STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A380	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pontotoc Nursing Home	176 South Main Street Pontotoc, MS 38863

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 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** Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to address resident equipment in disrepair, resulting in a resident continuing to use an unsafe and uncomfortable wheelchair for approximately one month for one (1) of 31 residents utilizing wheelchairs reviewed. Resident #4 Record review of the facility policy titled, “Medical Equipment Management Program Medical Equipment Repair” with a revision date of 4/22 revealed “Policy: The Biomedical-Clinical Services Department is responsible for providing safe, effective and timely repair of all Medical Equipment .” Record review of “(Proper Name) Biomed” record from 10/02/24 to 6/20/25 revealed no documentation regarding repair or replacement of Resident #4’s wheelchair. An observation and interview on 7/22/2025 at 8:55 AM, revealed Resident #4 sitting in a wheelchair in his room. The bilateral vinyl armrests were noted to be torn and tattered. Resident #4 stated, “The armrests are uncomfortable on my arms.” During an interview on 7/22/2025 at 10:40 AM, Certified Nurse Aide (CNA) #4 revealed that whenever resident equipment needs to be repaired or replaced, we put in a work order on the computer. The work order is called Biomed and goes to the maintenance department. After review of the Biomed work order for the past several months, she revealed that there was no order for the repair of Resident #4's wheelchair. An observation and interview on 7/22/2025 at 10:52 AM, the Administrator (ADM) confirmed that Resident #4's vinyl on both wheelchair armrests was tattered and torn. She stated, He has a new wheelchair that has been ordered. Resident #4 stated, “I’ve been waiting for a month for the new wheelchair. The Administrator confirmed that the wheelchair had been on order for about a month and revealed she would get him a new wheelchair right now. During an interview on 7/23/2025 at 8:30 AM, Maintenance worker #1 confirmed that he receives his work orders through a system called Biomed and checks the system several times throughout the day for any new work orders. He revealed that yesterday was the first time he was made aware that Resident #4's wheelchair needed to be replaced due to the armrest vinyl being torn. Record review of Resident #4's Demographics revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Type 2 diabetes with peripheral neuropathy. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/25 revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #4 was cognitively intact.

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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 0656 Level of Harm - 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 observation, resident and staff interview, record review, and facility policy review, the facility failed to implement Activity of Daily Living (ADL) care plans for Residents #1, #17, and #30 and failed to implement a pressure ulcer care plan for Resident # 6 for (4) four of 16 resident care plans reviewed. Findings Include: Review of the facility policy titled, “Plan of Care,” last revised 06/27/24, revealed, Policy: It is the policy of “Proper Name” to properly provide patient care planning… Procedure: 2.) “An interdisciplinary collaborative manner as appropriate to the needs of the patient should be utilized to develop and implement the care plan . Resident #1 Record review of the Care Plan for Resident #1 revealed under, Problem/Need: I require assistance w/ (with) ADLs (activities of daily living) r/t (related to) weakness, debility, and dementia. Also revealed under, Approaches: Personal Hygiene- Limited-Extensive x (times) 1 (one). During an observation and interview on 7/21/2025 at 11:18 AM, Resident #1 was sitting in his wheelchair in his room. He was unshaven, with black and gray facial hair approximately 1/4 (one-fourth) inch in length. The resident stated he wanted to be shaved but preferred to keep his mustache. On 7/22/2025 at 10:36 AM, an interview with Certified Nurse Aide (CNA) #5 confirmed Resident #1 needed shaving. An interview with the Minimum Data Set (MDS) Nurse on 7/24/25 at 9:15 AM revealed the purpose of the care plan was to give staff instruction and paint a picture of the residents care to be provided. She confirmed Resident #1's care plan was not followed for shaving. Record review of the “Demographics” revealed the facility admitted Resident #1 on 4/14/25 with a medical diagnosis of Unspecified Dementia. Record review of Resident #1’s “Flowsheet History” dated 7/18/25 revealed a Brief Interview for Mental Status (BIMS) summary score of 3, indicating the resident was severely cognitively impaired. Resident #6 Review of the “Care Plan” for Resident #6 revealed under, “Approaches: Observe for s/sx (signs/symptoms) of new skin breakdown during daily care document and report as indicated . An interview with the Director of Nursing (DON) on 7/24/25 at 9:20 AM revealed Resident #6 transferred to the hospital on 3/1/25 and returned on 3/9/25. Record review of Resident #6’s hospital stay “Integumentary Flowsheet History” revealed documentation on 3/7/25 of deep tissue injury (DTI) left heel. (continued on next page)

