STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noxubee County Nursing Home	78 Hospital Rd Macon, MS 39341

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 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review the facility failed to timely revise and implement a comprehensive, person-centered care plan for one (1) of eight (8) residents at risk for aspiration and choking risk. Resident #1. The facility's failure to revise the care plan and provide supervision on [DATE] at 11:20 AM, resulted in serious injury and death for Resident #1, who had a documented aspiration/choking risk. Resident #1 was not provided supervision while eating when staff served his lunch meal and stepped away from the table. Resident #1 began choking and required transfer to the emergency department where he was intubated and air lifted to another hospital for a higher level of care. Resident #1 expired after being taken off the ventilator on [DATE]. During the investigation, the SA identified Immediate Jeopardy (IJ) which began on [DATE] when Speech Therapy evaluated Resident #1 and recommended close supervision while eating.42 CFR 483.21 (b)(1) Comprehensive Care Plans (F657)- Scope/Severity J.This situation placed Resident #1 and other residents at risk for aspiration or choking in a situation that caused and was likely to cause serious injury, serious harm, serious impairment, or death.The SA notified the facility's Administrator of the IJ on [DATE] at 9:36 AM, and provided the Administrator with the IJ templates.The facility submitted an acceptable Removal Plan on [DATE], in which they alleged all corrective actions to remove the IJ was completed on [DATE], and the IJ removed on [DATE].The SA validated the Removal Plan on [DATE] and determined the IJ and SQC was removed on [DATE], prior to exit. Therefore, the scope and severity 42 CFR 483.21 (b)(1) Comprehensive Care Plans (F657) for were lowered from a J to a D while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Included:Record review revealed that the facility did not have a policy for updating and revising care plans.Record review of a Speech Therapy (ST) Note, dated [DATE], revealed recommendations for Resident #1 to have close supervision while eating. The recommended strategies included cyclic ingestion technique [two to three (2-3) sips per bite], small sips and bites, rate modification and general swallow techniques/precautions upright posture during meals.Record review of the care plan revealed Plan comments: Swallowing study shows risk for choking.I feed myself in the dining room after set-up only. Interventions included up in dining room for meals, will tolerate by mouth (PO) without signs/symptoms of aspiration, do not allow me to have straws, drink from cup, and serve mechanical soft with pureed meat diet. Review of the care plan revealed that it did not contain any information about the ST recommendations or the resident needing close supervision.Interview with the Minimum Data Set (MDS) nurse on [DATE] at 4:00 PM stated that the point of the care plan is for staff to know how to take care of residents. She stated that the nurse receiving recommendations or new orders is responsible for updating the care plan. She verified that Resident #1's care plan was not revised with the new ST recommendations for close supervision during meals, but that it should have been.Removal PlanThe facility failed to implement known swallowing safety interventions and close meal supervision on [DATE] at 11:20 A.M., for Resident #1 who had a documented aspiration/ choking risk, resulting in respiratory compromise and death, and failed to revise the comprehensive care plan for Resident #1 who was at (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	risk for aspiration and choking, to include Speech Therapy (ST) recommendation for precautions and supervision to prevent aspiration and choking.Corrective Actions:1.On [DATE] at approximately 11:20 A.M., Licensed Practical Nurse (LPN) #1 noted Resident #1 had a panicked look on his face, yelled help and grabbed his chest. LPN #1 immediately identified the resident was choking and initiated back blows and called for help.2.On [DATE] at approximately 11:21 A.M., additional staff arrived, lowered Resident #1 to floor and abdominal thrusts initiated. Although Resident had a faint pulse, attempts to clear the airway were unsuccessful.3.On [DATE] at 11:45 A.M., Resident #1 placed on stretcher and transported to local hospital emergency room (ER) via Registered Nurse (RN) #1, LPN #2, and LPN #3.4.On [DATE] at 11:45 A.M., Attending Physician was notified by the Charge Nurse regarding the incident, current resident's condition and an order was received to transfer to local ER.5.On [DATE] at 11:50 A.M., Resident # 1 's Responsible Party (RP) was notified of incident and transfer to local ER. RP reported that he would meet Resident # 1 at the ER.6.On [DATE] at 3:30 P.M., Resident #1 had a Laryngeal Mask Airway (LMA) inserted in local ER and transferred to outside hospital.7.On [DATE] at 3:30 P.M., RP was present in the ER and was made aware of Resident # 1's transfer to outside hospital.8.On [DATE] at 1:30 P.M. the incident was reported to the Mississippi Dept of Health (MSDH) via the hotline.9.On [DATE] at 8:30 AM., the facility conducted a Quality Assurance (QA) meeting attended by Minimum Data Set (MDS) Coordinator, Medical Director, Administrator, Infection Control /Staff Education/Quality Assurance Nurse, RN #2, Director of Therapy Services and ST and Dietary Manager. The QA Committee reviewed the incident, identified root causes, and approved systemic