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	06/18/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review the facility failed to ensure residents were treated with dignity, respect, privacy, and received necessary assistance with personal care in accordance with resident rights as evidenced by Resident #27 was unnecessarily exposed during catheter care and Resident #47 was denied requested assistance with drying beneath her breasts following a shower, resulting in prolonged moisture and a rash for two (2) of four (4) sampled residents for residents rights. (Resident #27 and Resident #47)Findings Include: Record review of the facility policy Residents Rights Policy with a revision date of 05/26 revealed, Every resident in this facility has the right to.11. Receive adequate care and appropriate healthcare, medical treatment and protective support services. 12. Be treated courteously, fairly and with fullest measures of dignity.17. Be treated with consideration and respect for their personal privacy including but not limited to. have facility staff personnel knock before entering their room. Record review of the facility policy Suprapubic Catheter Site Care with a review date of 01/24 revealed .Procedure.5. Assist resident to dorsal recumbent position and drape for privacy. Resident #27 On 06/17/26 at 10:06 AM, Licensed Practical Nurse (LPN) #4 was observed providing suprapubic catheter care for Resident #27. LPN #4 initially knocked on the door and explained the procedure to the resident. LPN #4 then exited the room to gather supplies and reentered without knocking. During care, LPN #4 pulled the resident's bed linens down to the knees, leaving the resident exposed from beneath her breasts to her knees. The exposure extended well beyond the suprapubic catheter site. The resident's vaginal area was exposed, and the resident was not draped for privacy. On 06/17/26 at 10:26 AM, during an interview, LPN #4 confirmed she did not knock upon reentering the room after obtaining supplies. LPN #4 stated she did not believe she needed to knock because she had already entered the room previously. LPN #4 stated the privacy curtain was closed. On 06/17/26 at 2:14 PM, during a follow-up interview, LPN #4 recanted her earlier statement and stated she had knocked both times before entering the room. LPN #4 stated that draping for privacy meant covering the resident during care and denied that Resident #27 had been exposed. LPN #4 stated the room door was closed and the privacy curtain was pulled. On 06/17/26 at 2:22 PM, during an interview, LPN #3 stated Resident #27's vaginal area should not have been exposed during suprapubic catheter care. LPN #3 stated LPN #4 failed to follow facility policy during the procedure. LPN #3 further stated staff should knock each time they enter a (continued on next page)

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 - Some	resident's room. On 06/17/26 at 3:05 PM, during an interview, Registered Nurse (RN) #1/Case Manager stated all staff are expected to knock each time they enter a resident's room. RN #1 stated LPN #4 should have draped the resident for privacy and only exposed the area necessary to provide catheter care. RN #1 stated staff are expected to follow facility policy when providing resident care. A record review of Resident #27's Face Sheet revealed an admission date of 3/18/19 with diagnoses including Neuromuscular Dysfunction of Bladder, Unspecified. A record review of Resident #27's Order Summary Report revealed an order dated 7/26/24 Cleanse area to suprapubic cath (catheter) with wound cleanser, pat dry, cover with split gauze, and secure with tape daily. A record review of Resident #27's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/28/26 revealed a Brief Interview for Mental Status (BIMS) score of five (5), indicating severe cognitive impairment. Resident #47 On 6/15/26 at 1:12 PM, during an interview, Resident #47 stated her only concern was her shower experience. The resident explained that she had difficulty drying herself after showering and specifically required assistance drying beneath her breasts because she could not adequately reach the area. The resident stated she had not previously asked staff for assistance because she felt it would be a bother. On 6/17/26 at 10:00 AM, during a follow-up interview, Resident #47 stated she requested assistance from Certified Nursing Assistant (CNA) #1 during her shower on 6/16/26 to dry beneath her breasts. Resident #47 reported CNA #1 told her she could not assist because it was a private area. Resident #47 stated she remained wet beneath her breasts following the shower. The resident reported the moisture caused a constant itchy and uncomfortable rash. Resident #47 stated she informed CNA #1 about the rash and was told to put some of your lotion on it. On 6/17/26 at 11:53 AM, during an interview, CNA #1 stated assisting residents with showering was part of her job responsibilities. CNA #1 stated this included washing and drying all body areas when residents required assistance. CNA #1 further stated Resident #47 informed her about a rash beneath her breast and that she reported the concern to LPN #1. On 6/17/26 at 12:01 PM, during an interview, LPN #1 stated that not any staff member had informed her of a rash beneath Resident #47's breast and that this was the first time she had heard of the concern. LPN #1 stated she would immediately notify the treatment nurse or Nurse Practitioner for assessment. On 6/17/26 at 12:11 PM, during an observation with the Nurse Practitioner, Resident #47 was observed to have a red, raised rash beneath her left breast. The Nurse Practitioner stated this type of rash can occur when moisture remains trapped beneath the breast. The Nurse Practitioner stated it is important for staff to thoroughly dry beneath the breasts during showering to help prevent skin irritation and breakdown. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/18/26 at 10:31 AM, during an interview, LPN #3, Staff Development Coordinator, stated CNAs are taught during training to provide residents with as much assistance as needed during showering and personal care. On 6/18/26 at 11:57 AM, during an interview, the interim Director of Nursing (DON) stated CNAs are expected to assist residents as needed during showers. The DON stated that drying beneath the breasts is important because moisture left in skin folds can cause skin irritation and breakdown. The DON further stated assisting residents with their needs is part of staff responsibilities. A record review of Resident #47's Face Sheet revealed the resident was admitted on [DATE] with diagnoses including Hypertensive Heart Disease with Heart Failure and Anxiety Disorder. A record review of Resident #47's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/26 revealed a Brief Interview for Mental Status (BIMS) score of (15), indicating the resident was cognitively intact.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview, record review, and facility policy review the facility failed to ensure residents were permitted to receive unopened mail and packages and failed to protect residents' rights to privacy and confidentiality for three (3) of (3) residents interviewed regarding receipt of mail (Residents #3, #9, and #32). This deficient practice had the potential to affect all residents residing in the facility who received mail or packages.Finding include: Record review of the facility policy, Resident Rights Policy, with a revision date of 5/26, revealed, Every resident in the facility has the right to: 17. Be treated with consideration and respect for their personal privacy .19. Receive unopened private mail .During an interview on 6/16/26 at 2:00 PM, the Activities Director mentioned that she had opened mail addressed to residents in the past. She explained that she was instructed to do so to ensure that residents were not ordering items that could be hazardous to their health. Additionally, she noted that she had been informed it was acceptable for nursing staff to open residents' mail at their discretion if they suspected a package contained something suspicious. The Activities Director now recognized that opening mail addressed to residents without their permission violated their rights.During an interview on 6/16/26 at 3:58 PM, Licensed Practical Nurse (LPN) #3 acknowledged it was a facility practice for staff to open resident mail. She stated the Social Services Director, and some other staff had been instructed to open resident packages if they had concerns regarding the contents.During an interview on 6/17/26 at 9:28 AM, Resident #32 mentioned that her brother frequently mailed packages to her from California. She noted that there had been occasions when packages addressed to her were opened prior to being delivered to her room. Although staff currently retaped the packages before delivery, it was still evident that they had been opened. Resident #32 expressed that she felt her privacy was being invaded and felt uneasy because she was unsure whether any items had been removed from the packages before they reached her.In an interview on 6/17/26 at 9:38 AM, Resident #3 indicated that facility staff had opened his mail. He noted that the staff member who opened the mail informed him she had always been told it was acceptable to open residents' mail. Resident #3 explained that he told the staff member that opening his mail violated his privacy rights and requested that staff discontinue the practice.In an interview on 6/17/26 at 1:55 PM, the son and resident representative of Resident #32 shared that he routinely sent his sister packages containing clothing, shoes, and snacks. He mentioned that Resident #32 had informed him that packages were being opened before she received them. After contacting the facility to inquire about why the packages were being opened, he was told it was standard practice to open all