STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255221	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven Hall Health Care Center	101 Mills Street Brookhaven, MS 39601

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review, staff interviews, and facility policy review, the facility failed to ensure the Payroll-Based Journal (PBJ) report for the October 1 through December 31 reporting period was submitted accurately and within the required Centers for Medicare & Medicaid Services (CMS) timeframe for one (1) of four (4) quarters reviewed. Findings include:A record review of the policy, Reporting Direct Care Staffing Information (Payroll-Based Journal), revised August 2022, revealed, Policy Statement Direct care staffing is reported electronically to CMS (Centers for Medicare and Medicaid) through the Payroll-Based Journal System .Policy Interpretation .10. Staffing information is collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter.At 11:52 AM on 3/30/26 in an interview with the Administrator, she revealed it is her corporate office that handles the Payroll-Based Journal (PBJ) submission process. She has not been granted access to ensure its timely submission.At 10:35 AM on 4/1/26, in an interview with the Corporate Payroll Representative, he revealed he is solely responsible for submitting the PBJ report and ensuring its timely submission. He explained that according to the Centers for Medicare & Medicaid Services (CMS), once the PBJ submission window opens, there are 45 days to submit the report accurately. For the October 1-December 31 reporting period, the cutˆoff date was 2/14/26. He stated he submitted the report on day 43, 2/12/26, and failed to verify the accuracy of the submission until he returned to the office on Monday, 2/16/26. At that time, he discovered he had submitted the wrong information, resulting in an error and causing the report to miss the 2/14/26 deadline. He explained that he should have verified the report was submitted correctly before the deadline, indicating the late submission was his fault. He stated he submitted the report on 2/12/26 which was day 43 and failed to verify the accuracy of the submission until he returned to the office on Monday, 2/16/26. At that time, he discovered he had submitted the wrong information, resulting in an error and causing the report to miss the 2/14/26 deadline. He explained that he should have verified the report was submitted correctly before the deadline, indicating the late submission was his fault.A record review of the email sent from the corporate compliance office revealed he submitted the report on Thursday 2/12/26. Verified a successful submission on Monday 2/16/26 after the 2/14/26 deadline.A record review of the PBJ Final File Validation Report revealed Submission Date/Time: 2/12/26 at 16:53:07 (4:53 PM).

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review the facility failed to ensure residents received care and services in accordance with professional standards of practice and physician oversight. Specifically, the facility failed to clarify and obtain appropriate physician guidance regarding administration of blood pressure medications prior to dialysis and failed to follow safe medication administration practices, resulting in the resident receiving medications that had the potential to cause hypotension during dialysis one (1) of (1) residents reviewed for dialysis care. Resident #14Findings Include: Record review of the facility policy Administering Medications dated 2001 revealed Medications are administered in a safe and timely manner and as prescribed . 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having a potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to express concerns. 21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document not administered and the reason in the electronic record. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.In an interview on 03/31/2026 at 10:35 AM, Resident #14 stated that nurses in the facility were giving his blood pressure medications prior to his dialysis appointment even when he told them he couldn't take it because it would drop his blood pressure (BP) to an unsafe level. Resident #14 stated that he was holding the medication on dialysis days prior to his admission to the facility.In an interview with Licensed Practical Nurse (LPN) #1 at 2:19 PM on 3/31/26, she confirmed that she has cared for the resident on 3/30/26 and 3/31/26 and confirmed that her documentation on the resident's Medication Administration Record (MAR) indicated that she gave the BP meds metoprolol and furosemide prior to his dialysis appointment on 3/30, but she stated she pulled them from the pack prior to administering and held them because they could lower his BP. She stated that she must have accidentally documented it as given, but she did not give it because nurses are taught not to give BP meds prior to dialysis because of the risk of hypotension.In an interview with LPN #2 at 2:25 PM, on 3/31/26 she stated that the resident goes to dialysis on Mondays, Wednesdays, and Fridays and she took care of him on his dialysis days of 3/20/26 and 3/25/26. She confirmed that BP meds such as metoprolol and furosemide should