

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Carthage Senior Care		STREET ADDRESS, CITY, STATE, ZIP CODE 302 Ellis Street Carthage, MS 39051	
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review, facility policy review, and staff interviews, the facility failed to ensure physician-ordered pressure ulcer treatments were consistently provided and documented, and failed to complete and document timely weekly wound assessments for two (2) of two (2) residents reviewed for pressure ulcer care (Residents #3 and #6). These failures resulted in actual harm for Resident #6, whose pressure ulcer worsened and developed a documented infection requiring additional physician-ordered treatment, and placed Resident #3 at risk for delayed healing, wound deterioration, and infection. Findings Include: Review of the facility policy titled Wound Treatment Management, revealed Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.7. Treatments will be documented of the Treatment Administration Record (TAR) or in the electronic health record . Resident #3 Record review of Resident #3's May 2026 and June 2026 TARs revealed that physician ordered wound care for a Stage 3 pressure ulcer was not documented as completed for 19 of 53 days reviewed. Record review of Resident #3's May 2026 Electronic (E)TAR revealed no wound care was documented as completed for the days of 05/01, 05/11, 05/12, 05/13, 05/14, 05/15, 05/20, 05/26, 05/27, 05/28, and 05/29. Record review of Resident #3's June 2026 ETAR revealed no wound care documentation for the days of 06/03, 06/04, 06/12, 06/13, 06/15, 06/16, 06/17, and 06/18. Record review of Resident #3's May 2026 TAR revealed a physician order effective 04/29/26, Cleanse stage 3 (three) pressure ulcer of coccyx/sacral area with ns (normal saline), pat dry, apply calcium alginate with silver or gelling fiber dressing with silver, and cover with bordered foam or super absorbent bordered dressing daily and prn (as needed). This order was changed and discontinued on 06/03/26. Record review of Resident #3's June 2026 TAR revealed a physician order with start date 06/05/26, Cleanse Stage 3 pressure ulcer of coccyx/sacral area with 1/4 (one-fourth) strength Dakins solution, pat dry, apply calcium alginate with silver, then apply split drainage sponge, and cover with 6x6 bordered gauze daily and prn. (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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #3's admission Record revealed an initial admission date of 05/15/24, with diagnoses that included Unspecified Dementia and Pressure Ulcer of Sacral Region, Stage 3. Record review of Resident #3's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/21/26 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 09 which indicated that she had moderate cognitive deficits. Resident #6 Review of the May 2026 TAR dated 5/1/2026-5/31/26 revealed a Physician order to Cleanse Stage IV Pressure Ulcer to Sacrum with 1/4 strength Dakins solution. Pat dry, pack wound with gelling fiber dressing with silver (or calcium alginate with silver), apply skin prep to peri wound and cover with bordered foam dressing or bordered super absorbent dressing daily and PRN (as needed), with a Start Date of 2/25/2026, The wound care order was not signed off as completed for the days of May 1, 11, 12, 13, 14, 15, 27, 28, and 29. Review of the June 2026 TAR dated 6/1/2026-6/30/26 revealed a Physician order to Cleanse Stage IV Pressure Ulcer to Sacrum with 1/4 strength Dakins solution. Pat dry, pack wound with gelling fiber dressing with silver (or calcium alginate with silver), apply skin prep to peri wound and cover with bordered foam dressing or bordered super absorbent dressing daily and PRN (as needed), with a Start Date of 2/25/2026, No documentation for the dates of June 8, 12, 16, 18, and 20 was noted. Record Review of Resident #3's May 2026 and June 2026 TARs revealed that physician ordered wound care for a Stage IV pressure ulcer was not documented as completed for 14 of 53 days reviewed. Record review of Resident #6 Weekly Wound Observation Reports with an effective date of 5/6/26 revealed it was opened and electronically signed by the Wound Treatment Nurse on 5/13/26, indicating the assessment was not completed as of those effective dates. Record review of Resident #6's Weekly Wound Observation Report, with effective dates of 5/19/26, 5/26/26, and 6/2/26, revealed that they were all opened and electronically signed by the Wound Treatment nurse on 6/3/2026, indicating the assessments were not completed as of those