

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2025
NAME OF PROVIDER OR SUPPLIER  Senatobia Healthcare & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  402 Getwell Dr Senatobia, MS 38668	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interview, record review, and facility policy review, the facility failed to ensure residents were free from misappropriation of medications for two (2) of eight (8) residents reviewed for drug diversion (Residents #14 and #42). Findings include:</p> <p>Review of the facility policy titled, "Drug Diversion," undated, revealed: "Policy: This facility recognizes the risks associated with diversion of controlled medications and monitors staff with access to controlled substances to prevent diversion."</p> <p>During an interview with the Administrator on 8/5/25 at 12:30 PM regarding the facility-reported incident MS #477259, he stated that during the investigation, it was discovered that on 6/21/25 at 1:45 AM, agency Licensed Practical Nurse (LPN) #2 signed out an oxycodone for Resident #14 on the controlled substance log, but the medication was not documented on the Medication Administration Record (MAR) as given. He stated video from that date and time showed LPN #2 preparing and taking routine medications to Resident #14's room but not accessing the narcotic lock box. The Administrator stated that during the investigation of another concern, Resident #42 reported he received only one pain pill from the agency nurse working the evening shift on 6/24/25. He stated the resident reported requesting his pain medication later in the shift, but the nurse never returned. The Administrator stated he reviewed video footage from 6/24/25 (3:00 PM to 11:00 PM) and found that LPN #2 did not enter Resident #42's room at any time after approximately 4:00 PM, when she had administered earlier medications. He stated that at 10:50 PM, LPN #2 signed out one hydrocodone for Resident #42 on the controlled substance log and signed that it was administered; however, the video showed she never entered the resident's room. The Administrator stated the facility attempted to have LPN #2 return for an interview and drug screen, but she did not report back. He further stated that at the end of her shift, LPN #2 stated she did not have a ride home and slept for several hours on a couch in the day room before leaving the facility. He confirmed that LPN #2 was made a "Do Not Work" status with the contracted agency. He confirmed that the incident and investigation results were presented to the Quality Assurance (QAPI) committee during the committee meeting on 6/26/25 and again on 7/31/25 in which the Medical Director attended, the facility policy was reviewed with no revisions made. LPN # 2 was not allowed to work at the facility after 6/24/25 and all the required agencies were notified.</p> <p>Resident #14 Record review of the Controlled Substance Record for Resident #14 revealed Oxycodone 5 mg (milligrams) tablet, one tablet, signed out by LPN #2 on 6/21/25 at 1:45 AM.</p> <p>Record review of the June 2025 MAR for Resident #14 revealed no documentation that the medication was administered on 6/21/25.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the "admission Record" revealed Resident #14 was admitted on [DATE] with a diagnosis of Femur Fracture.</p> <p>Resident #42 Record review of the Controlled Substance Record for Resident #42 revealed Hydrocodone 10/325 mg, one tablet, signed out by LPN #2 on 6/24/25 at 10:50 PM.</p> <p>Record review of the June 2025 MAR revealed the medication was documented as administered.</p> <p>Record review of the "admission Record" revealed Resident #42 was admitted on [DATE] with a diagnosis of osteomyelitis.</p> <p>During an interview with the Director of Nurses (DON) on 8/5/25 at 1:00 PM, she stated LPN #2 worked agency shifts on 6/18/25, 6/19/25, 6/20/25, and 6/24/25. She stated she audited the narcotic records for residents assigned to agency LPN #2 and confirmed that oxycodone had been signed out for Resident #14 on the Controlled Medication form without documentation on the MAR as administered. She stated the nurse was also not observed to access the narcotic box during that time per facility video monitoring. The DON stated diversion of narcotics poses a risk because the medication may be taken by the individual, can lead to adverse consequences for residents, and is not the staff's property to take.