Statement” revealed “I was ill-my temp (temperature) was 101 degrees and blood sugar had dropped to 67… I do not remember this.” In record review of the facility’s investigation revealed, on 12/30/25 the Director of Nurses (DON) received a call at 1:30 AM from the nurse on station one. (LPN #2). She stated “the nurse on station 2 isn’t able to complete her med (medication) pass, she keeps falling asleep, I don’t know what’s going on with her”.	F0838		

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F0838 SS = J	Continued from page 49 She advised her to send the nurse to the hospital. She said “I can’t be left here with both sides to do meds for 60 people” the DON advised her to call the scheduler to see if she was able to get a nurse to come in and send the nurse on station 2 home. She was able to get a nurse to come at 3:00 AM. After the DON reviewed the camera footage of the incident that took place, she phoned LPN #1 and did not receive a return call from LPN #1. According to the camera footage, the DON observed the nurse at the nurse’s station for about 2 hours. She pushed the cart into the hallway outside of the nurse’s station. At this point, she stared at the computer for a long time and swayed around almost falling. LPN #1 appeared to be under the influence of something. She was stumbling around, staring at the med cart fumbling through the cart looking for meds, would pull a med card and just stare at it for minutes. At one point, she fell asleep at themed cart, in the dining room, with her head resting on the cart, the cart started to roll away, and she woke up. There was a resident in the dining room during this time, and he witnessed this incident. The aides came to her several times and woke her up, asking if she was OK. An aide put a chair behind her after she almost fell down, sleeping on the cart. She did not complete her medication pass; she only gave meds to 2 residents. A record review of a signed statement by Certified Nurse Assistant (CNA) #1, dated 12/30/25 at 2:30 PM, revealed, “…around 8pm, she started falling asleep standing up. She started crying really loud and moaning. She went back and forth to the bathroom a lot. She fell asleep on the counter in the nurse’s station…At one point she fell asleep with the med cart open…Around 11:40 we went and got the nurse from Station 1, and she tried to help with med pass…couldn’t stay awake to pull meds or pass them. She almost fell down at the table. Her boyfriend/husband came to pick her up at 3:30…The resident’s kept calling us to get their meds, we kept having to wake her up to tell her that residents were needing meds.” A record review of a signed statement by CNA #2, dated 12/30/25 at 4:00 PM, revealed, “When came in for our shift (LPN #1) was fine. Then she came up to me in the dining room and said she didn’t feel good. Then she started crying and was half out of it. She was at the cart, leaned over with her eyes closed. Her legs were giving out, so I put a chair behind her. No one got their meds, everyone kept calling us for their meds. She kept going to sleep mid conversation. I wondered if she was ‘high as hell’. She went to the bathroom a bunch of times for a long time. She kept falling asleep while she was trying to sign the narc (narcotics) book.	F0838		

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F0838 SS = J	Continued from page 50 …We tried to get her to in an ambulance…but she refused…She was crying so loud I was having a hard time doing my charting…" A record review of the facility's "Medication Admin Audit Report" for "Station B" with "Documentation Type: Missed" for 12/29/25 through 12/30/25 revealed 25 residents had medications with no administration time. A record review of the facility's "Medication Admin Audit Report" for "Station B" with "Documentation Type: Late – 1.0 hours(s)" for 12/29/25 through 12/30/25 revealed 5 residents had medications that were administered late. A record review of the facility's daily staffing schedule for 12/29/25 at Building 1 revealed LPN #1 was assigned to Station 2 for the 7P-7A (7:00 PM to 7:00 AM) shift on 12/29/25. A record review of the facility's "Time Punch Report" revealed on 12/29/25, LPN #1 punched in on 12/29/25 at 7:00 PM and punched out on 12/30/25 at 3:00 AM. LPN #2 punched in on 12/29/25 at 6:30 PM and punched out on 12/30/25 at 7:14 AM. LPN #3 punched in on 12/30/25 at 3:45 AM and punched out on 12/30/25 at 2:45 PM. On 1/13/26 at 10:00 AM, during an interview, CNA #1 reported she was not aware of any contingency plan for staff call offs. CNA #1 confirmed that during the incident involving an impaired nurse on 12/29/25, medications were not administered as ordered and staff relied on informally notifying the nurse on the other unit as there was no defined supervisor on duty to address the unsafe conditions because the charge nurse had called-in. On 1/13/26 at 10:20 AM, during an interview with the DON she explained the facility assessment identifies general resident care needs and that includes medication administration. While reviewing the assessment, she was unable to determine a contingency plan regarding staffing needs when there is a call off by staff, so that the residents received continuity of care when staffing changes occurred. On 1/13/26 at 11:00 AM, during an interview with the Administrator, he acknowledged awareness of the incident involving an impaired licensed nurse who was unable to safely administer medications on 12/29/25 and the absence of a designated charge nurse on the shift. He confirmed the current facility assessment was dated 11/13/24 and that it should have been updated annually. When asked how the facility assessment is used to guide	F0838		