effective dates. Record review of Resident #6's Weekly Wound Observation Report, with effective date of 6/2/26 revealed the wound had deteriorated, wound measurements increased from last week; wound measurements last week per clinic nurse 5/26 &ndash; 4.4 cm (centimeters) x (by) 2.3 cm x 0.6 cm depth; wound measurements today per this nurse 4.7 cm x 2.8 cm x 0.9 cm depth, undermining 12 (12 o'clock) 0.9 cm max. Record review of Resident #6 Weekly Wound Observation Report with effective date of 6/9/26 revealed it was opened and electronically signed by the wound treatment nurse on 6/15/26, indicating the assessment was not completed on the effective date. The pressure ulcer was documented as infected. The Nurses Narrative Wound Note revealed, This nurse gave (Proper Name of Wound Doctor) (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	final results of wound culture obtained on 6/3/26 for review;.verbal orders as follows Augmentin 850mg-125mg PO (by mouth) BID (two times a day) x 10 days due to presence of Proteus Mirabilis in wound bed, utilize contact isolation precautions due to presence of light growth of MRSA (methicillin resistant staph aureus) in wound bed. Record review of the Wound Care Progress Note by the Proper Name of Wound Care Physician Date of Visit: June 9, 2026, revealed the Sacral wound is not improving . Obtain wound culture. Previous wound culture is positive for Staph. Noted increased drainage. Slight redness over wound border. Plan: Obtain wound culture, Start Augmentin 875 milligrams (mg) twice a day (BID), apply Aquacel rope packing every day, offloading by turning side to side every (q) 2 hours, RTC (return to clinic) one week. Record review of Resident #6 Weekly Wound Observation Report with an effective date of 6/16/26 revealed it was opened and electronically signed by the wound treatment nurse on 6/22/26, indicating the assessment was not completed on the effective date. Record review of the Wound Care Progress Note by the Proper Name of Wound Care Physician Date of Visit: May 12, 2026, revealed the Sacral wound is unchanged. Record review of the Wound Care Progress Note by the Proper Name of Wound Care Physician Date of Visit: May 26, 2026, revealed the Sacral wound is unchanged. Record review of the Wound Care Progress Note by the Proper Name of Wound Care Physician Date of Visit: June 23, 2026, revealed the Sacral wound is unchanged. During an interview on 6/23/2026 at 2:30 PM, the Director of Nursing (DON) acknowledged there were gaps in the Treatment Administration Record (TAR) for May and June 2026. The DON confirmed that he was unable to verify through documentation or staff validation that the treatments had been completed on the dates in question. The DON revealed the wound treatment nurse had been counseled and received disciplinary action on 6/2/26 for failing to document wound care and weekly wound assessments. He further acknowledged he was unaware that wound treatments continued to go undocumented after the disciplinary action. The DON also confirmed that the Wound Treatment Nurse was not completing the Weekly Wound Observation Report in a timely matter. Interview on 6/23/2026 at 4:02 PM, Registered Nurse (RN) treatment nurse, acknowledged that she failed to document wound treatments for Resident #3 and Resident #6 on multiple occasions during May and June 2026. She stated that the building was so large and the floor staff frequently requested her assistance, that she became overwhelmed and fell behind on her documentation and weekly body audits. The wound treatment nurse acknowledged receiving disciplinary action on 6/2/2026 for failing to complete and document weekly wound assessments and confirmed that, despite the counseling, she continued to fail to complete wound treatments as ordered by the physician. During an interview on 06/24/2026 at 8:35 AM, the Administrator revealed she was unaware that, following the counseling and disciplinary action with the treatment nurse, there had been a continued lack of documentation for Residents #3 and #6. (continued on next page)		

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Centers for Medicare & Medicaid Services

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of the admission Record revealed Resident #6's initial admission date of 01/02/24 with diagnoses that included Alzheimer's Disease with Late Onset and Pressure Ulcer of Sacral Region, Stage 3. Record review of Resident #3's MDS with an ARD of 6/16/26 revealed a BIMS summary score of 99 indicating the resident was unable to complete the interview.		