not be given prior to dialysis due to the fear of residents bottoming out while dialyzing. She stated that she didn't give blood pressure medications on the days prior to dialysis even though she charted that she did give them. She stated she just forgot to fix the documentation because it was hectic that day. She stated she didn't know to hold them prior to pulling the medications for the residents because there was no order in the system to hold before dialysis. She stated that the resident instructed her that he would not take them and refused.In a follow up interview with Resident #14 at 2:38 PM, on 3/31/26 he stated he never pulled any drugs out when the nurses gave them to him, so he took them every time, in fact he knows for certain he took them the day that he was given his flu vaccine on 3/25/26 because they were mixed in the cup with his other meds and he couldn't pick them out. He stated that he told the nurse that could kill him because he had dialysis later that day. He stated that he had notified the dialysis nurse prior to treatment that day and they told him you know better than to take them. He said he told the nursing staff, and no one listened. In an interview at 3:31PM, on 3/31/26 with LPN#3 (she confirmed that she did give the medications metoprolol and furosemide on 3/23/26 prior to the resident's dialysis appointment. She noted that there was no order to hold the drugs although she did confirm that she knows sometimes residents blood pressures can bottom out during dialysis treatment if they receive blood pressure pills prior to the procedure.In an interview with the Director of Nursing (DON) at 4:14 PM, on 3/31/26, she stated that the provider should have been (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	called by any one of the nurses administering the medications to Resident #14 to get a hold order or clarify the necessity of it being given. She stated that giving it prior to dialysis could have caused the resident's BP to drop to an unsafe level resulting in a possible trip to the emergency room or hospitalization. She further explained that when residents voice concern with medications being administered, nurses should investigate the manner but failed to do so in this instance. She also confirmed that medications should be accurately marked on the Medication Administration Record (MAR) to reflect whether they were given or not to avoid confusion.In an interview with Resident #14's dialysis nurse on 3/31/26 at 3:38 PM, she stated that it was reported to her one day last week (Monday) by the patient that he had taken his blood pressure medications prior to treatment. She stated that in his case, he was holding his medications prior to dialysis when he was living by himself prior to admission to the nursing home because his BP typically drops during dialysis treatment and if he takes his medications before treatment a consequence could be lower BP after treatment and difficulty getting it to come back up.In an interview at 12:09 PM on 4/1/26 with the Medical Director, he noted that while there typically has been a practice to hold BP meds prior to dialysis, there was never an established parameter that they have to be held. However, in the case of this resident, who had instructed nurses that he didn't normally take it because he had been instructed not to because he had a history of his blood pressure lowering during treatment, the nurses should have notified him to avoid lowering the resident's BP to an unsafe level and avoid complications.Record review of Resident #14's admission Record revealed the resident was admitted on [DATE] with diagnoses that included encounter for surgical aftercare following surgery on the genitourinary system.Record review of the Minimum Data Set (MDS) with an Assessment Reference (ARD) of 3/25/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.Record review of the March 2026 Medication Administration Record (MAR) revealed the resident had received Metoprolol 25mg and Furosemide 80mg at 8 AM prior to his 11AM dialysis appointments each time since his admission on [DATE] including the dates of 3/20/26,3/23/26, 3/25/26,3/27/26, and 3/30/26.Record review of the Order Summary Report with active orders as of 3/31/26 revealed orders dated 3/19/26 and start date of 3/20/26 for Metoprolol Succinate ER tablet Extended Release 24 Hour 25 mg (milligrams) Give 1 tablet by mouth one time a day related to Chronic Diastolic Congestive Heart Failure and Furosemide Oral Tablet 80mg give 80mg by mouth one time a day related to Chronic Diastolic Congestive Heart Failure.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interviews, record reviews, and facility policy review the facility failed to provide complete perineal (peri-care) for one (1) of two (2) residents observed for incontinent care. Resident #26Findings Include:Record review of the facility's policy Cather Care, Urinary dated 8/2022 revealed, .Routine Perineal Hygiene: 1. Wash basin, soap and water and washcloths; OR 2. Bathing wipes 3. Towels;4. Bed protector.Steps.1. Place the clean equipment on the bedside stand or overbed table. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Fill the basin over half (1/2) full of warm water (or if using bathing wipes, open the package). 