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F0838 SS = J	Continued from page 51 staffing decisions and contingency planning, he explained staffing decisions are generally based on census and daily schedules and was unable to identify how the facility assessment is used to determine supervisory coverage needed or continuity of care when staffing changes occur. Resident #1 A record review of the “Admission Record” revealed the facility admitted Resident #1 on 10/20/23 with diagnoses including Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated his cognition was severely impaired. A record review of the “Order Summary Report” with active orders as of 1/13/26, revealed Resident #1 had a Physician’s Order, dated 10/20/23, for Donepezil Hydrocholoride (HCL) Tablet 5 mg (milligram) Give 1 tablet by mouth at bedtime. 10/20/23). A record review of the Medication Administration Record (MAR) for December 2025 revealed there was no documentation indicating Resident #1 received the 12/29/25 8:30 PM dose of Donepezil HCL. Resident #2 A record of the “Admission Record” revealed the facility admitted Resident #2 on 9/8/25 with diagnoses including Cerebral Infarction. A record review of the Quarterly MDS with an ARD of 12/10/25 revealed Resident #2 had a BIMS score of 15 which indicated he was cognitively intact. A record review of the “Order Summary Report” with active orders as of 12/31/25, revealed Resident #2 had Physician’s Orders for Crestor Oral Tablet 20 MG Give 1 tablet by mouth at bedtime for hyperlipidemia (dated 9/8/25), Latanoprost Ophthalmic Solution 0.005% Instill 1 drop in both eyes at bedtime for glaucoma (dated 9/8/25), Novolog Solution 100 UNIT/ML (milliliter), subcutaneously before meals and at bedtime for Diabetes Mellitus, (dated 9/8/25), and Trazodone HCL Oral Tablet 150 MG Give 1 tablet by mouth at bedtime for insomnia (dated 9/8/25). A record review of the Medication Administration Record (MAR) for December 2025 revealed there was no	F0838		

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F0838 SS = J	Continued from page 52 documentation indicating Resident #2 receiving the scheduled medications for 8:00 PM or 9:30 PM on 12/29/25. Resident #3 A record review of the “Admission Record” revealed the facility admitted Resident #3 on 3/21/25 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction. A record review of the Quarterly MDS with an ARD 12/10/25 revealed Resident #3 had a BIMS score of 15, which indicated his cognition was intact. A record review of the “Order Summary Report” with active orders as of 12/31/25, revealed Resident #3 had Physician’s Orders for Accucheck AC (before meals) and HS (at bedtime) for Diabetes (dated 3/21/25), Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for neuropathy, Guaifenesin Oral Tablet 400 MG Give 3 tablets by mouth two times a day for cough to equal 1200 MG, (dated 5/15/25), Keppra Oral Tablet 1000 MG Give 1.5 tablet by mouth two times a day for seizure activity take 1.5 tablets to equal dose of 1500 MG (dated 3/21/25), and Lacosamide Oral Tablet 100 MG by mouth two times a day for seizures (dated 10/9/25). A record review of the Medication Administration Record (MAR) for December 2025 revealed there was no documentation indicating Resident #3 receiving any of his 12/29/25 8:30 PM medications. Resident #4 A record review of the “Admission Record” revealed the facility admitted Resident #4 on 7/1/25 with diagnoses including Senile Degeneration of Brain and Dementia. A record review of the Quarterly MDS with an ARD of 12/24/25 for revealed Resident #4 had a BIMS score of 9, which indicated her cognition was moderately impaired. impaired. A record review of the “Order Summary Report” with active orders as of 12/31/25, revealed Resident #4 had Physician’s Orders for Clonidine HCL Oral Tablet 0.2 MG Give 1 tablet by mouth at bedtime for Hypertension (dated 7/1/25), Duloxetine HCL Capsule Delayed Release Particles 60 MG Give 1 capsule by mouth two times a day for depression (dated 7/1/25), and Gabapentin Oral Tablet 600 MG Give 1 tablet by mouth two times a day for Neuropathy (dated 7/1/25).	F0838		

