STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A178	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jasper County NH	15 A South Sixth Street Bay Springs, MS 39422

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47873 Based on observation, record reviews, interviews, and facility policy review, the facility failed to treat residents in a dignified manner by posting clinical data in a resident room (Resident #85) and failing to knock before entering a resident's room (Resident #69) for two (2) of 21 sampled residents. Findings Include: A review of the facility's Dignity Policy, undated, revealed, .It is the policy of this facility to promote care for the residents .in a manner and environment that maintains or enhances each resident's dignity, with respect in full recognition of his or her individuality .Special Concerns .Respecting the resident's private space and property, knocking on doors and requesting permission to enter . Resident #69 On 11/5/23 at 12:10 PM, during an observation and interview with Licensed Practical Nurse (LPN) #2, Certified Nurse Aide (CNA) #2 entered Resident #69's room without knocking on the door, addressing the resident, or introducing herself and did not explain the purpose for her visit. CNA #2 placed the resident's meal tray on the bedside table, set it up for eating, and left the room. LPN #2 remarked that CNA #2's behavior did not align with proper protocol, noting that she should have knocked on the resident's door, waited for a response, entered the room, introduced herself, and explained the purpose for the visit. On 11/5/24 at 12:25 PM, in an interview with CNA #2, she admitted that she failed to knock on Resident #69's door before entering the room while the resident was receiving medication. She explained that her familiarity with the resident made her feel comfortable enough to skip this step, believing it would not offend the resident. However, she acknowledged her awareness of the facility's policy, which requires knocking, waiting for a response, and then entering the room with an introduction. CNA #2 confirmed that this protocol was included in her training program as well as during her orientation at the facility. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/6/24 at 9:00 AM, the Director of Nursing (DON) confirmed that CNA #2 should have knocked on Resident #6's door before entering the room. The DON emphasized that the facility's policy supports residents' rights to a home-like environment and personal dignity. She explained that knocking and acknowledging residents before entering their room is essential for maintaining privacy and dignity, as well as demonstrating common courtesy. A record review of the Admission Record revealed the facility admitted Resident #69 on 03/29/22 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction. A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/27/24 revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of 14, indicating that the resident was cognitively intact. Resident #85 During an observation on 11/04/24 at 11:17 AM, there was clinical documentation (Resident Baseline Care Plan) containing Resident #85's name and care details posted on a wall at the head of the bed. During an interview on 11/06/24 at 10:18 AM, Resident #85's family member explained that the documentation was meant to assist CNAs and staff in providing specific care for his grandfather, such as showing the direction and timing for turning the resident to prevent pressure sores. During an interview on 11/06/24 at 3:45 PM,LPN #2 stated that information on the resident's board was intended to make staff aware of specific care needs. LPN #2 acknowledged that the documents included the resident's name, which could be considered a dignity issue, and confirmed that this information was also available in the Electronic Medical Record (EMR). During an interview on 11/07/24 at 10:18 AM, the DON stated that the information on the resident's board was intended to guide staff who may be unfamiliar with the resident's care needs. She acknowledged that the same information was accessible in the EMR. A record review of the Admission Record revealed the facility admitted Resident #85 on 04/19/24 with diagnoses including Adult Failure to Thrive. A record review of the Quarterly MDS with an ARD of 10/14/24 revealed Resident #85 had a BIMS score of 3, which indicated his cognition was severely impaired.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 37415 Based on interviews, record review, and facility policy review, the facility failed to ensure grievances raised by resident council members were consistently resolved for six (6) of (12) months. Findings Include: A review of the facility's Grievance/Complaint Policy (undated) revealed It is the policy of this facility that a resident/responsible party/legal representative has the right to voice a grievance .All grievances should be directed/reported to Social Services . A review of the facility's Resident Council Policy (undated) revealed, It is the policy of this facility that residents have the right to form a Resident Council group to elect a governing body made up of fell ow residents who preside over the resident council, conduct regularly scheduled meetings .Purpose .to identify problems within the nursing home, to help resolve the problems that have been