

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Compere NH Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 865 North Street Jackson, MS 39202	
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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on Residents' Rights review, record review and interviews the facility failed to prohibit the use of physical restraint to unnecessarily inhibit freedom of movement for one (1) of five (5) sampled residents. Resident #1. Findings Included:Record review of the facility document titled, Resident Rights Updated 4/04/25 revealed the document stated, Employees shall treat all residents with kindness, respect, and dignity .Record review of the facility policy titled, PHYSICAL RESTRAINT dated 2/20/2012 revealed the policy stated, Restrains shall only be used for the safety and well-being of the residents and only after other alternatives have been tried unsuccessfully, and only with the informed consent from the resident, physician and/or responsible party.Physical restrains shall not be used to limit resident mobility.Record review of the Incident Report dated 7/18/26 prepared by Licensed Practical Nurse (LPN) #1 revealed Resident #1 was in bed with sheet tied to each side rail.Record review of the Final Investigation Report-Alleged Unauthorized Physical Restraint dated 7/21/26 revealed that, On the morning of July 18, 2026, at approximately 7:00 AM Registered Nurse (RN) # 1 working the cart.observed (Resident #1) restrained in her bed with a flat sheet secured from one side rail to the opposite side rail across her torso . According to record review of the Facility Investigation and an interview with the Administrator on 2/27/26 at 11:50 AM and with the Director of Nurses (DON) on 2/27/26 at 2:20 PM Registered Nurse (RN) #1 and LPN #1 removed the sheet immediately, assessed Resident #1 and noted no injury or distress, the licensed nurses then provided instruction to all nursing staff on duty regarding the use of unauthorized restraints and initiated an investigation. The Administrator reported the incident to SA within the required state and federal timeframe along with the final report. The DON initiated a mandatory In-Service Training regarding Residents Rights and Restraints for all nursing staff on 7/18/26 documented on In-Service Training Record with attached sign-in sheet dated 7/18/26. The DON initiated an audit of one hundred percent (100%) of residents and ensured that no restraints had been applied to any other residents in the facility and documented observations on Restraints Audit dated 7/18/26. The DON instituted monitoring of residents for three months documented on Restraints Monitoring record dated 7/18/26 through 7/27/26 to ensure that no unauthorized restraints were in use for any resident. The facility held an ad hoc Quality Assurance (QA) meeting on 7/27/26 documented on Quality Assurance Committee Meeting Agenda with attached sign-in sheet.On 7/29/26 at 11:33 AM, telephone interview with Certified Nursing Assistant (CNA) #1 revealed that the (CNA) had worked the nightshift on 7/17/26 and Resident #1 had been awake throughout the night, and the nursing staff supervised her to prevent her from getting up because she had had several recent falls. CNA #1 revealed that at approximately 4:30 AM she and CNA #1 had assisted Resident #1 to transfer from Geri recliner into bed and she had taken a flat sheet and folded it and tied each end to a quarter side rail on the left and right over and across the torso of Resident #1, whom she reported went to sleep and was resting (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quietly in bed with the bed in the lowest position. She confirmed that she had tied the sheet across the bed to protect the resident and remind her not to get out of bed if she awoke while the aides were conducting rounds and in the rooms of other residents. Record review of the written statement dated 7/20/26 and signed by Nursing Assistant (NA) #1 revealed she stated, I stated that it was a restraint. I regret I didn't go to the other hall and let the other nurse know what transpired or asked for her to watch Resident, now I know that was an option. Record review of the written statement dated 7/18/26 and signed by RN #1 revealed she stated, Upon arrival to my shift at 7 a.m. I rounded Unit B and observed a flat sheet tied across (Resident #1) abdomen from (left) side rail to (right) side rail. The statement revealed she and LPN #1 immediately removed the sheet and assessed the resident and noted no injuries. Record review of the Individual Employee Timecard for CNA #1 revealed she clocked in for duty on 7/17/26 at 11:01 PM and clocked out at 7:03 AM the following morning. Record review of the Personnel Action for CNA #1 dated 7/18/26 and signed by the Administrator revealed that the resident was separated due to Failure to obey orders, Improper