</p> <p>In a continued interview with the DON on 8/6/25 at 12:00 PM, she stated she interviewed Resident #42, who was cognitively intact, on 6/25/25. The resident reported he did not receive his night medications on 6/24/25, including pain medication, and that the nurse never returned after an early evening visit. The DON revealed immediate in-services on diversion and misappropriation was initiated on 6/26/25 and continued until 7/2/25 when all nurses had been educated. She also confirmed narcotic reconciliation audits were completed on five (5) residents weekly for four weeks as well with no concerns.</p> <p>In an interview with LPN #1 on 8/5/25 at 1:30 PM, she stated that on the morning of 6/25/25, Resident #42 complained that the agency nurse had not given him his medication the previous night. LPN #1 stated she immediately informed the DON and the charge nurse.</p> <p>In an interview with Registered Charge Nurse #1 on 8/6/25 at 2:00 PM, she stated that during follow-up assessments of all residents assigned to the agency LPN #2 on 6/24/25 (3:00 PM to 11:00 PM), Resident #42 again reported the nurse only came into his room once early in the shift and never returned to provide pain medication or other evening medications. She stated she assessed the resident to have no adverse findings related to not receiving his medications. She also confirmed that the provider and resident representative was notified for every possible affected resident.</p> <p>Based on the implementation of the facility's corrective actions on 6/25/25, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 7/3/25.</p> <p>Validation:</p> <p>The SA validated on 8/5/2025, through interview and record review that all corrective actions had been implemented as of 7/3/25, and the facility was in compliance as of 7/3/25, prior to the SA's entrance on 8/4/2025.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interview, record review, and facility policy review, the facility failed to ensure residents were free from significant medication errors for six (6) of 29 residents reviewed for medication administration. (Residents #12, #42, #79, #84, #108, and #111) Findings include:</p> <p>Review of the facility policy titled "Medication Errors," last reviewed 6/30/25, revealed: "Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors."</p> <p>During an interview with the Administrator on 8/5/25 at 12:30 PM regarding facility-reported incident, he stated that on the morning of 6/25/25, the day shift nurse reported that several of the evening shift medications from 6/24/25 were still in sealed packets on the unopened medication cart. He stated that agency Licensed Practical Nurse (LPN) #2, who had worked the medication cart on that shift, had signed all of the medications as administered in the electronic record. The administrator confirmed he expected nursing staff to follow the facility policy and current standards of practice for medication administration to prevent significant medication errors. He confirmed that the incident and investigation results were presented to the Quality Assurance (QAPI) committee during the committee meeting on 6/26/25 and again on 7/31/25, in which the Medical Director attended, the facility policy was reviewed with no revisions made. LPN # 2 was not allowed to work at the facility after 6/24/25 and all the appropriate agencies were notified.</p> <p>Resident #12 Record review of the June 2025 Medication Administration Record (MAR) for Resident #12 revealed Midodrine 5 mg (milligrams) (alpha-1 adrenergic agonist &amp; vasopressor), three tablets by mouth three times daily for low blood pressure, documented as administered by agency LPN #2 on 6/24/25.</p> <p>Record review of the "admission Record" revealed Resident #12 was admitted on [DATE] with diagnosis including heart failure.</p> <p>Resident #42 Record review of the June 2025 MAR for Resident # 42 revealed Fluconazole 200 mg (antifungal) one tablet four times daily for Candida infection, documented as administered by agency LPN #2 on 6/24/25.</p> <p>Record review of the "admission Record" revealed Resident #42 was admitted on [DATE] with a diagnoses including local infection of the skin and subcutaneous tissue and osteomyelitis.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE], Section C, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.</p> <p>Resident #79 Record review of the June 2025 MAR for Resident # 79 revealed Divalproex Sodium (Depakote) 500 mg (anticonvulsant) one tablet by mouth twice daily for partial seizures, documented as administered by agency LPN #2 on 6/24/25.