

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Holmes County Long Term Care Center - Durant		STREET ADDRESS, CITY, STATE, ZIP CODE 15481 Bowling Green Road Durant, MS 39063	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and facility policy review, the facility failed to ensure food was reheated and held in accordance with safe food handling standards for one (1) of 1 meal service observed. Findings include: Review of the facility policy titled Monitoring Temperatures of Cooked Foods with review date 3/24, revealed, 1 .cooked foods, after being cooked to the required minimum internal temperature, will be held on hot holding equipment that will keep the food at a minimum 135 degrees Fahrenheit or higher .2 .b. When the food is placed in the hot holding equipment. The temperature of the food should be 135 degrees Fahrenheit or higher. If it is below 135 degrees Fahrenheit, the food is reheated to 165 degrees Fahrenheit for 15 seconds and placed back in the holding equipment .All parts of reheated cooked foods must reach 165 degrees Fahrenheit for 15 seconds .5. Foods are discarded after being reheated once .During a follow-up visit to the kitchen on 7/8/2026 at 10:49 AM to check temperatures on the holding/steam table, the following food items did not meet the required hot holding temperature of 135 degrees Fahrenheit: Pureed Pork Chops read 120 degrees Fahrenheit Pureed Tomatoes read 100 degrees Fahrenheit Pureed Roll 110 degrees Fahrenheit Chopped Pork Chops 125 degrees Fahrenheit Hamburger Patty (Alternate) 125 degrees Fahrenheit The Dietary Manager instructed her staff to reheat the above items in the oven. After the first reheating, the following items reached temperatures above the minimum hot holding temperature of 135 degrees Fahrenheit; however, they did not reach the required reheating temperature of 165 degrees Fahrenheit for 15 seconds: Pureed Roll reached 140 degrees Fahrenheit Chopped Pork Chops reached 140 degrees Fahrenheit Hamburger Patty reached 145 degrees Fahrenheit The Dietary Manager instructed staff to reheat the pureed pork chops and pureed tomatoes a second time. The pureed pork chops then reached 140 degrees Fahrenheit, and the pureed tomatoes reached 130 degrees Fahrenheit. The Dietary Manager then instructed her staff to reheat the pureed tomatoes in a pot on the stove. The pureed tomatoes then reached 150 degrees Fahrenheit. In an interview on 07/08/26 at 11:00 am with the Dietary Manager about the reheating process, the Dietary Manager stated, They normally do reheat the food items twice, sometimes three times. It was observed during that interview that one of the reheated food items reached the required reheating temperature of 165 degrees Fahrenheit for 15 seconds before being returned to hot holding equipment. During an interview on 7/8/2026 at 11:34 AM, the Registered Dietitian (RD) confirmed food items should only be reheated one time. She stated reheating food multiple times increased the potential for bacterial growth and contamination, and food should be discarded after one reheating.		

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews, and facility policy review, the facility failed to implement and maintain an effective infection prevention and control program by failing to ensure staff disinfected multi-use glucometers using the manufacturer's required two-minute wet contact time and handled blood-contaminated soiled linens in accordance with facility policy. Specifically, staff failed to properly disinfect multi-use glucometers between resident use for three (3) of four (4) finger-stick blood glucose observations and failed to properly contain and remove blood-contaminated linens for one (1) resident observed on two (2) of three (3) survey days, creating the potential for the transmission of infectious organisms. Findings Include: Review of facility policy titled Handling Soiled Linen updated July 2019, revealed, Policy: It is the policy of this facility to handle, store, process, and transport linen in a safe and sanitary method to prevent the spread of infection. Review of facility policy titled, Glucometer Control Monitoring and Cleaning, dated, 11/25, revealed, The glucose monitors are to be cleaned before and after each use by a moist cloth dampened with a multi-germicide cleaning solution per manufacturer's recommendations. Review of facility, Disposable Germicide Wipes, revealed, This product kills bacteria in two (2) minutes . On 07/08/2026 at 11:02 AM through 11:19 AM during observation of finger stick blood glucose (FSBG) with a multi-use glucometer for three (3) residents it was observed that Licensed Practical Nurse (LPN) #2 wiped the glucometer between resident FSBG checks for four to five seconds with the disposable germicide wipe and each time then laid the glucometer machine back on top of the medication cart without a barrier present. Interview with LPN#2 on 07/08/26 at 11:50 AM with the Administrator present, stated she wasn't sure how long she was supposed to clean and keep the glucometer wet with the germicide wipe or how long she should wipe it and stated I think I wiped it for about 10 seconds. LPN #2 stated, I just wipe it off and reuse it. Interview with the Administrator confirmed that the wipe showed it was a two-minute wet contact time in order to properly disinfect the glucometer machine and confirmed that a few seconds wasn't an appropriate kill time for bacteria. During a medication pass observation on 7/8/2026 at 12:05 PM with LPN #4, she performed a blood glucose check for Resident #6. After obtaining the blood sample, LPN #4 placed the used glucometer, with the used lancet still inserted, directly on the resident's bedside table without a protective barrier while the glucometer processed the blood sample. After obtaining the blood glucose reading, she placed the used glucometer directly onto the medication cart without a protective barrier. LPN #4 then wiped the glucometer with a Disposable Germicide Surface Wipe for approximately four (4) to five (5) seconds before storing the glucometer in the medication cart. Soiled Linen (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During initial rounds on 7/7/2026 at 10:35 AM, observation of Resident #47's room (A2-A) revealed soiled linens lying on the floor. Upon further observation, the towels contained a red substance consistent with blood. During an interview on 7/7/2026 at 10:43 AM, Certified Nursing Assistant (CNA) #2 stated Resident #47 had fallen earlier that morning and had been transported to the emergency department. She stated, I came in late and didn't get here until 8:30 AM today so this was left by the other shift. She further stated the towels contained blood because the resident sustained a head laceration. When questioned regarding proper handling of the soiled linens, she stated, I have to put gloves on and put the items in the laundry cart in the hall. During an interview on 7/7/2026 at 10:47 AM with LPN #5, she confirmed the linens were contaminated with blood from the resident's fall and should have been placed in a yellow biohazard bag and transported to the laundry biohazard barrel for processing. During an interview on 7/9/2026 at 9:52 AM, the Director of Nursing (DON) confirmed blood-contaminated soiled linens should not be left on the floor. She stated the linens should be placed in a yellow biohazard bag and transported to the laundry biohazard barrel for processing. She further confirmed this process should be followed by all clinical staff to help prevent the spread of infection.