packages. The resident representative stated that after learning this, he reviewed each shipment with his sister upon delivery to ensure that all items originally sent remained in the package.In an interview on 6/17/26 at 3:00 PM, Resident #9 reported that some of her mail had been opened before it was delivered to her. She inquired with staff about why her mail had been opened and was told it was an accident. Resident #9 expressed skepticism about this explanation, noting that her name was clearly printed on the envelope. She stated that having her mail opened without permission made her feel terrible and violated her privacy.During an interview on 6/18/26 at 10:50 AM, the Administrator stated he was unsure where staff obtained the idea that they could open residents' mail without permission and acknowledged that doing so violated residents' rights to privacy.Resident # 9 A record review of the Face Sheet revealed the facility admitted Resident #9 on 9/6/25 with diagnoses including Type 2 Diabetes with Hyperglycemia. A record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/24/26 revealed a Brief Interview for Mental Status (BIMS) score of (15) indicating the Resident #9 is cognitively intact. Resident # 3A record review of the Face Sheet revealed the facility admitted Resident #3 on 6/26/25 with diagnoses including Primary Generalized OsteoarthritisA record review of the quarterly MDS with an ARD of 5/29/26 revealed a BIMS score of (15) indicating Resident #3 is cognitively intact.Resident # 32 A record review of Resident #32 Face Sheet revealed the facility admitted Resident #32 on 3/17/25 (continued on next page)

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	255214	A. Building B. Wing	06/18/2026

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with diagnoses including Type 2 Diabetes with Hyperglycemia. A record review of the MDS with an ARD of 5/19/26 revealed a BIMS score of (14), indicating Resident #32 is cognitively intact.

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	255214	A. Building B. Wing	06/18/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, and facility policy review the facility failed to ensure physician orders contained complete and accurate medication dosage instructions for one (1) of five (5) residents reviewed for medication administration. (Resident #28). Findings Include:A record review of the facility policy Oral Medication Administration Procedure with a revision dated of 03/25 revealed, .2. Ensure that an appropriate physician's order is in place.Verify.b. right dosage. On 06/17/26 at 8:05 AM, Licensed Practical Nurse (LPN) #2 was observed administering medications to Resident #28. During the observation, the physician order for Vitamin D3 was reviewed and directed staff to give one tablet daily. The order did not contain a dosage strength. LPN #2 administered (1) Vitamin D3 125 mcg (microgram) tablet to Resident #28.On 06/17/26 at 8:08 AM, LPN #2 was interviewed regarding the medication administration. LPN #2 stated there were two Vitamin D products available on the medication cart. LPN #2 presented one bottle labeled Vitamin D3 125 mcg and a second bottle labeled Vitamin D. Further review of the second bottle revealed Vitamin D3 as the active ingredient with a strength of 25 mcg. When asked how she determined which medication to administer, LPN #2 stated she selected the product labeled Vitamin D3. After reviewing the second bottle, LPN #2 acknowledged that both products contained Vitamin D3 and stated the physician order required clarification to ensure the resident received the correct prescribed dose.During an interview on 06/17/26 at 1:51 PM, the Interim Director of Nursing (IDON) stated the medication should have been held and the physician contacted for clarification before administration. The IDON stated the order had been written incorrectly and required clarification. The IDON further stated nurses should not independently determine which dosage of a medication to administer when the physician order is incomplete. The IDON stated potential consequences included administration of an excessive dose resulting in toxicity or administration of an insufficient dose that failed to meet the resident's clinical needs.A record review of the June 2026 Medication Administration Record (MAR) revealed nurse initials indicating that Resident #28 had received Vitamin D3 on 6/17/26.A record review of the Face Sheet revealed Resident #28 was admitted on [DATE] with a diagnose that included Other Paralytic Syndrome Following Cerebral Infarction Affecting Left Non-Dominant Side.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/1/26 revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 11 indicating Resident #28 had moderate cognitive impairmentA record review of Resident #28's Order Summary Report revealed an order dated 12/31/20 for Vitamin D3 Oral Tablet Give (1) tablet give 1 tablet by mouth one time a day related to Vitamin D deficiency.

