STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255050	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson Davis Community Hospital Ecf	1320 Winfield Street Prentiss, MS 39474

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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: 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 the 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.

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 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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and 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 (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.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.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on staff interview, record review, and facility policy review, the facility failed to ensure the Level I Preadmission Screening and Resident Review (PASRR) was completed accurately to reflect a diagnosis of Schizophrenia and the use of an antipsychotic medication for one (1) of (16) sampled reviewed. Resident #41.Findings include:A review of the facility's policy, admission Criteria, revised December 2016, revealed, Our facility will admit only those residents whose medical and nursing care needs can be met. Policy Interpretation and Implementation.8. Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with Medicaid Pre-admission Screening and Resident Review program (PASARR) to the extent practicable. 9. Potential residents with mental disorders or intellectual disabilities will only be admitted if the State mental health agency has determined (through the preadmission screening program) that the individual has a physical or mental condition that requires the level of services provided by the facility.A record review of the admission Record revealed the facility admitted Resident #41 on 9/19/23 with diagnoses including Schizophrenia.A record review of the Screening - Questionnaire Status: Submitted (Level I Screening) revealed Resident #41's Medications included Aripiprazole (antipsychotic medication). Further review revealed Disease Diagnoses did not include Schizophrenia and No was selected to indicate the resident was not taking an antipsychotic medication.A record review of the Comprehensive admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/25/23 (original MDS) revealed Resident #41 had a diagnosis of Schizophrenia.On 4/21/26 at 2:18 PM, during an interview with the Director of Nursing (DON), she reported Resident #41 did not have a PASRR Level II evaluation completed because it was not requested by the independent contractor. On 4/22/26 at 9:48 AM, during a follow-up interview with the DON, she reported Resident #41's PASRR was completed and submitted prior to her becoming the DON in 2024 and stated she was unaware the previous PASRR had been completed inaccurately, as it had not been brought to her attention.On 4/22/26 at 10:29 AM, during an interview with the Consultant, she reported she did not make determinations regarding PASRR Level II evaluations. She stated Resident #41 was admitted with a diagnosis of Schizophrenia and this diagnosis was documented on the initial Minimum Data Set (MDS) in 2023.On 4/23/26 at 11:53 AM, during an interview with the Administrator, she reported staff were currently receiving training on PASRR requirements and stated the expectation was for staff to accurately complete PASRR screenings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and facility policy review, the facility failed to implement care plan interventions related to wound care for one (1) of 16 sampled residents. Resident #1.Findings include:A review of the facility's policy, Care Plans, Comprehensive Person-Centered, dated 12/2016, revealed, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is.implemented for each resident.A record review of the Care Plan Report revealed Resident #1 had a Focus of Resident has actual skin breakdown. with an Interventions including, Cleanse Stage 4 pressure ulcer to left ankle with Vashe and pat dry. Apply A&D ointment to peri wound. Apply Aquacel AG to wound bed and cover with gauze and ABD pad. Wrap with conform daily and prn for soilage and dislodgement.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 gauze and ABD pad. Wrap with conform daily and prn (as needed) for soilage and dislodgement.During an observation on 4/21/26 at 2:20 PM, Registered Nurse (RN) #1 provided 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 per the resident's care plan intervention.During an interview on 4/21/26 at 2:46 PM, RN #1 confirmed she did not follow the physician's order or the care plan 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.During an interview on 4/22/26 at 2:58 PM, during an interview, the Director of Nursing (DON), reported care plans should be followed as written, and all staff should follow the care plan.During an interview on 04/22/26 at 3:08 PM, RN #2/Care Plan and Minimum Data Set (MDS) nurse stated the care plan is individualized for each resident and should be followed. She stated she expects staff to follow care plan while doing all 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.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 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 (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 gauze 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), provided 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 #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.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to ensure food was stored, labeled, and dated in accordance with professional standards for food safety during an annual recertification survey on 11/21/2024 and was cited again for the same deficiencies during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of seven (7) deficiencies cited. F812Findings include: A review of the facility's policy, Quality Assurance and Performance Improvement (QAPI) Program, revised August 2017, revealed, .This facility shall implement, and maintain an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) program that builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals . A record review of the Provider History Report revealed on 11/21/24, the facility was cited F812-Food Procurement, Store/Prepare/Serve-Sanitary A record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 11/21/24, revealed the facility received a citation for F812, .Based on observation, staff interview, and facility policy review, the facility failed to store food in accordance with professional standards for food safety related to expired foods, overly ripe produce, and scoops stored in dry bins touching food items for one (1) of two (2) kitchen observation.During the current recertification survey, the facility failed to ensure food was stored in a manner that maintained quality and freshness and was properly labeled and dated in accordance with professional standards for food safety for one (1) of two (2) kitchen observations.On 4/23/26 at 1:01 PM, during an interview with the Administrator, she reported it was important to maintain ongoing monitoring of plans of correction to ensure sustained compliance and prevent a decline in quality of care. She reported the dietary department was cited again due to a failure to maintain consistent monitoring of compliance with food safety practices.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 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 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 Percutaneous Endoscopic Gastrostomy (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.