Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	**1301 BELK BOULEVARD , OXFORD, Mississippi, 38655**

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M0000	Initial Comments The State Agency (SA) conducted an Annual Recertification survey along with Complaint Investigation (CI MS #2704344) at the facility from 03/09/26 through 03/12/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged and Infirm. The SA investigated CI MS #2704344 for confidentiality and privacy, and no deficiencies were cited. During the recertification survey the SA cited M500, M635, M645, and M715. The census at the time of the survey was 105 and the facility is licensed for 120 beds.	M0000		
M0500	45.17.2 Residents' Rights 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	M0500		

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

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M0500	Continued from page 1 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 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	M0500		

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M0500	Continued from page 2 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 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	M0500		

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M0500	Continued from page 3 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: Level IIBased on observation, resident interviews, record review, facility policy review, and staff interviews, the facility failed to ensure residents' rights were maintained, including the right to be from misappropriation, the right to be treated with dignity and respect, to have concerns and grievances addressed, and to receive care and services in a safe and respectful manner for 16 of 105 residents reviewed for resident rights (Residents #12, #21, #22, #25, #35, #39, #43, #44, #46, #52, #65, #67, #84, #96, #104, and #110). Findings include: Review of the facility policy titled "Resident Rights and Responsibilities" with a revision date of 10/10/2022, revealed, "The resident has a right to be treated with respect and dignity..." Review of facility policy titled "Grievance Policy" with revised date 10/6/2025, revealed, "...The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility...issuing written grievance decisions to the resident...3. A resident...may voice grievances with respect to care and treatment that has been furnished...the behavior of staff...and other concerns regarding their LTC (long term care) facility stay...7. Grievances may be voiced in the following forums...d. Verbal complaint during resident or family council meetings...9. d. The Grievance Official will take steps to resolve the grievance, record information about the grievance, and those actions on the grievance form...e. The Grievance Official...will keep the resident appropriately apprised of progress towards resolution of the grievances...10. Evidence demonstrating the results of all grievances will be maintained for a period of no less than three (3) years from the issuance of the	M0500		

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M0500	Continued from page 4 grievance decision...11. The facility will make prompt efforts to resolve grievances." Review of the facility policy titled “Abuse, Neglect, and Exploitation” revised 10/22 revealed under, “Policy: This facility’s policy is to protect each resident’s health, welfare, and rights by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.” Resident #44 Dignity and Respect During a resident interview conducted on 3/09/2026 at approximately 2:34 PM, Resident #44 stated that Certified Nursing Assistant (CNA) #2 had been rude to her. The resident stated that her son had washed her laundry and brought it back to the facility and when she asked the CNA to help her put her clothes away, the CNA stated, “I’m not laundry.” During an interview conducted with the Unit Manager Registered Nurse (RN) #1 on 3/10/2026 at approximately 2:05 PM, the Unit Manager stated the resident had previously complained that a CNA had been rude to her. The Unit Manager stated the CNA reportedly told the resident that her son should have folded her clothes. The Unit Manager stated the comment made the resident feel bad because she is close to her son. The Unit Manager stated she had a meeting with CNA #2 and spoke with her about how she speaks to residents. During an interview conducted with the Administrator and Assistant Director of Nursing (ADON) on 3/10/2026 at approximately 2:25 PM, the Administrator and ADON stated they were unaware the resident had reported the aide being rude to her and stated they were unaware of any education or in-service provided to the CNA regarding the concern. They stated, “We expect our staff to treat residents with dignity and respect.” During an interview conducted with CNA #2 on 3/12/2026 at approximately 10:05 AM, the CNA confirmed the resident had asked for help putting her clothes away. CNA #2 stated she told the resident, “I’m not laundry,” and acknowledged the statement could have been perceived as rude. CNA #2 confirmed that she should have just helped the resident with her needs.	M0500		

