STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perry County Nursing Center	202 Bay Avenue West Richton, MS 39476

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 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, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to the provision of care in a respectful and dignified manner when staff provided incontinent care for one (1) of nine (9) sampled residents without ensuring privacy. (Resident #1).Findings include:A review of the facility's document, A Matter of RIGHTS: A Guide to Your Rights and Responsibilities as a Resident, Copyright 2020, revealed, .Dignity and Respect: You have the right to dignity and respect in the care you receive.A review of the facility's Aide Check List, with the latest revision dated December 2020, revealed, .Ensure privacy for Residents.A record review of the admission Record revealed the facility admitted Resident #1 on 8/13/24 and he had diagnoses including Vascular Dementia.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/17/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated he was severely cognitively impaired.On 10/2/25 at 8:27 AM, during an observation, Certified Nurse Aide (CNA) #1 and CNA #3 were observed providing incontinence care and changing the incontinence brief for Resident #1. The CNAs lifted the resident using a sit-to-stand lift and removed his brief without pulling either his privacy curtain or that of his roommate. The resident's roommate was lying in bed, facing Resident #1, with a full view of the resident's perineal area. On 10/2/25 at 1:40 PM, during an interview, the Staff Development Coordinator stated the facility provided monthly in-service training on Resident Rights, including each resident's right to respect and dignity. She explained that all new staff received Resident Rights training during orientation, which included both video and one-on-one instruction on providing respectful and dignified care. She stated that CNAs were instructed to ensure privacy prior to beginning any care procedure and that competency checkoffs for Activities of Daily Living (ADL) care, including incontinence care, required demonstration of privacy measures.On 10/2/25 at 2:13 PM, during an interview, CNA #1 stated she had not considered the privacy issue while changing the resident in front of his roommate. She acknowledged that it was undignified to change the resident in full view of another resident.On 10/2/25 at 2:28 PM, during an interview, CNA #3 stated she was aware that residents had the right to privacy during care to maintain dignity. She acknowledged that she should have ensured the resident's privacy prior to beginning incontinence care and stated that the privacy curtain did not fully close around the resident's bed.On 10/2/25 at 2:55 PM, during an interview, the Director of Nursing (DON) stated her expectation was for staff to provide privacy for residents by using the room's privacy curtains during all personal care procedures. She confirmed that CNA #1 and CNA #3 failed to ensure Resident #1's privacy prior to providing incontinence care and stated that this failure violated the resident's right to respectful and dignified care.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure medications were administered in accordance with professional standards of quality and accepted standards of practice by not referencing the Medication Administration Record (MAR) during medication preparation and administration for one (1) of three (3) residents observed for medication administration (Residents #8). Findings include:Review of the facility's Oral Medication Administration Procedures, dated 03/25, revealed, . 3. Verify the physicians order, comparing the medication label to the MAR to verify the following: a. Right medication b. Right dosage c. Right route d. Right time e. Right resident .On 10/1/25 at 4:26 PM, during an observation, Licensed Practical Nurse (LPN) #1 prepared and administered medications to Resident #8 without reference to the MAR. The laptop on top of the medication cart displayed only the resident roster and not an individual MAR as LPN #1 prepared and administered medications.On 10/1/25 at 5:00 PM, during an interview, LPN #1 confirmed she prepared and administered medications for Resident #8 without use of the MAR. She stated she felt confident because she knew the residents' medications and reviewed the Twenty-Four (24)-Hour Report for new or changed physician orders.On 10/2/25 at 1:40 PM, during an interview, the Staff Development Coordinator stated that all licensed nurses received in-service training upon hire and at least annually regarding medication administration, including competency checkoffs. She stated the training required nurses to begin each medication pass by viewing the MAR to confirm physician orders and verify the five (5) rights of medication administration.On 10/2/25 at 2:55 PM, during an interview, the Director of Nursing (DON) stated it was not acceptable practice for nurses to go by memory or rely on the Twenty-Four (24)-Hour Report as a substitute for the MAR. The DON stated proper procedure required referencing each resident's MAR to confirm physician orders and ensure the five (5) rights of medication administration were followed for every resident. A record review of the admission Record revealed the facility admitted Resident #8 on 9/21/22 with current diagnoses including Type 2 Diabetes Mellitus.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/17/25 revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.A record review of the Order Summary Report revealed Resident #8 had Physician's Orders for Warfarin Sodium 5 milligrams (mg), one (1) tablet by mouth every evening on Monday through Friday, dated 8/5/25 and Oxycodone/Acetaminophen 10-325 mg, one (1) tablet by mouth every six (6) hours for pain, dated 11/26/24.A record review of the electronic Medication Administration Record (eMAR) for October 2025 revealed LPN #1 documented the 1700 (5:00 PM) administration of Warfarin Sodium and the 1800 (6:00 PM) administration of Oxycodone/Acetaminophen on 10/1/25.