corrective actions. Root Cause Analysis identified inadequate communication of ST recommendations, failure of supervision interventions during mealtime, and failure to revise resident care plans.10.Systemic corrective action implemented by Director of Therapy Services, MDS Coordinator, ST, and Infection Control/Staff Education/Quality Assurance Nurse on [DATE] for identification of residents with swallowing deficits, aspiration precautions or speech therapy recommendations and assessment for supervision needed.11.Systemic corrective action implemented by MDS Coordinator and Infection Control/Staff Education/Quality Assurance Nurse on [DATE] for review of ST recommendations to ensure any recommendations are immediately implemented and incorporated into resident care plans and electronic care systems.12.QA Committee adopted new policy for Care Plan Revisions upon Status Change to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy implemented on [DATE].13.QA Committee adopted new policy on Communication to make sure that therapy and nursing communicate any changes to a resident's diet/any needed equipment or any other change that is necessary to meet the resident's needs. Policy implemented on [DATE].14.Audits conducted by Infection Control/Staff Education/Quality Assurance Nurse and Director of Therapy Services to identify residents with swallowing precautions on [DATE] with 7 residents identified. Infection Control/Staff Education/Quality Assurance Nurse continued audit to ensure interventions are implemented consistently for lunch meal and the Charge Nurse will monitor meals for breakfast and supper and report to Infection Control/Staff Education/Quality Assurance Nurse any findings.15.Monitoring system implementation to ensure residents requiring direct meal supervision received supervision during meals.16.Staff education conducted by Infection Control/Staff Education/Quality Assurance Nurse regarding supervision requirements, aspiration precautions, choking prevention and implementation of swallowing interventions for those residents identified with swallowing deficits or aspiration precautions or per speech therapy recommendations and updating resident care plans with interventions. In-service conducted by Infection Control/Staff Education/Quality Assurance Nurse with nursing staff which refers to RN's, LPN's and Certified Nurse Assistants (CNA's), on [DATE]. No nursing staff will be allowed to work until education is completed.17. The facility alleged that all corrective measures were implemented on [DATE] and the immediate jeopardy was removed on [DATE].The SA validated on [DATE], through interview and record review that all corrective actions had been implemented as of [DATE], and the IJ was removed as of [DATE] prior to exit.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility investigation, staff interviews and record review the facility failed to provide adequate supervision and assistance during meals for one (1) of eight (8) residents at risk for aspiration and choking risk. Resident #1. The facility's failure to provide supervision on 5/4/26 at 11:20 AM, resulted in serious injury and death for Resident #1, who had a documented aspiration/choking risk. Resident #1 was not provided supervision while eating when staff served his lunch meal and stepped away from the table. Resident #1 began choking and required transfer to the emergency department where he was intubated and air lifted to another hospital for a higher level of care. Resident #1 expired after being taken off the ventilator on 5/8/26. During the investigation, the State Agency (SA) identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 4/27/26 when Speech Therapy evaluated Resident #1 and recommended close supervision while eating.The IJ and SQC existed at:42 CFR(s) 483.25(d)(1)(2) Accidents (F689) Scope/Severity J.This situation placed Resident #1 and other residents at risk for aspiration or choking in a situation that caused and was likely to cause serious injury, serious harm, serious impairment, or death.The SA notified the facility's Administrator of the IJ and SQC on 5/12/26 at 9:36 AM and provided the Administrator with the IJ templates.The facility submitted an acceptable Removal Plan on 5/12/26, in which they alleged all corrective actions to remove the IJ and SQC were completed on 5/12/26, and the IJ removed on 5/13/26.The SA validated the Removal Plan on 5/13/26 and determined the IJ and SQC was removed on 5/12/26, prior to exit. Therefore, the scope and severity for 42 CFR(s) 483.25(d)(1)(2) Accidents (F689) were lowered from a J to a D while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Included:Record review revealed that the facility did not have a policy related to supervision and monitoring to prevent accidents.Record review of the facility investigation revealed that on 5/4/26 at approximately 11:20 AM, staff served Resident #1 his lunch tray and stepped away from the table. Moments later, Resident #1 then yelled help and Licensed Practical Nurse #1 (LPN) saw that the resident had a panicked look on his face and placed his hand on his chest. LPN #1 realized that the resident was choking and immediately went to the resident and began back blows and called for help. Additional staff entered the dining room, the resident was assisted to the floor, and abdominal thrusts were initiated. Staff were unable to clear Resident #1's airway so he was transferred to the local emergency room. The physician and responsible party (RP) were notified. In the emergency room, the resident presented not breathing with a slow thready pulse. He was