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F0838 SS = J	Continued from page 53 A record review of the Medication Administration Record (MAR) for December 2025 revealed there was no documentation indicating Resident #4 receiving any of her 12/29/25 8:30 PM medications. The facility submitted the following acceptable Removal Plan on 1/13/26: On 1/13/2026 at 3:55pm the Immediate Jeopardy Templates for F600, F725, F609, F610, F838, F689 were provided to the Administrator. On 12/31/2025, Resident #1 sustained a burn from hot coffee at approximately 3:40pm. The facility failed to implement safeguards or supervision to protect other residents from exposure to the same hazard. Residents continued to have access to hot coffee in the Dining Room without supervision, temperature controls, or access restrictions. The facility failed to implement a thorough investigation and report to the State Agency. On 12/29/25, on the 7:00pm-7:00am shift, the residents on Station B remained under the care of an impaired licensed nurse who was unable to safely perform nursing duties. Medication Administration records showed multiple medications were not documented as administered or documented as given late. On 12/29/25, the 7:00pm-7:00am shift, there was no designated Charge Nurse after the scheduled charge nurse called in sick. Therefore, no nurse was designated to assume responsibility to supervise staff, coordinate care, or respond to unsafe conditions. This resulted in the Director of Nursing (DON) not being notified until 1:30am which allowed for the impaired nurse to stay in the facility until 3:30am. The facility failed to ensure the facility assessment dated 11/13/24 was updated appropriately and adequately identified staffing and supervisory needs by shift and failed to ensure individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments. The staffing plan did not include contingency planning for absence of supervisory nursing staff and did not ensure onsite licensed supervision when the scheduled charge nurse was absent. 1. On 1/12/26, coffee machines were removed out of service by the Maintenance Director. Individual pots of coffee will be made in the kitchen and temperatures of the pots will be monitored by the Dietary Department to ensure that the coffee served is at or below 140 degrees Fahrenheit. 2.Coffee Temperature logs were created and started on 1/13/2026 that indicate the staff member who tested the temperature of the coffee, the time and date. These	F0838		

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F0838 SS = J	Continued from page 54 logs will be turned into the Administrator daily. 3.Training for ALL staff, prior to their next scheduled shift beginning on 1/13/2026. Beginning on 1/13/26, no staff will be allowed to work until completion of training, provided by the Administrator, DON, and Staff Development Nurse. Accidents and Supervision including implementing immediate interventions. Abuse and Neglect Reporting and Investigation. Hot Liquids Policy. Notification of Administrator and Director of Nursing (DON) of unusual occurrences, High Risk Events and timely notification. Charge Nurse Delegation and Duties to include the assignment of charge nurse by the Scheduling Coordinator and Staff Development Nurse. If assigned charge nurse calls off, the off-going charge nurse will notify the DON for the next assignment. The DON and Administrator's phone numbers are posted on the Facility Assignment Grid. In the event that the charge nurse is impaired, the DON and Administrator will be contacted. Updated Facility Assignment Grid to include assignment for designated charge nurse. Medication Administration Documentation. 1.On 1/12/26, all Residents were evaluated for Safety with Hot Liquids by the DON, Resident Care Coordinators #1 and # 2, Registered Nurses (RN) #1, 2, and 3. 2.Administrator and DON were inserviced on 1/13/26 by the Director of Operations on conducting thorough investigations including root cause analysis and timely reporting to the State Agency. 3.The Facility Assessment was updated on 1/13/2026 by the Administrator to include a contingency plan for absence of supervisory nursing staff and adequately identified staffing needs by shift and building. 4.The facility's Assignment Grid was updated on 1/13/26 to reflect who the Charge Nurse would be each shift. 5.The Scheduler and the Staff Development nurse were inserviced by the DON on 1/13/26 on the new Assignment Grid and Charge Nurse Delegation. The Scheduler and/or Staff Development Nurse will designate on the Assignment Grid who the charge nurse will be. 6.On 1/13/26 all Resident records were reviewed for adverse effects from missed medication by the Corporate RNs with none found. 7.Emergency Quality Assessment and Assurance Committee Meeting held on 1/13/26. Attending the meeting was the	F0838		

