STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	**1455 NORTH LAKELAND DRIVE PO BOX 4128 WEST STATION, MERIDIAN, Mississippi, 39307**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 2/2/26 through 2/5/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F558, F605, F693, F695, and F880. The facility had a census of 61 and was licensed for 70 beds.	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's call light was maintained within reach as a reasonable accommodation for one (1) of (16) sampled residents. Resident #27. Findings include: A review of the facility's policy, "Call Bell/Light", dated July 2024, revealed, "…residents will have access to a call bell/light apparatus…3. Procedure A. Nursing Services will ensure that the call bell/light is within easy reach of the resident…" A record review of the facility's "Professional Development Program Record," dated 1/6/26 and 1/8/26, revealed, "…Course Goals & Learning Objectives…Call bell should be within reach at all times…" On 2/2/26 at 12:44 PM, during an observation, Resident #27 was observed lying in bed asleep. The resident's call light was observed on the floor beside the bed rather than within reach. Although the call light had a	F0558		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE PO BOX 4128 WEST STATION, MERIDIAN, Mississippi, 39307

(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
F0558 SS = D	Continued from page 1 clip attached, it was not secured to the resident, the bed linens, or the bed, leaving it inaccessible to the resident while in bed. On 2/2/26 at 12:50 PM, during an observation and interview with Certified Nursing Aide (CNA) #1, Resident #27's call light was on the floor beside the bed and out of the resident's reach. CNA #1 confirmed staff were trained so that call lights were to be left within resident reach. On 2/4/26 at 10:32 AM, during an interview, CNA #3, who is the CNA Coordinator, reported all CNA staff were trained to ensure call lights were within reach when leaving a resident's room, regardless of whether the resident could independently use the call light. She reported that staff received monthly in-service education and daily reminders regarding call light placement. On 2/5/26 at 9:45 AM, during an interview, the Director of Nursing (DON) reported her expectation was for staff to ensure residents were left with the call light within reach when exiting the resident's room. A record review of the "Face Sheet" revealed the facility admitted Resident #27 on 12/21/23 with diagnoses including Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/11/25 revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of one (1), which indicated his cognition was severely impaired.	F0558		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE PO BOX 4128 WEST STATION, MERIDIAN, Mississippi, 39307

(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
F0605 SS = D	Continued from page 2 §483.12 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-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	**1455 NORTH LAKELAND DRIVE PO BOX 4128 WEST STATION, MERIDIAN, Mississippi, 39307**

(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
F0605 SS = D	Continued from page 3 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure as-needed (PRN) orders for psychotropic medications were limited to (14) days unless the medication was re-evaluated and a duration was specified for one (1) of five (5) residents	F0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE PO BOX 4128 WEST STATION, MERIDIAN, Mississippi, 39307

(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
F0605 SS = D	Continued from page 4 reviewed for unnecessary medications. Resident #13. Findings include: A record review of the “Resident Face Sheet” revealed the facility admitted Resident #13 on 7/18/25 with diagnoses including Senile Degeneration of Brain and Persistent Mood Disorder. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/12/26 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident’s cognition was severely impaired. Section N revealed the resident was receiving antipsychotic, antianxiety, and antidepressant medications. A record review of Resident #13’s “Physician Order Report” dated 2/1/26 through 2/28/26 revealed an order with a start date of 8/1/25 for Lorazepam (Ativan) two (2) mg per milliliter (ml), give 0.5 ml sublingual every three (3) hours PRN for air hunger or anxiety. The order did not include a specified duration or evidence of re-evaluation every (14) days. On 2/3/26 at 2:07 PM, during an interview, Licensed Practical Nurse (LPN) #3 reported Resident #13 was receiving Ativan and Morphine. She reported the resident was monitored for decreased agitation and pain with Morphine and decreased agitation with Ativan and stated the resident was compliant with care and medications. On 2/5/26 at 11:15 AM, during a follow-up interview and record review with the Director of Nursing, she reported Resident #13 was on Lorazepam per hospice recommendations. She reported she believed the (14) day PRN requirement did not apply to hospice residents. On 2/5/26 at 11:30 AM, during an interview, the Nurse Practitioner reported she continued Lorazepam per hospice recommendations for comfort measures and stated she was not aware the (14) day PRN requirements applied to hospice residents but would apply this requirement going forward.	F0605		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous	F0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE PO BOX 4128 WEST STATION, MERIDIAN, Mississippi, 39307

