Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1202	(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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
M0000	Initial Comments Level IV 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 M500 related to both CI MS #2705336 and CI MS #2709753. Additionally, M640 was cited related to CI MS #2709753 only, and M225 and M735 were cited related to CI MS #2705336 only. The SA identified Immediate Jeopardy (IJ) that began on 12/31/25 at approximately 3:40 PM related to CI 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: 45.17.2 Resident Rights – M500 – Scope/Severity Level	M0000		

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

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M0000	Continued from page 1 IV 45.21.8 Accidents – M640 – Scope/Severity Level IV The IJ existed at: 45.21.6 Nursing Facility – M225 – Scope/Severity Level IV The facility Administrator was notified of the IJ and SQC on 1/13/26 at 3:40 PM. 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 from Level IV to Level II 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.	M0000		
M0225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility.	M0225		

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M0225	Continued from page 2 c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This LICENSURE 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.	M0225		

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M0225	Continued from page 3 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 twenty-nine (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. 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 45.4.1 Nursing Facility – M225 was lowered from a "Level IV" to a "Level II" 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	M0225		

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M0225	Continued from page 4 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. 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	M0225		

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M0225	Continued from page 5 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 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	M0225		

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M0225	Continued from page 6 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. 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	M0225		

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M0225	Continued from page 7 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 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.	M0225		

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M0225	Continued from page 8 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 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.	M0225		
M0500	45.17.2 Residents' Rights	M0500		

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M0500	Continued from page 9 Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a	M0500		

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M0500	Continued from page 10 citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or	M0500		

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M0500	Continued from page 11 individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	M0500		

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M0500	Continued from page 12 observations of impairment, the nurse remained responsible for resident care until approximately 3:00 AM on 12/30/25. Review of medication administration records showed multiple medications were not documented as administered and others were documented late, and 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 31, #2, #3, #4) and placing all twenty-nine (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. 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 45.17.2 Resident Rights – M500 was lowered from a "Level IV" to a "Level II" 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	M0500		

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M0500	Continued from page 13 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 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	M0500		

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M0500	Continued from page 14 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 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 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	M0500		

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M0500	Continued from page 15 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 with 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. 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	M0500		

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M0500	Continued from page 16 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 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	M0500		

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M0500	Continued from page 17 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 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	M0500		

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M0500	Continued from page 18 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. 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	M0500		

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M0500	Continued from page 19 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 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),	M0500		

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M0500	Continued from page 20 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. 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. On 1/13/26 at 9:17 AM, during an interview with 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	M0500		

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M0500	Continued from page 21 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. 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.	M0500		

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M0500	Continued from page 22 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 Administrator, DON, Infection Preventionist, Minimum	M0500		

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M0500	Continued from page 23 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.	M0500		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE 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 restrictions until 1/12/26. This deficient practice affected one (1) of four (4) sampled residents, with the potential to affect all residents who drink hot coffee.	M0640		

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M0640	Continued from page 24 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. 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 45.21.8 Accidents – M640 was lowered from a "Level IV" to a "Level II" 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. 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	M0640		

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M0640	Continued from page 25 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 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	M0640		

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M0640	Continued from page 26 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 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	M0640		

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M0640	Continued from page 27 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 at 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 #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	M0640		

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M0640	Continued from page 28 of the dietary door revealing, “Attention!!!! Every 2 hours whomever 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 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.	M0640		

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M0640	Continued from page 29 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 that 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 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 shift beginning on 1/13/2026. Beginning on 1/13/26, no	M0640		

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M0640	Continued from page 30 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 Coordinator, Dietary Manager, Housekeeping Supervisor,	M0640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1202	(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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M0640	Continued from page 31 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.	M0640		
M0735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical	M0735		

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M0735	Continued from page 32 findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This LICENSURE 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…"	M0735		

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M0735	Continued from page 33 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 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	M0735		

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M0735	Continued from page 34 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 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	M0735		

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M0735	Continued from page 35 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). 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	M0735		