| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255141 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/05/2026 |
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| PICAYUNE REHABILITATION AND HEALTHCARE CENTER | 1620 READ ROAD , PICAYUNE, Mississippi, 39466 |

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| F0000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted four (4) Complaint Investigations (CI MS #2733159, CI MS #2719784, CI MS #2712200, and CI MS #2711808), at the facility from 2/2/26 through 2/5/26. CI MS #2733159 was investigated related to neglect, accidents, and quality of care and F600 was cited. CI MS #2719784 was investigated related to nursing services, quality of care, and neglect, and there were no citations. CI MS #2712200 was a facility reported incident (FRI) investigated related to quality of care, rehabilitation services, and infection control, and there were no citations. CI MS #2711808 was investigated related to nursing services, accidents, and neglect, and there were no citations.<br><br>During the complaint survey, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 1/20/26, when the facility failed to protect Resident #1 from neglect by failing to provide necessary care and services following a fall, resulting in delayed assessment and delayed medical evaluation.<br><br>The IJ and SQC existed at:<br><br>CFR §483.12(a)(1) Freedom from Abuse, Neglect, and Exploitation (F600) – Scope and Severity “J”.<br><br>This failure placed Resident #1 and all residents at risk for falls in a situation that is likely to cause serious injury, serious harm, serious impairment, or death.<br><br>The facility Administrator was notified of the IJ on 2/4/26 at 4:00 PM and was presented with the IJ template.<br><br>The facility provided an acceptable Removal Plan on 2/4/26, in which they alleged all corrective actions to remove the IJ were completed on 2/4/26, and the IJ removed on 2/5/26.<br><br>The SA validated the Removal Plan on 2/5/26 and determined the IJ was removed on 2/5/26, prior to exit. Therefore, the scope and severity of CFR §483.12(a)(1) (F600) was lowered from a “J” to an “D” level while the | F0000 | | |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0000 | Continued from page 1<br>facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure sustained compliance with regulatory requirements.<br><br>The facility was licensed for 120 beds with a census of 103. | F0000 | | |
| F0600<br>SS = SQC-J | Free from Abuse and Neglect<br><br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br><br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interviews, record review, and facility policy review, the facility failed to provide necessary care and services to protect residents from neglect when staff failed to ensure safe transfers for a resident who required a mechanical lift, failed to ensure a licensed nurse timely assessed the resident following a fall, failed to initiate timely neurological monitoring, and failed to timely notify the physician of the fall and subsequent head injury for one (1) of six (6) residents reviewed for falls. Resident #1.<br><br>The facility's failure to ensure appropriate post-fall assessment, monitoring, communication, and timely medical evaluation resulted in serious harm to Resident #1 and placed other residents with falls at risk for serious harm, serious impairment, or death.<br><br>The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 1/20/26, when Resident #1 fell and was manually lifted back into bed without a licensed nurse assessment and without timely initiation of neurological monitoring or physician notification | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 2<br>following a suspected head injury. The facility Administrator was notified of the IJ on 2/4/26 at 4:00 PM and was presented with the IJ template. The facility provided an acceptable Removal Plan on 2/4/26, in which they alleged all corrective actions to remove the IJ were completed on 2/4/26, and the IJ was removed on 2/5/26.<br><br>The State Agency (SA) validated the Removal Plan on 2/5/26 and determined the IJ was removed on 2/5/26, prior to exit. Therefore, the scope and severity for CFR §483.12(a)(1) Freedom from Abuse, Neglect, and Exploitation (F600) was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.