identified . A record review of the resident council minutes revealed from 5/22/24 through 10/16/24, residents had recurring complaints regarding issues such as staff noise on the unit, staff clearing meal trays before residents finished eating, and the malfunctioning lift on the facility bus, which prevented outings. The minutes documented unresolved concerns regarding these issues over six (6) consecutive months. On 11/05/24 at 9:30 AM, during the resident council meeting, members expressed dissatisfaction with the facility's failure to resolve grievances, leading to the resignation of the council's president and vice president. The council decided to reconvene the meeting on 11/06/24 to invite department heads to discuss these unresolved issues. On 11/06/24 at 1:00 PM, the resident council met with the Dietitian, Dietary Manager, Social Worker, Activity Director, Director of Nursing (DON), and Administrator. During this meeting, residents reiterated concerns about staff noise, including talking loudly, yelling down the hall, and playing music at night. They also complained that staff frequently removed meal trays before residents could finish eating, leading some residents to hide food in napkins to ensure they had time to eat. Additionally, the residents reported that the lift on the facility bus had been broken for an extended period, preventing outings. The resident council members included Resident #1, Resident #2, Resident #10, Resident #53, Resident #57, Resident #61, Resident #66, Resident #74, Resident #79, and Resident #87. During an interview on 11/06/24 at 2:30 PM, the Social Services Director confirmed that all department heads receive copies of the resident council minutes. She explained that it is the responsibility of each department head to address and resolve complaints documented in these minutes. During an interview on 11/07/24 at 11:45 AM, the Activity Director stated that residents had not been to local shops since she began working at the facility in December. She was unaware that the facility had a van for resident transportation and stated she would discuss this with the Administrator. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/07/24 at 11:50 AM, the Administrator confirmed that the bus had been out of commission for approximately six (6) months due to a malfunctioning lift and door. He indicated plans to take the bus to a repair shop and acknowledged that residents could be transported in smaller groups using a facility van, which accommodates two (2) wheelchairs at a time. During an interview on 11/07/24 at 12:12 PM, the DON stated that she expects staff to allow residents ample time to finish their meals. She reported that staff had previously been in-serviced regarding noise reduction and the timing of tray removal but acknowledged that the issues had resurfaced. She noted that she would instruct staff to wait at least thirty (30) minutes after serving meals before entering resident rooms to collect trays and indicated plans to make unannounced visits to monitor compliance.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37415 Based on observation, interviews, record reviews, and facility policy review, the facility failed to maintain and provide a clean, sanitary, and home-like environment for one (1) of twenty-six (26) resident rooms on Unit 2. This affected Resident #2. Findings Include: A review of the facility's Environmental Policy (undated) revealed, .It is the policy of this facility to provide a safe, clean, comfortable, and homelike environment .Special Information - A determination of 'comfortable and homelike' should include whenever possible, the resident's or a representative of the resident's opinion of the living environment .'Environment' refers to any environment in the facility that is frequented by residents, including resident rooms, bathrooms . On 11/05/24 at 11:06 AM, during an observation and interview with Resident #2, the resident reported that her bathroom was not cleaned appropriately. A thick white substance (dust) was observed on the ceramic tile in the resident's bathroom and on the back of her recliner. During an interview on 11/07/24 at 11:00 AM, the housekeeper confirmed that she had failed to clean the ceramic tile in Resident #2's bathroom and to wipe down the resident's recliner. The housekeeper stated that she occasionally forgets to clean some residents' furniture and ceramic tiles but would ensure this was done daily going forward. During an interview on 11/07/24 at 11:10 AM, the Housekeeping Supervisor confirmed the facility failed to clean the dust on the ceramic tile in Resident #2's bathroom and on the back of her recliner. The supervisor stated that he conducted in-service training with staff, emphasizing that the ceramic tile in resident bathrooms and the residents' furniture should be cleaned daily to promote a home-like environment. During an interview on 11/07/24 at 11:20 AM, the Administrator stated that he expects the housekeeping staff to dust the residents' bathrooms and furniture to keep the environment clean and sanitized. A record review of the Admission Record for Resident #2 revealed an admitted [DATE], with diagnoses including Type 2 Diabetes. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/9/24 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident was cognitively intact.

