STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255270	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pontotoc Health & Rehab Center	278 West Eighth Street Pontotoc, MS 38863

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, facility policy review, and record review, the facility failed to implement the Activities of Daily Living (ADL) care plan for one (1) of 45 residents observed. (Resident #22) Findings Include: Review of facility policy titled, Comprehensive Plan of Care with revision date 2/17/25, revealed, It is the policy of this facility to .implement a comprehensive person-centered care plan for each resident .that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality . An observation on 12/01/2025 at 10:43 AM, with Resident #22 revealed the resident had hair on her upper lip measuring approximately one-half inch (1/2) in length and also on her chin measuring approximately one inch to one and one-half inches in length. Record review of the ADL care plan revealed, The resident has an ADL self-care performance deficit . Interview on 12/03/2025 at 12:15 PM with the Minimum Data Set (MDS) Coordinator confirmed that care plans are created as a guide for staff to ensure resident specific care. She further confirmed that the ADL care plan was not implemented for Resident #22. Record review of the admission Record revealed Resident #22 was admitted to the facility on [DATE] with medical diagnoses that included Cerebrovascular Disease, Tremor, and Unspecified Lack of Coordination. Record review of the MDS assessment with Assessment Reference Date (ARD) of 11/26/25, revealed under section C, a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.

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	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review and facility policy review the facility failed to provide Activities of Daily Living (ADL) care to maintain personal hygiene for one (1) of 45 residents observed. (Resident #22) Findings Include: Review of facility policy titled, Activities of Daily Living (ADL) with revision date 9/15/2022, revealed, .Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene . During an observation on 12/01/2025 at 10:43 AM, with Resident #22 revealed the resident had hair on her upper lip measuring approximately one-half inch (1/2) in length and also on her chin measuring approximately one inch to one and one-half inches in length. During an interview on 12/02/2025 at 10:19 AM, with Licensed Practical Nurse (LPN) #1 revealed Certified Nursing Assistants (CNAs) are responsible for ensuring that facial hair is removed from female residents unless the resident or their responsible party refuses. During an interview on 12/02/2025 at 10:23 AM, with Certified Nursing Assistant (CNA) #1, revealed Resident #22 did have very long facial hair on her chin and upper lip yesterday, 12/01/25. She stated that she did shave the resident today. She verified that removing facial hair on female residents was part of daily ADL care and that CNAs were responsible for that. She verbalized that Resident #22's family wanted her to be free from facial hair. She further verbalized that female residents should not have unwanted facial hair and it should be removed daily as needed. During an interview on 12/02/2025 at 10:36 AM with the Director of Nursing (DON), she confirmed that CNAs were responsible for daily ADL care which included removal of facial hair for female residents unless resident/family refused. She further verbalized that unwanted facial hair on female residents should be taken care of on a daily basis. Record review of the admission Record revealed Resident #22 was admitted to the facility on [DATE] with medical diagnoses that included Cerebrovascular Disease, Tremor, and Unspecified Lack of Coordination. Record review of the MDS assessment with Assessment Reference Date (ARD) of 11/26/25, revealed under section C, a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.

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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 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, resident and staff interview, record review and facility policy review the facility failed to ensure that a urinary catheter and urinary leg bag were secured correctly and maintained below the level of the bladder, resulting in the potential for backflow of urine, catheter dislodgement, and compromised urinary drainage for one (1) of two (2) residents reviewed with an indwelling catheter (Resident #9). Findings Include:Review of the facility policy titled Bladder and Bowel Habits, Urinary Incontinence and Catheter Care. with a revision date of 9/15/2022 revealed under Catheter Care; Catheter care shall follow these guidelines: The catheter bag must be kept in a patent position (below the level of the bladder). During an observation and interview on 12/01/2025 at 10:45 AM, an observation revealed a Velcro strap secured around Resident #9's left ankle, anchoring a urinary catheter tubing and a 600 cubic centimeter (cc) urinary leg bag, which was noted hanging off the lower left side of the bed and had approximately 300 cc of urine in the bag. Resident #9 revealed she has a catheter, and she had no idea why the strap was on her ankle. In an observation and interview on 12/01/2025 at 11:20 AM, Resident #9 was observed lying in bed with the Velcro strap securing the urinary tubing and the emptied urinary leg bag attached to the upper left positioning bar. The resident revealed they just came in, moved it from my ankle, and put it up here. The urinary drainage bag was positioned above Resident #9's bladder level. Resident #9 removed her covers to expose her left leg, and no urinary tube securement device was observed in place. An observation on 12/02/2025 at 8:35 AM, and again at 10:23 AM, revealed the white catheter leg strap remained secured to the upper left positioning bar, with the urinary leg bag hanging above the bladder level. During an observation and interview on 12/02/2025 at 11:30 AM, the urinary leg drainage bag remained suspended from the upper left positioning bar above the resident's bladder level and contained approximately 500 cc of yellow urine. The Director of Nurses (DON) stated, Oh, this bag needs to be emptied, and confirmed the drainage bag was improperly positioned above the bladder and not securely anchored. Resident #9 stated that she was instructed during a recent hospital stay that The bag was supposed to be kept low. The DON acknowledged that failing to secure the drainage bag and keeping it below bladder level could cause backflow of urine and increase the risk of catheter dislodgement. During an interview on 12/02/2025 at 3:24 PM, the Nurse Consultant confirmed that the urinary drainage bag must always be positioned below the bladder to ensure proper urine flow and that the catheter tubing must be properly secured to ensure proper placement. Record review of the admission Record revealed the facility admitted Resident #9 on 7/9/2024 with medical diagnoses that include Chronic Kidney Disease, Stage 3A, and retention of urine. Record review of Resident #9's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/25, revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact.