STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James T Champion	1455 North Lakeland Drive Meridian, MS 39307

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's call light was maintained within reach as a reasonable accommodation for one (1) of (16) sampled residents. Resident #27.Findings include:A review of the facility's policy, Call Bell/Light, dated July 2024, revealed, .residents will have access to a call bell/light apparatus.3. Procedure A. Nursing Services will ensure that the call bell/light is within easy reach of the resident.A record review of the facility's Professional Development Program Record, dated 1/6/26 and 1/8/26, revealed, .Course Goals & Learning Objectives.Call bell should be within reach at all times.On 2/2/26 at 12:44 PM, during an observation, Resident #27 was observed lying in bed asleep. The resident's call light was observed on the floor beside the bed rather than within reach. Although the call light had a clip attached, it was not secured to the resident, the bed linens, or the bed, leaving it inaccessible to the resident while in bed.On 2/2/26 at 12:50 PM, during an observation and interview with Certified Nursing Aide (CNA) #1, Resident #27's call light was on the floor beside the bed and out of the resident's reach. CNA #1 confirmed staff were trained so that call lights were to be left within resident reach.On 2/4/26 at 10:32 AM, during an interview, CNA #3, who is the CNA Coordinator, reported all CNA staff were trained to ensure call lights were within reach when leaving a resident's room, regardless of whether the resident could independently use the call light. She reported that staff received monthly in-service education and daily reminders regarding call light placement.On 2/5/26 at 9:45 AM, during an interview, the Director of Nursing (DON) reported her expectation was for staff to ensure residents were left with the call light within reach when exiting the resident's room.A record review of the Face Sheet revealed the facility admitted Resident #27 on 12/21/23 with diagnoses including Dementia.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/11/25 revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of one (1), which indicated his cognition was severely impaired.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure as-needed (PRN) orders for psychotropic medications were limited to (14) days unless the medication was re-evaluated and a duration was specified for one (1) of five (5) residents reviewed for unnecessary medications. Resident #13.Findings include:A record review of the Resident Face Sheet revealed the facility admitted Resident #13 on 7/18/25 with diagnoses including Senile Degeneration of Brain and Persistent Mood Disorder.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/12/26 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident's cognition was severely impaired. Section N revealed the resident was receiving antipsychotic, antianxiety, and antidepressant medications.A record review of Resident #13's Physician Order Report dated 2/1/26 through 2/28/26 revealed an order with a start date of 8/1/25 for Lorazepam (Ativan) two (2) mg per milliliter (ml), give 0.5 ml sublingual every three (3) hours PRN for air hunger or anxiety. The order did not include a specified duration or evidence of re-evaluation every (14) days.On 2/3/26 at 2:07 PM, during an interview, Licensed Practical Nurse (LPN) #3 reported Resident #13 was receiving Ativan and Morphine. She reported the resident was monitored for decreased agitation and pain with Morphine and decreased agitation with Ativan and stated the resident was compliant with care and medications.On 2/5/26 at 11:15 AM, during a follow-up interview and record review with the Director of Nursing, she reported Resident #13 was on Lorazepam per hospice recommendations. She reported she believed the (14) day PRN requirement did not apply to hospice residents.On 2/5/26 at 11:30 AM, during an interview, the Nurse Practitioner reported she continued Lorazepam per hospice recommendations for comfort measures and stated she was not aware the (14) day PRN requirements applied to hospice residents but would apply this requirement going forward.

