STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A389	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webster Health Services Nursing Facilty	70 Medical Plaza Eupora, MS 39744

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to accurately complete section I (active diagnoses) and O (special treatments and programs) of the Minimum Data Set (MDS) for four (4) of 14 sampled residents. Resident #6, #7, #29, and #34 Findings include: Review of facility letterhead revealed, (Proper name of facility) Long Term Care follows the RAI (Resident Assessment Instrument) Regulatory Requirements. This was signed by the Administrator and dated 8/20/25. Resident #6 Record review of Resident #6's Order dated 6/26/25 revealed, Admit to Hospice. Record review of the MDS Section O - Special Treatments, Procedures, and Programs with Assessment Reference Date (ARD) of 6/30/25 did not indicate hospice service was received by Resident #6. During an interview on 8/19/25 at 3:20 PM, the Director of Nursing (DON) revealed the MDS assessment's purpose was to reflect each resident's health status at the time of the assessment. Resident #6 was admitted to hospice service on 6/26/25 and the MDS assessment dated [DATE] did not indicate the resident received hospice services. She confirmed her expectation was for the assessment to be completed correctly, and the facility failed to submit an accurate assessment on 6/30/25 for a resident who received hospice services. Record review of Resident #6's Demographics form revealed an admission date of 3/17/25. Record review of Resident #6's Hospital Problems revealed a diagnosis of Alzheimer's Disease. Record review of Resident #6's MDS Section C - Cognitive Patterns dated 6/30/25 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident had severe cognitive impairment. Resident #7 Record review of the Quarterly MDS with an ARD of 6/9/25 revealed under section I (active diagnoses), Resident #7 was coded for having a diagnosis of bipolar disorder. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the “Hospital Problem List” revealed Resident #7 did not have a diagnosis of bipolar disorder. An interview with the Director of Nursing on 8/19/25 at 3:20 PM revealed Resident #7’s MDS was coded in error and confirmed the resident did not have a bipolar diagnosis. She revealed her expectations were for the MDS to be checked for accuracy before the assessment was closed and submitted. Record review of the Demographics” revealed the facility admitted Resident #7 on 4/1/20 with medical diagnoses that included History of Cerebrovascular Accident and Left Sided Hemiparesis. Record review of the Quarterly MDS with an ARD of 6/9/25 revealed under section C, a BIMS summary score of 15, indicating Resident #7 was cognitively intact. Resident #29 Record review of the Quarterly Minimum Data Set (MDS) with an ARD of 5/20/25 revealed under section I (active diagnoses), Resident #29 was marked for having a diagnosis of bipolar disorder. Record review of the “Hospital Problem List” revealed Resident #29 did not have a diagnosis of bipolar disorder. An interview with the Director of Nursing on 8/19/25 at 3:23 PM revealed Resident #29’s MDS was coded in error and confirmed the resident did not have a bipolar diagnosis. Review of the “Demographics” revealed the facility admitted Resident #29 on 9/2/24 with medical diagnoses that included Closed Fracture of First Lumbar Vertebra with Routine Healing. Review of the Quarterly MDS with an ARD of 5/20/25 revealed under section C, a BIMS summary score of 13, indicating Resident #29 was cognitively intact. Resident #34 Record review of Order dated 6/24/24 for Resident #34 revealed, Resident on hospice. Record review of Resident #34's MDS Section O - Special Treatments, Procedures, and Programs dated 5/26/25 did not indicate the resident received hospice services. During an interview on 8/19/25 at 3:21 PM, the DON revealed the MDS assessment reflected the health status of each resident and should be entered accurately. She stated Resident #34 was admitted to hospice on 6/19/24. She confirmed her expectation was for the assessment to be completed correctly and the facility failed to submit the 5/26/25 assessment accurately for a resident who received hospice services. Record review of Resident #34's Demographics record revealed an admission date of 7/5/21. Record review of Resident #34's Hospital Problems list revealed diagnoses of Congestive Heart Failure and Advanced Dementia. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's MDS Section C Cognitive Patterns with ARD of 5/26/25 revealed a BIMS score of 2 which indicated the resident had severe cognitive impairment.