</p> <p>Record review of the "admission Record" revealed Resident #79 was admitted on [DATE] with a diagnosis of symptomatic epilepsy and epileptic syndrome with partial seizures.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #84Record review of the June 2025 MAR for Resident # 84 revealed Hydralazine 50 mg (vasodilator antihypertensive) 1.5 tablets by mouth three times daily for hypertension, documented as administered by agency LPN #2 on 6/24/25.</p> <p>Record review of the &amp;ldquo;admission Record&amp;rdquo; revealed Resident #84 was admitted on [DATE] with a diagnosis of essential hypertension.</p> <p>Resident #108Record review of the June 2025 MAR for Resident # 108 revealed Carvedilol 25 mg (beta-blocker &amp;ndash; antihypertensive) one tablet twice daily for hypertension. &amp;hellip; Baclofen 10 mg (skeletal muscle relaxant) one tablet three times daily for muscle spasms. &amp;hellip; and Losartan 25 mg (angiotensin II receptor blocker &amp;ndash; antihypertensive) one tablet twice daily for hypertension, all documented as administered by agency LPN #2 on 6/24/25.</p> <p>Record review of the &amp;ldquo;admission Record&amp;rdquo; revealed Resident #108 was admitted on [DATE] with a diagnosis of hypertensive heart disease with heart failure and muscle spasm of the back.</p> <p>Resident #111Record review of the June 2025 MAR for Resident # 111 revealed Levetiracetam (Keppra) 750 mg (anticonvulsant) 1.5 tablets by mouth twice daily for seizure disorder, documented as administered by agency LPN #2 on 6/24/25.</p> <p>Record review of the &amp;ldquo;admission Record&amp;rdquo; revealed Resident #111 was admitted on [DATE] with a diagnosis of symptomatic epilepsy and epileptic syndrome with partial seizures.</p> <p>An interview with the Director of Nursing (DON) on 8/5/25 at 1:00 PM revealed she reviewed the medication records for all residents assigned to LPN #2 on 6/24/25 and confirmed that multiple medications were documented as given but were still in sealed packets on the medication cart the next morning. She stated that missed scheduled medications could result in adverse consequences, including elevated blood pressure, elevated pulse, anxiety, depression, and seizure activity. She confirmed the missed doses for Residents #12, #42, #79, #84, #108, and #111 were considered significant medication errors.</p> <p>During a continued interview with the DON on 8/6/25 at 12:00 PM, she stated she interviewed Resident #42, who reported he did not receive his night medications on 6/24/25, including pain medication, and that the nurse never returned to his room despite his calls. She stated LPN #2 later claimed she had computer issues, was behind on med pass, and signed off the medications in the system after giving them, not realizing some remained on the cart. The DON confirmed all nursing staff were educated on medication administration and medication errors immediately starting 6/26/25 -7/2/25 when the in-services were completed. She stated medication skills checkoffs were also completed on three nurses weekly times four weeks.</p> <p>An interview with LPN #1 on 8/5/25 at 1:30 PM confirmed that she found multiple sealed medication packets on the cart during her morning medication pass on 6/25/25. She stated she assessed the affected residents and found no one in pain or distress, with only Resident #42 voicing a complaint that his medications were not given.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Registered Charge Nurse on 8/6/25 at 2:00 PM confirmed she was aware residents did not receive their evening medications on 6/24/25. She stated the unopened packets were found on the cart, and all affected residents were assessed for adverse consequences, with no negative findings noted. Resident #42 again reported the nurse only came into his room once early in the shift and never returned with his medications. She also confirmed that the provider and resident representative was notified for every affected resident.</p> <p>Based on the implementation of the facility's corrective actions on 6/25/25, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 7/3/25.</p> <p>Validation:</p> <p>The SA validated on 8/5/2025, through interview and record review that all corrective actions had been implemented as of 7/3/25, and the facility was in compliance as of 7/3/25, prior to the SA's entrance on 8/4/2025.</p>		