STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	**135 RESIDENTIAL CENTER RD , CHOCTAW, Mississippi, 39350**

(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 a Complaint Investigation (CI MS #2798355 and CI MS #2718026), at the facility on 03/18/2026 through 03/19/2026. CI MS #2798355 and CI MS #2718026 were investigated for resident/patient/client abuse and quality of care. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and F740 was cited. The facility held a license for 120 beds, with a census of 112.	F0000		
F0600 SS = E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to protect residents from abuse for two (2) of (2) residents reviewed for abuse (Resident # 1 and Resident # 3). Specifically, the facility failed to prevent resident-to-resident inappropriate sexual contact, when (2) incidents occurred when one resident touched another resident inappropriately.	F0600		

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: 255339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026

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F0600 SS = E	Continued from page 1 Findings include: Record review of the facility policy “Resident Rights” revised 3/24, revealed, “…shall insure each resident of the following…J. THE RIGHT to be free from mental and physical abuses… Each resident has the right to a safe, secure, and homelike environment ...The facility is responsible for implementing interventions to prevent resident-to-resident altercations and to ensure supervision sufficient to protect residents from harm.” Resident #2 and Resident #3 On 03/18/2026 at 10:15 AM, during an interview with Resident #3, the resident reported that she was involved in an incident with Resident #2 on 03/06/2026 in the front lobby area. Resident #3 stated that Resident #2 approached her and touched her leg without her consent. She reported that she informed staff of the incident shortly after it occurred. Resident #3 stated that a nurse spoke with her one time regarding the incident. She indicated that the nurse asked what happened, but there was no further follow up discussion or additional inquiries from other staff members after that initial conversation. Resident #3 reported that she did not receive any updates regarding the outcome of the investigation. Resident #3 stated that she has not seen Resident #2 recently and was informed that he is no longer in the building at the time of the survey. However, she reported that she observed Resident #2's name still listed on the room across from hers, which caused her concern. Resident #3 stated that due to the incident, she plans to avoid Resident #2 if he returns. She reported that she intends to stay in her room or avoid common areas when he is present to prevent further confrontation. On 3/19/26 at 10:36 AM, the Director of Nursing (DON) revealed that, upon review of the incident involving Resident #2 and Resident #3 on 03/06/2026, he was informed that Resident #2 approached Resident #3 in the front lobby and touched her leg without consent. The DON stated the investigation confirmed the allegation through staff interviews and resident statements, and actions taken included assessment of the resident with no noted injuries, implementation of one-to-one observation, and referral to geriatric psychiatric services for further evaluation and management of behaviors. Record review of the facility investigation report dated 03/06/2026, Resident #2 approached Resident #3 while both were seated in the front lobby and touched	F0600		

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F0600 SS = E	Continued from page 2 her leg without consent. Resident #3 reported the incident to staff and stated, “I told him to quit and he did leave me alone.” Staff assessed Resident #3 and noted no physical injuries. Resident #2 Record review of the "Admission Record" revealed the resident was admitted on 03/25/2019 with diagnoses that included borderline intellectual functioning. Record review of Resident # 2’s “Brief Interview for Mental Status (BIMS) Summary Score "dated 2/27/26 revealed a BIMS score of 07 indicating the resident had severe cognitive impairment. Record review of Resident #2’s nurse’s note dated 04/03/2026, late entry at 2250 (10: 50 PM), revealed a female resident reported to the nurse that Resident #2 inappropriately touched her twice on her leg and between her thighs. The nurse documented that the residents were separated, and Resident #2 was escorted to his room and placed on one-to-one supervision. The DON and responsible parties were notified. Resident # 3 Record review of the "Admission Record" revealed the resident was admitted on 9/26/24 with diagnoses that included cognitive communication deficit. Record review of Resident # 3's "Health Status Note" dated 3/6/26 revealed no documentation of the inappropriate touching. Resident #1 and Resident #4 On 3/19/26 at approximately 10:30 AM, during an interview with Resident #1, the resident reported that an incident occurred in the hallway in front of the nurse’s station in which Resident # 4 touched her breasts without her consent. Resident #1 stated that the contact was inappropriate and unwanted. Resident #1 reported that immediately following the incident, she notified a Certified Nurse Aide (CNA) and informed the CNA that the resident had touched her inappropriately on her breast. She stated that she clearly described what occurred at the time of her report. Resident #1 was able to identify Resident #4 by name who had touched her breast. On 03/19/2026 at 10:36 AM, in an interview the DON, revealed that he was notified of the incident involving Resident #4 and Resident #1 on 01/13/2026 at	F0600		

