

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  25A374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Noxubee County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, staff interview and facility policy review the facility failed to maintain a clean and homelike environment as evidenced by a dirty air conditioning unit in one (1) of 30 rooms observed. room [ROOM NUMBER].</p> <p>Findings Include:</p> <p>Review of the facility policy, Routine Cleaning and Disinfection with revision date of February 2023, revealed, It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible .</p> <p>An observation on 06/09/25 at 11:23 AM and on 06/11/25 at 2:55 PM, in room [ROOM NUMBER], revealed a dirty air conditioning unit that had a damp, black substance scattered on the plastic slats on the front panel. There were also scattered food particles and dried crumbs on the front lower part of the thermostat section of the air conditioner unit.</p> <p>An observation in room [ROOM NUMBER] and interview with Licensed Practical Nurse (LPN #2) on 06/11/25 at 3:00 PM, confirmed that there was a black substance scattered throughout the front slats of the air conditioner unit. She revealed that the black substance looked like mildew, and this could cause respiratory issues for the resident if not taken care of and cleaned. She also confirmed that scattered food particles and crumbs were on the front lower part of the thermostat section and stated, It needs to be cleaned.</p> <p>During an observation in room [ROOM NUMBER] and interview with Director of Nurses (DON) on 06/11/25 at 3:10 PM, he confirmed the damp, black substance on the front panel of the air conditioner and the food particles and crumbs on the anterior right section under the thermostat control. The DON revealed that the black substance on the air conditioner looked like mildew and that this could cause respiratory problems. He also confirmed that by leaving the air conditioner dirty, they failed to ensure that they maintained a clean homelike environment for the residents.</p> <p>On 06/11/25 at 4:55 PM, an interview with the Maintenance Director, revealed that sometimes the residents eat their meals near the air conditioning units and would drop food in the units. He revealed that they removed the front panels of the air conditioner units three times a year and as needed, and cleaned them out good. He confirmed that the air conditioner unit in room [ROOM NUMBER], was left dirty and needed to be cleaned.</p>

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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on observation, resident and staff interviews, and facility policy review, the facility failed to address a grievance regarding answering a call light and providing Activities of Daily Living (ADL) care in a timely manner for one (1) of the 17 sampled residents. Resident #45</p> <p>Findings include:</p> <p>A review of the facility policy titled Policy Statement Filing Grievances/Complaints with a revision date of 3/17/17 revealed, .Staff will assist in completing and filing a grievance or complaint when such requests are made. Grievances include, but are not limited to, resident care, treatment, abuse, neglect .2. Grievances can be filed orally, in writing, or anonymously .4. Grievances will be responded to within 5 working days of the date the grievance was filed. Immediate action will be taken on grievances where alleged violations of any resident rights are reported to prevent further potential violations .</p> <p>An observation and interview on 6/09/25 at 10:20 AM, revealed Resident #45 lying in her bed and she was visibly upset. Resident #45 stated, It has been almost three hours that I have been sitting in a poopy diaper. The last time my diaper was changed was on the night shift. Resident #45 further revealed, I have put my call light on several times this morning. They come in and ask me what I need, and I tell them I need my diaper changed because I have had a bowel movement, then they turn the call light off and say they will get my aide. She revealed they need to take care of me instead of turning my light out and leaving. Resident #45 revealed that she had previously spoken with the Director of Nursing (DON) about this issue, and he is aware. She stated, I tried to talk with the DON last week, but he never got back with me. She became tearful and stated, I feel so useless. I'm not able to do anything for myself, and I'm at the mercy of everyone else. I haven't spoken to the Administrator because she has a lot on her plate to deal with.</p> <p>During an interview on 06/09/25 at 11:10 AM, the DON revealed that Resident #45 had some complaints about her call light not being answered on time in the past and having to wait to be changed. He confirmed that he had not formally written up a grievance to ensure the problem was addressed and a follow-up had not been conducted to see if her grievance was corrected.