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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, interview, and record review the facility failed to ensure a tube feeding bag was labeled with required information, including the date, time, type of feeding, and initials of the nurse preparing the tube feeding, in accordance with professional standards, for one (1) of two (2) residents reviewed for tube feeding. Resident #11.Findings include:A record review of the Resident Face Sheet revealed the facility admitted Resident #11 on 12/31/25 with diagnoses including Alzheimer's Disease.A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/6/26 revealed Resident #11 required a staff assessment for cognitive status and indicated her cognitive skills for daily decision making was severely impaired.A record review of the Physician Order Report: 02/01/2026 - 02/28/2026 revealed Resident #11 had a Physician's Order, dated 1/14/26 for Isosource 1.5 at 20 ML/HR (Milliliters per Hour) .On 2/2/26 at 12:32 PM, during an observation of Resident #11 and the resident's room, there was a tube feeding bag in use did not contain a date, time, type of feeding or initials of the nurse who prepared or hung the tube feeding.On 2/2/26 at 12:35 PM, during an observation and interview with the Director of Nursing (DON), she reviewed Resident #11's tube feeding bag and confirmed it did not contain a date, time, type of feeding, or initials of the nurse who hung the bag. She reported the night nurse who changes the tube feeding bag is responsible for labeling the bag. She explained the purpose of the labeling is to ensure the feeding bag is changed within (24) hours from the start of use.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review the facility failed to post required cautionary signage to indicate oxygen was in use for three (3) of (3) residents reviewed for oxygen administration. Residents #1, #11, and #39.Findings include:On 02/02/2026 at 2:17 PM, an observation of the residents' rooms and doors on 200-hall revealed 3 rooms (Residents #1, #11 and #39) where oxygen concentrators were in use with no sign cautioning that oxygen was in use posted on the doors. On 02/02/2026 at 3:09 PM, an interview and observation with the Director of Nursing (DON) confirmed there were no oxygen signs posted outside Residents #1, #11 and #39's doors. The DON noted the reason for having an oxygen sign posted is to inform people that a possible combustible is in this room. The DON affirmed that all nursing staff are responsible for assuring proper signage is posted on residents' doors. The DON noted she will put the signs up and will make sure that the staff are educated to perform this task.On 02/05/2026 at 1:30 PM, during an interview the Administrator acknowledged the failure of the facility's staff to place oxygen signs on Residents #1, #11 and #39's doors. The Administrator stated that the staff will be trained to make sure there are signs posted on all rooms that contain oxygen concentrators.Resident #1A record review of the Resident Face Sheet revealed the facility admitted Resident #1 on 10/18/24 with diagnoses including Tracheostomy.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/22/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating his cognition was intact. A record review of the Physician Order Report: 02/01/2026-02/28/2026 revealed Resident #1 had a Physician's Order, dated 10/31/2024, for O2 (Oxygen) via trach (Tracheostomy) collar - Flow 5L/Min (Liters per minute) .continuous. Resident #11A record review of the Resident Face Sheet revealed the facility admitted Resident #11 on 12/31/2025 with diagnoses including Alzheimer's disease with late onset. A record review of the admission MDS with an ARD of 01/06/2026 revealed Resident #11 required a staff assessment for mental status and his cognitive skills for daily decision making was severely impaired. A record review of the Physician Order Report: 02/01/2026-02/28/2026 revealed Resident #11 had a Physician's Order, dated 12/31/2025 for O2 at 2L per NC (Nasal Cannula).PRN (as needed). Resident #39 A record review of the Resident Face Sheet revealed the facility admitted Resident #39 on 12/15/2025 with diagnoses including Malignant Neoplasm of Esophagus. A record review of the admission MDS with an ARD of 12/21/2025 revealed Resident #39 had a BIMS score of 15 which indicated his cognition was intact. A record review of the Physician Order Report: 02/01/2026-02/28/2026 revealed Resident #39 had a Physician's Order dated 12/17/2025 for O2 at 2L via NC - continuous.