<br><br>Findings include:<br><br>A review of the facility's "Abuse Prohibition Policy", reviewed 6/2/25, revealed "…Intent: This protocol was intended to assist in the prevention of abuse, neglect…Definitions…Neglect is defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, good or services that a resident (s) requires but the facility fails to provide them to the resident (s), that has resulted in or may result in physical harm, pain…"<br><br>A review of the facility's policy, "Fall Prevention Program," dated 6/18/25, revealed "…5. If a fall occurs, the following will be done: a. The licensed nurse will complete a thorough assessment of the resident to evaluate for injury…k. If the resident with dementia sustains a fall, in addition to the nursing assessment, the facility will also prioritize diagnostics such as STAT (immediate)Xray/transfer to ER (emergency room) for appropriate investigation and intervention…"<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #1 on 01/25/18 and she had current diagnoses including Alzheimer's Disease.<br><br>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated her cognition was severely impaired. | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 3<br>A record review of the "Orders/Notes", dated 1/20/26, revealed Resident #1 "1/20/26 – Fall (with) injury, large bruise atop R (Right) shoulder." The "Orders/Notes", dated 1/23/26, revealed Resident #1 "1/21 fall (with) bruising to R shoulder/R arm neuro (neurological checks (1/24) …"<br><br>A record review of the facility's incident report, dated 1/21/2026 at 6:15 AM, revealed the "Incident Description" included a "Nursing Description" of "CNA (Certified Nurse Assistant) reported to this nurse while given patient care staff stated the resident was turned to the edge of the bed, resident then grabbed the sheet and pulled herself off the bed staff was unable to prevent resident from falling to the floor, and put her back into bed." "Statements," dated 1/22/26, revealed, "…CNA stated while providing incontinent care for (Proper Name of Resident #1), had one hand placed on her hip for support and using other hand to provide perineal care. Resident grabbed the sheet and pulled herself over toward edge of bed, causing her to fall. I was unable to catch resident and prevent from falling." A review of the "Agencies/People Notified" revealed the Physician was notified on 1/21/26 at 8:15 AM of the resident's fall. "Notes," dated 1/22/26, revealed, "Witnessed fall investigated by DON (Director of Nurses). While CNA was performing incontinent care, resident grabbed bed and pulled herself causing her to fall. CNA was unable to stop from hitting floor. The incident report did not include the date and time the fall actually occurred, which was on 1/20/26. The report described "Immediate Action Taken" as "Resident was assessed upon being notified of bruising atop resident's right shoulder. Assessed for ROM (Range of Motion)…"<br><br>A record review of the "Progress Note", dated 1/21/26 at 10:04 PM, for Resident #1 revealed, "Nurse called to resident's room by the aide to report new found ecchymosis (bruising) to pt's (patient's) right shoulder blade and her neck…Pt reports tenderness to light palpitation. Range of motion is guarded by resident, but functional. Resident also has bruising to her right side of her head with a hematoma, mild swelling and tenderness. Resident states she doesn't remember what happened…"<br><br>A record review of the "Progress Note" which indicated "Late Entry" that was "Created" on 1/22/26 at 1:21 PM with an "Effective Date" of 1/21/26 at 6:15 AM, for Resident #1 revealed, "CNA reported to this nurse while giving patient care staff stated the resident was turned to the edge of the bed, resident then grabbed the sheet and pulled herself off the bed staff was | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 4<br>unable to prevent resident from falling to the floor. CNA stated they put her back into the bed. Resident was assessed upon being notified of bruising atop resident's right shoulder. Assessed for ROM resident denied pain at that time…" The progress note did not indicate the date or time the fall actually occurred.<br><br>A record review of the "Order Summary Report" with active orders as of 1/25/26, revealed Resident #1 had a Physician's Order, dated 04/09/20, for Aspirin Tablet 81 milligrams (mg) and Plavix Tablet 75 mg, which are both antiplatelet agents (affects how the blood clots). Further review revealed a Physician's Order, dated 3/21/23 for "Hoyer lift (type of mechanical lift) x (times) 2 people for transfers."<br><br>A record review of the Medication Administration Record (MAR) for January 2026 revealed Resident #1 continued to be administered aspirin and Plavix from 1/21/26, which was the date her head injury was observed and documented, until 1/26/26 when Resident #1 was transferred to an acute care hospital for altered mental status.