

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER LAWRENCE CO NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 700 JEFFERSON STREET SOUTH PO BOX 398, MONTICELLO, Mississippi, 39654			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
M0000	Initial Comments		M0000				
	The State Agency (SA) conducted an Annual Recertification survey and Complaint Investigations (CI MS #3028222), at the facility from 6/15/26 through 6/18/26. The SA investigated CI MS #3028222 related to personal property missing. There were no citations related to the complaint investigation. During the annual recertification survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M620 and M1570.						
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of		M0500				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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M0500	Continued from page 1 pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the			M0500			

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M0500	Continued from page 2 facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.			M0500			

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M0500	Continued from page 3 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to ensure residents were treated with dignity, respect, privacy, and received necessary assistance with personal care in accordance with resident rights as evidenced by Resident #27 was unnecessarily exposed during catheter care and Resident #47 was denied requested assistance with drying beneath her breasts following a shower, resulting in prolonged moisture and a rash for two (2) of four (4) sampled residents for residents rights. (Resident #27 and Resident #47). Findings Include: Record review of the facility policy "Residents Rights Policy" with a revision date of 05/26 revealed, "Every resident in this facility has the right to...11. Receive adequate care and appropriate healthcare, medical treatment and protective support services. 12. Be treated courteously, fairly and with fullest measures of dignity...17. Be treated with consideration and respect for their personal privacy including but not limited to... have facility staff personnel knock before entering their room..." Record review of the facility policy "Suprapubic Catheter Site Care" with a review date of 01/24 revealed "...Procedure...5. Assist resident to dorsal recumbent position and drape for privacy. Resident #27 On 06/17/26 at 10:06 AM, Licensed Practical Nurse (LPN) #4 was observed providing suprapubic catheter care for Resident #27. LPN #4 initially knocked on the door and explained the procedure to the resident. LPN #4 then exited the room to gather supplies and reentered without knocking. During care, LPN #4 pulled the resident's bed linens down to the knees, leaving the resident exposed from beneath her breasts to her knees. The exposure extended well beyond the suprapubic catheter site. The resident's vaginal area was exposed, and the resident was not draped for privacy. On 06/17/26 at 10:26 AM, during an interview, LPN #4 confirmed she did not knock upon reentering the room after obtaining supplies. LPN #4 stated she did not believe she needed to knock because she had already entered the room previously. LPN #4 stated the privacy curtain was closed.			M0500			

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M0500	Continued from page 4 On 06/17/26 at 2:14 PM, during a follow-up interview, LPN #4 recanted her earlier statement and stated she had knocked both times before entering the room. LPN #4 stated that draping for privacy meant covering the resident during care and denied that Resident #27 had been exposed. LPN #4 stated the room door was closed and the privacy curtain was pulled. On 06/17/26 at 2:22 PM, during an interview, LPN #3 stated Resident #27's vaginal area should not have been exposed during suprapubic catheter care. LPN #3 stated LPN #4 failed to follow facility policy during the procedure. LPN #3 further stated staff should knock each time they enter a resident's room. On 06/17/26 at 3:05 PM, during an interview, Registered Nurse (RN) #1/Case Manager stated all staff are expected to knock each time they enter a resident's room. RN #1 stated LPN #4 should have draped the resident for privacy and only exposed the area necessary to provide catheter care. RN #1 stated staff are expected to follow facility policy when providing resident care. A record review of Resident #27's "Face Sheet" revealed an admission date of 3/18/19 with diagnoses including Neuromuscular Dysfunction of Bladder, Unspecified. A record review of Resident #27's "Order Summary Report" revealed an order dated 7/26/24 "Cleanse area to suprapubic cath (catheter) with wound cleanser, pat dry, cover with split gauze, and secure with tape daily." A record review of Resident #27's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/28/26 revealed a Brief Interview for Mental Status (BIMS) score of five (5), indicating severe cognitive impairment. Resident #47 On 6/15/26 at 1:12 PM, during an interview, Resident #47 stated her only concern was her shower experience. The resident explained that she had difficulty drying herself after showering and specifically required assistance drying beneath her breasts because she could not adequately reach the area. The resident stated she had not previously asked staff for assistance because she felt it would be a bother. On 6/17/26 at 10:00 AM, during a follow-up			M0500			