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure a resident receiving enteral feeding received appropriate care for one (1) of two (2) residents with a Percutaneous Endoscopic Gastrostomy (PEG) tube. Resident #20Findings Include:Review of the facility policy titled Enteral Feeding: Gastrostomy, PEG, Jejunostomy, unrevised, revealed under Policy: It is the policy of 'Proper name of the facility' that residents unable or unwilling to ingest oral nutrients should be properly provided nutrition and care.During an observation of a medication pass on 8/20/2025 at 12:10 PM with Licensed Practical Nurse (LPN) #1, she checked placement of Resident #20's feeding tube and withdrew three and one-half (3 1/2) 60 ml (milliliter) syringes of beige-colored gastric residual. She placed the contents into a non-measurable white Styrofoam cup, administered the resident's medication, and discarded the gastric residual by flushing it down the toilet.An interview with LPN #1 on 8/20/25 at 12:32 PM revealed Resident #20 had 150 cc's (cubic centimeters) of gastric residual and confirmed she did not return the residual contents back to the resident. LPN #1 revealed that Resident #20 received a bolus feeding at 10 AM and acknowledged that failing to return the stomach contents resulted in a lost feeding, which could lead to fluid and nutrient imbalance and possible weight loss.An interview with the Director of Nursing on 8/20/25 at 12:44 PM confirmed Resident #20's gastric residual should have been returned. She acknowledged that failure to do so could result in weight loss or electrolyte imbalance and stated this was a standard of nursing practice.Record review of the Demographics revealed the facility admitted Resident #20 on 8/2/24 with medical diagnoses that included Cerebral Infarction due to Unspecified Occlusion, Dysphagia, and Encounter for Attention to Gastrostomy.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/14/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 13, indicating Resident #20 was cognitively intact.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, record review, and facility policy review, the facility failed to follow infection prevention and control practices during blood glucose monitoring by not using a barrier and by cleaning the multiuse glucometer with an agent that was not effective against bloodborne pathogens for three (3) of eight (8) resident care opportunities observed. Resident # 8, Resident #22, and Resident #36Findings Include: Review of the facility policy titled “Care of Equipment: Cleaning, Disinfecting, and Storage,” revised 1/10/24, revealed under “Cleaning and Disinfecting: Any equipment/devices entering the room or treatment area should be cleaned and disinfected between patient use with the approved disinfectant and according to the manufacturer’s instructions for use (IFU), regardless of whether or not the equipment is visibly soiled. (e.g., glucometer) . During an observation on 8/19/2025 at 3:56 PM with Certified Nurse Aide (CNA) #1, she entered Resident #22’s room and placed the glucometer on the bedside table without a barrier. After completing the blood glucose reading, she exited the room and briefly wiped the end of the glucometer (at the strip insertion site) with an alcohol prep. CNA #1 then entered Resident #36’s room, placed the glucometer on the bedside table without a barrier while prepping the resident’s finger, and after completing the blood glucose reading, briefly swiped the end of the glucometer with an alcohol pad. Lastly, CNA #1 entered Resident #8’s room and placed the glucometer on the bedside table without a barrier. After obtaining the glucose reading, she again briefly swiped the glucometer with an alcohol wipe. Further observation revealed a bottle of Clorox Disinfecting Wipes available for use on the rolling cart, which was never used. An interview with CNA #1 on 8/19/25 at 4:16 PM confirmed she did not use a barrier during blood glucose monitoring. She acknowledged the purpose of using a barrier was to prevent cross contamination. She stated she used an alcohol wipe to clean the glucometer and reported that administration told her it was acceptable. CNA #1 explained she had Clorox wipes available but used them only after finishing all glucose checks to disinfect the machine. She admitted that not using a barrier and not cleaning the glucometer with the appropriate disinfecting agent between residents could cause the spread of infection. An interview with the Director of Nursing on 8/19/25 at 4:27 PM revealed the multiuse glucometer should be cleaned with the available Clorox wipes. She stated CNA #1 had been trained on using and properly disinfecting the machine. The Director of Nursing also confirmed that a barrier should be used to prevent cross contamination and the spread of infection. Record review of the “Demographics” revealed the facility admitted Resident #8 on 4/28/22 with a medical diagnosis that included Type 2 Diabetes Mellitus. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/23/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 13, indicating Resident #8 was cognitively intact. Record review of the “Demographics” revealed the facility admitted Resident #22 on 11/1/21 with a medical diagnosis that included Type 2 Diabetes Mellitus with Stage 4 Chronic Kidney Disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MDS with an ARD of 7/2/25 revealed under section C, a BIMS summary score of 99, indicating Resident #22 could not complete the interview. Record review of the “Demographics” revealed the facility admitted Resident #36 on 11/18/24 with a medical diagnosis that included Type 2 Diabetes Mellitus Without Complications. Record review of the MDS with an ARD of 8/4/25 revealed under section C, a BIMS summary score of 6, indicating Resident #36 was severely cognitively impaired.