</p> <p>In an interview on 6/11/25 at 9:10 AM, the Administrator revealed that she is the grievance officer and confirmed that no formal grievance had been written regarding the resident's concerns and complaints. She revealed the residents' complaint should have been written up as a grievance so that we could have addressed it and followed up to ensure it was resolved.</p> <p>Record review of the Revenue Cycle Face sheet revealed the facility admitted Resident #45 on 10/09/2023 with medical diagnoses that included acute Kidney Failure, Heart Failure, and Depression.</p> <p>Record review of Resident #45's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/3/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interviews and record review, the facility failed to ensure an as needed (PRN) psychotropic hypnotic medication for insomnia was limited to 14 days or to an appropriate time frame approved by the provider for one (1) of five (5) medication reviews. Resident #20</p> <p>Findings include:</p> <p>Record review of facility letterhead signed by the Administrator and dated 6/12/25 revealed, (Proper name of facility) does not have a policy on stop dates for psychotropic drugs.</p> <p>Record review of Resident #20's Orders revealed an order dated 4/17/25 for Zolpidem 5 milligram oral tablet . every night at bedtime PRN for insomnia.</p> <p>Record review of Consultant Pharmacist Recommendation to Physician dated 4/23/25, revealed, Ambien 5 mg (milligrams) qhs (every night at bedtime) PRN (as needed) for insomnia. May we extend the above order for 6 months? The physician's response was, Agree .Cont (continue) it 6 months.</p> <p>During an interview on 6/11/25 at 10:10 AM, Registered Nurse/Minimum Data Set Coordinator (RN/MDS) revealed Resident #20 had a psychotropic hypnotic medication ordered as needed (PRN) for insomnia and this order did not have the required stop date. She stated any PRN psychotropic medication should have a 14 day stop date or another date approved by the physician. She stated the pharmacist recommended the medication be extended for six months and the provider approved this recommendation, but it was overlooked by the facility staff and was not entered into the resident's orders.</p> <p>An interview with the Director of Nursing (DON) on 6/11/25 at 12:05 PM, revealed any PRN psychotropic medication should have a stop date of 14 days or longer if approved by the physician to ensure psychotropic PRN medication use is monitored and not extended if unnecessary. He stated Resident #20 was on a psychotropic hypnotic medication at bedtime as needed. He acknowledged the pharmacist made a recommendation for a six month stop date which was approved by the provider and the facility failed to enter this date into the resident's orders. He confirmed the facility failed to have the required stop date for a resident receiving a PRN hypnotic psychotropic medication.</p> <p>Record review of Resident #20's Revenue Cycle face sheet revealed the resident was admitted to the facility on [DATE] with diagnoses that included insomnia.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to implement a person-centered care plan for providing incontinent care for one (1) of the 18 care plans reviewed. Resident #45</p> <p>Findings include:</p> <p>Record review of facility policy titled Quality of Care undated revealed, Each resident shall receive optimal care to attain and/or maintain the highest mental and physical functional status as defined by the comprehensive assessment and plan of care. Additionally, the resident will receive the appropriate interventions to maintain or to improve his/her abilities.</p> <p>Record review of Resident #45's care plan, updated 4/9/25 revealed Plan Comments: I am incontinent of bowels . Outcomes .I will be kept clean &amp; dry of incontinent bowel .Interventions .Provide incontinence/pericare after each incontinent episode .</p> <p>Record review of Resident #45's care plan, updated 4/9/25 revealed Plan Comments: I have a potential for complications associated with urinary incontinence .Outcomes .I will be kept clean, dry, &amp; comfortable daily . Interventions . Provide peri-care after each incontinent episode .Assess me every 2 to 3 hrs (hours) and PRN (as needed) for incontinent episodes .</p> <p>During an observation and interview on 6/09/25 at 10:20 AM, revealed Resident #45 lying in her bed visibly upset and stated, It has been almost three hours that I have been sitting in a poopy diaper the last time my diaper was changed was on the night shift. Resident #45 further revealed, I have put my call light on several times this morning. They come in and ask me what I need, and I tell them I need my diaper changed because I have had a bowel movement. They turn the call light off and say they will get my aide but they never come back.