conduct, Violation of company rules, Carelessness and Oter and Remarks included, staff restrained resident using sheet and tied it to both siderails. Record review of the Notice of Termination for CNA #1 dated 7/20/26 and signed by the Administrator revealed that the CNA's employment at the facility was involuntarily terminated due to rule violation related to unauthorized use of a physical restraint of a resident and resident rights. On 7/27/26 at 11:50 AM, interview with the Administrator revealed that the facility had policies to ensure staff upheld the resident rights of each resident and prohibited the use of unauthorized restraints. She stated that the use of unauthorized restraints to prohibit the movement of a resident was strictly prohibited and encroached on the rights of the resident. She confirmed that in-service training was provided for all staff regarding resident rights and the employment of CNA #1 was terminated because her actions violated the rights of Resident #1 and facility policy. On 7/27/26 at 2:20 PM, an interview with the DON revealed that the facility had strict policy regarding the use of restraints and that the use of unauthorized restraints was not tolerated and was considered an action that would result in immediate termination of employment. She confirmed that Resident #1 had a personalized care plan with interventions to address her need for supervision and assistance while in and out of bed to provide for her safety and prevent falls that did not include restraints of any type. She confirmed the resident did not have a physician's order for any restraint. The DON confirmed that Resident #1 was out of the facility and admitted to an acute care facility at the time of the survey due to change of condition not related to the 7/18/26 incident. Record review of the admission Record for Resident #1 revealed the facility admitted her on 7/21/25 and she had diagnoses of dementia, hypertension and anxiety. Record review of the Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) 7/06/26 for Resident #1 revealed the facility assessed the resident had no Brief Interview for Mental Status (BIMS) score and documentation which indicated severely impaired cognitive skills for daily decision making and that the resident was dependent for bed mobility, surface-to-surface transfers and all activities of daily living. On 7/27/26 SA validated through record review of the Facility Investigation dated 7/18/26 and an interview with the Administrator on 7/27/26 at 11:50 AM and with the Director of Nurses (DON) on 7/27/26 at 2:20 PM that on 7/18/26 at approximately 7:00 AM RN #1 and LPN #1 removed the sheet immediately, assessed Resident #1 and noted no injury or distress, the licensed nurses then provided instruction to all nursing staff on duty regarding the use of unauthorized restraints and initiated an investigation. The Administrator reported the incident to SA within the required state and federal timeframe along with the final report according to record review of SA records. SA validated through record review of the Facility Investigation dated 7/18/26 and In-Service Training Records dated 7/18/26 and an interview with the Administrator on 7/27/26 at (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:50 AM and with the Director of Nurses (DON) on 7/27/26 at 2:20 PM that the DON initiated a mandatory In-Service Training regarding Residents Rights and Restraints for all nursing staff on 7/18/26 documented on In-Service Training Record with attached sign-in sheet dated 7/18/26. The SA validated through record review of the Facility Investigation dated 7/18/26 and Restraints Audit Record dated 7/18/26 an interview with the Administrator on 7/27/26 at 11:50 AM and with the Director of Nurses (DON) on 7/27/26 at 2:20 PM that the DON initiated an audit of one hundred percent (100%) of residents and ensured that no restraints had been applied to any other residents in the facility and documented observations on Restraints Audit dated 7/18/26. SA validated through record review of the Facility Investigation dated 7/18/26 and Restraint Monitory records and an interview with the Administrator on 7/27/26 at 11:50 AM and with the Director of Nurses (DON) on 7/27/26 at 2:20 PM that The DON instituted monitoring of residents for three months documented on Restraints Monitoring record dated 7/18/26 through 7/27/26 to ensure that no unauthorized restraints were in use for any resident. SA validated through record review of the Facility Investigation dated 7/18/26 and Quality Assurance Committee Meeting Agenda with attached sign-in sheet dated 7/27/26 and an interview with the Administrator on 7/27/26 at 11:50 AM and with the Director of Nurses (DON) on 7/27/26 at 2:20 PM that the facility held an ad hoc Quality Assurance (QA) meeting on 7/27/26 documented on Quality Assurance Committee Meeting Agenda with attached sign-in sheet.		