4. Place the wash basin or wipes on the bedside stand within easy reach. 5. Put on gloves. On 03/31/2026 at 3:09 PM, during an observation of peri care provided by Certified Nursing Assistant (CNA)#1 revealed CNA #1 gathered gown, gloves and brief and knocked on the door and entered the room. She then donned (put on) a gown and gloves. CNA #1 then adjusted the bed remote with gloves on. She did not wash her hands prior to applying gloves upon entry. She did not remove gloves and perform hand hygiene after touching the remote. CNA #1 removed the soiled brief and applied a clean brief without providing peri care using peri wipes or soap and water.On 03 31/26 at 3:41 PM, in an interview CNA #1 confirmed that she did not completely do peri care. She stated she changed the brief but forgot to gather supplies to provide peri- care. She confirmed she did not perform hand hygiene upon entry, after touching the bed remote and prior to changing the brief. She confirmed that the resident's wound could get infected if he is still soiled. She stated she uses soap and water or peri wipes when doing care.On 03/31/26 at 4:08 PM, in an interview with the Director of Nursing (DON) stated CNA #1 should have washed her hands upon entry and after touching remote then applied clean gloves. She should have used soap and water or peri wipes to do care. She stated Resident #26 could get skin breakdown, wound infection, Urinary Tract Infection (UTI) and have a body odor. She stated she expects staff to give proper care.On 03/31/26 at 4:36 PM, in an interview with Registered Nurse #1/Infection Preventionist (RN)/IP stated CNA #1 should have washed hands upon entry and prior to care. She should remove gloves after touching the bed remote. She should have performed peri care with soap and water, not just apply clean brief to Resident #26. She stated it could have a negative effect on Resident #26. Resident #26 could get a UTI or infection of the sacral wound. She stated CNAs should provide high quality care.Record review of Resident #26 admission Record revealed admission date of 2/27/23 with diagnosis of Personal history of UTI's dated 1/15/26, Pressure ulcer of other site, stage 2 dated 11/18/25 and Local infection of the skin, subcutaneous tissue unspecified dated 3/26/26, Quadriplegia C1-C4 incomplete and contracture unspecified.Record review of Resident #26's Order Summary Report revealed a physician's order dated 3/24/26 to culture wound to sacrum one time only for wound healing and an order dated 3/26/26 for ceftriaxone injection solution reconstituted 1 gram intramuscularly one time a day for infection for 5 days.Record review of Resident #26's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/19/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Section GG revealed he is dependent for toileting and hygiene.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interviews, record reviews and facility policy review the facility failed to implement and maintain an effective infection prevention and control program to prevent the spread of infection, as evidenced by improperly stored and dated oxygen (O2) tubing for Resident #1, incomplete perineal care for Resident #26 and improper handling of food items for Resident #27 for two (2) of three (3) days of survey. Findings include:Record review of the facility policy Departmental (Respiratory Therapy) Prevention of Infection dated 2/2018 revealed .Infection Control Considerations.7. Store the circuit in plastic bag, marked with date and resident's name, between uses . 9. Discard the administration set up every seven (7) days. Record review of the facility's Handwashing/Hand Hygiene, dated 12/2025 revealed, Hand hygiene is the primary means for preventing healthcare associated infections and the transmission of multidrug resistant organism (MRDO). This facility requires strict adherence to evidence-based hand hygiene practices for all personnel . Indications for hand hygiene 1. Hand hygiene is indicated: a. before touching a resident, b. before .handling food.g. after touching the resident's environment or belongings (e.g. bedrails, wheelchair, etc).Record review of the facility's Infection Control Policy dated 2001 revealed Purpose: To prevent, control and reduce the spread of infection among residents, staff and visitors in the facility, ensuring a safe and healthy environment.Resident #1On 03/30/2026 at 3:22 PM, observed Resident #1 sitting in a wheelchair with oxygen tubing beside the bed. The O2 tubing was not bagged and was wrapped around the O2 machine. The tubing was dated 3/19/26. Resident #1 stated he uses O2 sometimes.On 03/30/2026 at 3:26 PM, in an interview with Licensed Practical Nurse (LPN) #2 stated the tubing should be in a bag to prevent bacteria from getting on it. She stated the nurses are responsible for changing the tubing and the tubing should be changed weekly. She confirmed the tubing was not in a bag and was dated 3/19/26. On 03/31/2026 at 2:07 PM, in an interview the Director of Nursing (DON) stated oxygen tubing is supposed to be changed weekly. It should have been changed on 3/26/26. She stated the tubing should have been a bag. She stated the reason for putting it in a bag is to keep it off the floor and prevent infection. On 03/31/2026 at 2:16 PM, in an interview with Registered Nurse #1/Infection Preventionist (RN)/IP stated the tubing is supposed to be in a bag and it is changed weekly. We change tubing every Thursday. She confirmed that by not changing O2 tubing, it could put Resident #1 at risk for infection.Record review of Resident #1's admission Record revealed an admission date of 9/24/24 with diagnoses that included cerebral palsy and pneumonia.Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference (ARD) of 3/5/26 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicates the resident was cognitively intact. Record review of Resident #1's Order Listing Report revealed an order dated 2/24/26 Oxygen: Obtain SPO2(Peripheral capillary oxygen saturation) and apply oxygen 2L/min (liters/minute) via (by way of) nasal canula as needed to keep oxygen saturation > 92% check O2 sat(saturation) every shift.Resident #26During an observation of peri-care on 03/31/2026 at 3:09 PM, provided by Certified Nursing Assistant (CNA)#1 revealed CNA #1 gathered gown, gloves and brief and knocked on the door and entered the room. She then donned (put on) a gown and gloves. CNA #1 then adjusted the bed remote with gloves on. She did not wash her hands prior to applying gloves upon entry. She did not remove gloves and perform hand hygiene after touching the remote. CNA #1 removed the soiled brief and applied a clean brief without providing peri care using peri wipes or soap and water.During an interview on 03/31/26 at 3:41 PM, CNA #1 confirmed that she did not completely do peri care. She stated she changed the brief but forgot to gather supplies to provide peri- care. She confirmed she did not perform hand hygiene upon entry, after touching the bed remote and prior to changing the brief. She confirmed that the resident's wound could get infected if he is still soiled. She stated she uses soap and water or peri wipes when doing care.On 03/31/26 at 4:08 PM, in an interview with the Director of Nursing (DON) stated CNA #1 should have washed her hands upon entry and after touching remote then applied clean gloves. She should (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have used soap and water or peri wipes to do care. She stated Resident #26 could get skin breakdown, wound infection, urinary tract infection (UTI) and have a body odor. She stated she expects staff to give proper care.On 03/31/26 at 4:36 PM, in an interview with Registered Nurse #1/Infection Preventionist (RN)/IP stated CNA #1 should have washed hands upon entry and prior to care. She should remove gloves after touching bed remote. She should have performed peri care with soap and water, not just apply clean brief to Resident #26. She stated it could have a negative effect on Resident #26. Resident #26 could get another UTI or infection of the sacral wound. She stated CNAs should provide high quality care.Record review of Resident #26 admission Record revealed admission date of 2/27/23 with diagnoses that included Personal history of UTI's dated 1/15/26, Pressure ulcer of other site, stage 2 dated 11/18/25 and Local infection of the skin, subcutaneous tissue unspecified dated 3/26/26, Quadriplegia C1-C4 incomplete and contracture unspecified.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/19/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Section GG revealed he is dependent on toileting and hygiene.Resident #27On 03/30/26 at 12:12 PM an observation of various staff was setting up trays for residents. Medical Records (MR) staff placed a lunch tray in front of Resident #27. The tray contained mashed potatoes, green peas and a hamburger. The MR staff placed her bare left hand on his hamburger and cut it with a spoon.On 0/30/26 at 12:17 PM during an interview with MR staff she revealed she was unaware that she placed her bare hands-on Resident #27's food. She then recanted her statement and confirmed that she touched his hamburger. She stated she was trying to make sure he ate his food. She stated she should not have touched his food and that is cross contamination issue. On 03/31/26 at 2:07 PM, during an interview the Director of Nursing (DON) stated staff should never touch a resident's food with their bare hands. She stated it cross contamination issue with infection control. On 03/31/26 at 2:20 PM, in an interview with Registered Nurse #1(RN) /Infection Prevention stated staff should never touch residents' food with bare hands. She stated MR should have gotten resident another burger. She stated that it is cross contamination issue. She stated most residents are immune, compromised and this could cause the residents to get an infection.Record review of Resident #27 admission Record revealed an admission date of 10/24/25 with diagnoses that included malignant neoplasm of brain, unspecified and unspecified protein-calorie malnutrition.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/26/26 revealed a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident had sever cognitive impairment.Record review of Resident #27's Order Summary Report with active orders as of 3/31/26 revealed an order dated 10/24/25 for Regular diet, regular texture, regular/thin consistency.

