STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chadwick Community Care Center	1900 Chadwick Drive Jackson, MS 39204

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review and interviews, the facility failed to consult with the primary care provider regarding the psychosocial status of the resident which resulted in missed dialysis treatments for one (1) of three (3) residents dependent on dialysis treatments. Resident #1. Findings Included:Record review of the facility policy, Change in a Resident's Condition or Status revised February 2021 revealed, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .1. The nurse will notify the resident's attending physician or physician on call when there has been .significant change in the resident's physical/emotional/mental condition; need to alter the resident's medical treatment significantly; refusal of treatment or medications two (2) or more consecutive times) . On [DATE] at 1:32 PM during a telephone interview, the Resident Representative (RR) for Resident #1 revealed that she was concerned related to Resident #1 missing medical and dialysis appointments. She confirmed that the Assistant Director of Nurses (ADON), had reported that the resident was verbally combative toward staff and resistant to care with Licensed Practical Nurse (LPN) #1 on [DATE] and the Medical Records Nurse on [DATE]. The ADON had reported to her that Resident #1 had missed his dialysis treatments and she said that he was not able to make up the treatment on [DATE] due to their son's funeral. She was not aware of any grief counseling offered to the resident following the death of their son.On [DATE] at 3:30 PM interview with LPN #1 revealed he notified the dialysis center and the RR that the resident missed his dialysis treatment on [DATE]. On [DATE] at 9:49 AM, during an interview with the Nurse Practitioner (NP) #1, corroborating NP for Medical Doctor (MD) #1, revealed that she was on vacation the week of [DATE] and that NP #2 had visited the resident on [DATE]. She stated, following her review of her records, that she was not notified that Resident #1 had missed dialysis treatments on [DATE] or [DATE] and that there was no documentation that NP #2 was notified. She stated that she was able to refer residents to the contract, in-facility psychiatric services and that she would have had she been notified that his behaviors were interfering with his dialysis treatments or that his son had died in [DATE].On [DATE] at 2:00 PM, during an interview with Minimum Data Set (MDS) Nurse revealed that if a behavior was displayed or documented by a resident within seven (7) days of the Quarterly MDS assessment, it should be documented in Section E of the MDS by the Social Services Director (SSD), who was responsible for Behavior Assessment. She stated that if there had been a change in the behavior of the resident that affected resident care, the resident's RR and primary healthcare provider should be notified. She confirmed that the facility had contract, in-facility psychiatric care and that residents with behaviors that had the potential to affect their health or care could be referred to the service. On [DATE] at 2:20 PM, during an interview the SSD confirmed she completed cognition, mood and behavior sections of the Quarterly MDS. She confirmed that she was aware that Resident #1 had verbal outburst, cursed and used derogatory language toward staff. She said she did not know if any other staff had reported the behaviors to the resident's primary healthcare provider, but she had not. She confirmed that she was also able, along with other staff, to refer any resident to contract, (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in-facility psychiatric services and that Resident #1 had not been referred.On [DATE] at 2:52 PM, during an interview the Director of Nurses (DON) confirmed that dialysis treatments were necessary for Resident #1 and that any behavior that interfered with his receiving necessary care should be identified and addressed with his primary healthcare provider. She stated that the reason Resident #1 missed dialysis treatment on [DATE] was his behavior and make up day was scheduled for [DATE]. He missed the dialysis treatment on [DATE] because of the resident's behavior. She confirmed that the dialysis center wanted him to come on [DATE] for dialysis, in addition to the [DATE] visit that he attended, but he was unable to go on [DATE] because that was the day of his son's funeral. She said that the resident showed change of behavior during his stay and, Sometimes he is nice. She stated that she was not sure what the trigger was, but staff received the brunt of his behavior. She confirmed that she had not made a referral to behavioral health contract services or notified the resident's doctor or nurse practitioner that his behaviors interfered with his receiving his dialysis treatments as ordered and scheduled. She confirmed that the documentation dated [DATE] of the missed dialysis treatment did not include notification of the resident's primary health care provider.On [DATE] at 3:25 PM, during an interview the Administrator, confirmed that communication was important, and she expected staff to make all appropriate notifications to primary healthcare providers that may negatively affect resident health. She confirmed that the facility contracted in-facility psychiatric services which were available to all residents and required referral. She stated that she was not aware that Resident #1 had not been referred for grief counseling or for psychiatric services and that both would be appropriate for Resident #1. Record review of the admission Record revealed the facility admitted Resident #1 on [DATE] with diagnoses that included end stage renal disease (present on admission), and complete traumatic amputation of two or more right lesser toes with onset date [DATE].Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section E indicated Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). Record review of the Order Review History Report for Resident #1 revealed an active order with start date [DATE] for hemodialysis every Mon(day), Wed(nesday), Fri(day) @0620 (6:20) AM, (Proper name of transport company) to transport.for end stage renal disease.