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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 0656 Level of Harm - Actual harm Residents Affected - Few	Record review of the “Nursing Note” for Resident #6, dated 3/9/25 revealed, “Resident returned from proper name of hospital around 10 AM.” There was no documentation regarding any skin concerns. Record review of Resident #6’s body audits conducted on 3/9/25, 3/10/25, 3/13/25, 3/14/25, 3/15/25 revealed scattered bruising, no abrasion, no blister, no excoriation. There was no documentation regarding the left heel. Record review of Resident #6’s body audit conducted on 3/16/25 revealed, “Unstageable pressure injury to left posterior heel, dark purple, dry, hard, closed, without pain. Measures 4.5 x 2.2 x 0. ” Record review of Resident #6’s “Integumentary Flowsheet History” dated 7/15/25 revealed, “Redness to buttocks.” Record review of Resident #6’s “Wound History” dated 7/17/25 revealed, “Sacrum stage III pressure wound, red, slightly moist measuring 1.8 cm (centimeters) x 0.5 cm (centimeters) x 0.1 cm (centimeters) full thickness tissue loss with slough. On 7/23/25 at 11:12 AM, an interview with the DON confirmed Resident #6 developed a pressure injury to her left heel while in the hospital, and the wound was not identified in the facility until eight days later. Additionally, she revealed that after the resident’s body audit conducted on 7/15/25 identified redness to her buttocks, there was no documentation to show the skin concern was addressed. She confirmed the plan of care was not followed. On 7/24/25 at 8:30 AM, an interview with Registered Nurse (RN) #2 reconfirmed that on 7/15/25, she assessed the resident’s skin and noted redness to the buttocks. She revealed that she applied pink cream and a bandage to the area but did not document it or initiate wound care orders. An interview with the MDS Nurse on 7/24/25 at 9:00 AM confirmed Resident #6's skin care plan was not followed. Record review of the “Demographics” revealed the facility admitted Resident #6 on 2/13/25 with diagnoses including Dementia with Anxiety. Record review of the “Flowsheet Data” dated 5/16/25 revealed a BIMS summary score of 6, indicating Resident #6 was severely cognitively impaired. Resident# 17 During an observation on 7/22/25 at 10:30 AM, with Registered Charge Nurse #1, it was confirmed that Resident #17’s nails were long and jagged and needed to be trimmed. She stated it was her responsibility to trim the nails but confirmed she had not gotten around to it. Record review of the ADL care plan for Resident #17, last revised 7/11/25, revealed the problem: “I require assistance with ADLs … Approaches: Nail care as indicated. … Personal hygiene – limited to extensive assistance . (continued on next page)

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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 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview with the MDS nurse, on 7/22/25 at 11:30 AM, she confirmed that if staff had not trimmed Resident #17’s nails, they did not implement the resident’s ADL care plan. She revealed the purpose of the comprehensive care plan is to give staff a description of the type of care the residents require. Review of the “Demographic Report” for Resident #17 revealed the facility admitted the resident on 1/15/22 with a diagnosis of Hemiplegia affecting the left side as a late effect of Cerebrovascular Accident. Record review of Resident #17's BIMS, dated 7/11/25, revealed a score of 15, indicating the resident was cognitively intact. Resident #30 Record review of the Care Plan with a problem onset of 6/21/23 revealed, Problem/Need: ADL's I require assistance with my ADLs r/t Parkinson's .Approaches: Assistn with shaving as desired . On 7/21/2025 at 12:23 PM during an observation and interview with Resident #30 revealed that he had facial hair measuring one-half to one inch on his cheeks, chin, upper lip, and neck. During the interview, Resident #30 stated, I cannot shave myself and I would like to be shaved. During an interview with the MDS Coordinator at 12:41 PM on 7/22/25, confirmed that while Resident #30 was capable of taking showers independently with supervision, he has not been shaved in quite some time. She further confirmed there was no documentation indicating that Resident #30 had refused to be shaved. During an interview on 7/24/2025 at 9:37 AM, the MDS Coordinator confirmed that the ADL Care Plan, which includes assistance with shaving as desired, was not implemented. She verbalized that the purpose of this care plan was to serve as a guide for all staff involved in providing ADL care, ensuring consistency and quality across all shifts and personnel. A record review of Resident #30's Demographics revealed that the resident was admitted to the facility on [DATE], with diagnoses that included Parkinson’s Disease. A record review of Resident #30's Flowsheet History revealed a BIMS Summary Score of 13 with an Assessment Reference Date (ARD) of 5/30/25, which indicated that the resident was cognitively intact.