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, facility policy review, and staff interviews, the facility failed to ensure the residents' right to be free from physical restraints for one (1) of nineteen (19) sampled residents. Resident #35 Findings Include: Review of the facility policy titled Physical Restraints revealed, Restraints shall only be used for the safety and well-being of the residents and only after alternatives have been tried unsuccessfully. Record review of Resident #35's Order Summary Report did not reveal a physician order for the use of a seat belt and lack of quarterly assessments for restraints. Record review did not reveal a Care Plan addressing Resident #35s use of the seat belt. During an observation on 7/07/2026 at 11:47 AM, Resident #35 was observed wearing a seat belt while seated in his wheelchair in the dining room. During an observation and interview with Licensed Practical Nurse (LPN) #2 on 7/08/2026 at 11:45 AM, she stated, I have never seen him take off his seatbelt, and confirmed that the seatbelt would be a restraint. LPN #2 asked resident if he could take off his seat belt independently, Resident #35 was unable to answer the question, and he did not attempt to remove his seat belt. During an interview with the Administrator, she stated she was unaware Resident #35 was using a seat belt and confirmed that there was not a physician's order for the restraint and that there were no quarterly assessments completed. Record review of the admission Record revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/24/2026 revealed, under Section C, a Brief Interview for Mental Status (BIMS) with no score, indicating Resident #35 was severely cognitively impaired and was unable to answer the questions. Section P Restraints and Alarms, was coded as 0 not used, related to restraints while in wheelchair.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review, the facility failed to timely complete and transmit a discharge Minimum Data Set (MDS) assessment as required by the Centers for Medicare and Medicaid Services (CMS) guidelines for one (1) of nineteen (19) MDS reviews. Resident #1 Findings include: Review of the facility policy titled MDS Assessment, revealed It is the policy of this facility to follow the Resident Assessment Instrument (RAI) process as set forth by CMS protocol. Record review of Resident #1's MDS with an Assessment Reference Date (ARD) of 6/17/2026 revealed, under section Z0500, that the section had not been completed. An interview with the MDS Nurse on 7/09/2026 at 1:52 PM confirmed Resident #1 had discharged from the facility on 06/17/26 and went to the hospital and returned back to the facility on [DATE]. She confirmed that she had not completed the discharge assessment when the resident went out to the hospital. She explained that she was new to this position and confirmed that the assessments should be completed and submitted timely to have accurate resident information and for payment purposes. An interview with the Administrator on 7/09/26 at 1:54 PM revealed she expected the MDS assessment to be completed and submitted within the designated timeframe specified by CMS. Record review of the admission Record revealed the facility admitted Resident #1 on 12/11/2019 with medical diagnoses that included Unspecified Atrial Fibrillation. Record review of the MDS with an ARD of 6/17/2026 revealed, under Section C, a Brief Interview for Mental Status (BIMS) of 9, indicating Resident #1 was moderately cognitively impaired.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review, the facility failed to accurately code Section P of the Minimum Data Set (MDS) to reflect the resident's use of physical restraint for one (1) of nineteen (19) residents reviewed for MDS accuracy. Resident #35 Findings Include: Review of facility policy titled, MDS Assessment revealed, It is the policy of this facility to follow the Resident Assessment Instrument (RAI) process as set forth by Centers for Medicare and Medicaid Services (CMS) protocol. Record review of Resident #35's MDS with an Assessment Reference Date (ARD) of 6/24/2026 revealed Section P did not identify the resident's use of a seat belt as a physical restraint during the assessment reference period. During an interview on 7/09/2026 at 1:55 PM, the MDS Nurse confirmed Resident #35 used a seat belt during the assessment reference period and acknowledged the resident's use of the seat belt should have been coded in Section P of the MDS. Record review of the admission Record revealed Resident #35 was admitted on [DATE] with diagnoses including Unspecified Dementia. Record review of the MDS with an ARD of 6/24/2026 revealed, under Section C, a Brief Interview for Mental Status (BIMS) had no score, indicating Resident #35 was severely cognitively impaired.		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview, and facility policy review, the facility failed to notify the State Mental Health Authority of a resident with a significant change in status following an inpatient psychiatric admission for one (1) of four (4) Preadmission Screening and Resident Review (PASRR) reviewed. Resident #6 Findings Include:Record review of the facility policy titled Resident Assessment-Coordination with PASARR Program revealed under, Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Additionally revealed under, Policy Explanation and Compliance Guidelines: . 