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 **04/23/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON DAVIS COMMUNITY HOSPITAL ECF	**1320 WINFIELD STREET P.O. BOX 1288, PRENTISS, Mississippi, 39474**

(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 re-licensure survey at the facility from 4/20/26 through 4/23/26. 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 M500, M615, M815, and M1570.	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 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	M0500		

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

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M0500	Continued from page 1 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 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;	M0500		

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M0500	Continued from page 2 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 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: Based on observation, interview, record review, and	M0500		

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M0500	Continued from page 3 facility policy review, the facility failed to ensure a resident's right to privacy during medication administration for one (1) of five (5) residents reviewed for medication administration. Resident #5. Findings include: A review of the facility's policy, "Resident Rights Guidelines for all Nursing Procedures," revised 10/2010, revealed, "…To provide general guidelines for resident rights while caring for the resident. Preparation 1. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including…b. Resident dignity and respect…". On 4/21/26 at 11:01 AM, during an observation, Licensed Practical Nurse (LPN) #1 entered Resident #5's room to perform an accucheck and insulin administration. She gathered supplies, explained the procedure, and performed a finger stick to obtain a blood glucose level. The door remained open and the privacy curtain was not pulled during the entire procedure. Staff and other residents were observed passing in the hallway while care was being provided. LPN #1 administered ten (10) units of NovoLog insulin subcutaneously in the abdomen without providing privacy for the resident. On 4/21/26 at 11:28 AM, during an interview with LPN #1, she confirmed she did not close the door or pull the curtain during the accucheck and insulin administration. She reported she should have closed the door and pulled the curtain prior to providing care and acknowledged this was necessary to protect Resident #5's dignity. On 4/22/26 at 2:52 PM, during an interview with the Director of Nursing (DON), she reported LPN #1 should have provided privacy while completing the accucheck and administering the injection. She stated the expectation was for nursing staff to close the door and pull the curtain during care to maintain resident privacy. A record review of the "Admission Record" revealed the facility admitted Resident #5 on 2/2/26 with diagnoses including Type 2 Diabetes Mellitus. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/10/26 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident's cognition was moderately impaired.	M0500		

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M0500	Continued from page 4 A record review of the "Order Summary Report" revealed Resident #5 had a physician's order dated 2/2/26 for NovoLog insulin per sliding scale before meals and at bedtime.	M0500		
M0615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to follow physician orders for treatment of a pressure ulcer for one (1) of one (1) resident reviewed for wound care. Resident #1. Findings include: A review of the facility's policy, "Wound Care," revised June 2018, revealed, "…The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation 1. Verify that there is a physician's order for the procedure….Steps in the Procedure…8. Apply treatments as indicated…". A record review of the "Order Summary Report" revealed Resident #1 had a Physician's Order, dated 4/21/26 to "Cleanse Stage 4 pressure ulcer to the left ankle with Vashe and pat dry. Apply A&D Ointment to per wound. Apply Aquacel AG to wound bed and cover with auze and ABD pad. Wrap with conform daily and prn (as needed for soilage and dislodgement…" On 4/21/26 at 2:20 PM, during an observation, Registered Nurse (RN) #1, assisted by a Certified Nurse Aide (CNA), performed wound care for Resident #1's Stage 4 pressure ulcer to the left ankle. RN #1 removed the soiled dressing, performed hand hygiene, cleansed the wound with Vashe, and applied A and D ointment to the peri-wound and Aquacel AG to the wound bed. RN #1 then covered the wound with an ABD pad and wrapped with conform. RN #1 did not apply gauze prior to applying the ABD pad as ordered. On 4/21/26 at 2:46 PM, during an interview with RN	M0615		

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M0615	Continued from page 5 #1, she confirmed she did not follow the physician's order to apply gauze prior to the ABD pad. She reported the gauze was intended to help keep the wound dry and stated it was important for nurses to follow physician orders to prevent complications. On 4/22/26 at 2:58 PM, during an interview with the Director of Nursing (DON), she reported nurses were expected to follow physician orders as written, step by step, when providing wound care. A record review of the "Admission Record" revealed the facility initially admitted Resident #1 on 5/23/25 and he had diagnoses including Pressure Ulcer of the left ankle, Stage 4. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/26/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of (13), which indicated the resident was cognitively intact. A review of Section M revealed he had a Stage 4 pressure ulcer.	M0615		
M0815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure food was stored in a manner that maintained freshness and quality and was properly labeled and dated in accordance with professional standards for food safety for one (1) of two (2) kitchen observations. Findings include: A review of the facility's policy, "Storing: Food and Equipment," revealed, "Team members must store food in a manner that ensures quality, freshness and safeguards against foodborne illnesses…Scope of Responsibility…All team members must follow food and temperature guidelines, labeling, use-by-dates, food storage chart, freezing and leftover guidelines to ensure food and equipment criteria are met…". A record review of the "Safe Training," dated 2/1/25, revealed, "All Food must be properly labeled and dated…Ensure all food is labeled, including:	M0815		