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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 interview, record review and facility policy review, the facility failed to implement Activity of Daily Living (ADL) care plans for three (3) of 19 sampled residents. Resident #11, Resident #50, and Resident #60 Findings Include: Review of the facility policy titled Comprehensive Care Plans undated revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Resident #11 A record review of Resident #11's Care Plan Report revealed under Focus: Resident requires assistance with ADL's r/t (related to) weakness .Interventions . Nail care as needed or scheduled.On 6/22/26 at 1:05 PM an observation and interview revealed that Resident #11's fingernails on both hands were jagged and approximately one-half (1/2) inches past the tips of her fingers. A brown substance was observed underneath her nails. Resident #11 revealed, I don't do dishes anymore, so my fingernails get a lot of brown stuff underneath them, and further stated, When I used to do dishes, my nails were clean. I would like to have my nails trimmed and cleaned.Record review of the admission Record revealed Resident #11 was admitted to the facility on [DATE] with medical diagnoses that included Alzheimer's Disease and a need for assistance with personal care. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/28/26, revealed under Section C a Brief Interview for Minimum Status (BIMS) score of 10, which indicated Resident #11 is moderately cognitively impaired. Resident #50A review of Resident #50's Care Plan Report revealed under Focus: Resident requires assistance with ADL's r/t diagnoses, med regimen, fall risk and history, use of wheelchair. Interventions .Dependent with . personal hygiene.On 6/22/2026 at 12:55 PM an observation and interview revealed Resident #50 sitting in bed, repeatedly picking at her chin. Sporadic patches of facial hair were noted on her chin, approximately 1/4 inch in length. Resident #50 stated, I keep my fingers up here all the time trying to get these chin hairs picked out. Sometimes, my friends will say, oh, there you are, trying to pick those chin hairs out. She revealed I wish they would shave them off; I just don't like hair on my face. Record review of the admission Record revealed Resident #50 was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease and Alzheimer's Disease.Record review of the MDS with an ARD of 06/12/26, revealed under Section C a BIMS of 13, which indicated Resident #50 is cognitively intact. Resident #60A review of Resident #60's Care Plan Report revealed under Focus: Resident requires assistance with ADLs, . Interventions .Assist with personal hygiene & oral care daily & as needed or requested . On 6/22/2026 at 12:25 PM observation and interview revealed Resident #60 with approximately 1/4 inch sporadic facial hair on the sides of her mouth and chin area. Resident #60 stated, Oh yes, it's bad, I don't like having this chin hair and I want it shaved off.Record review of the admission Record revealed Resident #60 was admitted to the facility on [DATE] with medical diagnoses that included Alzheimer's Disease with late onset and need for assistance with personal care.Record review of the MDS with an ARD of 03/24/26, revealed under Section C a BIMS of 10, which indicated Resident #60 is moderately cognitively impaired. On 6/23/2026 from 2:05 PM to 2:30 PM during an interview and observation, CNA #2 revealed she is assigned to Residents #11, #50, and #60 today. CNA #2 confirmed Resident #11 had long, jagged fingernails with a brown substance underneath them and with the jagged nails she could scratch herself and cause a skin tear. She (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Resident #11 had received a shower earlier that day. I'm not sure why her fingernails were not cleaned. An observation revealed Resident #50 sitting in bed and picking at her chin hair with her fingers. CNA #2 confirmed that the resident had long facial hair and stated, I have honestly never shaven facial hair for any of the women residents that I have been assigned to. A continued observation and interview revealed Resident #60 with facial hair to her chin and sides of her mouth. She confirmed Resident #60 had facial hair approximately 1/4 inch long on her chin and sides of her mouth. On 6/23/2026 at 2:55 PM, during an interview Licensed Practical Nurse (LPN) #1 revealed that all residents should be adequately groomed, which included having their fingernails cleaned and trimmed, and also the female resident's facial hair should be removed and further revealed that this is part of their personal hygiene plan of care and if the residents were not clean like they should be then their plan of care was not being followed. On 6/25/2026 at 8:50 AM, the Registered Nurse (RN) MDS Coordinator revealed the purpose of the care plan is to direct staff in how they should provide care to each resident. She revealed that maintaining clean, trimmed fingernails and removing unwanted facial hair are part of personal hygiene. She confirmed that the ADL care plans had been developed for Residents #11, #50, and #60 and acknowledged that because their personal hygiene needs had not been adequately maintained, their plans of care had not been implemented as written.		