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M0500	Continued from page 5 Record review of the Admission Record revealed the facility admitted Resident #44 on 11/27/2020 with diagnoses that included Cerebral Infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/2025 revealed under Section C, a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #44 was cognitively intact. Resident #84 Dignity and Respect On 3/11/2026 at approximately 12:53 PM, an observation was conducted of Licensed Practical Nurse (LPN) #6 providing Percutaneous Endoscopic Gastrostomy tube (PEG) site care to Resident #84. During the observation, the LPN closed the privacy curtain between residents but left the door open while providing care. Resident #84 was sitting close to the door during the care, and another resident was wheeled by in a wheelchair and waved at Resident #84 during the care. When asked about privacy and dignity during the observation, LPN #6 stated she forgot to close the door, and residents should be treated with dignity and have privacy during care. During an interview with the Director of Nursing (DON) on 3/11/26 at 2:30 PM, the DON stated the door should have been closed and residents should have privacy and be treated with dignity and respect. Record review of the Admission Record revealed the facility admitted Resident #84 on 10/20/2022 with diagnoses that included Malignant Neoplasm of Larynx. Record review of the MDS with an ARD of 12/07/2025 revealed under Section C, a BIMS score of 10, indicating moderate cognitive impairment. Resident #67 Misappropriation Record review of Resident #46's March 2026 Medication Administration Record (MAR) revealed an order dated 1/1/26, "Seroquel oral tablet 200 MG (milligrams) give	M0500		

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M0500	Continued from page 6 1 (one) tablet by mouth one time a day" due at 0800 (8 AM). On 3/11/26 at 7:30 AM, an observation of a medication pass with Licensed Practical Nurse (LPN) #5 revealed the LPN did not have Resident #46's ordered Seroquel 200 milligram tablet and stated Resident #46 was out of the medication. LPN #5 then removed two (2) 100 milligram tablets from Resident #67's Seroquel medication card and administered the medication to Resident #46. Record review of Resident #67's March 2026 MAR revealed an order dated 8/11/25, "Seroquel oral tablet 100 MG (milligrams) give one (1) tablet by mouth at bedtime." An interview with LPN #5 on 3/11/26 at 8:46 AM confirmed he borrowed Resident #67's Seroquel to administer to Resident #46. He explained that he was not aware that he was not supposed to borrow medications and acknowledged Resident #67 lost two (2) doses of his medication which could create a medication shortage for him. LPN #5 further acknowledged medications belong to the resident for whom they were dispensed. An interview with the Director of Nursing (DON) on 3/11/26 at 1:39 PM confirmed medications should not be borrowed and stated the facility had a backup pharmacy available when medications were out of stock. She acknowledged medications dispensed by the pharmacy were considered the property of the resident for whom they were prescribed. Record review of the "Admission Record" revealed the facility admitted Resident #67 on 8/11/25 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting the Left Non Dominant Side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/24/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #67 was cognitively intact. Resident Council - Resident #12, #21, #22, #25, #35, #39, #43, #46, #52, #65, #67, #96, #104, #110	M0500		

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M0500	Continued from page 7 On 03/10/26 at 2:00PM the State Agency (SA) held a Resident Council meeting with Resident #12, Resident #21, Resident #22, Resident #25, Resident #35, Resident #39, Resident #43, Resident #46, Resident #52, Resident #65, Resident #67, Resident #96, Resident #104 and Resident #110 in attendance. When residents were asked if they had grievances that had not been addressed by the facility, 14 of the 16 residents' present reported they had voiced grievances to facility staff that had not been resolved and that it was in the meeting minutes. The residents stated that facility staff generally treated them well; however, they expressed multiple concerns regarding agency staff. Residents reported they were tired of having agency staff and stated that agency staff did not provide continuity of care because they did not know the residents or the facility routines. They stated that agency staff were frequently on their phones, they were rude and appeared uninterested in providing care. Residents also complained that agency nurses took excessive time to pass evening medications. Several residents stated that medications scheduled for 7:00–8:00 PM were sometimes not administered until 10:00–11:00 PM when agency nurses were working. Residents reported that these concerns had been ongoing for several months and stated the issues had been discussed repeatedly during Resident Council meetings. Residents indicated that the Licensed Social Worker (LSW) was aware of these concerns; however, they reported they had not received follow-up regarding their complaints and were unaware of any grievance investigation or outcomes. Record review of Resident Council meeting minutes dated 10/14/25, revealed, "...Old Business...Medications (not getting medications on time (mainly "agency staff" nurses) having to wait until after 10/11 to get 8:00 meds-Only with agency..." Record review of Resident Council meeting minutes dated 11/13/25, revealed, "...New Business...Bad attitudes from Agency staff..." Record review of Resident Council meeting minutes dated 12/9/25, revealed, "...Old Business...Bad attitudes from Agency staff-no change..." During an interview conducted on 3/10/26 at 3:25 PM with the Administrator and the Assistant Director of Nursing (ADON), they confirmed the facility had experienced problems with agency staff in the past, but stated each situation was addressed individually when complaints were reported. The Administrator and Assistant Director of Nursing (ADON) both confirmed	M0500		