(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
F0693 SS = D	Continued from page 5 endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure a tube feeding bag was labeled with required information, including the date, time, type of feeding, and initials of the nurse preparing the tube feeding, in accordance with professional standards, for one (1) of two (2) residents reviewed for tube feeding. Resident #11. Findings include: A record review of the “Resident Face Sheet” revealed the facility admitted Resident #11 on 12/31/25 with diagnoses including Alzheimer’s Disease. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/6/26 revealed Resident #11 required a staff assessment for cognitive status and indicated her cognitive skills for daily decision making was severely impaired. A record review of the “Physician Order Report: 02/01/2026 – 02/28/2026” revealed Resident #11 had a Physician’s Order, dated 1/14/26 for “Isosource 1.5 at 20 ML/HR (Milliliters per Hour) …” On 2/2/26 at 12:32 PM, during an observation of Resident #11 and the resident’s room, there was a tube feeding bag in use did not contain a date, time, type of feeding or initials of the nurse who prepared or hung the tube feeding. On 2/2/26 at 12:35 PM, during an observation and	F0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE PO BOX 4128 WEST STATION, MERIDIAN, Mississippi, 39307

(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
F0693 SS = D	Continued from page 6 interview with the Director of Nursing (DON), she reviewed Resident #11's tube feeding bag and confirmed it did not contain a date, time, type of feeding, or initials of the nurse who hung the bag. She reported the night nurse who changes the tube feeding bag is responsible for labeling the bag. She explained the purpose of the labeling is to ensure the feeding bag is changed within (24) hours from the start of use.	F0693		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to post required cautionary signage to indicate oxygen was in use for three (3) of (3) residents reviewed for oxygen administration. Residents #1, #11, and #39. Findings include: On 02/02/2026 at 2:17 PM, an observation of the residents' rooms and doors on 200-hall revealed 3 rooms (Residents #1, #11 and #39) where oxygen concentrators were in use with no sign cautioning that oxygen was in use posted on the doors. On 02/02/2026 at 3:09 PM, an interview and observation with the Director of Nursing (DON) confirmed there were no oxygen signs posted outside Residents #1, #11 and #39's doors. The DON noted the reason for having an oxygen sign posted is to inform people that a possible combustible is in this room. The DON affirmed that all nursing staff are responsible for assuring proper signage is posted on residents' doors. The DON noted she will put the signs up and will make sure that the staff are educated to perform this task. On 02/05/2026 at 1:30 PM, during an interview the Administrator acknowledged the failure of the facility's staff to place oxygen signs on Residents #1, #11 and #39's doors. The Administrator stated that the	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE PO BOX 4128 WEST STATION, MERIDIAN, Mississippi, 39307

(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
F0695 SS = D	Continued from page 7 staff will be trained to make sure there are signs posted on all rooms that contain oxygen concentrators. Resident #1 A record review of the “Resident Face Sheet” revealed the facility admitted Resident #1 on 10/18/24 with diagnoses including Tracheostomy. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/22/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating his cognition was intact. A record review of the "Physician Order Report: 02/01/2026-02/28/2026" revealed Resident #1 had a Physician’s Order, dated 10/31/2024, for “O2 (Oxygen) via trach (Tracheostomy) collar – Flow 5L/Min (Liters per minute) …continuous…” Resident #11 A record review of the "Resident Face Sheet" revealed the facility admitted Resident #11 on 12/31/2025 with diagnoses including Alzheimer's disease with late onset. A record review of the Admission MDS with an ARD of 01/06/2026 revealed Resident #11 required a staff assessment for mental status and his cognitive skills for daily decision making was severely impaired. A record review of the "Physician Order Report: 02/01/2026-02/28/2026" revealed Resident #11 had a Physician’s Order, dated 12/31/2025 for “O2 at 2L per NC (Nasal Cannula)…PRN (as needed)…” Resident #39 A record review of the "Resident Face Sheet" revealed the facility admitted Resident #39 on 12/15/2025 with diagnoses including Malignant Neoplasm of Esophagus. A record review of the Admission MDS with an ARD of 12/21/2025 revealed Resident #39 had a BIMS score of 15 which indicated his cognition was intact. A record review of the "Physician Order Report: 02/01/2026-02/28/2026" revealed Resident #39 had a Physician’s Order dated 12/17/2025 for O2 at 2L via NC – continuous…”	F0695		
F0880 SS = D	Infection Prevention & Control	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	**1455 NORTH LAKELAND DRIVE PO BOX 4128 WEST STATION, MERIDIAN, Mississippi, 39307**

(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
F0880 SS = D	Continued from page 8 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE PO BOX 4128 WEST STATION, MERIDIAN, Mississippi, 39307