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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 store and replace oxygen tubing in accordance with professional standards and facility policy for one (1) of two (2) residents reviewed for oxygen use. Resident #1. Findings include: Record review of the facility policy Departmental (Respiratory Therapy) Prevention of Infection dated 2/2018 revealed .Infection Control Considerations.7. Store the circuit in plastic bag, marked with date and resident's name, between uses . 9. Discard the administration set up every seven (7) days. On 03/30/2026 at 3:22 PM, observed Resident #1 sitting in a wheelchair with oxygen tubing beside the bed. The O2 tubing was not bagged and was wrapped around the O2 machine. The tubing was dated 3/19/26. Resident #1 stated he uses O2 sometimes.On 03/30/2026 at 3:26 PM, in an interview with Licensed Practical Nurse (LPN) #2 stated the tubing should be in a bag to prevent bacteria from getting on it. She stated the nurses are responsible for changing the tubing and the tubing should be changed weekly. She confirmed the tubing was not in a bag and was dated 3/19/26. On 03/31/2026 at 2:07 PM, in an interview the Director of Nursing (DON) stated oxygen tubing is supposed to be changed weekly. It should have been changed on 3/26/26. She stated the tubing should have been a bag. She stated the reason for putting it in a bag is to keep it off the floor and prevent infection. On 03/31/2026 at 2:16 PM, in an interview with Registered Nurse #1/Infection Preventionist (RN)/IP stated the tubing is supposed to be in a bag and it is changed weekly. We change tubing every Thursday. She confirmed that by not changing O2 tubing, it could put Resident #1 at risk for infection.Record review of the Order Listing Report revealed an order dated 2/24/26 Oxygen: Obtain SPO2(Peripheral capillary oxygen saturation) and apply oxygen 2L/min (liters/minute) via (by way of) nasal canula as needed to keep oxygen saturation > 92% check O2 sat(saturation) every shift.Record review of the admission Record revealed an admission date of 9/24/24 with diagnoses that included cerebral palsy and pneumonia. Record review of the Minimum Data Set (MDS) with an Assessment Reference (ARD) of 3/5/26 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicates the resident was cognitively intact.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure nursing staff were competent to perform duties related to safe medication administration and clinical decision making for one (1) of (1) residents reviewed for dialysis related care. Resident #14 Findings Include: Record review of the facility policy Administering Medications dated 2001 revealed Medications are administered in a safe and timely manner and as prescribed . 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having a potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to express concerns. 21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document not administered and the reason in the electronic record. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.During an interview on 03/31/2026 at 10:35 AM, Resident #14 stated that nurses in the facility were giving his blood pressure medications prior to his dialysis appointment even when he told them he couldn't take it because it would drop his blood pressure (BP) to an unsafe level. Resident #14 stated that he was holding the medication on dialysis days prior to his admission to the facility.Record review of the March 2026 Medication Administration Record (MAR) revealed the resident had received Metoprolol 25mg and Furosemide 80mg at 8 AM prior to his 11AM dialysis appointments each time since his admission on [DATE] including the dates of 3/20/26,3/23/26, 3/25/26,3/27/26, and 3/30/26.During an interview with Licensed Practical Nurse (LPN) #1 at 2:19 PM on 3/31/26, she confirmed that she has cared for the resident on 3/30/26 and 3/31/26 and confirmed that her documentation on the resident's Medication Administration Record (MAR) indicated that she gave the BP meds metoprolol and furosemide prior to his dialysis appointment on 3/30, but she stated she pulled them from the pack prior to administering and held them because they could lower his BP. She stated that she must have accidentally documented it as given, but she did not give it because nurses are taught not to give BP meds prior to dialysis because of the risk of hypotension.In an interview with LPN #2 at 2:25 PM on 3/31/26 she stated that the resident goes to dialysis on Mondays, Wednesdays, and Fridays and she took care of