</p> <p>During an interview on 6/10/25 at 2:30 PM, the Registered Nurse (RN) Minimum Data Set (MDS) Coordinator revealed she is responsible for developing the care plans. She revealed that the care plans are developed individually for each resident, so the staff will know how to care for that resident's specific needs. She confirmed Resident #45's care plan was not being followed regarding her incontinence care, and it should have been.</p> <p>Record review of the Revenue Cycle Face sheet revealed the facility admitted Resident #45 on 10/09/2023 with medical diagnoses that included acute Kidney Failure, Heart Failure, and Depression.</p> <p>Record review of Resident #45's MDS with an Assessment Reference Date (ARD) of 4/3/2025 Section H: Resident is always incontinent of urinary and bowel continence. Section C revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure Activities of Daily Living (ADLs) with incontinent care was provided for one (1) of 17 sampled residents. Resident #45</p> <p>Findings include:</p> <p>Record review of facility policy titled Quality of Care undated revealed, .The policy of the facility is to establish a minimum acceptable level of daily care, which shall include and involve the maximum utilization of the resident's capabilities, while providing the necessary assistance to accomplish the following: . Toileting .Staff is to check and change incontinent residents every 2 hours and prn (as needed) .</p> <p>On 6/09/25 at 10:20 AM, during an observation and interview revealed Resident #45 lying in her bed visibly upset and stated, It has been almost three hours that I have been sitting in a poopy diaper the last time my diaper was changed was on the night shift. Resident #45 further revealed, I have put my call light on several times this morning. They come in and ask me what I need, and I tell them I need my diaper changed because I have had a bowel movement and they turn the call light off and say they will get my aide.</p> <p>An observation from the hallway on 6/9/25 at 10:32 AM ,revealed Resident #45's call light was pressed and came on and Certified Nurse Aide (CNA) #1 entered the room, the call light was turned off, and CNA #1 exited the room within approximately fifteen (15) seconds. CNA #1 went down the hall and around a corner, then returned to the hall and began to pass ice and water to other rooms.</p> <p>An interview on 6/9/25 at 10:36 AM, Resident #45 revealed I turned on my call light, and the aide came in and asked me what I needed. I told her that I needed to be changed because I had a bowel movement. She told me, 'Okay,' and then turned off the call light, telling me she would let my aide know.</p> <p>During an interview on 6/9/25 at 10:45 AM, CNA #2 revealed she is assigned to the resident today and confirmed she started her shift at 6:45 AM and did her rounds on the resident this morning but the resident didn't say if she was wet or needed to be changed, she will usually let us know when she needs changing so I didn't change her. So, I moved on to the other hall and was giving a bed bath, and two aides came and told me that Resident #45 needed to be changed. She confirmed that she had not provided incontinent care to Resident #45 this morning because she was not wet when she initially made her rounds this morning.</p> <p>During an interview on 6/09/25 at 10:50 AM, CNA #3 revealed she went into Resident #45's room about 9:00 AM to see if she was ready for her whirlpool bath. The resident said she had to have a brief change first because she had a bowel movement. CNA #3 revealed, I then went and told her assigned aide, (Proper name of CNA #2), that the resident needed to be changed. CNA #3 revealed I am also able to provide incontinent care and I should have changed her brief instead of making her wait longer.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/9/25 at 11:10 AM, the Director of Nurses (DON) revealed the resident has had some complaints about her call light not being answered in a timely manner. He revealed that it is his expectation that residents receive incontinent care at least every 2 hours or more and for Resident #45 to be left soiled without being cleaned up for that amount of time is unacceptable.</p> <p>In an interview on 6/11/25 at 3:25 PM, the Administrator revealed that residents are supposed to receive incontinent care every two hours and as needed. She revealed that the CNAs should have made their rounds every two hours and provided care and should have changed the resident instead of turning the light off and not providing the care she needed.</p> <p>Record review of the Revenue Cycle Face sheet revealed the facility admitted Resident #45 on 10/09/2023 with medical diagnoses that included Acute kidney failure, Heart failure, and Depression.