8. Any level II resident who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional resident review. Examples include: a. A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms.Record review of Resident #6's Pre-admission Screening Application dated 10/4/18 revealed a Level II PASRR was indicated with a primary diagnosis of Schizophrenia and a secondary diagnosis of Major Depressive Disorder.An interview with Resident #6 on 7/7/26 at 1:59 PM revealed she had been transferred to an inpatient psychiatric facility twice since being admitted to the facility. The resident stated the last time she was transferred was after cutting up her roommate's shirt with scissors to make a pillowcase.Record review of Resident #6's Behavior Note dated 8/10/25 revealed the resident threatened acts of violence toward multiple residents. Additionally, a note dated 8/14/25 revealed the resident was bullying residents, making threats, and cut up another resident's shirt.Record review of the resident's inpatient psychiatric Transition Record revealed the resident was admitted on [DATE] with a diagnosis of Paranoid Schizophrenia.An interview with Social Services (SS) on 7/8/26 at 3:45 PM revealed she was responsible for submitting PASRR referrals. She confirmed the resident had schizophrenia and required an inpatient psychiatric stay due to escalating aggressive behaviors and cutting up her roommate's shirt. SS acknowledged this constituted a significant change in the resident's status. She confirmed she did not submit a status change referral to notify the state mental health authority and stated she was not aware this was a requirement.An interview with the Director of Nursing (DON) on 7/9/26 at 8:50 AM revealed she did not have knowledge related to the PASRR process. She confirmed Resident #6 experienced a significant change in status and acknowledged all PASRR requirements should have been met to ensure the resident received the necessary care in the appropriate setting.Record review of the admission Record revealed the facility admitted Resident #6 on 10/3/18 with medical diagnoses that included Major Depressive Disorder, Schizophrenia, Unspecified, and Anxiety Disorder.Record review of the Brief Interview for Mental Status (BIMS) dated 4/10/26 revealed a summary score of 15, indicating Resident #6 was cognitively intact.		

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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 observations, resident and staff interviews, record reviews, and facility policy review, the facility failed to develop a comprehensive care plan for restraint use (Resident #35) and for physician-ordered dietary interventions (Resident #76) and the facility failed to implement care plan interventions for pain management (Resident #16) and nail care (Resident #37 and #60) for five (5) of 19 care plans reviewed. Resident #16, Resident #35, Resident #37, Resident #60, Resident #76 Findings Include: Review of the facility policy titled Care Plans-Comprehensive dated 10/2016, revealed, .An individual (person centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident . Resident #16 Record review of Resident #16's Care Plan Report revealed, Focus: Resident is at risk for pain .Interventions: Document type, location, and severity of pain .Give medications as ordered . On 7/08/2026 at 2:00 PM, during the Resident Council Meeting Resident #16 stated she had not received her prescribed pain medication since returning from the hospital. During a resident interview, Resident #16 stated she had requested the medication daily for one week and rated her pain as an 8 to 10. Record review of the physician orders and Medication Administration Record (MAR) revealed an active order for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (milligrams) dated 7/2/2026. Observation of the medication cart on 7/8/2026 at 3:00 PM, revealed Hydrocodone-Acetaminophen Oral Tablet 5-325 Milligrams (MG) was not available on the medication cart for administration for Resident #16. During an interview on 7/09/2026 at 8:10 AM, the Minimum Data Set (MDS) Nurse confirmed Resident #16's pain management comprehensive care plan had not been implemented. She stated the purpose of the care plan is to communicate the resident's individualized interventions and guide staff in providing care. Record review of the admission Record revealed Resident #16 was admitted to the facility on [DATE] with a diagnosis of Heart Failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/21/2026 revealed, under Section C, a Brief Interview for Mental Status (BIMS) was 15, indicating Resident #16 was cognitively intact. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #35 Review of Resident #35's comprehensive care plan revealed it had not been developed to address the resident's use of a seat belt. Record review of Resident #35's Order Summary Report did not reveal a physician order for the use of a seat belt. On 7/07/2026 at 11:47 AM, during an observation Resident #35 was observed wearing a seat belt while seated in his wheelchair in the dining room. During an interview on 7/09/2026 at 8:11 AM, the MDS Nurse confirmed Resident #35's comprehensive care plan did not address the resident's use of the seat belt. She stated the purpose of the care plan is to communicate the resident's individualized care needs and interventions to staff. Record review of the admission Record revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia. Record review of the MDS with an ARD of 6/24/2026 revealed, under Section C, a BIMS with no score, indicating Resident#35 was severely cognitively impaired. Resident #37 Record review of Resident #37's Diabetes Mellites comprehensive care plan revealed, Diabetic nail care weekly by the nurse on Thursday. On 7/7/2026 at 12:37 PM and again on 7/9/2026 at 8:38 AM during an observation and interview with Resident #37, his fingernails were observed to be approximately one and one-half (1 1/2) inches in length with a dark brown substance underneath. Resident #37 stated, they need to be cut. During an interview on 07/09/2026 at 11:40 AM, the MDS Nurse confirmed that Resident #37's Diabetes Mellitus comprehensive care plan was not implemented since his fingernails had not been cleaned or cut. She stated, The purpose of the care plan is to tell the staff exactly how to care for that person specifically. It should be a one-stop shop that guides their care. Record review of the admission Record indicated Resident #37 was admitted to the facility on [DATE] with medical diagnoses that included Type 2 Diabetes Mellitus with Hyperglycemia. Record review of the MDS, with an ARD of 4/21/2026, revealed under Section C a BIMS score of 15, indicating Resident #37 was cognitively intact. Resident #60Record review of Resident #60's Care Plan Report revealed under, Focus: I have diagnosis of Diabetes Mellitus. The care plan also revealed the following interventions: .Diabetic nail care weekly by nurse on Tuesday . Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails .On 7/7/26 at 11:09 AM, an observation and interview with Resident #60 (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed he was diabetic and needed his toenails cut. The resident stated he had been asking staff for a while but could not get anyone to do it, stating, They didn't seem interested in anything I had to say; Then I was told later on they would have to get podiatry, but I am still waiting. Observation revealed both great toenails were excessively long, curved, and thick, measuring approximately two (2) inches in length. The remaining toenails were long, measuring approximately one-fourth (1/4) inch, with jagged outer edges. An interview with the MDS Nurse on 7/9/26 at 11:38 AM confirmed Resident #60's care plan for nail care had not been followed. She stated the resident had a podiatry referral on his care plan; however, the podiatrist came on Fridays, and the resident attended dialysis on those days. Record review of the admission Record revealed the facility admitted Resident #60 on 8/19/22 with medical diagnoses that included End Stage Renal Disease and Type 2 Diabetes Mellitus with other diabetic kidney complications. Record review of the BIMS dated 4/17/26 revealed a summary score of 15, indicating Resident #60 was cognitively intact. Resident #76 Record review of Resident #76's comprehensive care plan revealed it had not been developed to address the physician-ordered dietary intervention of double portions. On 7/7/2026 at 10:30 AM during an interview Resident #76 stated he was supposed to get double portions with his meals, but he hasn't received that since he had been admitted . Record review of Resident #76's Order Summary Report revealed, Regular diet Regular texture, Regular liquids consistency, Double Portions Active 06/26/2026. During an interview on 07/09/2026 at 11:43 AM, the MDS Nurse confirmed that Resident #76's Dietary/Nutrition comprehensive care plan had not been developed. She stated, The purpose of the care plan is to tell the staff exactly how to care for that person specifically. Record review of the admission Record indicated Resident #76 was admitted to the facility on [DATE] with medical diagnoses that included Heart Failure. Record review of the MDS, with an ARD of 7/2/2026, revealed under Section C a BIMS score of 10, indicating Resident #76 was moderately cognitively impaired.		

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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 observations, staff interviews, record reviews, and facility policy review, the facility failed to follow the standards of nursing practice for three (3) of 24 residents observed during medication and treatment care observations. Resident #15, Resident #21 and Resident #37. Findings Include: Review of facility policy titled, Standards of Nursing Practice, dated 04/26, revealed, It is the policy of this facility to follow (Proper name) Nurse Practice Act and the (Proper name) Board of Nursing Scope of Practice for all standards of nursing care and documentation . Resident #15 During a medication pass observation on 7/9/2026 at 8:37 AM with Licensed Practical Nurse (LPN) #1, she completed Resident #15's scheduled 8:00 AM medication pass; however, she did not administer the physician-ordered 4-ounce house supplement. Record review of Resident #15's Medication Administration Record (MAR) for July 2026, revealed an active physician order for House Supplement two times a day .4 ounces . During an interview on 7/9/2026 at 10:30 AM with the Director of Nursing (DON) and LPN #1, review of the MAR revealed LPN #1 documented that the house supplement had been administered, although it had not been given during the observed medication pass. When questioned about the documentation, LPN #1 asked the DON, Is that the house supplement? Record review of the admission Record indicated Resident #15 was admitted to the facility on [DATE] with medical diagnoses that included Hemiplegia, unspecified affecting right dominant side. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/8/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 9, indicating Resident #15 had moderate cognitive impairment. Resident #21 Record review of the July 2026 MAR revealed an active physician's order dated 06/03/23, Scopolamine Transdermal Patch 72 hour, apply 1 patch transdermal one time a day every 3 days for increased secretions and remove per schedule. Review of the MAR revealed that on 07/05/26 and 07/08/26 it was initialed by LPN #1 that it was removed and applied for both days. Record review of an active physician's order on the July 2026 MAR revealed an order dated 08/06/25 revealed, Juven two times a day to promote wound healing mix with water (H2O) at 0800 (8:00 AM) and 2000 (8:00 PM). An observation during medication administration on 07/08/26 at 8:24 AM with LPN #1 it was observed that the nurse did not administer Juven and did not remove nor apply the Scopolamine patch as (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Holmes County Long Term Care Center - Durant		STREET ADDRESS, CITY, STATE, ZIP CODE 15481 Bowling Green Road Durant, MS 39063	
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered by the physician. During record review reconciliation of medications, it was observed on the record that LPN #1 had initialed that she had removed and applied the Scopolamine patch and had administered the Juven. Interview on 07/08/2026 at 9:30 AM with LPN #1 confirmed that she had initialed that she had removed and applied a Scopolamine patch and had marked it as completed on the MAR but confirmed that she had not completed either of the medication administrations. She stated, I don't have a patch to remove, she is out of the medicine. LPN #1 stated that she was out of the patch to administer when she was working on 07/02/26 and thinks she reordered it then but will have to check to make sure. LPN #1 then looks into the computer system and discovered that the scopolamine patch had not been reordered and ordered it during the interview on 07/08/26 at 9:30 AM. LPN #1 confirmed that she did not administer the Juven but had marked it as completed on the MAR and stated, I'll go give it right now. LPN #1 confirmed that it is against the standards of nursing practice to initial a medication as completed and given, when it had not been administered. Record review of a Progress Note, dated 07/05/26 at 15:25(3:25 PM), Reorder. Patch not available, signed by LPN #1 Interview on 07/09/2026 at 8:45 AM with the Infection Control (IC) nurse confirmed that it has been a concern for a while now that the nurses are not reordering medications when the residents run out and stated, I might just need to go through