him on his dialysis days of 3/20/26 and 3/25/26. She confirmed that blood pressure meds such as metoprolol and furosemide should not be given prior to dialysis due to the fear of residents bottoming out while dialyzing. She stated that she didn't give blood pressure medications on the days prior to dialysis even though she charted that she did give them and just forgot to fix the documentation because it was hectic that day. She stated she didn't know to hold them prior to pulling the medications for the residents because there was no order in the system to hold before dialysis. She stated that the resident instructed her that he would not take them and refused.During a follow up interview with Resident #14 at 2:38 PM, on 3/31/26 he stated he never pulled any drugs out when the nurses gave them to him, so he took them every time, in fact he knows for certain he took them the day that he was given his flu vaccine on 3/25/26 because they were mixed in the cup with his other meds and he couldn't pick them out. He stated that he told the nurse that could kill him because he had dialysis later that day. He stated that he had notified the dialysis nurse prior to treatment that day and they told him you know better than to take them. He said he told the nursing staff, and no one listened. During an interview at 3:31PM, on 3/31/26 with LPN#3 she confirmed that she did give the medications metoprolol and furosemide on 3/23/26 prior to the resident's dialysis appointment. She noted that there was no order to hold the drugs although she did confirm that she knows sometimes residents blood pressures can bottom out during dialysis treatment if they receive blood pressure pills (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255221	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven Hall Health Care Center	101 Mills Street Brookhaven, MS 39601

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prior to the procedure.During an interview with Resident #14's dialysis nurse on 3/31/26 at 3:38 PM, she stated that it was reported to her one day last week (Monday) by the patient that he had taken his blood pressure medications prior to treatment. She stated that in his case, he was holding his medications prior to dialysis when he was living by himself prior to admission to the nursing home because his BP typically drops during dialysis treatment and if he takes his medications before treatment a consequence could be lower BP after treatment and difficulty getting it to come back up.During an interview with the Director of Nursing (DON) at 4:14 PM, on 3/31/26 she stated that the provider should have been called by any one of the nurses administering the medications to Resident #14 to get a hold order or clarify the necessity of it being given. She stated that giving it prior to dialysis could have caused the resident's BP to drop to an unsafe level resulting in a possible trip to the emergency room or hospitalization. She further explained that when residents voice concern with medications being administered, nurses should investigate the manner but failed to do so in this instance. She also confirmed that medications should be accurately marked on the Medication Administration Record (MAR) to reflect whether they were given or not to avoid confusion.In an interview at 12:09 PM on 4/1/26 with the Medical Director, he noted that while there typically has been a practice to hold BP meds prior to dialysis, there was never an established parameter that they have to be held. However, in the case of this resident, who had instructed nurses that he didn't normally take it because he had been instructed not to because he had a history of his blood pressure lowering during treatment, the nurses should have notified him to avoid lowering the resident's BP to an unsafe level and avoid complications.Record review of Resident #14's admission Record revealed the resident was admitted on [DATE] with diagnoses that included encounter for surgical aftercare following surgery on the genitourinary system.Record review of the Minimum Data Set (MDS) with an Assessment Reference (ARD) of 3/25/26 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.Record review of the Order Summary Report with active orders as of 3/31/26 revealed orders dated 3/19/26 and start date of 3/20/26 for Metoprolol Succinate ER tablet Extended Release 24 Hour 25 mg (milligrams) Give 1 tablet by mouth one time a day related to Chronic Diastolic Congestive Heart Failure and Furosemide Oral Tablet 80mg give 80mg by mouth one time a day related to Chronic Diastolic Congestive Heart Failure.