STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl River CO Nursing Home	305 West Moody Street Poplarville, MS 39470

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 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. 41306 Based on observation, interview, facility policy review, and record review, the facility failed to ensure a resident was free from the use of a physical restraint when facility staff loosely wrapped a resident's legs in a sheet to prevent the resident from removing his brief for one (1) of three (3) sampled residents. Resident #1 Findings include: A review of the facility policy, Use of Restraints, revised December 2007, revealed, .Policy Interpretation and Implementation 1. 'Physical Restraints' are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily .4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including .b. Tucking sheets so tightly that a bed-bound resident cannot move . A record review of the Admission Record revealed the facility admitted Resident #1 on 12/17/24 with diagnoses including Parkinson's Disease. A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident's cognition was severely impaired. A record review of the medical record revealed there was no documentation indicating Resident #1 had assessments, interventions, or Physician Orders for the use of a physical restraint. A record review of the Progress Note dated 5/8/25 at 6:18 (AM) revealed: AROUND 5:40 AM ON THIS MORNING 05/08/2025 THIS NURSE ENTERED THIS RESIDENT'S ROOM TO OBTAIN VITALS TO ADMINISTER MEDICATIONS. ONCE IN THE ROOM, THIS NURSE NOTICED THIS RESIDENT TUGGING AT HIS SHEET ON HIS LOWER EXTREMITIES .THIS NURSE FOUND THAT THE RESIDENT'S LEG HAD BEEN BOUND TOGETHER WITH TAPE .THE RESIDENT RESPONDED SAYING THANK YOU . The entry was signed by Licensed Practical Nurse (LPN) #1. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's investigation revealed that on 5/8/25, LPN #1 reported to the Director of Nursing (DON) that Resident #1 was found with a sheet wrapped around his legs and secured with tape. Certified Nurse Aides (CNAs) stated the intervention was used because the resident was frequently pulling off his brief and smearing feces. The tape was approximately six (6) inches long and placed mid-calf, over the sheet. The resident's arms and feet were not restricted. A red area was noted by the nurse, which resolved within an hour. On 5/19/25 at 6:15 PM, during an observation, Resident #1 was non-verbal, and was laying in his bed with sheets over his lower extremities. His bed was in the low position with a floor mat next to bed. On 5/20/25 at 10:00 AM, during an interview with LPN #1, she confirmed she found Resident #1 with his legs wrapped in a flat sheet and a piece of tape. She immediately removed the tape and sheet and notified the DON. She confirmed she did not leave the items in place for a witness to observe. On 5/20/25 at 10:20 AM, during an interview with CNA #1, she confirmed that she and CNA #2 attempted to prevent the resident from removing his brief by placing him in a burrito wrap using a sheet and secured it with tape. She confirmed he could move his arms and legs, and the tape was not in contact with his skin. On 5/20/25 at 12:24 PM, during an interview with CNA #2, she explained they wrapped the sheet around the resident's lower body and applied a six (6) inch piece of tape across the sheet to keep him from accessing his brief. She confirmed the intervention was not ordered or approved. On 5/20/25 at 12:30 PM, during an interview with the Director of Nursing, she confirmed the sheet and tape were applied to control the resident's behavior without a physician's order or care plan intervention. She stated the resident retained full movement of upper extremities and feet. There was no injury observed, and there was a reddened area that resolved within one (1) hour. She confirmed the intervention was deemed a violation of policy but not abuse. The CNAs involved received suspensions and re-education. On 5/20/25 at 12:45 PM, during an interview with the Administrator, she confirmed the incident was thoroughly investigated and concluded the resident retained the ability to remove the sheet and tape. She emphasized the action was a policy violation, not abuse, and the CNAs were suspended and retrained. She stated the State Agency would have been notified if criteria for abuse had been met. On 5/20/25 at 1:15 PM, during an interview with Registered Nurse (RN) #1 and the DON present, she confirmed that no bruises, scratches, or skin tears were observed. The healing scabbed area on the right calf had been present before the incident. She confirmed the tape did not touch the skin.