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure that a resident who was unable to perform activities of daily living (ADLs) received personal hygiene and incontinence care in a safe and dignified manner, consistent with accepted standards of practice, for one (1) of nine (9) sampled residents (Resident #1).Findings include:A review of the facility's policy, Activities for Daily Living, reviewed 09/25, revealed, .Procedure.2. ADLs shall include, but are not limited to personal hygiene, bathing, voiding, toileting, repositioning, and meals offered.A review of the facility's Aide Check List, dated 12/20, revealed, .DOES YOUR RESIDENT HAVE.3. Resident shaved-males and females .A review of the facility's policy, Disposable Brief, dated of 01/24, revealed, .Procedure.REMOVING SOILED BRIEF 4. For a bedbound resident: a. loosen the tapes (tabs) securing the soiled brief. b. Assist the resident to roll onto their side facing away from you.APPLYING A CLEAN BRIEF 6. For the bedbound resident.b. Assist the resident to roll to their side, facing away from you.e. assist the resident to turn onto their back, ensuring that the brief stays in place while they turn.A record review of the admission Record revealed the facility admitted Resident #1 on 8/13/24 with diagnoses including Vascular Dementia.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/17/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident was severely cognitively impaired. The MDS revealed the resident required substantial/maximal assistance for toileting hygiene, showering/bathing, dressing the lower body, and toilet transfer, and required partial/moderate assistance for personal hygiene, including shaving.On 10/1/2025 at 1:45 PM, during an observation, Resident #1 was observed with a short gray beard and mustache. On 10/2/2025 at 8:20 AM, during an observation, Resident #1 continued to have a short gray beard.On 10/2/2025 at 8:27 AM, during an observation and interview, Certified Nurse Aide (CNA) #1 and CNA #3 were observed providing incontinent care for Resident #1 in his room. The CNAs lifted the resident with a sit-to-stand lift and removed his soiled brief while the resident was suspended in the lift. The CNAs attempted to cleanse the resident's perineal area and apply a clean brief while he remained suspended. Resident #1 continued to have a short beard and mustache and had not been shaved. The Director of Nursing (DON) entered the room and instructed both CNAs that incontinence care should be provided with the resident in bed rather than while suspended in the lift. Both CNAs verbalized they were unaware of this procedure.On 10/2/2025 at 8:37 AM, during an interview, CNA #4 stated she was the designated shower aide and was responsible for shaving male residents during showers unless the resident declined or there were safety concerns. She reported Resident #1 received a shower on 10/1/25 but was not shaved due to jerking movements. CNA #4 stated she did not report this to the assigned CNA or the nurse. She acknowledged she knew she was required to report unusual signs, symptoms, or uncompleted ADL tasks to the nurse for follow-up.On 10/2/2025 at 1:40 PM, during an interview, the Staff Development Coordinator stated sit-to-stand lifts were designed for transfers and were not safe for incontinence care. She confirmed all CNAs received training, including competency checkoffs for ADL care, which covered appropriate incontinent care techniques.On 10/2/2025 at 2:13 PM, during an interview, CNA #1 stated she should have known better than to use a sit-to-stand lift to provide incontinence care. She stated she thought the shower aide was responsible for shaving residents on their shower days. CNA #1 acknowledged that Resident #1 required assistance with transfers using the sit-to-stand lift and stated she was unaware that incontinence care should be performed after transferring the resident into bed.On 10/2/2025 at 2:28 PM, during an interview, CNA #3 stated she believed the shower aide was responsible for shaving residents during showers. CNA #3 confirmed Resident #1 required assistance with transfers using the sit-to-stand lift and stated she was not aware that residents who could not stand independently should be transferred into bed before incontinence care.On 10/2/2025 at 2:55 PM, during an interview, the DON stated her expectation was for staff to provide complete ADL care, including shaving, while honoring resident preferences. She confirmed male residents should be shaved during showers unless refused, and that shaving was part of personal hygiene. The DON stated nurses and management were responsible for supervising resident care. She confirmed that providing incontinence care while a resident was suspended in a sit-to-stand lift presented a risk and was inconsistent with standards of practice. She stated the purpose of the lift was for transfers only and that residents unable to stand unassisted should receive incontinence care in bed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure respiratory medications were administered in accordance with manufacturer's instructions by not instructing a resident to rinse the mouth following administration of an inhaled corticosteroid for one (1) of three (3) medication administrations reviewed, Resident #4. Findings included:A review of the facility's policy, Administration of Medications, revised 03/25, revealed, PURPOSE: To administer medications in accordance with best practice.A record review of the admission Record revealed the facility admitted Resident #4 on 6/10/25 with current diagnoses including Chronic Obstructive Pulmonary Disease (COPD).A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/16/25 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact.A record review of the Order Summary Report revealed Resident #4 had a Physician's Order, dated 9/12/25 for Symbicort Inhalation Aerosol 80-4.5 micrograms (mcg)/ACT, two (2) puffs to be inhaled orally two (2) times daily, related to COPD.A record review of the Medication Administration Record (MAR) for October 2025 revealed Licensed Practical Nurse (LPN) #2 documented Symbicort Inhalation Aerosol for Resident #4 as administered on 10/2/25.A record review of the SYMBICORT 80/4.5 (budesonide 80 mcg and formoterol fumarate dihydrate 4.5 mcg) Inhalation Aerosol manufacturer's package insert, dated 07/2019 revealed, . WARNINGS AND PRECAUTIONS: Localized infections: Candida albicans infection of the mouth and throat may occur. Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk.On 10/2/25 at 7:50 AM, during an observation, Licensed Practical Nurse (LPN) #2 administered Symbicort, an oral inhalation medication, to Resident #4 and failed to instruct the resident to rinse his mouth following inhalation.On 10/2/25 at 7:56 AM, during an interview, LPN #2 confirmed she did not provide water or instruct Resident #4 to rinse his mouth after using the inhaler.On 10/2/25 at 2:55 PM, during an interview, the Director of Nursing (DON) stated that residents should be instructed and assisted as needed to rinse their mouths and spit out the water after administration of an oral inhaler to prevent the risk of thrush. She stated that the facility did not have a specific medication administration policy for oral inhalers and that nurses were expected to follow the manufacturer's instructions provided with the medication.