STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255214	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence CO Nursing Center	700 Jefferson Street South Monticello, MS 39654

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255214	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence CO Nursing Center	700 Jefferson Street South Monticello, MS 39654

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and facility policy review, the facility failed to implement care plan interventions during wound care for two (2) of (2) wound care observations (Residents #2 and #3). Findings include:A review of the facility's policy, Care Plan Process, with a review date of 12/24, revealed, . The comprehensive care plan is an interdisciplinary communication tool.The facility staff shall follow the care plan.Resident #2A record review of the Order Summary Report revealed Resident #2 had a physician's order, dated 7/4/25, to Cleanse excoriated area to the right hip with wound cleanser, pat dry, apply Santyl ointment . and Hydrofera blue classic daily to the wound. Secure with adhesive foam until healed. There was also an order, dated 8/22/25, to Cleanse stage 3 pressure ulcer to sacrum with wound cleanser, pat dry, apply Santyl, gentamicin 0.1%, nystatin powder, calcium alginate and cover with border foam dressing daily. A record review of the Care Plan Report revealed a Resident #2 had Interventions including .Cleanse Stage 3 Pressure Ulcer to Sacrum with Wound Cleanser, Pat Dry. and Cleanse excoriated area to the Rt (Right) hip with wound cleanser, pat dry.On 9/4/25 at 9:50 AM, during an observation of wound care provided to Resident #2, Licensed Practical Nurse (LPN) #1 did not pat the wound on the right hip dry before applying Santyl, gentamicin, nystatin powder, calcium alginate, and foam dressing. LPN #1 also did not dry the sacral wound before applying calcium alginate and foam dressing, contrary to the physician's orders and the resident's care plan.A record review of the admission Record revealed the facility admitted Resident #2 on 12/24/20 with diagnoses including a Pressure Ulcer.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/16/25 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident was severely cognitively impaired.Resident #3A record review of the Care Plan Report revealed Resident #3 had Interventions including Cleanse Stage 2 to sacrum with wound cleanser, pat dry.A record review of the Order Summary Report revealed Resident #3 had a physician's order, dated 6/20/25, to Cleanse Stage 2 pressure wound to the sacrum with wound cleanser, pat dry, lightly pack calcium alginate to the wound and secure with adhesive foam until healed.On 9/4/25 at 10:35 AM, during an observation of wound care for Resident #3, LPN #1 cleansed the sacral wound with gauze soaked in wound cleanser, inserted gauze into the wound bed with a cotton swab and applied calcium alginate without patting the wound dry as ordered and care planned.On 9/4/25 at 11:04 AM, during an interview, LPN #1 acknowledged that she did not pat dry the wounds prior to applying the dressings and confirmed she did not follow the physician's orders or the care plan.On 9/4/25 at 3:25 PM, during an interview, the Director of Nursing (DON) stated LPN #1 did not follow the care plan during wound care for Residents #2 and #3. She stated her expectation is that all staff follow the care plan when providing care to residents.On 9/4/25 at 4:34 PM, during an interview, Registered Nurse (RN) #1, the MDS/Case Manager, stated that staff should follow the care plan, which is developed to direct resident care. She confirmed LPN #1 did not follow the care plan and explained that the care plan is designed to inform staff of the resident's care needs.A record review of the admission Record revealed the facility admitted Resident #3 on 3/18/19 with diagnoses including a Pressure Ulcer.A record review of the Quarterly MDS with an ARD of 7/7/25 revealed Resident #3 had a BIMS score of 4, which indicated the resident was severely cognitively impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255214	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence CO Nursing Center	700 Jefferson Street South Monticello, MS 39654

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255214	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence CO Nursing Center	700 Jefferson Street South Monticello, MS 39654