the carts and reorder the medications myself. Interview with the DON on 07/09/26 at 2:05 PM confirmed that the nurses knew better than to ever mark a medication as given if you don't have it to give and stated, That's falsifying documents, they know better than that. Record review of the admission Record revealed that Resident #21 was admitted to the facility on [DATE] with diagnosis that Dysphagia and Encounter for Attention to Gastrostomy. Record review of the MDS with an ARD of 05/22/26 revealed item C0100 was coded 0 on the BIMS indicating that the resident is rarely or never understood and interview should not be conducted. Resident #37 During an observation and interview with the DON on 7/9/2026 at 10:05 AM, she confirmed that Resident #37's fingernails were very long and dirty with a dark black/brown substance underneath. She confirmed Resident #37 had a physician order for weekly diabetic nail care documented on the Treatment Administration Record (TAR). Record review of the TAR, with the DON, revealed an order for Diabetic nail care weekly by nurse on Thursday. Diabetic nail care was documented as completed on 7/2/2026 by the Treatment Nurse. During an interview on 7/9/2026 at 10:26 AM, with the DON and the Treatment Nurse, the Treatment Nurse acknowledged he did not perform diabetic nail care for Resident #37 on 7/2/2026, although he (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented on the TAR that the care had been completed. During an interview on 7/9/2026 10:38 AM, the Administrator confirmed nurses should not document care that has not been provided or medications/supplements that have not been administered. Record review of the admission Record indicated Resident #37 was admitted to the facility on [DATE] with medical diagnoses that included Type 2 Diabetes Mellitus with Hyperglycemia. Record review of the Minimum Data Set (MDS), with an ARD of 4/21/2026, revealed under Section C a BIMS score of 15, indicating Resident #37 was cognitively intact.		

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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 observations, resident and staff interviews, record reviews, and facility policy review, the facility failed to ensure necessary nail care services were provided for residents requiring assistance for two (2) of eight (8) residents reviewed for activities of daily living (ADLs). Resident #37 and Resident #60 Findings Include: Review of facility policy titled Nail Care Policy dated 2/2026, revealed, .4. Routine nail care, to include trimming and filing, will be provided on a regular schedule identified by the facility. Nail care will be provided between scheduled occasions as the need arises . Resident #37 During observations and interviews with Resident #37 on 7/7/2026 at 12:37 PM and again on 7/9/2026 at 8:38 AM, his fingernails were observed to be approximately one and one-half (1 1/2) inches in length with a dark brown/black substance underneath. Resident #37 stated, They need to be cut. During an observation and interview with the Director of Nursing (DON) on 7/9/2026 at 10:05 AM, she confirmed that Resident #37's fingernails were very long and dirty with a dark black/brown substance underneath. She confirmed Resident #37 had a physician order for weekly diabetic nail care documented on the Treatment Administration Record (TAR). Record review of Resident #37's TAR for July 2026, revealed, .Diabetic nail care weekly by nurse on Thursday one time a day every Thursday. Record review of the admission Record indicated Resident #37 was admitted to the facility on [DATE] with medical diagnoses that included Type 2 Diabetes Mellitus with Hyperglycemia. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/21/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #37 was cognitively intact. Resident #60 An observation and interview with Resident #60 on 7/7/26 at 11:09 AM revealed he was diabetic and needed his toenails cut. He stated he had been asking staff for a while but could not get anyone to do it stating, They didn't seem interested in anything I had to say; Then I was told later on they would have to get podiatry, but I am still waiting. Both his big toenails were excessively long, curved and thick, measuring approximately 2 inches in length. His other toenails were long, measuring approximately one-fourth (1/4) inch with jagged outer edges. An observation and interview on 7/8/26 at 3:21 PM with Registered Nurse (RN) #1 revealed the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility has podiatry that comes to the facility monthly to cut the residents toenails. RN #1 stated she was not sure the last time the resident was seen explaining that Resident #60 goes to dialysis and he may have missed the podiatrist. She stated she was not aware of the residents' need for nail care. RN #1 confirmed his toenails were excessively long and jagged stating, I didn't know they had gotten this bad. She revealed the resident could have a skin concern and infection risk since he had diabetes. An interview with the Director of Nursing (DON) on 7/9/26 at 8:36 AM revealed that the staff should have addressed Resident #60's nailcare specifically because he was a diabetic. She acknowledged staff should have coordinated podiatry care on his offsite dialysis days confirming his risk were infection and skin concerns. Record review of the admission Record revealed the facility admitted Resident #60 on 8/19/22 with medical diagnoses that included End Stage Renal Disease and Type 2 Diabetes Mellitus with other Diabetic Kidney Complications. Record review of the BIMS dated 4/17/26 revealed a summary score of 15, indicating Resident #60 was cognitively intact.