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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 observation, interview, facility policy review and record review, the facility failed to ensure a resident received appropriate perineal care and in accordance with professional standards of practice for one (1) of three (3) residents reviewed for personal hygiene care (Resident #45). Findings Include:Record review of the facility policy Perineal Care with a revision date of 01/24 revealed .Preparing For Care.6. Perform hand hygiene and apply gloves . 5. Wash genital area, moving from front to back while using a clean portion of the washcloth or pre-moistened wash wipe for each stroke. 6. When soap is used, rinse genital area rinsing area moving front to back using a clean portion of the washcloth or premoistened wash wipe for each stroke. 7. Dry genital area moving from front to back with towel. 8. Assist the resident to turn onto side facing away from you with leg slightly bent at the knee. 9. With a new washcloth or premoistened wash wipe, clean the anal area from front to back using a clean area of the washcloth or premoistened wash wipe after each stroke. 10. When soap is used, rinse genital area moving from front to back using a clean portion of the washcloth or premoistened wash wipe for each stroke. 11. Dry area using same method .On 06/16/26 at 2:40 PM, Certified Nursing Assistant (CNA) #2, assisted by CNA #3, was observed providing peri-care to Resident #45. Prior to care, CNA #2 obtained supplies from a linen cart in the hallway including a lift pad, brief, and towels. Either of the CNAs did not perform hand hygiene before initiating care or during the procedure. During care, CNA #2 turned on the faucet while wearing gloves, wet a hand towel, and applied soap. CNA #3 lowered the bed linens and removed the residents' brief. CNA #3 cleansed the residents' left and right thigh areas using a single front-to-back stroke with the same soapy washcloth. CNA #3 then cleansed the vaginal area one time without folding the washcloth or using a clean portion of the cloth for each stroke. After cleansing the vaginal area, the CNAs failed to rinse soap from the resident's skin and immediately dried the resident with a towel. CNA #3 then turned the resident onto her left side. CNA #2 flipped the same wet soapy washcloth over one time and cleansed the buttocks area using a single front-to-back stroke before drying the area. The CNAs did not use a basin of clean water, did not rinse the washcloth between uses, did not rinse soap from the resident's skin, did not perform hand hygiene during care, and did not wear gowns despite physician orders requiring Enhanced Barrier Precautions during hygiene care. Following completion of care, the CNAs removed their gloves and performed hand hygiene in the hallway.On 06/16/26 at 2:47 PM, during an interview, CNA #3 confirmed perineal care was not completed correctly. CNA #3 stated she was nervous and forgot the proper procedure. CNA #3 acknowledged the deficient care placed the resident at risk for infectionOn 06/16/26 at 2:50 PM, during an interview, CNA #2 confirmed she and CNA #3 did not wear gowns, did not use a barrier, did not use a basin, and did not perform hand hygiene before or during care. CNA #2 stated she believed Resident #45 did not have a basin available. CNA #2 acknowledged that peri-care was not completed according to facility policy and confirmed soap was not rinsed from the resident's skin.On 06/16/26 at 2:59 PM, an observation of Resident #45's closet with CNA #2 and CNA #3 revealed a basin was present. CNA #2 stated she was unaware the resident had a basin. CNA #2 acknowledged the basin should have been used and stated the care provided exposed Resident #45 to cross contamination and infection. CNA #2 again stated she was nervous and forgot the proper procedure.On 06/17/26 at 2:34 PM, during an interview, Licensed Practical Nurse (LPN) #3/ Infection Preventionist, stated staff should have used a basin during care and should have rinsed soap from the resident's skin before drying. LPN #3 stated the CNAs failed to follow facility policy throughout the procedure. LPN #3 stated the resident was placed at risk for infection, including urinary tract infection, and that failure to wear gowns during Enhanced Barrier