intubated in the emergency room and was transferred to another hospital for a higher level of care.Record review of a Long Term Care (LTC) Note, dated 4/24/26, for Resident #1 revealed Speech Therapy (ST) was consulted due to the resident having increased coughing during meals.Record review of a Speech Therapy Note, dated 4/27/26, revealed recommendations for Resident #1 to have close supervision while eating. The recommended strategies included cyclic ingestion technique [two to three (2-3) sips per bite], small sips and bites, rate modification and general swallow techniques/precautions upright posture during meals. ST notes also indicated that Resident #1 scored a nine (9) out of 30 on the Standardized Mini-Mental State Examination (SMMSE), indicating that the resident is severely cognitively impaired.Record review of a LTC Note, dated 4/29/26, for Resident #1 revealed that during dinner the resident began to cough and choke. The resident coughed up a large amount of food. Before the nurse could identify what, the resident choked on, he began to immediately eat again and choked again. Resident was able to cough up the food, and the nurse identified the food item as a dinner roll and had it removed from the resident's diet.Record review of a ST Note, dated 4/30/26 revealed that the nurse reported Resident #1's choking incident that occurred on 4/29/26 and ST reiterated that the resident required close supervision precautions to the nurse.Record review of hospital triage note, dated 5/4/26, for Resident (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#1 revealed resident arrived cyanotic, unresponsive, was not breathing and staff was unable to obtain a pulse. Cardiopulmonary Resuscitation (CPR) was initiated.Record review of Final Report from the local emergency room (ER) dated 5/4/26, for Resident #1 revealed that resident was being transported to a higher level of care via helicopter related to posturing after post choking cardiac arrest and possibly had anoxic brain injury.Record review of LTC Note dated 5/8/26, for Resident #1 revealed that the resident's RP notified the facility that the resident passed away at 5:22 PM on 05/08/26 after being removed from the ventilator.Interview with LPN #1 on 5/11/26 at 2:30 PM, she verified that she and the staff in the dining room were aware that Resident #1 was at risk for aspiration and choking and were aware of ST recommendations to prevent aspiration and choking. She verified that the resident required repetitive cues to follow the recommendations from the speech therapist. She further stated that his short-term memory was bad, and you can tell him to take small bites and he will but then he will go right back to taking large bites. She stated that she had repositioned the resident and instructed him to take small bites, chew and then swallow. She then stepped away to check on other residents. Another resident had asked her for fluids and when she went to get the fluids Resident #1 called out and put his hand on his chest and was choking. She stated she immediately initiated back blows to attempt to dislodge the food and called for help. She verified additional staff assisted resident to the floor and began abdominal thrust, but they were unsuccessful in clearing his airway; so, the resident was transferred to the ER.On 5/11/26 at 2:36 PM, an observation with LPN #1, revealed the location that Resident #1 was sitting in dining room at the time of incident and she verified that he was sitting at the table that was facing the wall and staff were unable to see his face. There were two (2) Certified Nursing Assistants (CNA) sitting with other residents at a table diagonally across from where the resident was and this put Resident #1's back to the CNAs.Interview on 5/11/26 at 2:45 PM with ST revealed Resident #1 was at risk for aspiration and choking. Her recommendations were for Resident #1 to have close supervision while eating. She indicated that this meant that the staff should be present one on one with the resident to ensure that he is following his recommended strategies to prevent aspiration and choking. She verified the recommended strategies included 2 to 3 sips per bite, small sips and bites, rate modification and general swallow techniques/precautions, and upright posture during meals. She verified the resident required consistent cues to perform safe swallowing due to his impaired cognition. She stated she notified the Hall Nurse and Charge Nurse of the recommendations so they can enter them into the system to ensure that staff are aware.Interview with the Administrator (ADM) on 5/11/26 at 3:30 PM she agreed that Resident #1 should have received close supervision and consistent cueing during meals.Interview with the ADM on 5/12/26 at 8:45 AM, she verified there were no orders or communications in the system regarding the ST recommendations for Resident #1.Interview on 5/12/26 at 10:15 AM with CNA #2 verified that she was working in the dining room at lunch on 5/4/26. She stated she passed out trays and then sat down to assist another resident to eat. She stated that she was aware of Resident #1's need for cues and supervision. She stated usually someone is with him while he eats. She verified that from where she was sitting, she could not see the resident eating because his back was to her. She verified that no one was at the table with the resident. She stated he called out and it was noted that he was choking. She verified she assisted the nurse in moving the resident and providing care until he was transferred out.Telephone interview on 5/12/26 at 12:28 PM, with Charge Nurse #1 (CN) she stated that she did not receive any ST recommendations for Resident #1 on 4/27/26. She stated that ST spoke to the Hall Nurse. She further verified that she works in the dining room at times and is aware of the supervision and cues that the resident required for eating safely.Record review of demographics form revealed the facility admitted Resident #1 on 12/2/24.Record review of Diagnosis and Problems list revealed Resident #1 had a diagnosis of Cerebrovascular Accident and Difficulty Swallowing.Removal PlanThe facility failed to implement known swallowing safety interventions and close meal supervision on 05/04/26 at 11:20 A.M., for Resident #1 who had a documented aspiration/ choking risk, resulting in respiratory (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	compromise and death, and failed to revise the comprehensive care plan for Resident #1 who was at risk for aspiration and choking, to include Speech Therapy (ST) recommendation for precautions and supervision to prevent aspiration and choking.Corrective Actions:1.On 05/04/26 at approximately 11:20 A.M., Licensed Practical Nurse (LPN) #1 noted Resident #1 had a panicked look on his face, yelled help and grabbed his chest. LPN #1 immediately identified the resident was choking and initiated back blows and called for help.2.On 05/04/26 at approximately 11:21 A.M., additional staff arrived, lowered Resident #1 to floor and abdominal thrusts initiated. Although Resident had a faint pulse, attempts to clear the airway were unsuccessful.3.On 05/04/26 at 11:45 A.M., Resident #1 placed on stretcher and transported to local hospital emergency room (ER) via Registered Nurse (RN) #1, LPN #2, and LPN #3.4.On 05/04/26 at 11:45 A.M., Attending Physician was notified by the Charge Nurse regarding the incident, current resident's condition and an order was received to transfer to local ER.5.On 05/04/26 at 11:50 A.M., Resident # 1 's Responsible Party (RP) was notified of incident and transfer to local ER. RP reported that he would meet Resident # 1 at the ER.6.On 05/04/26 at 3:30 P.M., Resident #1 had a Laryngeal Mask Airway (LMA) inserted in local ER and transferred to outside hospital.7.On 05/04/26 at 3:30 P.M., RP was present in the ER and was made aware of Resident # 1 's transfer to outside hospital.8.On 05/04/26 at 1:30 P.M. the incident was reported to the Mississippi Dept of Health (MSDH) via the hotline.9.On 5/12/26 at 8:30 AM., the facility conducted a Quality Assurance (QA) meeting attended by Minimum Data Set (MDS) Coordinator, Medical Director, Administrator, Infection Control /Staff Education/Quality Assurance Nurse, RN #2, Director of Therapy Services and ST and Dietary Manager. The QA Committee reviewed the incident, identified root causes, and approved systemic corrective actions. Root Cause Analysis identified inadequate communication of ST recommendations, failure of supervision interventions during mealtime, and failure to revise resident care plans.10.Systemic corrective action implemented by Director of Therapy Services, MDS Coordinator, ST, and Infection Control/Staff Education/Quality Assurance Nurse on 05/12/26 for identification of residents with swallowing deficits, aspiration precautions or speech therapy recommendations and assessment for supervision needed.11.Systemic corrective action implemented by MDS Coordinator and Infection Control/Staff Education/Quality Assurance Nurse on 05/12/26 for review of ST recommendations to ensure any recommendations are immediately implemented and incorporated into resident care plans and electronic care systems.12.QA Committee adopted new policy for Care Plan Revisions upon Status Change to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy implemented on 05/12/26.13.QA Committee adopted new policy on Communication to make sure that therapy and nursing communicate any changes to a resident's diet/any needed equipment or any other change that is necessary to meet the resident's needs. Policy implemented on 05/12/26.14.Audits conducted by Infection Control/Staff Education/Quality Assurance Nurse and Director of Therapy Services to identify residents with swallowing precautions on 05/12/26 with 7 residents identified. Infection Control/Staff Education/Quality Assurance Nurse continued audit to ensure interventions are implemented consistently for lunch meal and the Charge Nurse will monitor meals for breakfast and supper and report to Infection Control/Staff Education/Quality Assurance Nurse any findings.15.Monitoring system implementation to ensure residents requiring direct meal supervision received supervision during meals.16.Staff education conducted by Infection Control/Staff Education/Quality Assurance Nurse regarding supervision requirements, aspiration precautions, choking prevention and implementation of swallowing interventions for those residents identified with swallowing deficits or aspiration precautions or per speech therapy recommendations and updating resident care plans with interventions. In-service conducted by Infection Control/Staff Education/Quality Assurance Nurse with nursing staff which refers to RN's, LPN's and Certified Nurse Assistants (CNA's), on 05/12/26. No nursing staff will be allowed to work until education is completed.17. The facility alleged that all corrective measures were implemented on 05/12/26 and the immediate jeopardy was removed on 05/13/26.The SA (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	validated on 5/13/26, through interview and record review that all corrective actions had been implemented as of 5/12/26, and the IJ was removed as of 5/13/26 prior to exit.