STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255226	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Natchez Rehabilitation and Healthcare Center	344 Arlington Avenue Natchez, MS 39120

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 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)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to identify and provide needed resident-centered care for a resident who is unable to carry out Activities of Daily Living (ADL) to maintain good personal hygiene for one (1) of three (3) sampled residents, Resident #1. Findings include:Record review of the admission Record for Resident #1, revealed the facility initially admitted the resident on 9/04/2018 and the resident had diagnoses of diabetes, schizophrenia, peripheral vascular disease (PVD), and malignant neoplasm of prostate.Record review of the Other Payment Assessment Minimum Data Set (MDS) with Assessment Reference Date (ARD) 9/29/25 for Resident #1 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severely impaired cognition. Record review of the Care Plan for Resident #1 revealed the resident had a Focus listed as Resident is at risk for further decline in cognition with intervention included as COMMUNICATION .The resident understands consistent, simple directive sentences. Provide the resident with necessary cues- stop and return if agitated. On 12/02/25 at 10:59 AM during a telephone interview with the complainant for Complaint 2668575, she revealed that she was concerned because the last time she had been able to visit in 2024 Resident #1 was wearing clothes wet with urine and had an odor.On 12/02/25 at 1:00 PM observation and interview revealed Resident #1 walking in the hallway of the facility and sitting in the front lobby. The resident was neat, clean, and dressed appropriately with a malodorous smell. Resident #1 had a slight, short, grey facial beard, and reported that the staff assisted him with shaving on his shower days and that he was satisfied with that.On 12/02/25 at 1:20 PM an interview with the Social Services Director (SSD) revealed she was familiar with Resident #1 and his family member who had his Power of Attorney. She stated that she had spoken several times with the complainant regarding care plans, care plan meetings and the financial account of Resident #1. She reported that the complainant had visited the facility last on 7/26/24 and that the complainant refused to sign paperwork related to becoming the Resident Representative (RR) for the resident, who preferred at the time to act as his own RR and at the time had the capability to do so. The SSD confirmed that in July to August 2025 Resident #1 had a change in cognition and behavior with increased confusion; she confirmed that the resident was no longer cognitively able to make decision for himself regarding his care.On 12/02/25 at 4:35 PM observation and interview with Resident #1 revealed the resident had a foul odor of urine and feces. He sat in a chair with [NAME] upholstery, when he stood up he left two wet spots on the chair and there were corresponding wet spots approximately five (5) inches by three (3) inches, approximately the size of a standard index card, on each side of the back of his cotton pants.On 12/02/25 at 4:45 PM observation of the Room of Resident #1 revealed Resident #1's bed was unmade and there was fecal matter on the fitted and top sheet on his bed, and the room had a foul odor of urine and feces observable from outside the resident's room in the hallway.On 12/02/25 at 4:50 PM observation of Resident #1 and interview with the Director of Nursing (DON) revealed she stated that Resident #1 smelled awful and noted that the resident had a colostomy bag and was incontinent of bladder and wore incontinence briefs, which he insisted on changing himself. She stated that the resident had a history of refusal of care. She said the resident also had history of picking at his colostomy bag resulting in leakage of his bag, but that the facility had not attempted any intervention to prevent the behavior. Observation revealed that during an interaction between the DON and Resident #1, the DON offered assistance to the resident with hygiene and the resident told the DON that he did not smell bad, which indicated a lack of self-awareness, but went with her willingly and without complaint to his room where the DON changed the sheets on the resident's bed, and provided supplies and assistance for hygiene and incontinence care for Resident #1 without problem. She stated that the residents also frequently refused bathing activities, and the facility staff had not attempted provision of incentives to cooperate with care.On 12/03/25 at 11:40 AM observation revealed Resident #1 was walking around in the hallway and lobby wearing cotton knit pants with an approximately three (3) by five (5) inch wet area in the middle of the seat of his pants. The resident's pants left a corresponding wet spot on the chair he sat in in the DON's office.On 12/03/25 at 2:45 PM an interview with Certified Nursing Assistant (CNA) #1 revealed the facility had provided in-service training via computer software regarding provision of care for residents with dementia, confusion and difficult behaviors. She confirmed that Resident #1 was able to provide some self-care and required supervision and set-up assistance. She explained that he required reminders and encouragement for bathing activities and that he would go change his pants if they became wet with urine