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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. 43283 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical restraints by not identifying and documenting the use of a seatbelt as a restraint for one (1) of 21 sampled residents. Resident #44. Findings Include: A review of the facility's Restraint Policy dated 09/18/14 revealed, .It is the policy of this facility that restraints will be used as follows: 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, which restricts freedom of movement or normal access to one's body . On 11/04/24 at 12:07 PM, during an observation, Resident #44 was sitting in a wheelchair in the day room with a seatbelt attached across the waistline. When asked if she could remove the seatbelt, Resident #44 was unable to understand the request. At 1:20 PM on 11/05/24, during an interview with Certified Nurse Aide (CNA) #1, she reported that although Resident #44 understands some instructions, she is unable to remove the seatbelt independently, and staff have to remove it for her. She confirmed that the resident is dependent on staff for Activities of Daily Living (ADLs) and requires a full-body lift with transfers. On 11/06/24 at 9:30 AM, during an interview with Licensed Practical Nurse (LPN) #1, she stated that Resident #44 was a fall risk due to her diagnoses, but had not experienced recent falls. She added that Resident #44 is forgetful and sometimes displays behaviors in the evening with increased anxiety, attempting to get out of the chair to go home. During an additional interview at 2:10 PM on 11/06/24, LPN #1, explained that Resident #44 cannot always remove the seatbelt on demand, depending on her mood. She stated that in the evenings, the resident sometimes tries to release the seatbelt herself when she becomes intent on going home, which indicates her behavior changes. LPN #1 confirmed that if Resident #44 cannot remove the seatbelt on command, it should be considered a restraint, as it restricts her from getting out of the wheelchair. At 2:15 PM on 11/06/24, during an observation with LPN #1, Resident #44 was unable to remove the seatbelt when prompted by the nurse. Resident #44 attempted multiple times, saying, I can't do it, you do it, indicating she could not remove it independently. LPN #1 confirmed that Resident #44 could not remove the seatbelt at that time. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/24 at 2:50 PM, during an interview with Registered Nurse (RN) #1, she confirmed that Resident #44 cannot remove the seatbelt on command consistently. She noted that although Resident #44 had experienced previous falls, no falls had occurred in the past six (6) months, and she should have been re-evaluated for seatbelt use. RN #1 confirmed that if the resident cannot remove the seatbelt on command, it acts as a restraint, as it restricts her movement and ability to exit the wheelchair. She acknowledged that the facility had not considered the seatbelt a restraint, nor had an assessment or consent been completed for its use. At 4:00 PM on 11/06/24, during an interview with the Director of Nursing (DON), she explained that Resident #44 had been using the seatbelt for an extended period. The DON confirmed that the resident has a low Brief Interview for Mental Status (BIMS) score and dementia, with variable memory. She also stated that while the resident occasionally removes the seatbelt for her sister or some staff members, she has not had falls in the past six (6) months but remains a fall risk. The DON admitted that staff only check the seatbelt once a week to ensure Resident #44 can remove it independently, and she had not been informed that the resident was unable to remove the seatbelt consistently. The DON confirmed that the seatbelt was not identified as a restraint and stated the facility aims to avoid restraints. At 4:40 PM on 11/06/24, during an interview with the Administrator, he reported awareness that Resident #44 could not remove the seatbelt on command consistently. He explained that the resident's ability to remove it varies depending on the day and who is asking. The Administrator emphasized that the facility tries to avoid restraints and expects staff to assess properly for restraints. A record review of the Order Summary Report revealed Resident #44 had a physician order, dated 8/1/24 to Ensure Resident Can Remove Self-Release Alarming Seatbelt On Que . A record review of the Admission Record revealed the facility admitted Resident #44 on 07/17/20 with diagnoses including Parkinson's Disease. A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/10/24 revealed Resident #44 had a BIMS score of (4), indicating severely impaired cognition. Section GG indicated no range of motion limitations for upper or lower extremities, and the resident used a wheelchair. Section J showed no recent falls, and Section P indicated no trunk restraint was used in or out of bed. A record review of Resident #44's medical record revealed there were no assessments for a restraint or a consent for the seatbelt use.