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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 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 observation, resident and staff interviews, record review, and facility policy review the facility failed to provide Activities of Daily Living (ADL) care for three (3) of 42 residents observed during the initial tour related to nail care for Resident #17 and failed to shave Residents #1 and #30. Findings Include: The facility provided a statement on letterhead signed by the Director of Nursing that revealed, “(Proper name) of the facility does not have a personal hygiene policy.” Review of the facility policy titled, Nails, Care of, last revised 08/06/24, revealed: “Policy: It is the policy of 'Proper Name' Nursing Home that nails should be properly cared for . Resident #1 On 7/21/2025 at 11:18 AM, an observation and interview with Resident #1 revealed he had black and gray facial hair approximately 1/4 (one-fourth) inch in length and stated he wanted to be shaved but preferred to keep his mustache. An interview with Certified Nurse Aide (CNA) #5 on 7/22/2025 at 10:36 AM revealed Resident #1 should be shaved every time he received a bath. She stated it was the shower aide’s responsibility to ensure this was done and confirmed the resident needed shaving. An interview with the Director of Nursing (DON) on 7/22/2025 at 10:40 AM revealed that male residents were to be shaved once weekly or as requested. She confirmed that Resident #1 was unshaven and acknowledged that this gave him an untidy appearance. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/18/25 revealed Resident #1 required substantial/maximal assistance with personal hygiene, including shaving. Record review of the “Demographics” revealed the facility admitted Resident #1 on 4/14/25 with a medical diagnoses including Unspecified Dementia. Record review of Resident #1’s “Flowsheet History” dated 7/18/25 revealed a Brief Interview for Mental Status (BIMS) summary score of 3, indicating the resident was severely cognitively impaired. Resident #17 An observation on 7/21/25 at 10:30 AM revealed Resident #17's nails were approximately 1/2 inch long and jagged in appearance. Resident #17 stated she could not remember the last time her nails were trimmed but stated she would like them trimmed. An observation of Resident #17's nails with CNA #1 on 7/22/25 at 10:28 AM revealed the resident's nails were long and jagged. CNA #1 confirmed the nails needed to be trimmed. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 7/22/25 at 10:30 AM with Registered Charge Nurse #1 revealed Resident #17's nails were long and jagged and needed to be trimmed. She stated it was her responsibility to trim the nails but confirmed she had not gotten around to it. She stated a concern with the resident’s nails not being trimmed was that the resident could scratch herself. Record review of the “Demographics” for Resident #17 revealed the facility admitted the resident on 1/15/22 with a diagnosis of hemiplegia affecting the left side as a late effect of cerebrovascular accident. Record review of Resident #17's BIMS, dated 7/11/25, revealed a score of 15, indicating the resident was cognitively intact. Review of Section GG of the MDS – Functional Abilities, dated 7/11/25, revealed a code of 03 which indicated Resident #17 required partial/moderate assistance for personal hygiene. Resident #30 During an observation and interview on 7/21/2025 at 12:23 PM with Resident #30 revealed that he had facial hair measuring one-half to one inch on his cheeks, chin, upper lip, and neck. During the interview, Resident #30 stated, I cannot shave myself and I would like to be shaved, but (Proper Name of CNA#3) doesn't work here anymore, and she was the one who always shaved me. When asked if he would allow someone else to shave him, he agreed that he would. During an interview with CNA#2 on 7/22/25 at 10:43 AM concerning Resident #30, she confirmed that residents are typically shaved on their designated shower days, which for Resident #30 are Tuesday, Thursday, and Saturday nights. However, when the medical record was reviewed with CNA #2, it was noted that there was no documentation regarding personal hygiene, specifically shaving, for Resident #30. During an interview on 7/22/25 at 11:00 AM with the DON, she validated that it is standard practice for residents to be shaved during shower days. An interview with the MDS Coordinator at 12:41 PM on 7/22/25 confirmed that while Resident #30 was capable of taking showers independently with supervision, he has not been shaved in quite some time. The MDS Coordinator acknowledged that CNA#3 typically performed the shaving tasks but is currently on educational leave. She stated that the CNA's responsible for showering residents should have offered to shave Resident #30 during those times. She further confirmed there was no documentation indicating that Resident #30 had refused to be shaved. A record review of Resident #30's Demographics revealed that the resident was admitted to the facility on [DATE], with diagnoses that included Parkinson’s Disease. A record review of Resident #30's Flowsheet History revealed a BIMS Summary Score of 13 dated 5/30/25, which indicated that the resident was cognitively intact.