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M0500	Continued from page 8 that they didn't consider this issue a grievance and the things they considered to be grievances would be something such as missing items or missing clothing. When they were asked to describe the facility's grievance process, neither the Administrator nor the ADON were able to clearly describe the process. Both stated that the LSW handled grievances but did not provide additional information regarding how grievances were received, investigated, tracked, or how outcomes were communicated to residents. The Administrator and ADON did not indicate that grievances raised during Resident Council meetings regarding agency staff behavior and delayed medication administration would be considered grievances requiring investigation and follow-up. On 03/11/2026 at 8:24 AM, an interview was conducted with the Licensed Social Worker (LSW), she stated she was responsible for handling grievances and confirmed that she attended the resident council meetings each month. When asked about residents' grievances regarding how they were treated by agency staff, the LSW stated, "It's written in every Resident Council meeting," and confirmed that the issue had not been resolved. Record review of the "Admission Record" indicated that the facility admitted Resident #12 on 9/4/2024 with a medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/27/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 13 which indicated Resident #12 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #21 on 4/12/2022 with a medical diagnosis that included Cerebral Infarction, Unspecified. A record review of the MDS with an ARD of 3/4/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #21 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #22 on 2/14/2025 with a medical diagnosis that included Other Schizophrenia. A record review of the MDS with an ARD of 2/14/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #22 was cognitively intact.	M0500		

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M0500	Continued from page 9 Record review of the "Admission Record" indicated that the facility admitted Resident #25 on 1/8/2019 with a medical diagnosis that included Cerebral Infarction, Unspecified. A record review of the MDS with an ARD of 12/14/25 revealed under section C, a BIMS summary score of 13 which indicated Resident #25 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #35 on 5/23/2024 with a medical diagnosis that included Other Cerebrovascular Disease. A record review of the MDS with an ARD of 2/10/26 revealed under section C, a BIMS summary score of 14 which indicated Resident #35 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #39 on 12/3/2025 with a medical diagnosis that included Type 2 Diabetes Mellitus without complications. A record review of the MDS with an ARD of 2/5/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #35 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #43 on 11/14/2025 with a medical diagnosis that included Chronic Kidney Disease, Stage 4. A record review of the MDS with an ARD of 2/17/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #43 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #46 on 11/16/2022 with a medical diagnosis that included Acute Upper Respiratory Infection. A record review of the MDS with an ARD of 1/29/26 revealed under section C, a BIMS summary score of 14 which indicated Resident #46 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #52 on 2/6/2026 with a medical diagnosis that included Epilepsy, Unspecified, Not Intractable, with Status Epilepticus. A record review of the MDS with an ARD of 1/19/26 revealed under section C, a BIMS summary score of 15 which indicated Resident #52 was cognitively intact.	M0500		

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M0500	Continued from page 10 Record review of the "Admission Record" indicated that the facility admitted Resident #65 on 8/22/2025 with a medical diagnosis that included Hypothyroidism. A record review of the MDS with an ARD of 2/23/26 revealed under section C, a BIMS summary score of 12 which indicated Resident #65 had moderate cognitive impairment. Record review of the "Admission Record" indicated that the facility admitted Resident #67 on 8/11/2025 with a medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side. A record review of the MDS with an ARD of 12/24/25 revealed under section C, a BIMS summary score of 15 which indicated Resident #67 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #96 on 11/3/2023 with a medical diagnosis that included Type 2 Diabetes Mellitus with hyperglycemia. A record review of the MDS with an ARD of 1/27/26 revealed under section C, a BIMS summary score of 13 which indicated Resident #96 was cognitively intact. Record review of the "Admission Record" indicated that the facility admitted Resident #104 on 2/18/2022 with a medical diagnosis that included Moderate Protein-Calorie Malnutrition. A record review of the MDS with an ARD of 12/22/25 revealed under section C, a BIMS summary score of 8 which indicated Resident #104 had moderate cognitive impairment. Record review of the "Admission Record" indicated that the facility admitted Resident #110 on 7/17/2013 with a medical diagnosis that included Multiple Sclerosis. A record review of the MDS with an ARD of 12/4/25 revealed under section C, a BIMS summary score of 15 which indicated Resident #110 was cognitively intact.	M0500		
M0635	45.21.7 Gastric feeding Gastric feeding. Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube is unavoidable. The residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal	M0635		