<br><br>A record review of the "Emergency Department Encounter", dated 1/26/26 revealed the "Chief Complaint" as "…Altered Mental Status Patient had fall on 1/21, patient had left sided facial droop…History…staff went to feed her at 1145 and found her confused with a left-sided facial droop…CT (Computed Tomography) Noncontrast head…Findings: There is hemispheric subdural on the right extending from the vertex through to inferior skull base on the right involving the frontal, parietal, temporal and occipital lobes with extension posteriorly medially into the interhemispheric fissure. This measures at least 1.8 cm (centimeter). There is approximately 8 mm(millimeter) of right-to-left midline shaft with compression of the right lateral ventricle and slight dilatation of the left lateral ventricle…Medical Decision Making…transferred for…higher level of care…"<br><br>A record review of the "ED Provider Notes," from acute hospital with higher level of care, dated 1/26/26 revealed "History" of "…She has a history of a fall 5 days ago where she struck her head but did not seek medical attention…CT of the head in outlying facility shows large intracranial bleed.." Further review revealed, "…I have discussed with patient's husband via telephone…I was able to detail for him the findings on the head CT identifying both acute and chronic blood...which could enlarge, particularly in a patient who has been on blood thinning medications including aspirin and Plavix…" | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 5<br><br>On 2/3/26 at 2:00 PM, during an interview with CNA #1, she explained that on 1/20/26 at approximately 10:00 PM, Resident #1 fell to the floor after slipping between the bed and the wall and landed on her right side. CNA #1 stated she notified Licensed Practical Nurse (LPN) #3 and LPN #1 of the fall and obtained assistance from CNA #2 to return the resident to bed. CNA #1 also confirmed the resident required the use of a mechanical lift for transfers. CNA #1 was unable to explain why a mechanical lift was not used or why the resident was returned to bed prior to a licensed nurse assessing the resident. CNA #1 was unable to confirm when a licensed nurse assessed Resident #1 following the fall.<br><br>On 2/3/26 at 2:15 PM, during an interview with CNA #2, she confirmed that she assisted CNA #1, in placing Resident #1 back into the bed. She reported that a mechanical lift was not used and that they manually lifted the resident by her arms and legs to return her to bed. She reported that facility policy requires staff to immediately notify a nurse following a fall so the residents can be assessed and, if needed, a mechanical lift used to assist with transferring. She reported being confused as to why a nurse was not present in the room at that time.<br><br>On 2/3/26 at 3:30 PM, during an interview with LPN #3, she explained that she was working on 1/20/26. She denied that CNA #1 had informed her that Resident #1 had fallen on 1/20/26.<br><br>On 2/3/26 at 4:00 PM, during an interview with LPN #1, she reported she was working the night of 1/20/26 and was not informed of Resident #1's fall at the time it occurred. LPN #1 stated she first became aware of the fall at approximately 6:00 AM on 1/21/26 and at that time notified the physician and family and initiated neurological checks. LPN #1 confirmed that she had documented the fall on the 24-Hour report, which is the "Orders/Notes" notes. LPN #1 confirmed that CNA #1 was present and witnessed the fall. LPN #1 reported she did not complete an incident report or document the event until 1/22/26, which was two (2) days after the fall occurred and explained the documentation was entered as late documentation in a nurse's note per direction of the DON.<br><br>On 2/3/26 at 4:30 PM, during an interview with LPN #2, she reported that on 1/21/26 at approximately 10:00 PM she observed a hematoma on the right side of Resident #1's head. LPN #2 stated she notified the DON in the early morning hours of 1/22/26. LPN #2 reported she did | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 6<br>not notify the medical provider because she believed the injury appeared old based on the yellow discoloration of the surrounding bruising. LPN #2 confirmed she was not aware Resident #1 had fallen on 1/20/26, did not complete neurological monitoring during her shift on 1/21/26, and did not notify the medical provider on 1/21/26 that Resident #1 had a head injury.<br><br>On 2/4/26 at 9:00 AM, during an interview with the DON, he confirmed he did not become aware of Resident #1's fall until 1/22/26 at approximately 7:41 AM, when LPN #2, contacted him by phone. He reported he was informed that the resident had sustained bruising to her shoulder and was at her neurological baseline at that time. He explained he was not informed of the presence of a hematoma and reported he did not review the nursing notes, dated 1/21/26, that had documented the hematoma. The DON confirmed he assessed the resident on 1/22/26, which was two (2) days after the fall occurred on 1/20/26. He admitted that he did not physically assess the resident's head at that time. The DON confirmed the medical provider was notified of the resident's fall at that time and received a physician order to obtain a right shoulder x-ray for Resident #1. The DON further confirmed that following the notification on 1/22/26, he initiated an investigation into the incident. He identified that CNA #1 did not follow facility expectations by failing to obtain licensed nursing to assess the resident after the fall. He also identified that LPN #2, did not follow facility expectations by failing to notify the medical provider of the resident's hematoma that she discovered on 1/21/26.