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews and facility policy review, the facility failed to provide uninterrupted enteral feedings for a resident who received nutrition through Percutaneous Endoscopic Gastrostomy (PEG) tube for one (1) of three (3) residents reviewed with PEG tubes for nutrition. Resident #21 Findings Include: Record review of the facility policy, with no date, titled Transcribing Physician Orders, stated, It is the policy of this facility to follow the attending physician's orders as written . Procedure: Orders will be followed and medications will be administered according to the prescribed physician's instruction Record review of the Medication Administration Record (MAR) revealed a physician's order dated 04/17/26, Enteral feed order two times a day for enteral feeding to run 22 hours daily related to Dysphagia. Two Cal @ (at) 50 milliliters (ml) hour (hr.) for 22 hr. Start at eight (8) PM to provide 2200 kcal (kilocalories), 92-gram protein . Observation on 07/08/2026 at 8:30 AM revealed that Resident #21's PEG feedings were not infusing and that there was a full bottle of Two Cal feeding with the tubing wrapped in paper that had not been set up and the feeding machine pump was turned off. Interview with Licensed Practical Nurse (LPN) #1 on 07/08/26 at 8:45 AM confirmed that the PEG feeding was not on, was not infusing and confirmed that she had arrived at work around 6:30 AM this morning and had not been in the resident's room until now to see that it wasn't infusing. LPN #1 confirmed that the feeding should only be off for two (2) hours and that it would have been turned off at 1800 (6:00 PM) last night and should have been turned back on at 2000 (8:00 PM) last night. Record review of the Treatment Administration Record (TAR) July 2026 revealed that on 07/07/26 it was initialed as turned off at 1800 and initialed as turned on at 2000. Interview with the Director of Nursing (DON) on 07/09/26 at 2:00 PM confirmed that LPN #1 had shared with her that the PEG feeding for Resident #21 was not infusing when she walked into the room. The DON confirmed that it should have been infusing in order to maintain eternal nutrition and because it was a physician's order that it should have been turned back on after two hours. Record review revealed that Resident #21 was admitted to the facility on [DATE] with diagnosis that Dysphagia and Encounter for Attention to Gastrostomy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/22/26 revealed Item C0100 was coded 0 on the Brief Interview for Mental Status Score (BIMS) indicating that the resident is rarely or never understood and interview should not be conducted.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure prescribed pain medication was administered and available as ordered for one (1) of six (6) residents interviewed during a Resident Council Meeting. Resident #16 Findings Include: Review of the facility policy titled Pain Assessment/Management revealed, It is the policy of this facility to provide guidelines in the identification and treatment of the residents at risk for acute and chronic pain. Each resident's pain will be assessed in an approach designed to increase comfort and promote dignity through administering alternative interventions or medications. During the Resident Council Meeting on 7/08/2026 at 2:00 PM, Resident #16 stated she had not received her prescribed pain medication since returning from the hospital a week ago. During a resident interview, Resident #16 stated she had requested the medication daily for one week and rated her pain as an 8 to 10. Record review of the physician orders and Medication Administration Record (MAR) revealed an active order for HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (milligrams) give one tablet by mouth every six (6) hours as needed for pain dated 7/2/2026. Record review of the MAR and pain assessments revealed documented pain scores of 0 during the period the ordered HYDROcodone-Acetaminophen Oral Tablet 5-325 MG was unavailable. Observation of the medication cart on 7/8/2026 at 3:00 PM, revealed HYDROcodone-Acetaminophen Oral Tablet 5-325 MG was not available on the medication cart for administration for Resident #16. During an interview with Licensed Practical Nurse (LPN) #1 at 3:01 PM confirmed there was no Hydrocodone-Acetaminophen Oral Tablet 5-325 MG available in the medication cart for Resident #16. LPN #1 confirmed there was an active physician order on the MAR for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG but that they did not have it to administer. On 7/08/2026 at 3:30 PM, an interview was conducted with the Administrator confirmed the medication order had been submitted to the pharmacy following the resident's return from the hospital; however, the medication had not been received by the facility. The Administrator confirmed Hydrocodone-Acetaminophen Oral Tablet 5-325 MG was not available for administration and acknowledged no follow-up had occurred to ensure the medication had been received from the pharmacy. Record review of the admission Record revealed Resident #16 was admitted to the facility on [DATE] with a diagnosis of Heart Failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/21/2026 revealed, under Section C, a Brief Interview for Mental Status (BIMS) was 15, indicating Resident #16 was cognitively intact.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews and facility policy review, the facility failed to provide pharmaceutical services to assure the accurate acquiring, receiving, and administering of all drugs and biologicals to meet the needs of each resident for one (1) of 29 medication administrations. Resident #21 Findings Include: Review of facility policy titled, Transcribing Physicians Orders, with no date, revealed, .Orders will be followed and medications will be administered according to the prescribed physician's instructions . Record review of the July 2026 Medication Administration Record (MAR) revealed an active physician's order dated 06/03/23, Scopolamine Transdermal Patch 72 hour, apply one (1) patch transdermal one time a day every three (3) days for increased secretions and remove per schedule. Review of the MAR revealed that on 07/05/26 and 07/08/26 it was initialed by LPN #1 that it was removed and applied for both days. On 07/08/26 at 8:24 AM an observation during medication administration with Licensed Practical Nurse (LPN) #1 it was observed that the nurse did not remove nor apply the Scopolamine patch as ordered by the physician. During record review reconciliation of medications, it was observed on the MAR that LPN #1 had initialed that she had removed and applied the Scopolamine patch on 07/05/26 and 07/08/26. On 07/08/2026 at 9:30 AM interview with LPN #1 confirmed that she had initialed that she had removed and applied a Scopolamine patch and had marked it as completed on the Medication Administration Record (MAR) but confirmed that she had not completed the medication administration. She stated, I don't have a patch to remove, she is out of the medicine. LPN #1 stated that the resident was out of the patch to administer when she was working on 07/02/26 and thinks she reordered it then but will have to check to make sure. LPN #1 then looks into the computer system and discovered that the scopolamine patch had not been reordered and she ordered it during the interview on 07/08/26 at 9:30 AM. LPN #1 confirmed that she thought it had been reordered but she just realized it had not and confirmed that the resident has been without the medication since 07/02/26 and the nurse on the medication cart who administered the last patch should