STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255287	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pass Christian Health and Rehabiliation Center	538 Menge Avenue Pass Christian, MS 39571

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure medications were properly secured, safeguarded, and tracked to prevent misappropriation of resident property, resulting in a prescribed injectable medication pen being unaccounted for and lost for one (1) of four (4) residents reviewed for medication diversion. Resident #1.Findings included:A policy review of the facility's Abuse/Neglect/Exploitation & Misappropriation policy, revised 11/16/2022, defined misappropriation as the deliberate misplacement, exploitation, or wrongful use of a resident's property, including diversion of medications for staff use or personal gain.A policy review of the facility's Medication Storage policy, revised 11/7/2025, revealed all medications must be secured in locked compartments, accessible only to authorized personnel, and remain under direct observation during medication pass or secured at all times to prevent loss or diversion.A policy review of the facility's Controlled Substance Administration & Accountability Policy revealed safeguards must be in place to prevent loss or diversion, including accurate documentation, reconciliation of delivered medications, and proper storage upon receipt.A record review of the pharmacy Packing Slip Proof of Delivery revealed Resident #1's Mounjaro 5 mg (milligrams)/0.5 ml (milters) pens were delivered on 2/27/26 at 12:32 AM and electronically signed as received by Licensed Practical Nurse (LPN) #1.A record review of the facility's investigation Quality Improvement Data Collection Form dated 3/3/26 revealed that on 3/1/26 the facility was unable to locate the Mounjaro medication for Resident #1.A record review of the Controlled Substance Log dated 2/27/26 revealed the Mounjaro medication was not documented upon receipt, and no accountability record was initiated.A record review revealed no documentation to confirm the medication was secured in the medication refrigerator, no evidence of ongoing tracking, and no reconciliation of the medication after delivery.A record review of the Transfer/Discharge Report revealed the resident was admitted on [DATE] with diagnoses including type 2 diabetes mellitus.A record review of physician orders revealed Resident #1 was prescribed Tirzepatide (Mounjaro) 5 mg /0.5 ml for management of diabetes.During an interview on 4/14/26 at 10:00 AM, LPN #1 confirmed the medication was received and placed in the medication room refrigerator but was later discovered to be missing.During an interview on 4/14/26 at 11:00 AM, LPN #2 stated she ordered the medication on 2/26/26 and upon returning to work on 3/1/26, discovered the medication was not available. After contacting the pharmacy, she was informed the medication had been delivered on 2/27/26. LPN #2 reported the missing medication to the Director of Nursing (DON) and Administrator.During an interview on 4/14/26 at 11:15 AM, the pharmacist stated the facility is expected to verify all delivered medications within 24 hours and report discrepancies promptly. The pharmacist confirmed the facility did not notify the pharmacy of the missing medication until 3/2/26, despite delivery occurring on 2/27/26.During an interview on 4/14/26 at 11:30 AM, LPN #3 stated she and LPN #1 checked the medication delivery against the manifest; however, no documentation was completed to reflect receipt or secure storage, and the medication was not entered into the accountability log.During an interview on 4/14/26, the Director of Nursing (DON) confirmed the facility was unable to locate the medication and acknowledged there was no documentation to verify proper receipt, storage, or tracking of the medication. The DON further (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed the medication was not added to the controlled substance accountability log and that both the medication and associated documentation were missing. The DON stated staff were verbally re-educated following the incident.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure medications were documented in accordance with physician orders and professional standards of practice for one (1) of four (4) residents reviewed for receiving insulin. Nursing staff documented routine insulin as being administered several hours after the prescribed administration time. Resident #2.Findings include:Record review of the facility policy Medication Administration revealed Policy: Medications are to be administered. as ordered by the physician and in accordance with accepted professional standards of practice .12. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.20. Sign medication administration record (MAR) after administration.Record review of the Order Summary Report with active orders as of 2/1/26 revealed an order dated 1/6/26 for Insulin Glargine Subcutaneous Solution 100 unit/ml (milliliters) 49 units sq (subcutaneously) at bedtime for diabetes.A record review of the Location of Administration Report dated 2/1/26 through 2/28/26 revealed the following: On 2/6/27 medication ordered for 9PM was documented on 2/7/26 at 02:05 AM. On 2/11/26 medication was documented at 12:05 AM on 2/12/26. On 2/11/26 the medication was documented at 12:05 AM on 2/12/26. On 2/12/26 medication documented at 12:14 AM on 2/13/26. On 2/16/26 medication documented at 11:55 PM. On 2/17/26 medication documented at 11:43 PM. On 2/20/26 medication documented at 11:11 PM. On 2/21/26 medication documented at 11:44 PM. During an interview, on 4/14/26 at 10:00 AM, Licensed Practical Nurse (LPN) # 1 confirmed the insulin was documented outside of the ordered time frame. Staff were unable to provide a clinical rationale for documenting insulin several hours late. LPN #1 stated the resident was given the medication at the right time and stated she documented later when she has time. The nurse also stated, I try to the best I can. During an interview, on 4/14/26 at 10:30 AM, the Director of Nursing (DON) confirmed insulin is a time-critical medication and should be administered and documented as ordered. The DON acknowledged that administering insulin several hours after the scheduled time is not consistent with professional standards of practice and increases the risk for unstable blood glucose levels. The DON also stated the medication should be documented after being administered. During an interview, on 4/14/26 at 11:00 AM, the Administrator stated he expects nursing staff to follow physician orders and facility policy when administering medications.A record review of the admission Record revealed the resident was admitted on [DATE] with diagnoses that included chronic systolic (congestive) heart failure and type 2 diabetes without complications.A record review of the quarterly Minimum Data Set with an Assessment Reference Date of 2/8/26 revealed a Brief Interview for Mental Status score of 8 which indicated the resident had moderate cognitive impairment.