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
SHADY LAWN HEALTH AND REHABILITATION	**60 SHADY LAWN PLACE , VICKSBURG, Mississippi, 39180**

(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 requirement and cited M690.	M0000		
M0620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review, and facility policy review, the facility failed to ensure a Foley (indwelling catheter) securement device was in place to prevent tension and pulling on the catheter for one (1) of two (2) residents reviewed for bowel and bladder/catheters. (Resident #53). Findings include: A review of the facility's policy "Incontinence Management," revised 01/2020, revealed, "… Management of an Indwelling Catheter in the Long-Term Care Setting … Secure catheters to the upper thigh or lower abdomen to avoid bladder and urethral trauma …" A record review of the "Admission Record" revealed the facility admitted Resident #53 initially on 1/27/26 and readmitted on 3/12/26 with diagnoses including Bladder-Neck Obstruction. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/02/26	M0620		

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

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M0620	Continued from page 1 revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of seven (7), which indicated the resident's cognition was severely impaired. A review of Section H revealed the resident had an indwelling catheter. A record review of the "Order Recap Report" revealed Resident #53 had a Physician's Order, dated 3/17/26, for "… Foley Cath 20 Fr (French) 10 cubic centimeter (cc) bulb DX (diagnosis): obstructive urinary retention … Foley Cath Care with soap and water every shift and as needed …" On 3/24/26 at 4:34 PM, during an observation of catheter care completed by Certified Nurse Aide (CNA) #1 with assistance from CNA #2 for Resident #53, residue was observed on the resident's left inner thigh. CNA #1 reported the residue appeared to be from a catheter securement device that had come off. During the same interview, CNA #1 reported residents with catheters are to have a securement device in place to prevent pulling and stated she would notify the nurse to apply a new device. On 3/25/26 at 12:56 PM, during an interview with Registered Nurse (RN) #1, she reported residents with indwelling catheters are required to have a securement device in place at all times to prevent tension, pulling, and complications. On 3/25/26 at 1:34 PM, during an observation and interview with RN #2 for Resident #53, the resident was observed lying in bed with pants on, with catheter tubing extending through the right pant leg to a drainage bag, and no catheter securement device was in place. RN #2 reported residents with catheters are to have a securement device in place and confirmed the device is used to prevent pulling and complications. She stated CNAs are expected to notify the nurse if the device is not in place so a new device can be applied. RN #2 confirmed no staff had reported the absence of a securement device for Resident #53. On 3/25/26 at 1:45 PM, during an interview with CNA #3, she reported she provided care to Resident #53 on 3/24/25 and 3/25/26 and did not recall seeing a catheter securement device in place on either day. She confirmed she had not reported the absence of the device to the nurse and stated it is the CNA's responsibility to notify the nurse if the device is not in place. On 3/25/26 at 4:05 PM, during an interview with the Director of Nursing (DON), she reported all residents	M0620		

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M0620	Continued from page 2 with indwelling catheters are required to have a securement device in place to prevent pulling and tension. She confirmed she expects CNAs to notify nursing staff immediately when a device is not in place so it can be reapplied, unless the resident refuses and the refusal is care planned.	M0620		