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, staff interview, record review, and facility policy review, the facility failed to assess and implement timely interventions to address skin integrity concerns, resulting in progression of a pressure injury and delayed wound healing for one (1) of three (3) residents reviewed for pressure ulcers. (Resident #6) Findings include: Review of the facility policy titled “Assessment and Reassessment of Patients” with a revision date of 5/12/25 revealed under, “Policy: It is the policy of (proper name of facility) that patients should be properly assessed and reassessed.” Also revealed under, “Procedure: … 6. Wound assessments and measurements should be performed at start of care, resumption of care, and recommended weekly. Reassessment should be performed any time there is a significant change noted . ” Record review of Resident #6’s hospital “Integumentary Flowsheet History” revealed documentation on 3/7/25 of deep tissue injury (DTI) left heel. An interview with the Director of Nursing (DON) on 7/24/25 at 9:20 AM revealed Resident #6 transferred to the hospital on 3/1/25 and returned on 3/9/25. Record review of the “Nursing Note” for Resident #6, dated 3/9/25 revealed, “Resident returned from “proper name” of hospital around 10 AM.” There was no documentation regarding any skin concerns. Record review of Resident #6’s body audits conducted on 3/9/25, 3/10/25, 3/13/25, 3/14/25, 3/15/25 revealed scattered bruising, no abrasion, no blister, no excoriation. There was no documentation on the left heel. Record review of Resident #6’s body audit conducted on 3/16/25 revealed, “Unstageable pressure injury to left posterior heel, dark purple, dry, hard, closed, without pain. Measures 4.5 x 2.2 x 0. ” Record review of Resident #6’s wound care “Work List Task Details” revealed an order dated 3/16/25, “Unstageable pressure injury to left, posterior heel. Clean with betadine and leave OTA (open to air) daily at 10:00 AM.” Record review of Resident #6’s “Integumentary Flowsheet History” dated 7/15/25 revealed, “Redness to buttocks.” Record review of Resident #6’s “Wound History” dated 7/17/25 revealed, “Sacrum stage III pressure wound, red, slightly moist measuring 1.8 cm (centimeters) x 0.5 cm (centimeters) x 0.1 cm (centimeters) full thickness tissue loss with slough. Record review of Resident #6’s wound care “Work List Task Details” revealed an order dated 7/17/25, “Cleanse stage III pressure ulcer to sacral area with NS (normal saline) or DWC (dermal wound cleanser), pat dry with 4 x 4 gauze, apply collagen with silver, cover with dry dressing. Change T (Tuesday)/Th (Thursday)/Sat (Saturday) and prn (as needed).” (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 7/23/25 at 11:12 AM confirmed Resident #6 developed a pressure injury on her left heel while in the hospital, and the wound was not identified in the facility until eight days later, at which point it had progressed to an unstageable pressure injury. She revealed it would have been the charge nurse’s responsibility to assess the resident’s skin on readmission and then weekly thereafter. She confirmed there were no interventions implemented when the resident returned to address the skin concern. The DON explained that after the body audit conducted on 7/15/25 identified redness to the resident’s buttocks, no treatment was initiated. She confirmed interventions should have been implemented. She stated, I thought we were better than that. She acknowledged that the lack of assessment and follow-through with treatment could have caused both wounds to progress and worsen. An interview with Registered Nurse (RN) #2 on 7/24/25 at 8:30 AM revealed she was the charge nurse working on 3/9/25 when Resident #6 returned from the hospital. She confirmed she did not perform a body audit on readmission and stated, I don't remember doing one. She explained that on 7/15/25, she assessed the resident’s skin and noted redness to the buttocks. She revealed that she applied pink cream and a bandage to the area but did not document it or initiate wound care orders. She stated, As far as why I didn't, I get busy, and it just fell through the cracks. An observation on 7/24/25 at 9:50 AM with Resident #6 during wound care revealed the left heel (unstageable due to eschar) revealed a round eschar covered wound. The wound bed was black; peri wound intact with no redness or irritation. Edges were well defined. The sacral wound (stage III) was oval shaped, yellow adherent slough covered, edges well defined, peri wound without redness or irritation. Record review of the “Demographics” revealed the facility admitted Resident #6 on 2/13/25 with diagnoses including Dementia with Anxiety. Record review of the “Flowsheet Data” dated 5/16/25 revealed a Brief Interview for Mental Status (BIMS) summary score of 6, indicating Resident #6 was severely cognitively impaired.