STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senatobia Healthcare & Rehab	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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, resident and staff interview, record review and facility policy review the facility failed to ensure medications were administered in accordance with physician's orders and accepted standards of practice for four (4) of 4 residents observed during medication administration observation on one (1) of two (2) halls. The facility's medication error rate was 100%. This had the potential to affect residents through delayed medication administration. Resident #1, Resident #2, Resident #3 and Resident #4. Cross Reference F760Findings Include: Review of the facility policy Medication Errors dated 09/09/25 revealed Policy Explanation and Compliance Guidelines .2. The facility must ensure that it is free of medication error rates of 5% or greater as well as significant medication error events An observation and interview on 05/13/26 at 10:48 AM with Licensed Practical Nurse (LPN) #1 revealed that she was assigned to 27 residents today. She revealed that all residents should receive their medications within one hour of the time ordered and stated that the nurses had from an hour before until an hour after to get them done. LPN #1 revealed that she tried to prioritize, get the residents that complained about getting late medications first, and then she administered medications to the ones who didn't mind getting them late. She revealed that the nurses had many responsibilities and it was often hard to get their medications administered on time. She revealed that the nurses had to get their own resident vital signs, do minor treatments, give medications and they had certain days they had to work in the dining room during lunch. LPN #1 revealed that on the days she was assigned to the dining room, she had to leave her medication cart, help with lunch, and then resume her morning medication pass. She revealed that sometimes she could finish her medication pass by 11:00 AM and sometimes she would finish by 1:00 PM. LPN #1 revealed that she was running late today and had eleven more residents including Resident #1, Resident #2, Resident #3, and Resident #4 left to be caught up with morning medication pass. A phone interview at 11:09 AM with Anonymous Complainant, revealed that she was a nurse who previously worked at the facility and she was concerned about medications being administered late. She revealed that she reported this to the Administrator, the Registered Nurse (RN) Supervisor, and Director of Nursing (DON) while she worked there and nothing was done to correct it. She revealed that while working there, she had to prioritize residents with the most critical medications and catch the rest when she could and stated, these residents deserve better than this. She revealed that it was pure chaos some days trying to keep up and it was often 2:00 PM before she finished administering morning medications. Resident #1 An observation and interview on 05/13/26 at 12:15 PM with Resident # 1 revealed that her medications were late most of the time. She stated, If you consider eleven o'clock, one o'clock or two o'clock on time, then I'm getting them on time. She revealed that she had mentioned it before, but it didn't do any good. Resident #1 revealed that she was on a fluid pill and would like to get her medicines earlier. Record review of Resident #1's Medication Administration Record revealed that she had Acidophilus, Allopurinol, Digoxin, Diprolene External Ointment, Duloxetine Hydrochloride, Ergocalciferol, Estrace Vaginal Cream, Ezetimibe, Magnesium Oxide, Omeprazole, Potassium Chloride, Torsemide, Carvedilol, Colace, and Metformin ordered to be administered at 9:00 AM. Record review of Resident #1's Medication Administration History Report revealed that on 05/13/26, her 9:00 AM scheduled medications were administered late. Her morning (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications were signed as administered by LPN #1 at 11:04 AM. Record review of Resident #1's admission Record revealed an admission date of 11/28/24 and that she had diagnoses including Heart Failure and Unspecified Cardiac Arrhythmia. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/13/26 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated no cognitive deficits. Resident #3 An observation during medication passes with LPN #1, on 05/13/26 at 12:52 PM, revealed that Resident #3's 8:00 AM and 9:00 AM medications were administered late. Resident #3's medications were Albuterol Sulfate Inhalation Nebulization Solution, Allopurinol, Aspirin, Blink Tears Ophthalmic Solution, Breyna Inhalation Aerosol, Cranberry, Hemocyte-F, Lasix, Metoprolol Tartrate, Osteo Bi-Flex, Pataday Ophthalmic Solution, Preservision, Refresh Ophthalmic Solution, Sennosides, and Spironolactone. Record review of Resident #3's Administration History Report revealed that the medications Allopurinol and Aspirin were scheduled for 8:00 AM and Albuterol Sulfate Inhalation, Blink Tears Ophthalmic Solution, Breyna Inhalation Aerosol, Cranberry, Hemocyte-F, Lasix, Metoprolol Tartrate, Osteo Bi-Flex, Pataday Ophthalmic Solution, Preservision, Refresh Ophthalmic Solution, Sennosides, and Spironolactone were scheduled for 9:00 AM. Resident #3's medications were documented as administered by LPN #1 at 12:52 PM. Record review of Resident #3's admission Record revealed an admission date of 01/06/25 and that she had diagnoses that included Unspecified Heart Failure, Vascular Dementia, and Exudative Age-Related Macular Degeneration. Resident #2 An observation during medication passes on 05/13/26 with LPN #1, revealed that Resident #2 received her scheduled 9:00 AM medications at 1:08 PM. Resident #2's medications administered at this time were Ferrous Sulfate, Glycolax, Lactobacillus, Lamotrigine, Omeprazole, Sertraline Hydrochloride, Solifenacin Succinate, Apixaban, Lacosamide, Levetiracetam, Sennosides, and Midodrine. Record review of Resident #2's Administration History Report revealed that all of her scheduled 9:00 AM medications were administered at 1:08 PM. Resident #2's scheduled 9:00 AM medications were Ferrous Sulfate, Glycolax, Lactobacillus, Lamotrigine, Omeprazole, Sertraline Hydrochloride, Solifenacin Succinate, Apixaban, Lacosamide, Levetiracetam, Sennosides, and Midodrine. Record review of Resident #2's admission Record revealed an admission date of 11/18/24 and that she had diagnoses including Epilepsy, and Long Term (Current) Use of Anticoagulants. Resident #4 Record review of Resident #4's Administration History Report revealed that his scheduled 9:00 AM medications were documented as completed at 11:28 AM. His scheduled 9:00 AM medications