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48181 Based on staff, Resident Representative (RR) interview and record review, the facility failed to provide written notification to the resident or RR of a transfer to an acute care hospital for one (1) of (21) residents sampled. (Resident #7) Findings Include: A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/24 indicated Resident #7 was discharged to an acute hospital and it was anticipated she would return to the facility. On 11/06/24 at 8:38 AM, during an interview with the Director of Nursing (DON), she acknowledged that the facility did not provide written documentation to Resident #7's Representative (RR) to inform them of the resident's transfer to the hospital or the reason for the transfer. The DON confirmed that the facility calls the resident's RR by phone to inform them that the resident has been sent to the hospital. On 11/06/24 at 8:45 AM, during an interview with the RR, she stated that facility staff spoke with her in person regarding the resident being sent to the hospital and the reason for the hospitalization . The RR confirmed she did not receive written documentation related to the hospitalization . On 11/06/24 at 9:02 AM, during an interview with the Administrator, he acknowledged that the facility failed to notify Resident #7's RR in writing regarding the reason for her hospitalization . A record review of the Admission Record revealed the facility admitted Resident #7 on 03/16/10 with diagnoses including Anoxic Brain Damage.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 43283 Based on interviews, record review, and facility policy review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASARR) for a resident receiving psychotropic medications and diagnosed with a new mental health diagnosis for one (1) of one (1) resident reviewed for PASARR. (Resident #69) Findings Include: Record review of the Resident Assessment-Coordination with PASARR Program, undated, revealed Policy: This facility coordinates assessment with the preadmission screening and resident review (PASARR) under Medicaid to ensure that individual with a mental disorder, intellectual disability or related condition receives care and services in the most integrated setting appropriate to their needs .9.Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review . A record review of Resident #69's Pre-Admission Screening (PAS), dated 03/25/22 revealed the Level II Referral Criteria had negative responses to all questions regarding the need for a Level II evaluation, indicating there was no history of mental illness or the use of psychotropic medications. A record review of Resident #69's Physician Orders List revealed Resident #69 started Seroquel on 08/07/23 for increased psychotic behaviors and hallucinations. A record review of the Admission Record revealed the facility admitted Resident #69 on 03/29/22 with diagnoses including Unspecified Psychosis Not Due to a Substance or Known Physiological Condition and Unspecified Hallucinations, both with an onset date of 08/07/23. A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/27/24 revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Section I noted diagnoses of Anxiety Disorder, Depression, and a Psychotic Disorder (other than Schizophrenia). Section N indicated the resident had taken antipsychotic, antianxiety, and antidepressant medications during the look-back period. On 11/06/24 at 4:15 PM, during an interview with the Director of Nursing (DON), she explained the staff member who completed Resident #69's initial PAS was no longer employed at the facility, and the completion date was prior to her tenure as the DON. After reviewing the resident's medical record, she confirmed that only the PAS screening from the resident's admission was available, which did not indicate the need for a Level II evaluation. The DON acknowledged that Resident #69 experienced a change in mental health status with a new diagnosis after her admission to the facility and was prescribed a psychotropic medication, including Seroquel. She was unaware that a new diagnosis or initiation of psychotropic medication would necessitate another screening to determine if a Level II evaluation was indicated. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 4:40 PM on 11/06/24, during an interview with the Administrator, he confirmed his awareness that a Level II PASARR is required if a resident undergoes a significant change, including a new diagnosis or medication. He stated he expects his staff to adhere to these regulations.