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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, interview, record review, and facility policy review, the facility failed to prevent the possible spread of infection during medication administration for two (2) of five (5) residents observed. Specifically, for Resident #30, staff failed to maintain clean supplies by returning a box of gloves taken into the resident's room to a clean linen cart, and for Resident #5, staff failed to follow enhanced barrier precaution requirements by not wearing an isolation gown during medication administration via percutaneous endoscopic gastrostomy (PEG) tube.Findings include:A review of the facility's policy, Infection Control Plan 2025 - 2026, dated March 2024, revealed, .The mission of the infection.prevention, and control program is to prevent and control infections and to promote the well-being of patients, healthcare workers, and visitors through a commitment to excellent.patient care, effective use of resources, and continuous improvement.A review of the facility's Enhanced Barrier Precautions Protocol, undated, revealed, 1. Enhanced Barrier Precautions (EBP) are required for the following resident categories: All residents with multidrug-resistant organisms (MDROs)., chronic wounds or indwelling medical devices. A green sticker will be placed on the outside of the resident's door to identify residents on EBP. 3. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities.Device care or use.feeding tube.A record review of the facility's Professional Development Program Record revealed Licensed Practical Nurse (LPN) #3 and LPN #2 received education on hand hygiene, contact precautions, enhanced barrier precautions, and personal protective equipment (PPE) on from 5/20/25 through 5/22/25.A record review of the Review Check-Off List revealed LPN #3 received training related to Infection Prevention on 10/27/25.Resident #5A record review of the Resident Face Sheet revealed the facility admitted Resident #5 on 6/2/23 with diagnoses including Dysphagia.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/1/25 revealed Resident #5's Brief Interview for Mental Status (BIMS) was not completed and coded as 99. A record review of the Physician Order Report: 02/01/2026 - 02/28/2026 revealed all medications for Resident #5 were to be administered per PEG or PO (by mouth). On 2/4/26 at 7:30 AM, during an observation and interview, Licensed Practical Nurse (LPN) #2 administered medications via PEG tube to Resident #5. A green enhanced barrier precaution indicator was observed on the resident's door. However, the nurse did not wear an isolation gown during the medication administration. LPN #2 confirmed she did not wear an isolation gown while administering medications via PEG tube and stated she believed gowns were only required for residents on contact isolation.On 2/4/26 at 8:00 AM, during an interview, Registered Nurse (RN) #1 stated staff are trained to wear isolation gowns when providing care to residents identified with enhanced barrier precautions and that green indicators on doors identify required personal protective equipment.On 2/4/26 at 8:30 AM, during an interview, the Director of Nursing (DON) stated staff are expected to wear gowns when providing PEG tube care for residents on enhanced barrier precautions and confirmed the nurse failed to follow facility policy.Resident #30A record review of the Resident Face Sheet revealed the facility admitted Resident #30 on 2/20/25 with diagnoses including Allergic Rhinitis.A record review of the Quarterly MDS with an ARD of 11/10/25 revealed Resident #30 had a BIMS score of 12, which indicated her cognition was moderately impaired.A record review of the Physician Order Report: 02/01/2026 - 02/28/2026 revealed Resident #30 had a Physician's Order, dated 6/26/25 for Saline Nasal Spray.On 2/3/26 at 8:35 AM, during an observation, LPN #3 removed a full box of gloves from a clean linen cart, entered Resident #30's room, administered nasal saline spray, and then returned the box of gloves to the clean linen cart.On 2/3/26 at 9:00 AM, during an interview, LPN #3 stated she placed the gloves back on the clean linen cart after use and did not believe the gloves were contaminated once taken into the resident's room. LPN #3 returned the gloves back to Resident #30's room and stated she didn't care because she didn't pay for them.On 2/5/26 at 8:15 AM, during an interview, the Director of Nursing (DON) stated gloves are considered contaminated once taken into a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's room and should not be returned to the clean supply areas. The DON stated staff are expected to remove only the gloves needed for resident care and to follow infection control policies.On 2/5/26 at 1:00 PM, during an interview, the Administrator stated staff are expected to always follow infection control and enhanced barrier precaution policies. The Administrator confirmed staff should not return supplies taken into resident rooms to clean areas and should wear gowns when administering PEG tube medications.