</p> <p>Record review of Resident #45's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/3/2025 Section H: Resident is always incontinent of urinary and bowel continence. Section C revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on staff interview, record review, and facility letterhead review, the facility failed to monitor residents for side effects of anticoagulant medication use for two (2) of five (5) medication reviews. Resident #27 and Resident #56</p> <p>Findings include:</p> <p>Record review of facility letterhead signed by the Administrator and dated 6/12/25 revealed, (Proper name of nursing home) does not have a policy on anticoagulant monitoring.</p> <p>Resident #27</p> <p>Record review of Resident #27's Orders revealed an order dated 8/26/24 for Apixaban (Eliquis) 5 milligram oral tablet) .BID (two times daily).</p> <p>During an interview on 6/10/25 at 3:40 PM, Licensed Practical Nurse (LPN) #3 revealed Resident #27 received an anticoagulant medication and acknowledged awareness of the risk of anticoagulant medication use and the need to observe for bruising or bleeding. She revealed there was not an area in the computer documentation to prompt the nurses to monitor or to document that the resident was monitored for bleeding or bruising.</p> <p>During an interview on 6/11/25 at 10:10 AM, the Registered Nurse/Minimum Data Set (RN/MDS) acknowledged Resident #27 received an anticoagulant medication and monitoring for side effects had not been documented. She revealed the nurses should observe for bleeding and bruising and report if noted, but there was no documentation to prompt the nurses to monitor this routinely or verify this was done. She confirmed that residents receiving an anticoagulant medication should be monitored due to their risk for bleeding and this was not done.</p> <p>An interview with the Director of Nursing (DON) on 6/11/25 at 12:05 PM, revealed Resident #27 received an anticoagulant medication that could cause excessive bleeding and needed to be monitored for bleeding and bruising. He revealed that monitoring would help ensure the resident was evaluated and treated promptly to prevent complications. He confirmed the facility failed to monitor a resident on an anticoagulant medication for bleeding and/or bruising and document their observations.</p> <p>Record review of Resident #27's Revenue Cycle Face sheet revealed an original admission date of 8/26/24 with the most recent admit date of 5/6/25 and diagnoses that included Venous thrombosis and Embolism.</p> <p>Resident #56</p> <p>An interview and observation on 06/11/25 at 9:50 AM, with LPN #2 revealed that they were supposed to pay close attention to the residents on anticoagulants. She revealed that they looked at labs, monitored for bleeding or bruising throughout the shift to make sure they didn't have any side effects of taking the blood thinners. An observation revealed LPN #2 pull Resident #56's information up on the computer screen on the medication cart and she confirmed that there was no documentation of monitoring for anticoagulant side effects for him and stated, I don't know why it's not getting done.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with RN #1, revealed that there was not a monitoring section for anticoagulants in their system. She revealed that the nurses were supposed to monitor for side effects of anticoagulants and if they noticed anything abnormal, they were to document it. RN #1 confirmed that Resident #56 was on an anticoagulant and there was no documentation found where the nurses monitored for side effects and also confirmed that inadequate monitoring placed the resident at risk for bleeding.</p> <p>Record review of Resident #56's Revenue Cycle Face Sheet revealed an admission date of 05/16/25 and that he had diagnoses that included Peripheral Vascular Disease and Atrial Fibrillation.</p> <p>Record review of Resident #56's Orders revealed an order dated 05/16/25 for Apixaban 5 mg (milligrams) by mouth twice a day and there was no order to monitor for bruising or bleeding.</p> <p>Record review of Resident #56's Medication Administration Record (MAR) for June 2025 revealed that he received Apixaban 5 mg (milligrams) orally bid (two times a day) and there was no monitoring tool in place for staff to monitor for signs of bleeding or bruising with the anticoagulant.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure medications were stored properly in a secure manner in the medication cart for one (1) of five (5) medication administration observations.</p> <p>Findings Include:</p> <p>Review of the facility policy titled Medication Storage, undated, revealed .1. General Guidelines: c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart .</p> <p>An observation on 06/11/25 at 9:05 AM, revealed a medication card of Lasix tablets on top of an unattended medication cart. An observation revealed Licensed Practical Nurse (LPN) #1 walked away from the medication cart down to the end of the hall in the sitting area and assisted a resident in a wheelchair to her room to receive her medications.