Precaution care increased the risk of cross contamination to other residents. LPN #3 stated the care provided placed Resident #45 at increased risk for infection.On 06/17/26 at 3:10 PM, during an interview, Registered Nurse (RN) #1, Case Manager, stated staff should have used a basin to properly provide (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care. RN #1 stated hand hygiene should have been performed before, during, and after care. RN #1 stated the washcloth should have been rinsed before continued use and soap should have been rinsed from the resident's skin before drying. RN #1 stated staff failed to follow facility policy during the entire procedure. RN #1 stated the deficient practice placed the resident at risk for urinary tract infection, skin irritation, and skin breakdown. RN #1 stated her expectation was that all staff provide care according to facility policy and accepted standards of practice.Record review of the Face Sheet revealed an admission date of 11/13/23 with diagnoses that included Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease Affecting Left Non-Dominant side and encounter for attention to colostomy.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/1/26 revealed a Brief Interview for Mental Status (BIMS) score of 1, which indicated severe cognitive impairment.Record review of the Order Summary Report with active orders as of 6/17/26 revealed an order dated1/17/26 Enhanced Barrier Precautions- gown and gloves to be worn during high contact resident care activities.hygiene, changing briefs.Clean stoma with soap and water pat dry wipe skin around stoma with skin prep .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on interview, observation, and record review, the facility failed to accommodate food preferences for one (1) of (15) residents reviewed for food and nutrition services. (Resident #32). Findings Include:On 06/15/26 at 12:09 PM, during an interview, Resident #32 stated she had requested two (2) boiled eggs, (2) slices of bacon, and oatmeal for breakfast. Resident #32 stated she spoke with the Dietary Manager (DM), who agreed to provide the requested breakfast items. The resident stated she only received the requested breakfast one time after making the request.On 06/16/26 at 11:20 AM, during an interview, Resident #32 stated she was served (1) slice of bacon, scrambled eggs, (1) slice of toast, and oatmeal. Resident #32 stated (2) boiled eggs were handwritten on her tray card but were not included on her meal tray. Resident #32 stated she wanted the breakfast items she had requested.On 06/17/26 at 7:53 AM, an observation of Resident #32's breakfast tray revealed grits, scrambled eggs, sausage patty, and biscuits. The tray did not contain bacon, oatmeal, or boiled eggs as requested by the resident.On 06/17/26 at 11:02 AM, during an interview, the Dietary Manager stated Resident #32 had requested breakfast changes and the requested items had been added to the tray card. The Dietary Manager stated Resident #32 did not receive boiled eggs on 06/15/26 or 06/17/26 because the cook did not prepare them. The Dietary Manager further stated Resident #32 did not receive boiled eggs on 06/16/26 because the facility had run out of eggs. The Dietary Manager stated a food delivery arrived on the evening of 06/16/26 and eggs were available on 06/17/26. The Dietary Manager stated there was no reason Resident #32 should not have received the requested boiled eggs when they were available and acknowledged the resident's needs should have been met.On 06/18/26 at 1:40 PM, during an interview, the Nursing Home Administrator (NHA) stated he expected dietary staff to provide residents with their requested food preferences whenever possible. The NHA stated, This is the resident's home.A record review of the Face Sheet revealed an admission date of 3/17/25 with diagnoses that included Type 2 Diabetes Mellitus Hyperglycemia and Morbid (Severe) Obesity Due to excess calories.A record review of the Order Summary Report revealed a physician order dated 3/17/25, LCS/NSOT (Low Concentrated Sweets/No salt on tray) diet, Regular texture, Regular consistency.A record review of Resident #32's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/19/26 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicates the resident is cognitively intact.