<br><br>On 2/4/26 at 12:44 PM, during an interview with the Medical Provider, he confirmed that he was not aware of Resident #1's fall that occurred on 1/20/26 until 1/22/26. At that time, he ordered an x-ray of the right shoulder due to complaints of shoulder pain. He reported he was not informed that Resident #1 had a hematoma to her head and that no one had called him at the time it was documented on 1/21/26 by the nurse. He stated that had he been notified of the hematoma, he would have ordered the resident to be transferred to the local emergency room for further evaluation.<br><br>On 2/4/26 at 2:06 PM, during an interview with the Administrator, she confirmed she was not aware of Resident #1's fall that occurred on 1/20/26 until 1/22/26, two (2) days after the fall occurred. The Administrator confirmed facility policy required CNAs to immediately report any resident fall to the nurse in charge. She confirmed CNA #1 did not notify nursing | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 7<br>staff of the fall on 1/20/26 and that the resident was transferred back to bed without a licensed nurse assessment. The Administrator further confirmed LPN #1 did not report the fall to nursing leadership, including the DON on 1/20/26 or 1/21/26.<br><br>The facility submitted the following acceptable Removal Plan on 2/4/26.<br><br>On 01/20/2026 at approximately 10:00 PM, Resident #1 experienced a fall during activities of daily living (ADL) care. Certified Nursing Assistant (CNA) #1 was assisting with ADL care when Resident #1, while being repositioned onto her side, grasped the bed and inadvertently pulled herself off, resulting in a fall to the floor. Licensed Practical Nurse (LPN) #1 was notified at 6:15 am on 01/21/2026 and began neuro checks that day. On 01/26/2026, Resident #1 showed left facial droop and slurred speech and was sent to the hospital. The investigation found staff did not use proper lifting techniques, assess Resident #1 quickly, or notify the physician promptly after the fall and head injury.<br><br>Corrective Actions<br><br>On 01/22/2026, at approximately 7:41 a.m., the Director of Nursing (DON) was notified by Licensed Practical Nurse (LPN) #2 regarding discoloration observed on Resident #1’s right shoulder.<br><br>On 01/22/26 at approximately 8:15 a.m., the Registered Nurse (RN)#1 assessed Resident #1 and obtained an order for right shoulder X-ray.<br><br>On 01/22/26 at approximately 09:20 a.m., the Director of Nursing (DON) contacted Licensed Practical Nurse (LPN) #3 to inquire about any knowledge regarding Resident #1’s fall. Licensed Practical Nurse (LPN) #3 reported having no knowledge of the incident.<br><br>On 1/22/2026 at approximately 9:30 a.m, the Director of Nursing (DON) interviewed Certified Nurse Assistant (CNA) #1 regarding Resident #1's fall. Certified Nurse Assistant (CNA) #1 gave a verbal account of the incident.<br><br>On 1/22/2026 at approximately 9:40 am, the Director of Nurses interviewed Licensed Practical Nurse (LPN)#1 regarding Resident #1's fall. Licensed Practical Nurse (LPN) #1 gave a verbal account of the incident.<br><br>On 01/22/2026 at approximately 11:15 a.m., X-ray findings for Resident #1's right shoulder indicated no | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 8<br>evidence of acute fracture or dislocation.<br><br>On 01/22/2026 at approximately 1:00 pm, Licensed Practical Nurse (LPN) #1 initiated a facility-based incident report regarding Resident #1's fall and subsequently completed the associated documentation of the event.<br><br>On 01/22/2026 at approximately 1:15pm, Director of Nurses reviewed Resident #1 Neuro check log to ensure no abnormalities. Resident #1 remained at baseline with current neuro checks in place every four hours to monitor neuro deficits.<br><br>On 01/22/2026 at approximately 10:00pm Neuro checks continued Resident #1 at every eight (8) hours intervals. No neurological deficits were found. The resident remained at the baseline.<br><br>On 01/24/2026 at approximately 6:15am, Neuro checks were completed for Resident #1.<br><br>On 01/26/26 at approximately 12:30pm Resident #1 was noted to have drooped to left side and slurred speech. Nurse Practitioner (NP) #1 was notified, and orders were obtained to transfer to local hospital.