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M0635	Continued from page 11 eating skills. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, record review, and staff interviews, the facility failed to ensure tube feeding or supplements administered through a Percutaneous Endoscopic Gastrostomy (PEG) tube were administered according to physician orders and care planning for one (1) of two (2) residents with a PEG tube (Resident #84). Findings include: Review of the facility policy titled “Enteral Nutrition,” revised 3/17/2023, revealed liquid nutritional supplements and substitutes will be given to the resident as ordered by the physician. On 3/09/2026 at 11:00 AM, Resident #84 was observed in his room administering a brown liquid through his PEG tube using a syringe. A record review conducted on 3/09/2026 revealed there were no physician orders indicating the resident was permitted to independently administer tube feeding or supplements through the PEG tube. Record review also revealed no documentation indicating the resident had been assessed for the ability to safely self-administer tube feeding or supplements. An interview conducted with Registered Nurse (RN) #1 on 3/10/2026 at 2:00 PM revealed the tube feeding formula or supplements must be administered by staff, and staff are responsible for monitoring the resident’s intake. An interview conducted with the Administrator and Assistant Director of Nursing on 3/10/2026 at 2:20 PM revealed the resident should not have been independently administering liquids through his PEG tube. The Assistant Director of Nursing stated allowing the resident to administer liquids independently would prevent staff from accurately monitoring intake and output and ensuring the feeding was administered appropriately. Record review of the Admission Record revealed the facility admitted Resident #84 on 10/20/2022 with diagnoses that included Malignant Neoplasm of Larynx. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/07/2025 revealed	M0635		

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M0635	Continued from page 12 under Section C, a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment.	M0635		
M0645	45.21.9 Nutrition Nutrition. Residents shall maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless residents ' clinical condition indicates that this is unavoidable. All residents shall receive diets as orders by their physician or nurse practitioner/physician assistant. Residents identified with significant nutritional problems shall receive appropriate medical nutrition therapy based on current professional standards. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III Based on resident interview, record review, and staff interviews, the facility failed to ensure fluid restrictions were implemented and monitored for one (1) of six (6) residents reviewed for dialysis services (Resident #5). This deficient practice resulted in the resident experiencing fluid volume overload requiring hospitalization. Findings include: The facility did not provide a policy related to monitoring or implementing fluid restrictions for residents. Review of a statement on facility letterhead dated 3/11/26 and signed by the Administrator revealed “(Proper Name of Facility) does not have a policy related to fluid restrictions or management of fluids. The staff follow physician orders.” During an interview conducted with Resident #5 on 3/09/2026 at 3:12 PM, the resident communicated by writing on a white board and indicated she had recently been hospitalized. Record review revealed physician's order dated 08/28/25 for hemodialysis on Monday, Wednesday, and Friday and the resident had a physician order for a fluid restriction of 1000 milliliters (ml) per day. Record review of physician diet orders revealed Resident #5 was ordered a renal diet with a 1000 milliliter (ml) fluid restriction. The order indicated the resident may receive 240 ml with each meal and 70 cubic centimeters (cc) with each medication pass.	M0645		

