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 **03/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NICHOLS CENTER	**1308 HIGHWAY 51 NORTH P O DRAWER 720, MADISON, Mississippi, 39110**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
M0000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 3/23/26 to 3/26/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M630.	M0000		
M0630	45.21.6 Mental and psycho-social Mental and psycho-social. A resident who displays adjustment difficulty receives appropriate treatment and services to address the assessed problem. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide psychiatric services in accordance with professional standards of practice for one (1) of three (3) residents reviewed for unnecessary medications. Resident #53. Findings Include: Record review of the facility policy “Behavioral Health Services” dated 4/01/18 revealed, “It is the policy of this facility that all residents receive care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning…” Record review of the “Progress Notes” dated 2/3/26 through 3/12/26 revealed no psychiatric follow up notes were available and a behavior was marked “YES” on the progress notes indicating behaviors had been present. During an interview on 3/26/26 at 10:45 AM, the Director of Nursing (DON), stated Resident #53 was not being followed by psychiatric services despite receiving an antipsychotic medication. She stated the facility manages short term residents differently and does not automatically initiate psychiatric consultations based on antipsychotic use. She stated a consult is only initiated if behaviors are observed and warrant evaluation. She confirmed Resident #53 had not	M0630		

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

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M0630	Continued from page 1 been referred to psychiatric services. She further stated the facility does not have a policy specifying when psychiatric consultation should be obtained. During a follow up record review and interview on 3/26/26 at 11:21 AM, the DON confirmed the documented behavior entries but stated no descriptive notes were included. She stated the entries were made in error and attributed them to the nurse selecting options in the electronic record without supporting documentation. During an interview on 3/26/26 at 11:26 AM, Licensed Practical Nurse (LPN) # 2 stated that although no recent behaviors were observed, upon admission Resident #53 exhibited confusion, restlessness, and cursing toward staff during care. The nurse also reported current concerns including poor oral intake, with the resident often refusing facility meals and waiting for food from his wife. During an interview on 3/26/26 at 11:31 AM, Certified Nurse Aide (CNA) #1 stated Resident #53 does not typically exhibit inappropriate behaviors toward staff but has cursed at his wife when she attempted to assist with movement of his affected right side following a prior stroke. During an interview on 3/26/26 at 12:04 PM, LPN # 2 stated Resident #53 had not exhibited recent behaviors but demonstrated confusion, aggression, and cursing during the first week following admission.The nurse reported that the resident's wife indicated he had been off his antipsychotic medication prior to admission. During a follow up interview on 3/26/26 at 12:38 PM, the DON stated psychiatric follow up is important for residents receiving antipsychotic medications to monitor for adverse effects such as changes in mental status, weight loss, mood changes, or behavioral changes. She stated when behaviors are identified, nursing staff should notify a practitioner, and a psychiatric evaluation would be appropriate. She also stated newly admitted rehabilitation residents may require closer monitoring due to recent transitions from acute care settings. Record review of the Minimum Data Set (MDS) with an Assessment Review Date (ARD) of 3/7/26 revealed a Brief Interview for Mental Status score (BIMS) of 11 which indicated moderate cognitive impairment. Record review of the "Face Sheet" revealed Resident #58 was admitted to the facility on 1/30/26 with diagnoses that included Alzheimer's disease.	M0630		

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M0630	Continued from page 2 Record review of the “Order Summary Report” revealed an order dated 1/30/26 for an antipsychotic drug “Seroquel (Quetiapine) 100 milligrams (mg) by mouth at bedtime. There were no orders for a psychiatric consultation or follow up.	M0630		