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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 record review, facility policy review, and interview the facility failed to develop a person-centered comprehensive care plan to meet and address the resident's psychosocial needs for one (1) of four (4) sampled residents. Resident #1.Findings Included:Record review of the facility policy, Interdisciplinary Comprehensive Care Planning with effective date 6/02/16 revealed, The comprehensive care plan is an interdisciplinary communication tool It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The interdisciplinary team in conjunction with the resident and his/her family and/or responsible party as appropriate will develop, evaluate and amend as needed.Record review of the care plans for Resident #1 revealed there was not a care plan in place that addressed resident behaviors or psychosocial needs.On 6/30/26 at 12:50 PM, during an interview with Resident #1, he revealed that he required assistance and confirmed that he had a habit of cursing staff.On 7/02/26 at 8:44 AM, during a telephone interview the Medical Record Nurse stated that he was not aware of a care plan that addressed the behaviors that negativity affected Resident #1's health or his care. He confirmed that missing dialysis treatments had the potential to negatively affect the resident's health. On 7/02/25 at 10:24 AM, interview with Licensed Practical Nurses (LPN) #2 revealed she had witnessed Resident #1 being verbally abusive, using vulgar language toward staff, refusing care and medications and this was reported to the Director of Nursing (DON) who went into his room and received the same treatment. She stated that the resident's behavior was so egregiously abusive that there were times when direct care staff, following multiple attempts, would refuse to go back into his room to provide care. She said she was not aware of any care plan that addressed the resident's behaviors. On 7/02/26 at 11:00 AM, during a record review and interview with Certified Nursing Assistant (CNA) #2 confirmed that he was assigned to the care of Resident #1 on 7/02/26. CNA #2 reported that Resident #1 displayed verbally aggressive behavior that erupted with no warning and resulted in the resident demanding him to get out of his room. He stated that he was not aware of any specific interventions developed to address the behavior of Resident #1. The record review revealed CNA #2 accessed care instructions for Resident #1 on the resident care software with no interventions for behaviors listed. On 7/02/26 at 12:22 PM, during an interview with the Assistant Director of Nurses (ADON) revealed no one notified her that Resident #1 missed dialysis treatments on 6/10/26 and 6/11/26. She stated that she was not aware of any care plan or person-centered interventions that addressed Resident #1's behaviors.On 7/02/26 at 2:20 PM, during an interview the Social Services Director (SSD) revealed Resident #1 had no care plan developed that addressed his behavior. She confirmed that she was aware that Resident #1 had verbal outburst, cursed and used derogatory language toward staff. On 7/02/26 at 2:52 PM, the DON said she was not aware that a care plan was not in place to address Resident #1's behaviors that affected the resident's care or psychosocial needs or a care plan related to the death of his son. She confirmed that dialysis was necessary care for Resident #1 and that any behavior that interfered with his receiving needed or necessary care should be identified and addressed. On 7/02/26 at 3:25 PM, during an interview the Administrator said she expected individualized care plans to be developed and implemented for each resident. She stated that the purpose of the care plan was to provide staff with interventions for the care of each resident. She confirmed that the care plan also provided measurable goals which enabled nursing staff to assess the effectiveness of approaches. Record review of the admission Record revealed the facility admitted Resident #1 on 11/12/24 with diagnoses that included of end stage renal disease (present on admission), and complete traumatic amputation of two or more right lesser toes with onset date 6/18/25.Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/12/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, which (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the resident was cognitively intact. Section E indicated Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others).