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F0838 SS = J	Continued from page 55 Administrator, DON, Infection Preventionist, Minimum Data Set (MDS) Nurse, Social Services Director and Social Services Assistance, Medical Records, Admissions Coordinator, Dietary Manager, Housekeeping Supervisor, Maintenance Supervisor, Human Resources and Central Supply. The Medical Director was present via telephone. The Hot Liquid Policy, Medication Administration Policy, and Sufficient Nursing Policy were reviewed with no changes recommended or made. Summary of incident was discussed with actions taken including training and monitoring. 8.The Attorney General Office and the Mississippi Board of Nursing were notified on 1/12/26 by the Administrator of incident involving LPN #1. LPN #2 was reported to the Agency that she works for and is not allowed to work at this facility. The facility alleges that all corrective actions to remove the immediacy were completed on 1/13/26 and IJ removed on 1/14/26. Validation: The SA validated the removal plan on 1/13/26 and the immediacy was removed on 1/14/26 prior to exit.	F0838		
F0842 SS = E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F0842		

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F0842 SS = E	Continued from page 56 (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F0842		

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F0842 SS = E	Continued from page 57 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to maintain complete and accurate medical records to document the services provided for four (4) of (4) sampled residents (Residents #1, #2, #3, and #4). Specifically, review of the Medication Administration Records (MARs) for the night shift of 12/29/25 revealed multiple medications were not documented as administered and medication administration could not be verified as accurate and timely. Findings include: A review of the facility's policy "Administering Medications" revised 8/2/22 revealed, "Medications shall be administered in a safe and timely manner, and as prescribed…Policy Interpretation and Implementation…10. The resident must be observed taking the medication…14…The nurse will document on the EMAR (Electronic Medication Administration Record) when the medication is administered to the resident…" A record review of the facility's "Medication Admin Audit Report" for "Station B" with "Documentation Type: Missed" for 12/29/25 through 12/30/25 revealed 25 residents had medications with no administration time. A record review of the facility's "Medication Admin Audit Report" for "Station B" with "Documentation Type: Late – 1.0 hours(s)" for 12/29/25 through 12/30/25 revealed 5 residents had medications that were administered late. On 1/12/26 at 7:30 AM, during an interview with the Director of Nursing (DON), she confirmed the facility policy requires licensed nurses to document all medications administered, held, or not administered on the Medication Administration Record (MAR) at the time of administration. She confirmed the facility had an impaired nurse on 12/29/25 but she had been told by Licensed Practical Nurse (LPN) #2 that the residents' medications had been administered. She did not verify	F0842		