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F0600 SS = E	Continued from page 3 approximately 7:50 PM. The DON stated that initial reports indicated inappropriate touching in the hallway and that immediate actions included separating the residents and assessing the alleged victim for injury. The DON reported that upon review of facility camera footage, it was confirmed that Resident #4 touched Resident #1's breast while passing her in the hallway. The DON revealed that the facility's investigation determined staff responded promptly to the allegation by separating the residents, assessing Resident #1 with no injuries noted, and placing Resident #4 on one-to-one observation. The DON stated that a referral was made for geriatric psychiatric evaluation and that the resident was transferred for further treatment related to inappropriate behaviors. The DON further reported that notifications were made to the physician, responsible party, and state agency per facility protocol. Record review of a second facility investigation dated 01/13/2026, Resident #4 was reported to have touched Resident #1 on the breast in the hallway. Resident #1 confirmed the contact and stated she told him to go away. Review of facility camera footage confirmed that Resident #4 touched Resident #1's breast while passing her in the hallway. Resident # 1 Record review of the "Admission Record" revealed the resident was admitted on 05/06/26 with diagnoses that included vascular dementia. Record review of Resident #1's "BIMS Evaluation" dated 01/19/2026 revealed a score 8 indicating the resident had moderate cognitive impairment. Record review of Resident #1's "Health Status Note" dated 1/13/2026 at 10:05 PM, revealed Resident #1 reported to the CNA that Resident # 4 was inappropriate with her "touching her boobs in the hallway in front of the nurses station…" Resident # 4 Record review of the "Admission Record" revealed the resident was admitted on 4/15/25 with diagnoses that included cognitive communication deficit. Record review of a "BIMS Evaluation" dated 7/9/25 revealed Resident #4's BIMS Summary Score was 13 indicating the resident was cognitively intact. Record review of Resident # 4's "Health Status Note"	F0600		

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F0600 SS = E	Continued from page 4 dated 12/23/2025 at 1:50 PM, revealed “Resident was noted to be touching another resident inappropriately at nurses desk. When redirected he just looked at the nurse and kept rolling in w/c (wheelchair). DON and Assistant Director of Nursing (ADON) notified." Record review of Resident #4’s “Health Status Note” dated 1/14/2026 at 4 PM, revealed Resident#4 left the facility to a local psychiatric facility for treatment for behavioral issues. On 03/19/2026 at 10:20 AM, during an interview the Licensed Nursing Home Administrator (LNHA) stated that, as part of the facility’s investigation, statements were obtained from staff and residents, and available video footage was reviewed when applicable. She stated the investigation determined that inappropriate contact had occurred between residents and confirmed that staff did respond once the incident was reported. She further stated that the alleged residents were placed on increased supervision, including one-to-one monitoring, and referred for further evaluation to address behavioral concerns. She stated that notifications were made in accordance with facility protocol, including notifying the physician, responsible parties, and appropriate agencies. She noted that from an administrative standpoint, the facility attempted to follow its abuse and investigation procedures and took steps to prevent immediate recurrence. However, the LNHA acknowledged that while the facility responded to the incident, there were areas where the response could have been improved for the affected resident(s). She stated that the facility should have implemented more consistent and ongoing follow-up with the affected residents(s), including routine check-ins to assess fear, anxiety, or other psychosocial effects following the incident. She further stated that the investigation identified a need for stronger communication with the affected residents regarding the protective measures that were put in place, to ensure they felt safe and reassured after the incident. She acknowledged that clearer and more consistent documentation and communication with the interdisciplinary team regarding follow-ups would have supported better monitoring of the resident’s well-being. The LNHA stated that services to the affected resident(s) could have been improved by providing more consistent emotional support, more structured and timelier follow-up, and ongoing evaluation of the resident’s sense of safety. She stated that while the facility acted, additional measures would have better ensured the residents’ rights were fully upheld and that they were protected from potential psychosocial harm.	F0600		

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F0600 SS = E	Continued from page 5 On 03/19/2026 at 10:58 AM, in an interview with the Social Worker, she stated that she was aware of the incident involving the resident(s) #1, #2, #3 and #4 and acknowledged that the affected residents should have received more focused follow-up and supportive services after the allegation was made. She stated that, in accordance with the facility's Resident Rights Policy, residents have the right to feel safe, to be free from abuse, and to have their concerns acknowledged and addressed. She stated that once the allegation was reported, the facility should have ensured the immediate emotional and psychological needs of the resident(s) were assessed, including speaking with them privately, validating their concerns, and ensuring they felt heard. Record review revealed that in both incidents, the residents were in common areas without effective supervision at the time of the events. Although staff responded after the incidents occurred, the facility failed to implement sufficient interventions to prevent inappropriate resident-to-resident contact prior to the incidents.	F0600		
F0740 SS = E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review the facility failed to ensure residents received the necessary behavioral health care and services, specifically, the facility failed to proactively assess and implement effective behavioral interventions to address inappropriate sexual behaviors for two (2) of five (5) sampled residents reviewed for behavioral concerns. Resident #1 and Resident #3. Findings include: Record review of the facility policy "Resident Rights"	F0740		