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M0815	Continued from page 6 Food stored in its original container, Food not stored in original container…When to Discard…by use-by-date indicated when storing or sooner if quality is an issue or by manufacturer's use-by-date…How Long to Keep…Food should be discarded or used by the use-by date. The use-by date is the last date the manufacturer recommends use of the food and may be referred to as an expiration date…Prepared Food Held more than 24 Hours. Food that has been prepared and will be held for more than 24 hours must be labeled and dated with the following: Name of the product (common name) Preparation date…". On 4/20/26 at 10:36 AM, during an observation and interview with Assistant Dietary Manager (DD) #2, upon opening refrigerator #3, an odor consistent with decaying cabbage was noted. Three (3) bags of shredded cabbage were observed and confirmed to be expired, including two (2) bags dated 4/5/26 and one (1) bag dated 3/15/26, which appeared deteriorated. During the same observation, six (6) sandwiches prepared for residents were observed in the reach-in cooler without labels or dates. During the interview, DD #2 reported it was the responsibility of all dietary staff to check and rotate dates and remove expired items. She stated the cabbage had been served the previous Thursday and confirmed the sandwiches were prepared that day but were not labeled or dated. On 4/22/26 at 2:55 PM, during an interview with Dietary Manager (DD) #1, accompanied by Assistant Dietary Manager (DD) #2, DD #1 reported her expectation was for all dietary staff to ensure food items were properly dated and labeled and to maintain compliance with food safety practices, including proper stock rotation and disposal of expired items. She reported managerial staff would begin monitoring dietary aides to ensure compliance with labeling, dating, and removal of expired food items. On 4/23/26 at 11:49 AM, during an interview with the Administrator, she was informed of the findings related to expired and undated food items. She reported her expectation was for the dietary department to ensure all food items were properly dated and labeled and that expired food items were discarded.	M0815		
M1570	48.58.1 Infection Control The following infection control standards shall be met:	M1570		

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M1570	Continued from page 7 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to perform hand hygiene to prevent the potential spread of infection during medication administration for one (1) of five (5) residents reviewed for medication administration. Resident #4. Findings include: A review of the facility's policy, "Infection Control Guidelines for All Nursing Procedures," revised April 2024, revealed, "…To provide guidelines for general infection control while caring for residents...General Guidelines 1. Standard precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease. 5. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol based hand rub…for all the following situations…i. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident…". On 4/21/26 at 1:14 PM, during an observation, Licensed Practical Nurse (LPN) #2 administered medication via Percutaneous Endoscopic Gastrostomy (PEG) tube to Resident #4. LPN #2	M1570		

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M1570	Continued from page 8 applied a gown and performed hand hygiene before applying gloves. She verified tube placement by aspiration and auscultation. She then removed her gloves, performed hand hygiene, and applied clean gloves. LPN #2 paused the feeding pump while wearing gloves and proceeded to administer medications via the PEG tube without removing the gloves and performing hand hygiene after contact with the feeding pump, which was in the immediate resident environment. On 4/21/26 at 2:05 PM, during an interview with LPN #2, she confirmed she did not remove gloves and perform hand hygiene after pausing the feeding pump and prior to administering medications. She reported this was an infection control concern and acknowledged residents could develop infections when infection control practices were not followed. On 4/22/26 at 2:55 PM, during an interview with the Director of Nursing (DON), she reported LPN #2 should have performed hand hygiene prior to administering medications via the PEG tube after touching the feeding pump. She stated failure to follow proper hand hygiene practices could result in infection and reported the expectation was for nursing staff to follow infection control guidelines at all times. On 4/23/26 at 9:28 AM, during an interview with Registered Nurse (RN) #3, Infection Preventionist (IP), she reported staff should remove gloves and perform hand hygiene when gloves become contaminated, not only when visibly soiled. She stated failure to perform hand hygiene could result in the spread of infection and negatively impact residents. A record review of the “Admission Record” revealed the facility admitted Resident #4 on 2/3/26 with diagnoses including Cerebral Infarction. A record review of the “Order Summary Report” revealed Resident #4 had a physician’s order dated 2/3/26 for nothing by mouth (NPO) and required all tube feedings and medications to be administered via PEG tube. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/26 revealed Resident #4 required a staff assessment for cognition and had severely impaired cognitive skills for daily decision making.	M1570		