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	04/22/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interviews, record review, and facility policy review, the facility failed to ensure an indwelling catheter was managed in a manner to prevent possible complications when nursing staff failed to assess and respond timely to a resident's complaint of catheter-related discomfort for one (1) of (1) residents reviewed for urinary catheters. Resident #1.Findings include:A review of the facility's policy, Quality of Care, revised 08/24, revealed, .1. Commitment to Quality of Care. The Facility is committed to providing care and services necessary to work toward, attain and/or maintain each resident's physical, mental and psychosocial well-being.3. Assessment and Treatment. The assessment and treatment of residents should be undertaken by competent and qualified individuals who have the authority and responsibility to conduct that assessment and treatment.A review of the facility's Standing Orders, dated 2/27/26, revealed, .Urinary System: If resident has Foley catheter, check for patency.If over 6 hours of no or decreased output, notify Provider.A record review of the Order Summary Report revealed Resident #1 had a Physician's Order, dated 10/2/25, to Change catheter and catheter bag monthly and prn (as needed) . A record review of the Bladder Voiding and Toilet Use record revealed Resident #1 had documented urine output on 3/17/26 at 6:23 AM of 400 milliliters (ml) and at 1:12 PM of 1000 milliliters (ml). A record review of the Client Coordination Note Report revealed a note for Resident #1, dated 3/17/26, entered by the hospice nurse, which documented, Patient requesting catheter to be changed today while hospice nurse in building.Patient states he felt his catheter was clogged up and burning noted to penis. Patient's catheter changed.blood noted to tubing and large amount of sediment noted. On 4/20/26 at 12:45 PM, during an interview with the Hospice Registered Nurse (RN), she explained that on 3/17/26 at 9:42 AM, she received a text message from Licensed Practical Nurse (LPN) #1 asking when she would return to the facility, as Resident #1 was complaining of urinary spasms and requesting his Foley (indwelling catheter) be changed. She reported she did not return to the facility until 3/17/26 at 3:07 PM and, upon changing the catheter, obtained a return of 600 milliliters (ml) of urine with sediment, which occurred over five (5) hours after notification from the facility.On 4/20/26 at 1:11 PM, during an interview with LPN #1, she explained that on 3/17/26 at approximately 8:50 AM, she was informed that Resident #1 requested his catheter be changed due to urinary spasms. She confirmed she did not assess the resident or evaluate catheter output during her shift and that the catheter was not changed until the hospice nurse returned later that afternoon.On 4/20/26 at 1:30 PM, during an interview with Resident #1, he reported that on 3/17/26, he informed staff early in the day that he was experiencing bladder spasms and discomfort and requested his catheter be changed. He reported the catheter was not changed until the hospice nurse returned later that afternoon. He confirmed he did not repeatedly request assistance throughout the day after his initial report.On 4/20/26 at 2:00 PM, during an interview with the Director of Nursing (DON), she explained that nursing staff are expected to assess residents promptly when complaints such as bladder spasms or catheter discomfort are reported. She confirmed that nursing staff should have assessed the resident and, if indicated, changed the catheter or obtained appropriate orders without waiting for hospice to return.On 4/20/26 at 2:20 PM, during an interview with the Administrator, he explained that staff are (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected to provide timely assessment and intervention when residents report symptoms and confirmed nursing staff should not delay care when it can be addressed by facility staff.On 4/21/26 at 10:00 AM, during an interview with the Nurse Practitioner (NP), she confirmed that when a resident reports bladder spasms, with or without a catheter, the resident should be assessed promptly by facility nursing staff.A record review of the Face Sheet revealed the facility admitted Resident #1 on 5/5/25 with diagnoses including Multiple Sclerosis. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/18/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of (15), which indicated the resident was cognitively intact.