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F0740 SS = E	Continued from page 6 revised 3/24, revealed, "…shall insure each resident of the following…J. THE RIGHT to be free from mental and physical abuses… Each resident has the right to a safe, secure, and homelike environment ...The facility is responsible for implementing interventions to prevent resident-to-resident altercations and to ensure supervision sufficient to protect residents from harm." Record review of the facility's "Behavioral Health Services" policy revealed, "It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well-being...." Resident #2 and Resident #3 During an interview on 03/18/2026 at 10:15 AM, with Resident #3, the resident reported that she was involved in an incident with Resident #2 on 03/06/2026 in the front lobby area. Resident #3 stated that Resident #2 approached her and touched her leg without her consent. She reported that she informed staff of the incident shortly after it occurred. Resident #3 stated that a nurse spoke with her one time regarding the incident. She indicated that the nurse asked what happened, but there was no further follow up discussion or additional inquiries from other staff members after that initial conversation. Resident #3 reported that she did not receive any updates regarding the outcome of the investigation. Resident #3 stated that she has not seen Resident #2 recently and was informed that he is no longer in the building at the time of the survey. However, she reported that she observed Resident #2's name still listed on the room across from hers, which caused her concern. Resident #3 stated that due to the incident, she plans to avoid Resident #2 if he returns. She reported that she intends to stay in her room or avoid common areas when he is present to prevent further confrontation. In an interview on 3/19/26 at 10:36 AM, the Director of Nursing (DON) revealed that, upon review of the incident involving Resident #2 and Resident #3 on 03/06/2026, he was informed that Resident #2 approached Resident #3 in the front lobby and touched her leg without consent. The DON stated the investigation confirmed the allegation through staff interviews and resident statements, and actions taken included assessment of the resident with no noted injuries, implementation of one-to-one observation, and referral to geriatric psychiatric services for further evaluation and management of behaviors. Record review of the facility investigation report	F0740		

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F0740 SS = E	Continued from page 7 dated 03/06/2026, Resident #2 approached Resident #3 while both were seated in the front lobby and touched her leg without consent. Resident #3 reported the incident to staff and stated, “I told him to quit and he did leave me alone.” Staff assessed Resident #3 and noted no physical injuries. Resident #2 Record review of the "Admission Record" revealed the resident was admitted on 03/25/2019 with diagnoses that included borderline intellectual functioning. Record review of Resident # 2’s “Brief Interview for Mental Status (BIMS) Summary Score” dated2/27/26 revealed a BIMS score of 07 indicating the resident had severe cognitive impairment. Record review of Resident #2’s nurse’s note dated 04/03/2026, late entry at 2250 (10:50 PM), revealed a female resident reported to the nurse that Resident #2 inappropriately touched her twice on her leg and between her thighs. The nurse documented that the residents were separated, and Resident #2 was escorted to his room and placed on one-to-one supervision. The DON and responsible parties were notified. Resident # 3 Record review of the "Admission Record" revealed the resident was admitted on 9/26/24 with diagnoses that included cognitive communication deficit. Record review of Resident # 3's "Health Status Note" dated 3/6/26 revealed no documentation of the inappropriate touching.Resident #1 and Resident #4 During an interview on 3/19/26 at 10:30 AM, with Resident #1, the resident reported that an incident occurred in the hallway in front of the nurse’s station in which Resident # 4 touched her breasts without her consent. Resident #1 stated that the contact was inappropriate and unwanted. Resident #1 reported that immediately following the incident, she notified a Certified Nurse Aide (CNA) and informed the CNA that the resident had touched her inappropriately on her breast. She stated that she clearly described what occurred at the time of her report. Resident #1 was able to identify Resident #4 by name who had touched her breast. In an interview on 03/19/2026 at 10:36 AM, the DON, revealed that he was notified of the incident involving Resident #4 and Resident #1 on 01/13/2026 at	F0740		

