STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255304	(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 3/23/26 through 3/26/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656 and F658. The facility had a census of 52and was licensed for 60 beds.	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F0656		

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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F0656 SS = D	Continued from page 1 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to develop and implement a comprehensive, person-centered care plan to address a stage two pressure ulcer for one (1) of (1) residents reviewed for care planning. Resident #38. Findings Include: Record review of the facility's "Care Plan" policy updated 2/20/20 revealed “Each resident will have a person-centered plan of care to identify problems, needs, and strengths that will identify how the interdisciplinary team will provide care...7. The care plan will be reviewed and/or revised at quarterly intervals in conjunction with the completion of MDS assessments (quarterly), significant change, annual and with changes in residents' condition as needed...” On 03/26/2026 12:54 PM, in an interview with Registered Nurse (RN) #2/ Minimum Data Set (MDS) nurse stated that care plans are supposed to be updated by nurses on the floor when they receive a new physician order. She stated they discuss care plans in clinical and if it is not updated then she updates it. She stated the comprehensive care plan is used by nurses, Certified Nurse Assistants (CNAs) and physicians. She confirmed the care plan was not updated and should have been updated. On 03/26/2026 1:14 PM, in an interview with the Director of Nursing (DON) stated the area was put in	F0656		

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F0656 SS = D	Continued from page 2 the system as a skin tear. She stated the care plan should have been updated after the physician orders diagnosis as a stage two pressure wound. She stated the care plan is used by all staff to give care. She stated the nurses are responsible for updating the care plan as well as the nurse that "takes the order off." She stated her expectations for all staff is to do what they are supposed to do. Record review of the “Face Sheet” for Resident #38 revealed an admission date of 9/20/24 with diagnoses that included Pressure ulcer of right ankle, Stage 2 with an onset date of 3/16/26. Record review of Resident #38 "Order Summary Report’ revealed an order dated 3/17/26 “Clean Stage 2 pressure ulcer to right ankle with wound cleanser. Pat dry. Apply calcium alginate to wound bed. Cover with bordered foam. every day shift related to PRESSURE ULCER OF RIGHT ANKLE, STAGE 2.” Record review of Resident #38’s Minimum Data Set (MDS) with Assessment Reference Date (ARD) 12/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident has severe cognitive impairment. Record review of Resident #38 comprehensive care plans revealed there were no goals or interventions related to the stage 2 pressure area on Resident #38’s right ankle.	F0656		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, 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:	F0658		

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F0658 SS = D	Continued from page 3 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 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 the resident’s wife indicated he had been off his antipsychotic medication prior to admission.	F0658		

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F0658 SS = D	Continued from page 4 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. 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.	F0658		