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F0842 SS = E	Continued from page 58 documentation of the medications at that time and was not aware that the residents' medications were not documented as administered. She explained that she expected staff to document medication at the time administered. On 1/12/26 at 10:47 AM, during an interview with LPN #2, she confirmed that she accessed the medication cart and pulled medications for LPN #1 who was impaired, however, she did not administer the medications herself. LPN #2 reported that she did not document the medications on the MARs and did not accompany or observe the impaired nurse during medication administration. She confirmed that she did not visually verify that the correct medications were administered to the correct residents and did not perform any checks to ensure medications were given as ordered. She explained that she assumed the medications were administered correctly based on the impaired nurse's familiarity with the residents. She reported that no follow-up verification was completed to confirm that all medications were administered, documented, or administered accurately to the appropriate residents on Station 2 during that medication pass on 12/29/25. Resident #1 A record review of the "Admission Record" revealed the facility admitted Resident #1 on 10/20/23 with diagnoses including Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated his cognition was severely impaired. A record review of the "Order Summary Report" with active orders as of 1/13/26, revealed Resident #1 had a Physician's Order, dated 10/20/23, for Donepezil Hydrocholoride (HCL) Tablet 5 mg (milligram) Give 1 tablet by mouth at bedtime. 10/20/23). A record review of the Medication Administration Record (MAR) for December 2025 revealed there was no documentation indicating Resident #1 received the 12/29/25 8:30 PM dose of Donepezil HCL. Resident #2 A record of the "Admission Record" revealed the facility admitted Resident #2 on 9/8/25 with diagnoses including Cerebral Infarction.	F0842		

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F0842 SS = E	Continued from page 59 A record review of the Quarterly MDS with an ARD of 12/10/25 revealed Resident #2 had a BIMS score of 15 which indicated he was cognitively intact. A record review of the "Order Summary Report" with active orders as of 12/31/25, revealed Resident #2 had Physician's Orders for Crestor Oral Tablet 20 MG Give 1 tablet by mouth at bedtime for hyperlipidemia (dated 9/8/25), Latanoprost Ophthalmic Solution 0.005% Instill 1 drop in both eyes at bedtime for glaucoma (dated 9/8/25), Novolog Solution 100 UNIT/ML (milliliter), subcutaneously before meals and at bedtime for Diabetes Mellitus, (dated 9/8/25), and Trazodone HCL Oral Tablet 150 MG Give 1 tablet by mouth at bedtime for insomnia (dated 9/8/25). A record review of the Medication Administration Record (MAR) for December 2025 revealed there was no documentation indicating Resident #2 receiving the scheduled medications for 8:00 PM or 9:30 PM on 12/29/25. Resident #3 A record review of the "Admission Record" revealed the facility admitted Resident #3 on 3/21/25 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction. A record review of the Quarterly MDS with an ARD 12/10/25 revealed Resident #3 had a BIMS score of 15, which indicated his cognition was intact. A record review of the "Order Summary Report" with active orders as of 12/31/25, revealed Resident #3 had Physician's Orders for Accucheck AC (before meals) and HS (at bedtime) for Diabetes (dated 3/21/25), Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for neuropathy, Guaifenesin Oral Tablet 400 MG Give 3 tablets by mouth two times a day for cough to equal 1200 MG, (dated 5/15/25), Keppra Oral Tablet 1000 MG Give 1.5 tablet by mouth two times a day for seizure activity take 1.5 tablets to equal dose of 1500 MG (dated 3/21/25), and Lacosamide Oral Tablet 100 MG by mouth two times a day for seizures (dated 10/9/25). A record review of the Medication Administration Record (MAR) for December 2025 revealed there was no documentation indicating Resident #3 receiving any of his 12/29/25 8:30 PM medications. Resident #4 A record review of the "Admission Record" revealed the	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255343	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF PICAYUNE	**2797 COOPER ROAD , PICAYUNE, Mississippi, 39466**

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F0842 SS = E	Continued from page 60 facility admitted Resident #4 on 7/1/25 with diagnoses including Senile Degeneration of Brain and Dementia. A record review of the Quarterly MDS with an ARD of 12/24/25 for revealed Resident #4 had a BIMS score of 9, which indicated her cognition was moderately impaired. impaired. A record review of the “Order Summary Report” with active orders as of 12/31/25, revealed Resident #4 had Physician’s Orders for Clonidine HCL Oral Tablet 0.2 MG Give 1 tablet by mouth at bedtime for Hypertension (dated 7/1/25), Duloxetine HCL Capsule Delayed Release Particles 60 MG Give 1 capsule by mouth two times a day for depression (dated 7/1/25), and Gabapentin Oral Tablet 600 MG Give 1 tablet by mouth two times a day for Neuropathy (dated 7/1/25). A record review of the Medication Administration Record (MAR) for December 2025 revealed there was no documentation indicating Resident #4 receiving any of her 12/29/25 8:30 PM medications.	F0842		