

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER The Nichols Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1308 Highway 51 North Madison, MS 39110	
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. Based on interview, record review, and facility policy review, the facility failed to develop and implement a comprehensive, person-centered care plan to address a stage two pressure ulcer for one (1) of (1) residents reviewed for care planning. Resident #38. Findings Include:Record review of the facility's Care Plan policy updated 2/20/20 revealed Each resident will have a person-centered plan of care to identify problems, needs, and strengths that will identify how the interdisciplinary team will provide care .7. The care plan will be reviewed and/or revised at quarterly intervals in conjunction with the completion of MDS assessments (quarterly), significant change, annual and with changes in residents' condition as needed .On 03/26/2026 12:54 PM, in an interview with Registered Nurse (RN) #2/ Minimum Data Set (MDS) nurse stated that care plans are supposed to be updated by nurses on the floor when they receive a new physician order. She stated they discuss care plans in clinical and if it is not updated then she updates it. She stated the comprehensive care plan is used by nurses, Certified Nurse Assistants (CNAs) and physicians. She confirmed the care plan was not updated and should have been updated.On 03/26/2026 1:14 PM, in an interview with the Director of Nursing (DON) stated the area was put in the system as a skin tear. She stated the care plan should have been updated after the physician orders diagnosis as a stage two pressure wound. She stated the care plan is used by all staff to give care. She stated the nurses are responsible for updating the care plan as well as the nurse that takes the order off. She stated her expectations for all staff is to do what they are supposed to do.Record review of the Face Sheet for Resident #38 revealed an admission date of 9/20/24 with diagnoses that included Pressure ulcer of right ankle, Stage 2 with an onset date of 3/16/26.Record review of Resident #38 Order Summary Report' revealed an order dated 3/17/26 Clean Stage 2 pressure ulcer to right ankle with wound cleanser. Pat dry. Apply calcium alginate to wound bed. Cover with bordered foam. every day shift related to PRESSURE ULCER OF RIGHT ANKLE, STAGE 2. Record review of Resident #38's Minimum Data Set (MDS) with Assessment Reference Date (ARD) 12/21/25 revealed a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident has severe cognitive impairment. Record review of Resident #38 comprehensive care plans revealed there were no goals or interventions related to the stage 2 pressure area on Resident #38's right ankle.		

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to provide psychiatric services in accordance with professional standards of practice for one (1) of three (3) residents reviewed for unnecessary medications, Resident #53. Findings Include: Record review of the facility policy Behavioral Health Services dated 4/01/18 revealed, It is the policy of this facility that all residents receive care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning. Record review of the Progress Notes dated 2/3/26 through 3/12/26 revealed no psychiatric follow up notes were available and a behavior was marked YES on the progress notes indicating behaviors had been present. During an interview on 3/26/26 at 10:45 AM, the Director of Nursing (DON), stated Resident #53 was not being followed by psychiatric services despite receiving an antipsychotic medication. She stated the facility manages short term residents differently and does not automatically initiate psychiatric consultations based on antipsychotic use. She stated a consult is only initiated if behaviors are observed and warrant evaluation. She confirmed Resident #53 had not been referred to psychiatric services. She further stated the facility does not have a policy specifying when psychiatric consultation should be obtained. During a follow up record review and interview on 3/26/26 at 11:21 AM, the DON confirmed the documented behavior entries but stated no descriptive notes were included. She stated the entries were made in error and attributed them to the nurse selecting options in the electronic record without supporting documentation. During an interview on 3/26/26 at 11:26 AM, Licensed Practical Nurse (LPN) # 2 stated that although no recent behaviors were observed, upon admission Resident #53 exhibited confusion, restlessness, and cursing toward staff during care. The nurse also reported current concerns including poor oral intake, with the resident often refusing facility meals and waiting for food from his wife. During an interview on 3/26/26 at 11:31 AM, Certified Nurse Aide (CNA) #1 stated Resident #53 does not typically exhibit inappropriate behaviors toward staff but has cursed at his wife when she attempted to assist with movement of his affected right side following a prior stroke. During an interview on 3/26/26 at 12:04 PM, LPN # 2 stated Resident #53 had not exhibited recent behaviors but demonstrated confusion, aggression, and cursing during the first week following admission. The nurse reported the resident's wife indicated he had been off his antipsychotic medication prior to admission. During a follow up interview on 3/26/26 at 12:38 PM, the DON stated psychiatric follow up is important for residents receiving antipsychotic medications to monitor for adverse effects such as changes in mental status, weight loss, mood changes, or behavioral changes. She stated when behaviors are identified, nursing staff should notify a practitioner, and a psychiatric evaluation would be appropriate. She also stated newly admitted rehabilitation residents may require closer monitoring due to recent transitions from acute care settings. Record review of the Minimum Data Set (MDS) with an Assessment Review Date (ARD) of 3/7/26 revealed a Brief Interview for Mental Status score (BIMS) of 11 which indicated moderate cognitive impairment. Record review of the Face Sheet revealed Resident #58 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease. Record review of the Order Summary Report revealed an order dated 1/30/26 for an antipsychotic drug Seroquel (Quetiapine) 100 milligrams (mg) by mouth at bedtime. There were no orders for a psychiatric consultation or follow up.		