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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 review, and facility policy review, the facility failed to assist residents in maintaining acceptable personal hygiene as evidenced by failing to clean and trim fingernails (Resident #11) and failing to remove unwanted facial hair (Residents #50 and #60) for three (3) of 57 residents observed. Findings Include: Review of the facility policy titled ADL (Activity of Daily Living) Care Policy, dated 8/23, revealed, It is the policy of this facility to provide appropriate treatment and services in relation to ADL care to residents to ensure all ADL needs are met on a daily basis, while attaining or maintaining the residence of highest, practicable, physical, mental, and social well-being. Review of the facility policy titled Nail Care Policy, dated 2/26, revealed, .3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis .Resident #11An observation and interview on 6/22/26 at 1:05 PM revealed that Resident #11's fingernails on both hands were jagged and approximately one-half (1/2) inches past the tips of her fingers. A brown substance was observed underneath her nails. Resident #11 stated, I don't do dishes anymore, so my fingernails get a lot of brown stuff underneath them, and further stated, When I used to do dishes, my nails were clean. I would like to have my nails trimmed and cleaned. An observation on 6/23/26 at 1:25 PM, Resident #11's fingernails remained unchanged from the prior day. Record review of the admission Record revealed Resident #11 was admitted to the facility on [DATE] with medical diagnoses that included Alzheimer's Disease and a need for assistance with personal care. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/28/26, revealed under Section C a Brief Interview for Minimum Status (BIMS) of 10, which indicated Resident #11 is moderately cognitively impaired. Resident #50An observation and interview on 6/22/2026 at 12:55 PM revealed Resident #50 sitting in bed, repeatedly picking at her chin. Sporadic patches of facial hair were noted on her chin, approximately one-fourth (1/4) inch in length. Resident #50 stated, I keep my fingers up here all the time trying to get these chin hairs picked out. Sometimes, my friends will say, oh, there you are, trying to pick those chin hairs out. She stated, I wish they would shave them off; I just don't like hair on my face. Record review of the admission Record revealed Resident #50 was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease and Alzheimer's Disease. Record review of the MDS with an ARD of 06/12/26, revealed under Section C a BIMS of 13, which indicated Resident #50 is cognitively intact. Resident #60Observation and interview on 6/22/2026 at 12:25 PM, revealed Resident #60 with approximately 1/4 inch sporadic facial hair on the sides of her mouth and chin area. Resident #60 stated, Oh yes, it's bad, I don't like having this chin hair. I want it shaved off. An observation on 6/23/2026 at 11:00 AM revealed Resident #60's facial hair remained unchanged from the prior day. Record review of the admission Record revealed Resident #60 was admitted to the facility on [DATE] with medical diagnoses that included Alzheimer's Disease with late onset and need for assistance with personal care. Record review of the MDS with an ARD of 03/24/26, revealed under Section C a BIMS of 10, which indicated Resident #60 is moderately cognitively impaired. During an observation and interview on 6/23/2026 from 1:35 PM to 1:55 PM, Certified Nurse Aide (CNA) #3 stated that she is part of the shower team and that the resident's fingernails are cleaned when the resident receives a shower or bed bath. She revealed that for residents who are diabetic, the nurse is responsible for trimming their nails, and she wasn't sure whether Resident #11 was diabetic. She confirmed that Resident #11's fingernails were long and jagged and needed to be cleaned. CNA #3 further confirmed that Residents #50 and #60 had long facial hair and that she could shave it for them. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 6/23/2026 from 2:05 PM to 2:30 PM, CNA #2 revealed she is assigned to Residents #11, #50, and #60 today. CNA #2 confirmed Resident #11 had long, jagged fingernails with a brown substance underneath them and with the jagged nails she could scratch herself and cause a skin tear. CNA #2 stated, I can clean her fingernails, but I'm new to working on this hall and honestly have never done her nail care and am unsure if she is diabetic or not. She revealed Resident #11 had received a shower earlier that day. I'm not sure why her fingernails were not cleaned. An observation revealed Resident #50 sitting in bed and picking at her chin hair with her fingers. CNA #2 confirmed that the resident had long facial hair and stated, I have honestly never shaven facial hair for any of the women residents that I have been assigned to. A continued observation and interview revealed Resident #60 with facial hair to her chin and sides of her mouth. She confirmed Resident #60 had facial hair approximately 1/4 inch long on her chin and sides of her mouth. Resident #60 stated, I've not had my facial hair removed since I've been here at the facility. If I had a razor, I would do it myself. I just don't like all these chin hairs; they look terrible. CNA #2 revealed she would make sure that both Resident #50 and #60's facial hair is shaved. During an interview on 6/23/2026 at 2:55 PM, Licensed Practical Nurse (LPN) #1 revealed that all residents should be adequately groomed, which included having their fingernails cleaned and trimmed, and also the female resident's facial hair should be removed and further revealed that this is part of their personal hygiene care and each resident should be kept clean and presentable. In an interview on 6/24/2026 at 9:40 AM, the Director of Nurses (DON) revealed it is our expectation that our residents' personal hygiene is maintained, which also includes their fingernails to be kept clean and trimmed, and if the female resident chooses for their facial hair to be shaven, then that should be honored.		

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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. Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure medications were properly labeled, dated, and stored for one (1) of two (2) medication rooms and one (1) of two (2) medication carts reviewed (A Hall). Findings Include: Review of the facility policy, Medication Storage in the Facility, without a date, revealed, . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock and disposed of according to facility procedures . Observation of the A Hall medication room refrigerator with Licensed Practical Nurse (LPN) #1 on 06/24/2026 at 12:00 PM revealed one (1) opened vial of Novolog insulin dated 05/18/26 that remained in use beyond the manufacturer's recommended 28-day storage period after opening. During an interview on 06/24/2026 at 12:45 PM, LPN #1 confirmed the insulin remained in use beyond the 28-day expiration period. LPN #1 stated expired medications may become less effective and could cause a resident to become ill. She further stated expired insulin loses potency and may not effectively control blood glucose levels. During an interview on 06/24/2026 at 1:00 PM, the Director of Nursing (DON) stated insulin should be removed from use 28 days after opening. The DON stated nurses were responsible for monitoring expiration dates and acknowledged expired insulin may lose effectiveness. Observation of the A Hall medication cart on 06/24/2026 at 12:05 PM revealed an Albuterol HFA 90 microgram (mcg) inhaler remained in use beyond the manufacturer's printed expiration date of 04/08/2026. During an interview on 06/24/2026 at 12:45 PM, LPN #1 confirmed the inhaler remained in use beyond its expiration date and acknowledged expired medications may be less effective and could cause a resident to become ill. During an interview on 06/24/2026 at 1:00 PM, the DON stated expired inhalers should be removed from use, and nurses were responsible for monitoring expiration dates. The DON acknowledged expired inhalers may not be as effective. Observation on 06/24/26 at 12:06 PM of the A Hall medication storage area revealed one (1) bottle of chewable antacid tablets with an expiration date of 08/2025 that remained available for use. Interview with LPN #1 on 06/24/26 at 12:06 PM confirmed the medication remained available for administration despite being expired. Observation on 06/24/26 at 12:07 PM of the A Hall medication cart revealed the following medications had been opened but were not labeled with an opening date: Two (2) bottles of cough syrup One (1) bottle of liquid Acetaminophen One (1) bottle of liquid Iron supplement One (1) bottle of liquid laxative One (1) bottle