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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 observations, interviews, record review and facility policy review the facility failed to prevent the possibility of spreading infection during perineal care for one (1) of four (4) care observations. Resident #45. Findings Include:Record review of the facility policy Hand Hygiene with a revision date of 01/24 revealed Purpose: To cleanse hands to prevent transmission of infection or other conditions. To provide clean health environment for residents, staff and visitors .Procedure. 2. Hand hygiene should be performed between all contacts with residents or when entering and exiting a resident's room. 3. Before and after procedures 3. Before and after applying gloves.Record review of the facility's Enhanced Barrier Precaution signage revealed EVERYONE MUST Clean their hands, including before entering and when leaving the room. Wear gloves and a gown for the following high contact Resident Care Activities . Changing briefs or assisting with toileting.Record review of the facility policy Enhanced Barrier Precautions (EBP) with a revision date of 3/24 revealed . EBP involves gown and gloves use during high-contact resident care activities for residents known to be colonized .For resident for whom EBP are indicated, EBP is employed when performing the following.Changing briefs or assisting with toileting.During an observation on 06/16/26 at 2:40 PM, Certified Nursing Assistant (CNA) #2, assisted by CNA #3, was observed providing peri-care to Resident #45. Prior to care, CNA #2 obtained supplies from a linen cart in the hallway including a lift pad, brief, and towels. Either of the CNAs did not perform hand hygiene before initiating care or during the procedure. During care, CNA #2 turned on the faucet while wearing gloves, wet a hand towel, and applied soap. CNA #3 lowered the bed linens and removed the residents' brief. CNA #3 cleansed the residents' left and right thigh areas using a single front-to-back stroke with the same soapy washcloth. CNA #3 then cleansed the vaginal area one time without folding the washcloth or using a clean portion of the cloth for each stroke. After cleansing the vaginal area, the CNAs failed to rinse soap from the resident's skin and immediately dried the resident with a towel. CNA #3 then turned the resident onto her left side. CNA #2 flipped the same wet soapy washcloth over one time and cleansed the buttocks area using a single front-to-back stroke before drying the area. The CNAs did not use a basin of clean water, did not rinse the washcloth between uses, did not rinse soap from the resident's skin, did not perform hand hygiene during care, and did not wear gowns despite physician orders requiring Enhanced Barrier Precautions during hygiene care. Following completion of care, the CNAs removed their gloves and performed hand hygiene in the hallway.During an interview on 06/16/26 at 2:47 PM, CNA #3 confirmed peri-care was not completed correctly. CNA #3 stated she was nervous and forgot the proper procedure. CNA #3 acknowledged the deficient care placed the resident at risk for infection.During an interview on 06/16/26 at 2:50 PM, CNA #2 confirmed she and CNA #3 did not wear gowns, did not use a barrier, did not use a basin, and did not perform hand hygiene before or during care. CNA #2 stated she believed Resident #45 did not have a basin available. CNA #2 acknowledged that peri-care was not completed according to facility policy and confirmed soap was not rinsed from the resident's skin.During an observation on 06/16/26 at 2:59 PM, of Resident #45's closet with CNA #2 and CNA #3 revealed a basin was present. CNA #2 stated she was unaware the resident had a basin. CNA #2 acknowledged the basin should have been used and stated the care provided exposed Resident #45 to cross contamination and infection. CNA #2 again stated she was nervous and forgot the proper procedure.During an interview on 06/17/26 at 2:34 PM, Licensed Practical Nurse (LPN) #3/ Infection Preventionist, stated staff should have used a basin during care and should have rinsed soap from the resident's skin before drying. LPN #3 stated the CNAs failed to follow facility policy throughout the procedure. LPN #3 stated the resident was placed at risk for infection, including urinary tract infection, and that failure to wear gowns during Enhanced Barrier Precaution care increased the risk of cross contamination to other residents. LPN #3 further stated contaminated linens should have been bagged and not placed against staff uniforms. LPN #3 stated the care provided placed Resident #45 at increased risk for infection.During an interview on 06/17/26 (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	06/18/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 3:10 PM, Registered Nurse (RN) #1, Case Manager, stated staff should have used a basin to properly provide care. RN #1 stated hand hygiene should have been performed before, during, and after care. RN #1 stated the washcloth should have been rinsed before continued use and soap should have been rinsed from the resident's skin before drying. RN #1 stated staff failed to follow facility policy during the entire procedure. RN #1 stated the deficient practice placed the resident at risk for urinary tract infection, skin irritation, and skin breakdown. RN #1 stated her expectation was that all staff provide care according to facility policy and accepted standards of practice.Record review of the Face Sheet revealed an admission date of 11/13/23 with diagnoses that included Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease Affecting Left Non-Dominant side and encounter for attention to colostomy.Record review of the Order Summary Report with active orders as of 6/17/26 revealed an order dated1/17/26 Enhanced Barrier Precautions- gown and gloves to be worn during high contact resident care activities.hygiene, changing briefs.Clean stoma with soap and water pat dry wipe skin around stoma with skin prep . A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 6/1/26 revealed a Brief Interview for Mental Status (BIMS) score of 1, which indicates severe cognitive impairment.