</p> <p>An interview on 06/11/25 at 9:15 AM with LPN #1 revealed that medications were supposed to be locked up in the the medication carts when unattended. She confirmed that she left the Lasix 40 milligram (mg) medication card face down on the medication cart while she walked down the hall to get a resident to come to her room. LPN #1 confirmed that medications should never be left on top of the cart and by doing so could allow someone to come up to the cart, grab the medicine and possibly take something they were not supposed to have.</p> <p>An interview on 06/11/25 at 9:54 AM, with the Director of Nursing (DON), revealed that leaving medications unattended on top of the medication cart was unacceptable practice and was a safety issue. He revealed that a resident could walk by and take the medications and could possibly take something they were not supposed to take. He confirmed that medications were supposed to be within sight of the person administering the medications or be locked in the medication cart.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and facility policy review the facility failed to utilize protective barriers to prevent possible contamination and spread of bacteria during two (2) of five (5) resident medication administration observations. Resident #1 and Resident #43.</p> <p>Findings Include:</p> <p>Review of the facility policy, Administration of Eye Drops or Ointments Policy with revision date of 04/24/23 revealed, Eye medications are administered as ordered by the physician and in accordance with professional standards of practice .5. Administration: a. Remove medication cap and place on clean, dry surface (i.e. tissue or paper towel) to prevent contamination</p> <p>Resident #1</p> <p>An observation on 06/11/25 at 8:20 AM, during Resident #1's medication pass revealed Licensed Practical Nurse (LPN) #1, removed Timolol eye drop bottle from the box and placed it on the overbed table with no barrier in use and had not sanitized the overbed table prior to placing the eye drop bottle on the table. LPN #1 administered the eye drops, placed the eye drop bottle back on the overbed table and then returned it to the medication cart.</p> <p>An interview on 06/11/25 at 8:30 AM, with LPN #1 confirmed that she did not place the eye drop bottle on a barrier and that she had placed it directly on the overbed table while she administered Resident #1's other medications. LPN #1 revealed that not utilizing a barrier with the bottle of eye drops could cause spread of germs and cross contamination and she should not have placed the eye drops on the dirty surface.</p> <p>Record review of Resident #1's Revenue Cycle Face Sheet revealed an admission date of 10/15/1991 and that she had diagnoses that included Cerebral Palsy, Ocular Hypertension of the Right Eye, and Unspecified Keratoconus of the Right Eye.</p> <p>Record review of Resident #1's Orders revealed an order dated 06/11/24 for Timolol Ophthalmic 0.5% solution to instill one drop in the right eye daily.</p> <p>Resident #43</p> <p>An observation on 06/11/25 at 8:50 AM, during Resident #43's medication pass, revealed LPN #1 removed the Systane eye drop bottle from the box, she administered the eye drops and then placed the eye drop bottle on the overbed table with no barrier in use and had not sanitized the table prior to placing the medication there. LPN #1 administered Resident #43's other medications, picked up the eye drop bottle from the overbed table and returned it to the medication cart.</p> <p>An interview on 06/11/25 at 8:58 AM, LPN #1 revealed that she did not clean the overbed table prior to setting the eye drop bottle down and confirmed that she should have placed it on a barrier. She stated, I forgot. LPN #1 revealed that not using a protective barrier and by placing the eye drops directly on the overbed table, could cause the spread of germs and cross contamination. She revealed that she would make sure she used a protective barrier going forward.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  25A374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2025
NAME OF PROVIDER OR SUPPLIER  Noxubee County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 06/11/25 at 9:54 AM, with the Director of Nursing (DON), revealed that the nurses were supposed to use protective barriers when providing care including during medication administration. He confirmed that LPN #1 placing Resident #1 and Resident #43's eye drop bottles on the overbed table during medication administration without a barrier was an infection control issue and it could cause the spread of germs and bacteria.</p> <p>Record review of Resident #43's Revenue Cycle Face Sheet revealed an admission date of 06/28/23 and that she had diagnoses that included Alzheimer's Disease and Major Depressive Disorder.</p> <p>Record review of Resident #43's Orders revealed an order dated 10/30/24 for Systane Complete Optimal Dry Eye Relief ophthalmic solution (ocular lubricant) to instill one drop both eyes two times a day.</p>		