have reordered the medication. Record review of a Progress Note, dated 07/05/26 at 15:25 (3:25 PM), Reorder. Patch not available, signed by LPN #1 On 07/09/2026 at 8:45 AM interview with the Infection Control (IC) nurse confirmed that it has been a concern for a while now that the nurses are not reordering medications when the residents run out and stated, I might just need to go through the carts and reorder the medications myself. On 07/09/26 at 2:05 PM interview with the DON confirmed that the nurse who gives the last of a medication should always reorder the medication and that it is just one click on the reorder button in the computer. Record review of the admission Record revealed that Resident #21 was admitted to the facility on [DATE] with diagnosis that Dysphagia and Encounter for Attention to Gastrostomy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/22/26 revealed Item C0100 was coded 0 on the Brief Interview for Mental Status Score (BIMS) indicating that the resident is rarely or never understood and interview should not be conducted.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the medication error rate was five (5) percent (%) or less for two (2) of twenty-nine medication opportunities. Medication error rate of 6.90% Findings Include: Review of facility policy titled Medication Error Rate Policy dated 3/2026, revealed, Policy: The facility is committed to maintaining a medication error rate of less than 5%, in accordance with Centers for Medicare and Medicaid Services (CMS) requirements for long-term care facilities. Medication administration practices will be monitored through routine medication pass observations, audits, and Quality Assurance and Performance Improvement (QAPI) activities . Resident #21 Record review of the [DATE] Medication Administration Record (MAR) revealed an active physician's order dated [DATE], Scopolamine Transdermal Patch 72 hour, apply one (1) patch transdermal one time a day every three (3) days for increased secretions and remove per schedule. Review of the MAR revealed that on [DATE] and [DATE] it was initialed by LPN #1 that it was removed and applied for both days. An observation of medication administration on [DATE] at 8:24 AM with Licensed Practical Nurse (LPN) #1 it was observed that the nurse did not remove nor apply the Scopolamine patch as ordered by the physician. During record review reconciliation of medications, it was observed on the MAR that LPN #1 had initialed that she had removed and applied the Scopolamine patch on [DATE] and [DATE]. Interview on [DATE] at 9:30 am with LPN #1 confirmed that she had initialed that she had removed and applied a Scopolamine patch and had marked it as completed on the Medication Administration Record (MAR) but confirmed that she had not completed the medication administration. She stated, I don't have a patch to remove, she is out of the medicine. LPN #1 stated that the resident was out of the patch to administer when she was working on [DATE] and thinks she reordered it then but will have to check to make sure. Record review of a Progress Note, dated [DATE] at 15:25 (3:25 PM), Reorder. Patch not available, signed by LPN #1. Record review of the admission Record revealed that Resident #21 was admitted to the facility on [DATE] with diagnosis that Dysphagia and Encounter for Attention to Gastrostomy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed Item C0100 was coded 0 on the Brief Interview for Mental Status (BIMS) indicating that the resident is rarely or never understood and interview should not be conducted. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23 Review of the facility policy titled Medication Administration Policy revealed, under Policy, Medications are administered by licensed nurses . as ordered by the physician and in accordance with professional standards of practice. Additionally, under Policy Explanation and Compliance Guidelines, the policy revealed, .10. Review MAR (Medication Administration Record) to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with the MAR to verify resident name, medication name, form, dose, route, and time. 12. Identify expiration date. If expired, notify the nurse manager . During a medication pass observation with Licensed Practical Nurse (LPN) #4 on [DATE] at 11:17 AM, LPN #4 administered Atrovent 0.03% (percent) nasal spray, one (1) spray into each nostril. Record review of Resident #23's [DATE] Medication Administration Record (MAR) revealed an order dated [DATE] for, Atrovent nasal spray solution 0.03% (percent) (Ipratropium Bromide (Nasal), two (2) sprays in both nostrils before meals related to Vasomotor Rhinitis. An interview with LPN #4 on [DATE] at 11:50 AM confirmed she administered one spray into each nostril to Resident #23 instead of the ordered two sprays. She stated she became nervous and made a mistake. LPN #4 further stated the resident required the medication for allergies and his condition could worsen if the medication was not administered as ordered by the physician. An interview with the Director of Nursing (DON) on [DATE] at 8:50 AM revealed her expectation was for nurses to review the MAR, compare the medication with the MAR to ensure accuracy, administer the medication as ordered, and then document administration. She stated the nurses were new graduates; however, her expectation was that all medications be administered as ordered. Record review of the Resident Dashboard revealed Resident #23 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia and Parkinson's Disease. Record review of the MDS with an ARD of [DATE] revealed, under Section C, a BIMS score of 15, indicating Resident #23 was cognitively intact.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and facility policy reviewed, the facility failed to properly secure and store medications for two (2) of four (4) medications carts. Medication cart B and Medication cart E. Findings Include: Record review of facility policy titled, Medication Storage in the Facility, with no date, stated, Medications and biologicals are stored safely, securely and properly Observation on [DATE] at 8:40 AM during medication administration on B hall medication cart revealed a bottle of liquid vitamin with an expiration date of 06/26. Interview with Licensed Practical Nurse (LPN) #1 confirmed that the liquid vitamin was expired and was in use for a resident and stated, Pharmacy comes once a month and usually checks our med carts for expired stuff and removes it, but I guess that one got missed. LPN #1 confirmed that she should have checked the expiration date before she prepared the medication for administration. An observation on [DATE] at 11:03 AM during medication administration with LPN #2 on E hall it was observed that the nurse had drawn up three (3) resident's insulin into syringes and left two (2) of the 3 insulin filled syringes unsecured on top of the medication cart and walked down the hall to the day room to administer an insulin to a resident. Interview with LPN #2 on [DATE] at 11:04 AM confirmed that she should have stored the insulin filled syringes in the locked medication cart and that was not safe to leave medications unsecured while she was away from the medication cart. Interview with the Director of Nursing (DON) on [DATE] at 2:05 PM confirmed that all medications should be checked for expirations prior to administering and that insulin and other medications should never be left unattended and unsecured while the nurse is away from the cart.