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47873 Based on observation, staff interview, record review and facility draft policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) for one (1) of three (3) residents reviewed as high risk for acquiring multi-drug-resistant organisms (MDROs) Resident #69 and had the potential to affect six (6) residents identified as high risk for MDROs. Findings Include: Record review of the facility policy Draft Enhanced Barrier Precautions Policy dated reviewed 9/28/24 revealed This policy aims to mitigate the risk of transmission of Multidrug-Resistant Organisms (MDROs) within our facility by implementing Enhanced Barrier Precautions (EBP). This policy seeks to prevent the spread of MDRO's among residents and staff members by expanding the use of personal protective equipment (PPE) during high contact resident care activities for certain residents .Policy Explanation and Compliance Guidelines .4. Examples of indwelling medical devices for EBP should include but are not limited to .feeding tube . On 11/05/24 at 12:10 PM, during an observation, Licensed Practical Nurse (LPN #1) entered Resident # 69's room to administer medication via the residents Percutaneous Endoscopic Gastrostomy (PEG) tube. LPN #1 did not put on a gown while accessing the PEG tube and administering the medication. During an interview with LPN #1 on 11/05/24 at 12:25 PM, she admitted that she had forgotten to wear a gown and noted that there was no signage or other indicators to alert the staff that Resident #69 resident required EBP, nor was PPE readily accessible. She acknowledged the importance of EBP in preventing the transmission of MDROs, particularly during high-contact activities with residents who have PEG tubes, catheters, or central lines. During an interview with the Director of Nursing (DON) on 11/06/24 at 9:00 AM, she confirmed that the facility had developed a Performance Improvement Plan (PIP) for EBP training, initiated in September 2024. She indicated that the facility's policies were being revised to enhance compliance with EBP guidelines. On 11/06/24 at 9:25 AM, an interview with Registered Nurse (RN) #1 revealed that the facility follows standard precautions and uses transmission-based precautions for contact, droplet, and airborne pathogens. RN #1 confirmed that EBP protocols require the use of gowns and gloves during high-contact care activities involving residents with PEG tubes, catheters, and central lines. She noted that the facility currently had no policies in place to incorporate enhanced barrier precautions but was updating their infection control policies to include EBP guidelines. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/7/24 at 10:45 AM, the Licensed Nursing Home Administrator (LNHA) disclosed that the facility was currently under a PIP for EBP training, which began in September 2024. He indicated that facility policies were being revised to improve compliance with EBP guidelines. The revised policy aims to reduce the transmission of MDROs within the facility by implementing enhanced barrier precautions, specifically through expanded use of PPE during high-contact care activities. The LNHA expressed that his expectation for nursing staff was to follow universal precautions consistently, along with any additional protective measures necessary to prevent resident exposure to potential pathogens. A record review of the Admission Record revealed the facility admitted Resident #69 on 03/29/22 with diagnoses including Benign Neoplasm of the Brain.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jasper County NH	15 A South Sixth Street Bay Springs, MS 39422

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37415 Based on observation and interviews, the facility failed to maintain an audible call light system for one (1) of (16) rooms observed on Unit 4 hall. room [ROOM NUMBER] Findings Include: On 11/04/24 at 11:12 AM, during an observation, the call light in room [ROOM NUMBER] was noted to be hanging from the outlet. The resident in the room activated the call light, but it did not illuminate above the door or sound. During an interview and observation on 11/04/24 at 11:15 AM, Housekeeper #3 attempted to activate the call light unsuccessfully and stated this was the first time she noticed the light not working, despite Resident #76 frequently using the call light for assistance. During an interview and observation on 11/04/24 at 11:20 AM, Licensed Practical Nurse (LPN) #3 also attempted to activate the call light in room [ROOM NUMBER] and confirmed it was not working properly. She stated she was unaware that the call light was not functioning. She explained that both residents in the room typically used the call light when assistance was needed. She noted that, had she known the light was out, she would have notified maintenance, as they maintain a log at the nurse's station to record broken items. During an interview on 11/04/24 at 11:25 AM with both residents in room [ROOM NUMBER], both reported being unaware of how long the call light had been nonfunctional. They stated that if staff did not respond when they pressed the button, they would yell for assistance, and staff would come into the room. During an interview on 11/04/24 at 11:30 AM, the Maintenance Director confirmed the call light was not working and explained that the call light box needed replacement. He stated that he planned to obtain a new box and complete the replacement as soon as possible, adding that he had been unaware of the malfunction prior to this incident.