were Aspirin, Carvedilol, Cholecalciferol, Colace, Cymbalta, Divalproex Sodium, Fish Oil Omega-3, Hemocyte Plus, Insulin Glargine, Lactulose, Lisinopril, Multivitamin-Minerals, and Oxcarbazepine. Record review of Resident #4's admission Record revealed an admission date of 12/01/17 and that he had diagnoses that included Type II Diabetes Mellitus and Unspecified Epilepsy. An interview on 05/13/26 at 1:20 PM with Registered Nurse (RN) Supervisor, revealed that she expected nurses to administer medications within a two-hour window of ordered time, they had from one hour before until one hour after. RN Supervisor revealed that if nurses had trouble completing medication administration timely, they should ask for help. She revealed that if medications could not be administered within the two-hour window, the medications should not be given, and they should call the provider and await further instructions. RN Supervisor also revealed that not administering medications within the ordered timeframe was not acceptable and agreed that this was considered medication errors. An interview and record review on 05/13/26 at 1:30 PM with Director of Nursing (DON), revealed that she expected nurses to administer medications within the required time frame. She revealed that they were busier during the day, and she realized that some days were harder than others, but the nurses should be able to get their medications administered timely. DON reviewed the Administration History Report on Resident #1, Resident #2, Resident #3, and Resident #4 and verified that fifty-five medications out of fifty-five ordered medications were administered late resulting in a one hundred percent error rate. She revealed that this failure could result in adverse reactions and stated this was not acceptable practice.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, resident and staff interview, record review and facility policy review the facility failed to administer physician ordered significant medications timely for one (1) of four (4) medication carts observed. Cross Reference F759Findings Include:Review of the facility policy Medication Errors dated 09/09/25 revealed, It is the policy of this facility to provide protection 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 .Resident #1On 05/13/26 at 12:15 PM an observation and interview with Resident # 1 revealed that her medications were late most of the time. She stated, If you consider eleven o'clock, one o'clock or two o'clock on time, then I'm getting them on time. She revealed that she had mentioned it before, but it didn't do any good. Resident #1 revealed that she would like to take her medications earlier. Record review of Resident #1's Medication Administration Record revealed an order for Digoxin 125 MCG (Micrograms) to Give 0.5 tablet by mouth one time a day every Monday, Tuesday, Wednesday, Thursday, Friday for Arrhythmias. This medication was ordered to be administered at 9:00 AM. Record review of Resident #1's Administration History Report revealed that on 05/13/26, her 9:00 AM scheduled Digoxin medication was administered late. It was administered by Licensed Practical Nurse (LPN) #1 at 11:04 AM which resulted in a significant medication that was given later than ordered by the physician. Record review of Resident #1's admission Record revealed an admission date of 11/28/24 and that she had diagnoses including Heart Failure and Unspecified Cardiac Arrhythmia. Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/13/26 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated no cognitive deficits. Resident #2On 05/13/26 at 1:08 PM an observation during medication administration pass with LPN #1 revealed that Resident #2 received her scheduled 9:00 AM medications four hours later than ordered. Resident #2's medications included Lamotrigine, Lacosamide, and Levetiracetam which resulted in significant medication given later than ordered by the physician. Record review of Resident #2's Administration History Report revealed that her scheduled 9:00 AM medications were administered at 1:08 PM by LPN #1. Resident #2's scheduled 9:00 AM medications included Lamotrigine 100mg, Lacosamide 200mg, and Levetiracetam 750 MG (2 tablets) for diagnosis of Epilepsy.Record review of Resident #2's admission Record revealed an admission date of 11/18/24 and that she had diagnoses including Epilepsy, and Long Term (Current) Use of Anticoagulants. Resident #4Record review of Resident #4's Administration History Report revealed that his scheduled 9:00 AM medications were documented as completed at 11:28 AM by LPN #1. His scheduled 9:00 AM medications included Divalproex Sodium Delayed Release 500mg for epilepsy, Insulin Glargine Solution 100 units/milliliter inject 40 units for diabetes, and Oxcarbazepine150 mg for epilepsy. Record review of Resident #4's admission Record revealed an admission date of 12/01/17 and that he had diagnoses that included Type II Diabetes Mellitus and Unspecified Epilepsy.On 05/13/26 at 1:30 PM an interview and record review with Director of Nursing (DON) revealed that she expected nurses to administer medications within the required time frame. She revealed that they were busier during the day, and she realized that some days were harder than others, but the nurses should be able to get their medications administered timely. DON reviewed the Administration History Report on Resident #1, Resident #2, and Resident #4 and verified that their medications were administered late and stated this was unacceptable practice. She confirmed that the medications Digoxin, Lamotrigine, Lacosamide, Levetiracetam, Divalproex Sodium, Insulin Glargine, and Oxcarbazepine were significant and could cause adverse outcomes if not given according to physician orders. She further revealed that not administering these drugs timely could result in increased seizure activity, worsening heart arrhythmias, and elevated blood sugars. An interview on 05/13/26 at 3:00 PM with facility Nurse Practitioner (NP), revealed that Levetiracetam, Lacosamide, Lamotrigine, and Divalproex Sodium were all anti-convulsant medications prescribed to treat seizures and that it was important that these (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications be administered on time to prevent possible complications. She revealed that if seizures were uncontrollable, administering these drugs late could result in possible breakthrough seizure activity. NP further revealed that consecutive late administration of these drugs increased the likelihood of adverse effects. She also revealed that Digoxin was a drug that treated abnormal heart rhythms and it required blood levels to be drawn routinely and confirmed that it was important for this drug to be administered timely as well.