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F0740 SS = E	Continued from page 8 approximately 7:50 PM. The DON stated that initial reports indicated inappropriate touching in the hallway and that immediate actions included separating the residents and assessing the alleged victim for injury. The DON reported that upon review of facility camera footage, it was confirmed that Resident #4 touched Resident #1's breast while passing her in the hallway. The DON revealed that the facility's investigation determined staff responded promptly to the allegation by separating the residents, assessing Resident #1 with no injuries noted, and placing Resident #4 on one-to-one observation. The DON stated that a referral was made for geriatric psychiatric evaluation and that the resident was transferred for further treatment related to inappropriate behaviors. The DON further reported that notifications were made to the physician, responsible party, and state agency per facility protocol. Record review of a second facility investigation dated 01/13/2026, Resident #4 was reported to have touched Resident #1 on the breast in the hallway. Resident #1 confirmed the contact and stated she told him to go away. Review of facility camera footage confirmed that Resident #4 touched Resident #1's breast while passing her in the hallway. Resident # 1 Record review of the "Admission Record" revealed the resident was admitted on 05/06/26 with diagnoses that included vascular dementia. Record review of Resident #1's "BIMS Evaluation" dated 01/19/2026 revealed a score 8 indicating the resident had moderate cognitive impairment. Record review of Resident #1's "Health Status Note" dated 1/13/2026 at 10:05 PM, revealed Resident #1 reported to the CNA that Resident # 4 was inappropriate with her "touching her boobs in the hallway in front of the nurses station…" Resident # 4 Record review of the "Admission Record" revealed the resident was admitted on 4/15/25 with diagnoses that included cognitive communication deficit. Record review of a "BIMS Evaluation" dated 7/9/25 revealed Resident #4's BIMS Summary Score was 13 indicating the resident was cognitively intact. Record review of Resident # 4's "Health Status Note"	F0740		

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F0740 SS = E	Continued from page 9 dated 12/23/2025 at 1:50 PM, revealed “Resident was noted to be touching another resident inappropriately at nurses desk. When redirected he just looked at the nurse and kept rolling in w/c (wheelchair). DON and Assistant Director of Nursing (ADON) notified." Record review of Resident #4’s “Health Status Note” dated 1/14/2026 at 4 PM, revealed Resident#4 left the facility to a local psychiatric facility for treatment for behavioral issues. During an interview on 03/19/2026 at 10:20 AM, the Licensed Nursing Home Administrator (LNHA) stated that, as part of the facility’s investigation, statements were obtained from staff and residents, and available video footage was reviewed when applicable. She stated the investigation determined that inappropriate contact had occurred between residents and confirmed that staff did respond once the incident was reported. She further stated that the alleged residents were placed on increased supervision, including one-to-one monitoring, and referred for further evaluation to address behavioral concerns. She stated that notifications were made in accordance with facility protocol, including notifying the physician, responsible parties, and appropriate agencies. She noted that from an administrative standpoint, the facility attempted to follow its abuse and investigation procedures and took steps to prevent immediate recurrence. However, the LNHA acknowledged that while the facility responded to the incident, there were areas where the response could have been improved for the affected resident(s). She stated that the facility should have implemented more consistent and ongoing follow-up with the affected residents(s), including routine check-ins to assess fear, anxiety, or other psychosocial effects following the incident. She further stated that the investigation identified a need for stronger communication with the affected residents regarding the protective measures that were put in place, to ensure they felt safe and reassured after the incident. She acknowledged that clearer and more consistent documentation and communication with the interdisciplinary team regarding follow-ups would have supported better monitoring of the resident’s well-being. The LNHA stated that services to the affected resident(s) could have been improved by providing more consistent emotional support, more structured and timelier follow-up, and ongoing evaluation of the resident’s sense of safety. She stated that while the facility acted, additional measures would have better ensured the residents’ rights were fully upheld and that they were protected from potential psychosocial harm.	F0740		

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F0740 SS = E	Continued from page 10 In an interview with the Social Worker, on 3/19/2026 at 10:58 AM, she stated that she was aware of the incident involving the resident(s) #1, #2, #3 and #4 and acknowledged that the affected residents should have received more focused follow-up and supportive services after the allegation was made. She stated that, in accordance with the facility's Resident Rights Policy, residents have the right to feel safe, to be free from abuse, and to have their concerns acknowledged and addressed. She stated that once the allegation was reported, the facility should have ensured the immediate emotional and psychological needs of the resident(s) were assessed, including speaking with them privately, validating their concerns, and ensuring they felt heard. Record review revealed that in both incidents, the residents were in common areas without effective supervision at the time of the events. Although staff responded after the incidents occurred, the facility failed to implement sufficient interventions to prevent inappropriate resident-to-resident contact prior to the incidents.	F0740		