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M0645	Continued from page 13 Record review of Nurses Notes dated 01/02/26 at 10:44 AM stated, "Resident found to be in respiratory distress, oxygen (O2) 76%, on 3L (liters), Respiratory 30, Manual Blood pressure 150/68. O2 increased to 86% on 5L. Resident appearing weak and unable to ambulate safely independently, NP (Nurse Practitioner) at bedside with orders to send resident to ER (Emergency Room) for respiratory distress." Record review of hospital records revealed the resident was hospitalized on 01/02/26 for volume overload and discharged on 1/03/2026. The hospital assessment noted the resident “presented with volume overload symptoms related to getting too much fluid at the nursing home.” Record review of the January 2026 Treatment Administration Record and Nurses Notes documentation revealed a lack of a continuous daily monitoring system to ensure the resident’s fluid intake remained within the ordered restriction. Record review of "Assessment History," revealed a lack of intake and output (I&O) documentation in order to properly monitor I&O's for the following dates of 01/03/26 through 02/05/26. Record review of fluid intake documentation dated 2/26/2026, 02/27/26, 03/02/26, 03/03/26, 03/04/26, 03/06/26, 03/07/26 and 03/08/26 revealed the resident received 480 ml at three separate times for the 24-hour period totaling 1,440 ml, which exceeded the ordered 1000 ml fluid restriction. Record review further revealed the physician was not notified when the fluid restriction was exceeded on these dates. An interview conducted with a Certified Nursing Assistant (CNA) #3 on 3/11/2026 at 11:30 AM revealed CNA #3 stated that she used the drinking cups on the resident's meal tray to document the resident’s intake. She demonstrated how for the daily meals the resident would have two (2) eight-ounce cups of juice and coffee for breakfast and 2 eight-ounce cups of liquid for the lunch and supper meals. CNA #3 confirmed that each eight-ounce cup is 240ml and it would total 480ml per meal for a total of 1,440ml per 24-hour period. CNA #3 confirmed that this would be over the daily fluid intake ordered by the physician. During an interview conducted with the Director of Nursing (DON) on 3/11/2026 at 11:45 AM, the DON stated that she was unaware that the resident was receiving over her total daily fluid amount and although staff were documenting fluid intake, they were not totaling the intake at the end of the shift and were not notifying the physician when the resident exceeded the	M0645		

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M0645	Continued from page 14 ordered 1000 ml restriction. The DON confirmed that they needed to do a better job monitoring the fluid intake and that it was not always documented and tracked daily to prevent fluid volume overload. An interview conducted with the Administrator on 3/11/26 at 2:05 PM revealed residents with fluid restrictions should have monitoring in place to ensure ordered fluid limits are not exceeded and the physician should be notified if restrictions are exceeded and confirmed that this was not occurring for Resident #5. Interview on 03/11/26 at 3:00 PM with the dialysis nurse at the dialysis facility confirmed that Resident #5 had come to dialysis on 12/28/25, 12/30/25 and was scheduled to come for dialysis on 01/02/26 but had to be sent to the ER prior to her chair time due to fluid overload. Record review of the Admission Record revealed the facility admitted Resident #5 on 8/27/2025 with diagnoses that included End Stage Renal disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/2026 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. MDS Section O revealed the resident received dialysis services while residing in the facility.	M0645		
M0715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, staff interviews, and medication competency checklist review, the facility failed to ensure that insulin was properly labeled and stored in accordance with professional standards and manufacture's instruction for use after opening for one (1) of two (2) medications carts reviewed. C hall med cart Findings Include: Review of the "Medication Administration Competency Checklist" revealed under, "23. Insulin dated when open." Also revealed under, "24. Insulin discarded	M0715		

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M0715	Continued from page 15 after 28 days per manufacturer's instructions." During an observation of the medication cart on C hall with Licensed Practical Nurse (LPN) #5 on 3/11/26 at 12:32 PM revealed the following insulins were in use and exceeded the manufacturer's 28-day room temperature storage limit or were not dated when opened: Resident #1 – Open vial of Insulin Lispro without an open date Resident #13 – Insulin Lispro vial with an open date of 1/2/26 Resident #13 – Insulin Glargine insulin pen without an open date Resident #44 – Insulin Aspart with an open date of 1/17/26 Resident #46 – Insulin Aspart with an open date of 1/30/26 Resident #46 – Fiasp Insulin with an open date of 1/25/26 Resident #67 – Insulin Lispro vial with an open date of 1/30/26 Record review of the manufacturer's storage instructions for Fiasp insulin, Insulin Lispro, Insulin Aspart, and Insulin Glargine revealed that once opened these insulins may be stored at room temperature for up to 28 days, after which the product should be discarded. During an interview with LPN #5, on 3/11/26 at 12:48 PM, he confirmed the insulins were in use and were expired past the 28 days that insulin may be stored at room temperature. He revealed that once insulin was expired it lost its potency and may not be as effective at controlling residents' blood sugars. He confirmed Resident #1 and Resident #13 had insulin in use that was not labeled with an open date, revealing staff could not determine if they were administering expired insulin. During an interview with the Director of Nursing (DON) on 3/11/26 at 1:39 PM, she revealed insulin should be removed from the medication carts after 28 days from the open date. She stated the nurses were responsible	M0715		

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M0715	Continued from page 16 for checking the insulins and ensuring they were not expired. The DON acknowledged that lack of dating the insulin when opening and the use of out-of-date insulin could cause the insulin to not be as effective.	M0715		