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255332	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Holmes County Long Term Care Center - Durant		STREET ADDRESS, CITY, STATE, ZIP CODE 15481 Bowling Green Road Durant, MS 39063	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident and staff interviews, record reviews, and facility policy review, the facility failed to ensure hot meals were served at a palatable temperature for two (2) of four (4) residents reviewed for dining services. Residents #6 and #43 Findings Include: Review of the facility policy titled Food Palatability Policy dated 4/26 revealed under, Purpose: To ensure all residents receive meals that are palatable, appetizing, nutritious, and served at appropriate temperatures to promote adequate nutritional intake, resident satisfaction, and quality of life. Also revealed under, Procedure: . 2. Hot foods will be served hot . 6. Dietary leadership will routinely evaluate appearance, taste, texture, temperature, and acceptability .An interview with Resident #6 during the initial tour on 7/7/26 at 12:06 PM revealed she ate her meals in her room and stated her food was cold almost every meal. Resident #43, her roommate, stated her food was cold as well but reported she never voiced her concerns to the staff because she just ate it. An observation of the lunch meal served at 12:16 PM revealed Resident #6 was served a hot dog on a bun with French fries. She stated the meal was cold. The plate was not warm to the touch, and the resident touched a French fry stating, Here, feel. The French fry was observed cold to the touch. An observation of the dining room on 7/8/26 at 12:07 PM revealed lunch trays for C and D Hall were brought to the floor in a metal rolling food cart and picked up by an aide at 12:08 PM. Resident #43 received her tray first at 12:10 PM, followed by Resident #6. The meal consisted of fried pork chop, creamed potatoes, stewed tomatoes, and a biscuit. Both residents stated their food was cold. Resident #43 stated, Mine might be lukewarm bordering on cold and the biscuit is not warm at all. At that time, immediately after Resident #6 received her meal tray, it was requested the tray temperatures be obtained. The Dietary Manager (DM) came to the resident's room and tested the food temperatures at 12:17 PM. The pork chop measured 80 degrees, the stewed tomatoes measured 90 degrees, and the mashed potatoes measured 110 degrees. Both residents stated the food temperature was not acceptable and verbalized they preferred their food to be served warm. An interview with the Dietary Manager (DM) on 7/8/26 at 12:28 PM confirmed hot foods should be served warm and palatable to the residents. She stated staff check food temperatures in the kitchen, use dome plate covers, and transport hall trays in a covered cart. She further stated the kitchen did not use plate warmers because none were available, which could allow food to lose heat after it was plated. Record review of the admission Record revealed the facility admitted Resident #6 on 10/3/18 with medical diagnoses that included Major Depressive Disorder, Schizophrenia, Unspecified, and Anxiety Disorder. Record review of the Brief Interview for Mental Status (BIMS) dated 4/10/26 revealed a summary score of 15, indicating Resident #6 was cognitively intact. Record review of the admission Record revealed the facility admitted Resident #43 on 1/18/24 with medical diagnoses that included Allergic Rhinitis and Unspecified Dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/14/26 revealed under Section C a BIMS summary score of 8, indicating Resident #43 was moderately cognitively impaired.		

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NAME OF PROVIDER OR SUPPLIER Holmes County Long Term Care Center - Durant		STREET ADDRESS, CITY, STATE, ZIP CODE 15481 Bowling Green Road Durant, MS 39063	
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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to provide the necessary care and services to meet a resident's nutritional needs by failing to implement a physician-ordered dietary intervention for one (1) of fifty-six (56) residents reviewed. Resident #76 Findings include: Review of facility policy titled Large Portions with review date 12/23, revealed, Policy: Large portions will be served when ordered by the physician or requested by the consultant dietitian, Director of Food and Nutrition Services, or resident. Resident requests will be honored .Double portions are discouraged, but if ordered, two complete trays are delivered to the resident .During an interview on 7/7/2026 at 10:30 AM, Resident #76 stated he was supposed to receive double portions with his meals but had not received them since his admission. Review of Resident #76's Order Summary Report revealed, Regular diet Regular texture, Regular liquids consistency, Double Portions Active 06/26/2026. During an interview on 7/7/2026 at 12:32 PM, Resident #76 confirmed he did not receive double portions on his lunch tray. During an observation on 7/8/2026 at 12:13 PM, Resident #76's lunch tray was observed and did not include double portions. During an interview on 7/8/2026 at 12:18 PM, the Registered Dietitian (RD) confirmed Resident #76 had a physician order for double portions and stated, Typically I tell them to give two (2) trays when they have an order for double portions. She further stated the order for double portions was requested by the resident's family upon admission because he was a big eater. Record review of the admission Record indicated Resident #76 was admitted to the facility on [DATE] with medical diagnoses that included Heart Failure. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/2/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 10, indicating Resident #76 had moderate cognitive impairment.		