<br><br>On 01/26/2026 at approximately 12:34 Resident #1 was transferred to local hospital via stretcher.<br><br>On 01/29/2026 at approximately 6:45pm, the Director of Nursing (DON) received notification from Licensed Practical Nurse (LPN) #1 that she resigned from employment effective immediately.<br><br>On 01/30/2026 at approximately 10:00am an audit was conducted by the Director of Nursing (DON) on all current residents that had an accident or incident occur in the past thirty (30) days to determine the potential of any further residents affected. The results indicated no negative outcomes.<br><br>On 02/03/2026 at approximately 5:30 p.m., the Director of Nurses provided education to all licensed nurses and Certified Nursing Assistants on fall prevention, safe handling, and proper resident transfers. Training also included fall prevention along with neuro checks. change in condition notifications, Abuse and Neglect protocols, Resident Rights, and the Vulnerable Adult Act. All staff must complete this training before returning to work.<br><br>On 2/4/2026 at 4:00 P.M. Agency (SA) notified Administrator of Immediate Jeopardy. State Agency (SA) | F0600 | | |

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| PICAYUNE REHABILITATION AND HEALTHCARE CENTER | 1620 READ 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 |
|---|---|---|---|---|
| F0600 SS = SQC-J | Continued from page 9<br>provided the facility with the Immediate Jeopardy templates.<br><br>On 02/04/2026 at approximately 5:00pm Medical Director, Administrator, Director of Nursing, Infection Preventionist, Assistant Director of Nursing, and Corporate Clinical Specialist held Ad hoc Quality Assurance Performance Improvement Meeting to include Resident #1 fall occurring on 01/20/2026 along with investigation, immediate jeopardy, along with the corrective action plan. The fall prevention policy was evaluated and reviewed to incorporate updated procedures and training for new staff on adhering to the Interact Care Path for acute mental status changes.<br><br>On 02/04/2026 at approximately 6:00 P.M., a Resident Council Meeting was held with the Assistant Director of Nursing, the Resident Council President, and eleven (11) resident members. They were informed that the facility received one Immediate Jeopardy citation due to inadequate lifting techniques and failure to assess a resident after a fall.<br><br>On 02/04/2026 at approximately 6:15 p.m., the Administrator, Director of Nursing, and Corporate Clinical Specialist conducted a comprehensive review of the investigation, including all relevant components such as interviews, statements, and electronic records, to perform a root cause analysis. The outcome of this analysis identified a failure in communication as the primary issue.<br><br>On 02/04/2026 at approximately 6:30 p.m., Certified Nurse Assistant (CNA) #2 received individual training from the Administrator on how to identify each resident's lifting status according to their specific care plan, as well as safe handling and lifting procedures along with receiving a disciplinary action.<br><br>On 02/04/2026 at approximately 6:45pm Licensed Practical Nurse (LPN) #2 received one to one Inservice from the Administrator and Director of Nurses on Abuse and Neglect, Resident Rights, Vulnerable Adults act, notification of change in condition, fall prevention, and safe patient handling and moving protocols along with receiving a disciplinary action.<br><br>On 02/04/2026 at approximately 6:50 p.m., Certified Nursing Assistant (CNA) #1 received individual training from the Administrator regarding how to identify each resident's lifting status according to their specific care plan, as well as safe handling and lifting procedures along with receiving a disciplinary action. | F0600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255141 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/05/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PICAYUNE REHABILITATION AND HEALTHCARE CENTER | 1620 READ ROAD , PICAYUNE, Mississippi, 39466 |

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|---|---|---|---|---|
| F0600 SS = SQC-J | Continued from page 10<br>On 02/04/2026 at approximately 7:30 p.m., the Director of Nursing (DON) conducted a training session for all licensed nursing staff regarding adherence to the Interact Care path for acute mental status changes following post-fall assessments. Completion of this training is mandatory for all staff prior to their return to work.<br><br>Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 02/04/2026 and the Immediate Jeopardy was removed on 02/05/2026.<br><br>Validation:<br><br>The SA validated the removal plan through observations, interviews, and record reviews on 2/5/26 and the immediacy was removed on 2/5/26 prior to exit. | F0600 | | |