of antacid One (1) bottle of Nasal Spray Interview with LPN #1 on 06/24/26 at 12:08 PM confirmed the medications were in use and lacked opening dates, preventing staff from determining whether the products remained within the manufacturer's recommended use period. She acknowledged expired medications may become less effective and could cause a resident to become ill. In an interview with the DON on 06/24/26 at 1:00 PM he confirmed medications should be labeled with the opening date when first opened and nurses were responsible for ensuring medications were appropriately dated and removed from use when expired. The DON acknowledged that without an opening date, staff could not determine whether the medications remained safe for administration.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review and facility policy review the facility failed to utilize Enhanced Barrier Precautions (EBP) during 2 (two) of 3 (three) care observations. Resident #3. Findings Include: Review of the facility policy Enhanced Barrier Precautions revealed It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .3. Implementation of Enhanced Barrier . b. PPE (Personal Protective Equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities 4. High-contact resident care activities include: .f. Changing briefs or assisting with toileting .g. Wound care: any skin opening requiring a dressing . An observation on 06/24/26 at 11:40 AM of Resident #3's wound care revealed non-adherence to enhanced barrier precautions. Registered Nurse (RN) Treatment Nurse washed her hands, applied clean gloves and failed to don a gown. She completed wound care to Resident #3's Stage 3 Pressure Ulcer to her sacrum as ordered by the physician. During the same observation, CNA #1 assisted with repositioning the resident and changed the resident's soiled brief following a bowel movement without wearing a gown. An interview with Certified Nursing Assistant (CNA) #1 on 06/24/26 at 3:00 PM revealed that residents requiring EBP were identified by a green dot outside the resident's room and included residents with wounds or indwelling devices. CNA #1 acknowledged Resident #3 required EBP and confirmed that she failed to wear the required gown while assisting with wound care and while providing incontinent care by changing the resident's soiled brief following a bowel movement. CNA #1 stated, I forgot because she caught me off guard, and acknowledged that both gloves and a gown should have been worn to prevent the transmission of germs during direct resident care. An interview on 06/24/26 at 3:15 PM with RN Treatment Nurse revealed that residents requiring EBP were identified by a green indicator outside the resident's room and that residents with wounds or indwelling devices required the use of both gowns and gloves during direct care. She confirmed that gowns were readily available and confirmed that she failed to wear the required gown while performing Resident #3's wound care, stating, I just forgot. RN Treatment Nurse acknowledged that failure to wear the appropriate PPE increased the risk of transmitting germs and could result in infection. An interview on 06/24/26 at 3:30 PM with Infection Preventionist revealed that the purpose of EBP was to reduce the transmission of infectious organisms between residents and healthcare personnel. She confirmed that gowns and gloves were readily available, and staff were expected to wear both gowns and gloves when providing direct care to residents with wounds or indwelling devices. She further confirmed that failure to follow EBP could result in the spread of germs and increased risk of infection. Record review of Resident #3's June 2026 Treatment Administration Record (TAR) revealed a physician order with start date 06/05/26, Cleanse Stage 3 pressure ulcer of coccyx/sacral area with 1/4 (one-fourth) strength Dakins solution, pat dry, apply calcium alginate with silver or gelling fiber dressing with silver, then apply split drainage sponge, and cover with 6x6 bordered gauze daily and prn. Record review of Resident #3's admission Record revealed an initial admission date of 05/15/24, with diagnoses including Unspecified Dementia and Pressure Ulcer of Sacral Region, Stage 3. Record review of Resident #3's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/21/26 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 09 which indicated that she had moderate cognitive deficits.		