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, record review, and facility policy review, the facility failed to provide wound care in accordance with professional standards of practice and physician's orders, specifically failing to cleanse wounds with proper technique and dry wounds prior to dressing application, and placing a resident (Resident #2) in two (2) briefs, which increased the risk for skin breakdown and infection, for (2) of three (3) sampled residents reviewed for wound care (Residents #2 and #3).Findings include:A record review of the facility's Dressing Change Policy and Procedure with a review date of 8/21 revealed, .Steps in the Procedure. 14. Dry the skin surrounding the area by patting with a soft 4 X (by) 4.Resident #2On 9/4/25 at 9:50 AM, an observation of Licensed Practical Nurse (LPN) #1 providing wound care revealed Resident #2 was wearing two briefs. LPN #1 removed the soiled dressing and cleansed the hip wound by wiping back and forth across the wound bed multiple times with the same gauze rather than discarding it after a single pass. A second gauze was used in the same manner. LPN #1 did not pat the wound dry prior to applying Santyl, gentamicin, nystatin powder, calcium alginate, and foam dressing as ordered. LPN #1 repeated the same technique when cleansing the sacral wound, wiping back and forth with gauze, and again did not dry the wound before applying calcium alginate and foam dressing.A record review of the admission Record revealed the facility admitted Resident #2 on 12/24/20 with diagnoses including a Pressure Ulcer. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/16/25 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident was severely cognitively impairedA record review of the Order Summary Report revealed Resident #2 had a Physician's Order, dated 7/4/25 to Cleanse excoriated area to the right hip with wound cleanser, pat dry, apply Santyl ointment.and Hydrofera blue classic daily to the wound. Secure with adhesive foam until healed. There was also an order dated 8/22/25 to Cleanse stage 3 pressure ulcer to sacrum with wound cleanser, pat dry, apply santyl, gentamicin 0.1%, nystatin powder calcium alginate and cover with border foam dressing daily.Resident #3On 9/4/25 at 10:35 AM, an observation of Resident #3 receiving wound care revealed LPN #1 cleansed the sacral wound using gauze soaked in wound cleanser, then inserted gauze into the wound bed with a cotton swab, and applied calcium alginate without patting the wound dry as ordered.A record review of the Order Summary Report revealed Resident #3 had a Physician's Order, dated 6/20/25, to Cleanse Stage 2 pressure wound to the sacrum with wound cleanser, pat dry, lightly pack calcium alginate to the wound and secure with adhesive foam until healed.On 9/4/25 at 10:23 AM, during an interview with Certified Nursing Assistant (CNA) #1, she stated that placing two briefs on a resident was against her training and could contribute to skin breakdown or rash.On 9/4/25 at 11:04 AM, during an interview with Licensed Practical Nurse (LPN) #1, she acknowledged that she did not pat dry the wounds prior to applying the dressings and confirmed that she did not follow the physician's orders. She stated she did not clean Resident #2's wound correctly and thought she had folded or flipped the gauze. She explained that a wound should be dried before covering to reduce the risk of further breakdown and infection. She acknowledged that her actions placed the residents at risk for infection. She also stated that no resident should be double briefed, as doing so can irritate the skin.On 9/4/25 at 12:11 PM, during an interview, the Director of Nursing (DON) stated that residents should never be double briefed because it can contribute to skin breakdown. She further explained that wounds should be cleaned using either a top-to-bottom or circular motion, discarding gauze after each use. She stated wounds must always be dried before dressing application, and that failure to do so could result in moisture contributing to skin breakdown or infection.On 9/4/25 at 2:00 PM, during an interview, CNA #2 stated she had provided perineal care for Resident #3 earlier that morning and acknowledged that she had placed two briefs on the resident. CNA #2 stated she had previously received in-service training on the risks of double briefing.A record review of the admission Record revealed the facility admitted Resident #3 on 3/18/19 with current diagnoses including a Pressure Ulcer. A record review of the Quarterly MDS with an ARD of 7/7/25 revealed Resident #3 had a BIMS score of 4, which indicated the resident was severely cognitively impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255214	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence CO Nursing Center	700 Jefferson Street South Monticello, MS 39654

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 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 follow infection prevention and control practices by placing wound care supplies on an undisinfected bedside table during treatment, creating the potential for cross-contamination and infection, for one (1) of two (2) wound care observations (Resident #3).Findings include:A review of the facility's policy, Infection Control, revised 4/21, revealed The facility will maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment with minimal exposure to the transmission of disease and infection.On 9/4/25 at 10:35 AM, during an observation of wound care provided to Resident #3's sacral wound, Licensed Practical Nurse (LPN) #1 entered the resident's room with supplies carried on a white disposable barrier. She placed the barrier on the foot of the resident's bed, then placed a bottle of hand sanitizer and clean gloves directly on the resident's bedside table without disinfecting the surface. LPN #1 donned (put on) gloves, then removed the resident's soiled dressing and placed it in a biohazard bag. She then removed her gloves, sanitized her hands, and reapplied gloves obtained from the bedside table. LPN #1 repeated this process four times, each time retrieving gloves and sanitizer from the undisinfected bedside table before continuing wound care.On 9/4/25 at 11:04 AM, during an interview, LPN #1 confirmed she did not disinfect the bedside table before placing wound care supplies on it. She stated she should have cleaned the table before and after wound care and acknowledged her actions placed the resident at risk for infection.On 9/4/25 at 12:24 PM, during an interview, the Director of Nursing (DON) stated LPN #1 should have disinfected the bedside table and used a barrier before placing supplies on it. She explained that failure to follow this practice could lead to infection.On 9/4/25 at 2:23 PM, during an interview, LPN #2, the facility's Infection Preventionist (IP) nurse, confirmed that no items should be placed on a bedside table without first disinfecting it. She stated that germs present on the surface could be transferred to the gloves and sanitizer bottle, then carried to the resident's wound during care, creating a risk of infection.A record review of the admission Record revealed the facility admitted Resident #3 on 3/18/19 with current diagnoses including a Pressure Ulcer of sacral region, stage 2.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/7/25 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident was severely cognitively impaired.A record review of the Order Summary Report revealed Resident #3 had a physician's order, dated 6/20/25, to Cleanse Stage 2 pressure wound to the sacrum with wound cleanser, pat dry, lightly pack calcium alginate to the wound and secure with adhesive foam until healed.