(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
F0880 SS = D	Continued from page 9 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to prevent the possible spread of infection during medication administration for two (2) of five (5) residents observed. Specifically, for Resident #30, staff failed to maintain clean supplies by returning a box of gloves taken into the resident's room to a clean linen cart, and for Resident #5, staff failed to follow enhanced barrier precaution requirements by not wearing an isolation gown during medication administration via percutaneous endoscopic gastrostomy (PEG) tube. Findings include: A review of the facility's policy, "Infection Control Plan 2025 - 2026," dated March 2024, revealed, "…The mission of the infection…prevention, and control program is to prevent and control infections and to promote the well-being of patients, healthcare workers, and visitors through a commitment to excellent…patient care, effective use of resources, and continuous improvement…" A review of the facility's "Enhanced Barrier Precautions Protocol," undated, revealed, "1. Enhanced Barrier Precautions (EBP) are required for the	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE PO BOX 4128 WEST STATION, MERIDIAN, Mississippi, 39307

(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
F0880 SS = D	Continued from page 10 following resident categories: All residents with multidrug-resistant organisms (MDROs)…, chronic wounds or indwelling medical devices… A green sticker will be placed on the outside of the resident's door to identify residents on EBP… 3. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities…Device care or use…feeding tube…" A record review of the facility's "Professional Development Program Record" revealed Licensed Practical Nurse (LPN) #3 and LPN #2 received education on hand hygiene, contact precautions, enhanced barrier precautions, and personal protective equipment (PPE) on from 5/20/25 through 5/22/25. A record review of the "Review Check-Off List" revealed LPN #3 received training related to "Infection Prevention" on 10/27/25. Resident #5 A record review of the "Resident Face Sheet" revealed the facility admitted Resident #5 on 6/2/23 with diagnoses including Dysphagia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/1/25 revealed Resident #5's Brief Interview for Mental Status (BIMS) was not completed and coded as 99. A record review of the "Physician Order Report: 02/01/2026 – 02/28/2026" revealed all medications for Resident #5 were to be administered per PEG or PO (by mouth). On 2/4/26 at 7:30 AM, during an observation and interview, Licensed Practical Nurse (LPN) #2 administered medications via PEG tube to Resident #5. A green enhanced barrier precaution indicator was observed on the resident's door. However, the nurse did not wear an isolation gown during the medication administration. LPN #2 confirmed she did not wear an isolation gown while administering medications via PEG tube and stated she believed gowns were only required for residents on contact isolation. On 2/4/26 at 8:00 AM, during an interview, Registered Nurse (RN) #1 stated staff are trained to wear isolation gowns when providing care to residents identified with enhanced barrier precautions and that green indicators on doors identify required personal protective equipment.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A418	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE PO BOX 4128 WEST STATION, MERIDIAN, Mississippi, 39307

(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
F0880 SS = D	Continued from page 11 On 2/4/26 at 8:30 AM, during an interview, the Director of Nursing (DON) stated staff are expected to wear gowns when providing PEG tube care for residents on enhanced barrier precautions and confirmed the nurse failed to follow facility policy. Resident #30 A record review of the “Resident Face Sheet” revealed the facility admitted Resident #30 on 2/20/25 with diagnoses including Allergic Rhinitis. A record review of the Quarterly MDS with an ARD of 11/10/25 revealed Resident #30 had a BIMS score of 12, which indicated her cognition was moderately impaired. A record review of the “Physician Order Report: 02/01/2026 – 02/28/2026” revealed Resident #30 had a Physician’s Order, dated 6/26/25 for “Saline Nasal Spray…” On 2/3/26 at 8:35 AM, during an observation, LPN #3 removed a full box of gloves from a clean linen cart, entered Resident #30’s room, administered nasal saline spray, and then returned the box of gloves to the clean linen cart. On 2/3/26 at 9:00 AM, during an interview, LPN #3 stated she placed the gloves back on the clean linen cart after use and did not believe the gloves were contaminated once taken into the resident’s room. LPN #3 returned the gloves back to Resident #30’s room and stated she didn't care because she didn't pay for them. On 2/5/26 at 8:15 AM, during an interview, the Director of Nursing (DON) stated gloves are considered contaminated once taken into a resident's room and should not be returned to the clean supply areas. The DON stated staff are expected to remove only the gloves needed for resident care and to follow infection control policies. On 2/5/26 at 1:00 PM, during an interview, the Administrator stated staff are expected to always follow infection control and enhanced barrier precaution policies. The Administrator confirmed staff should not return supplies taken into resident rooms to clean areas and should wear gowns when administering PEG tube medications.	F0880		