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review and interviews, the facility failed to provide the appropriate treatment and services to address known psychosocial concerns in order to attain the highest practicable mental and psychosocial well-being for one (1) of four (4) sampled residents. Resident #1. Findings Included:Record review of the facility policy, Behavioral Health Services with Revised Date February 2019 revealed, The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care .Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care.During a telephone interview, on [DATE] at 1:32 PM, the Resident Representative (RR) for Resident #1 revealed that she was concerned related to the resident missing medical and dialysis appointments. She confirmed that the Assistant Director of Nurses (ADON), had reported that the resident was verbally combative toward staff and resistant to care. She said that Licensed Practical Nurse (LPN) #1 on [DATE] and the Medical Records Nurse on [DATE] had reported to her that Resident #1 had missed his dialysis treatments. Resident #1 stated that he could not make up the treatment on [DATE] due to their son's funeral. She was not aware of any grief counseling offered to the resident following the death of their son.During an interview on [DATE] at 9:49 AM, Nurse Practitioner (NP) #1, corroborating NP for MD #1, revealed that she was on vacation the week of [DATE] and that NP #2 had visited the resident on [DATE]. She stated, following her review of her records, that she was not notified that Resident #1 had missed dialysis treatments on [DATE] or [DATE] and that there was no documentation that NP #2 was notified. She stated that she was able to refer residents to the contract, in-facility psychiatric services and that she would have made the referral, had she been notified that his behaviors were interfering with his dialysis treatments or that his son had died in [DATE].During an interview on [DATE] at 2:00 PM, the Minimum Data Set (MDS) Nurse revealed that if a behavior was displayed or documented by a resident within seven (7) days of the Quarterly MDS assessment, it should be documented in Section E of the MDS by the Social Services Director (SSD), who was responsible for Behavior Assessment. She stated that if there had been a change in the behavior of the resident that affected resident care, the resident's RR and primary healthcare provider should be notified. She confirmed that the facility had contract, in-facility psychiatric care and that residents with behaviors that had the potential to affect their health or care could be referred to the service.During an interview on [DATE] at 2:20 PM, the Social Services Director (SSD) confirmed she completed cognition, mood and behavior sections of the Quarterly MDS. She confirmed that she was aware that Resident #1 had verbal outburst, cursed and used derogatory language toward staff. She said she did not know if any other staff had reported the behaviors to the resident's primary healthcare provider, but she had not. She confirmed that she was also able, along with other staff, to refer any resident to contract, in-facility psychiatric services and that Resident #1 had not been referred.During an interview on [DATE] at 2:52 PM, the Director of Nurses (DON) confirmed that dialysis treatments were necessary for Resident #1 and that any behavior that interfered with his receiving necessary care should be identified and addressed with his primary healthcare provider. She stated that the reason Resident #1 missed dialysis treatment on [DATE] was his behavior and make up day was scheduled for [DATE] and he missed dialysis treatment on [DATE] because of the resident's behavior. She confirmed that the dialysis center wanted him to come on [DATE] for dialysis, in addition to the [DATE] visit, but he was unable to go on [DATE] because that was the day of his son's funeral. She said that the resident had shown a change in behavior during his stay. The DON stated that, Sometimes he is nice. She stated that she was not (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sure what the trigger was, but staff received the brunt of his behavior. She confirmed that she had not made a referral to behavioral health contract services or notified the resident's doctor or NP that his behavior interfered with his receiving his dialysis treatments as ordered and scheduled. She confirmed that the documentation dated [DATE] of the missed dialysis treatment did not include notification of the resident's primary health care provider.During an interview on [DATE] at 3:25 PM, the Administrator confirmed that communication was important, and she expected staff to make all appropriate notifications to primary healthcare providers that may negatively affect resident health. She confirmed that the facility contracted in-facility psychiatric services were available to all residents and required a referral. She stated that she was not aware that Resident #1 had not been referred for grief counseling or for psychiatric services and that both would be appropriate for Resident #1. Record review of the admission Record revealed the facility admitted Resident #1 on [DATE] with diagnoses that included of end stage renal disease (present on admission), and complete traumatic amputation of two or more right lesser toes with onset date [DATE].Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section E indicated Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). Record review of the Order Review History Report revealed an active order with start date [DATE] for Hemodialysis every Mon(day), Wed(nesday), Fri(day) @0620 (6:20) AM.(Proper name of transport company) Transportation to transport.for end stage renal disease. He did not have any physician's orders for any psychoactive medications.