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M0500	Continued from page 5 interview, Resident #47 stated she requested assistance from Certified Nursing Assistant (CNA) #1 during her shower on 6/16/26 to dry beneath her breasts. Resident #47 reported CNA #1 told her she could not assist because it was a private area. Resident #47 stated she remained wet beneath her breasts following the shower. The resident reported the moisture caused a constant itchy and uncomfortable rash. Resident #47 stated she informed CNA #1 about the rash and was told to "put some of your lotion on it." On 6/17/26 at 11:53 AM, during an interview, CNA #1 stated assisting residents with showering was part of her job responsibilities. CNA #1 stated this included washing and drying all body areas when residents required assistance. CNA #1 further stated Resident #47 informed her about a rash beneath her breast and that she reported the concern to LPN #1. On 6/17/26 at 12:01 PM, during an interview, LPN #1 stated that not any staff member had informed her of a rash beneath Resident #47's breast and that this was the first time she had heard of the concern. LPN #1 stated she would immediately notify the treatment nurse or Nurse Practitioner for assessment. On 6/17/26 at 12:11 PM, during an observation with the Nurse Practitioner, Resident #47 was observed to have a red, raised rash beneath her left breast. The Nurse Practitioner stated this type of rash can occur when moisture remains trapped beneath the breast. The Nurse Practitioner stated it is important for staff to thoroughly dry beneath the breasts during showering to help prevent skin irritation and breakdown. On 6/18/26 at 10:31 AM, during an interview, LPN #3, Staff Development Coordinator, stated CNAs are taught during training to provide residents with as much assistance as needed during showering and personal care. On 6/18/26 at 11:57 AM, during an interview, the interim Director of Nursing (DON) stated CNAs are expected to assist residents as needed during showers. The DON stated that drying beneath the breasts is important because moisture left in skin folds can cause skin irritation and breakdown. The DON further stated assisting residents with their needs is part of staff responsibilities. A record review of Resident #47's "Face Sheet" revealed the resident was admitted on 8/11/22 with diagnoses including Hypertensive Heart Disease with			M0500			

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M0500	Continued from page 6 Heart Failure and Anxiety Disorder. A record review of Resident #47's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/26 revealed a Brief Interview for Mental Status (BIMS) score of (15), indicating the resident was cognitively intact.		M0500				
M0620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident's clinical condition indicates that catheterization is necessary. These residents shall receive treatment and services to prevent urinary tract infections. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, facility policy review and record review, the facility failed to ensure a resident received appropriate perineal care and in accordance with professional standards of practice for one (1) of three (3) residents reviewed for personal hygiene care (Resident #45) Findings Include: Record review of the facility policy "Perineal Care" with a revision date of 01/24 revealed "...Preparing For Care...6. Perform hand hygiene and apply gloves... 5. Wash genital area, moving from front to back while using a clean portion of the washcloth or pre-moistened wash wipe for each stroke. 6. When soap is used, rinse genital area rinsing area moving front to back using a clean portion of the washcloth or premoistened wash wipe for each stroke. 7. Dry genital area moving from front to back with towel. 8. Assist the resident to turn onto side facing away from you with leg slightly bent at the knee. 9. With a new washcloth or premoistened wash wipe, clean the anal area from front to back using a clean area of the washcloth or premoistened wash wipe after each stroke. 10. When soap is used, rinse genital area moving from front to back using a clean portion of the washcloth or premoistened wash wipe for each stroke. 11. Dry area using same method..." On 06/16/26 at 2:40 PM, Certified Nursing Assistant (CNA) #2, assisted by CNA #3, was observed providing peri-care to Resident #45. Prior to care, CNA #2 obtained supplies from a linen cart in the hallway including a lift pad, brief, and towels. Either of the CNAs did not perform hand hygiene before		M0620				

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M0620	Continued from page 7 initiating care or during the procedure. During care, CNA #2 turned on the faucet while wearing gloves, wet a hand towel, and applied soap. CNA #3 lowered the bed linens and removed the residents' brief. CNA #3 cleansed the residents' left and right thigh areas using a single front-to-back stroke with the same soapy washcloth. CNA #3 then cleansed the vaginal area one time without folding the washcloth or using a clean portion of the cloth for each stroke. After cleansing the vaginal area, the CNAs failed to rinse soap from the resident's skin and immediately dried the resident with a towel. CNA #3 then turned the resident onto her left side. CNA #2 flipped the same wet soapy washcloth over one time and cleansed the buttocks area using a single front-to-back stroke before drying the area. The CNAs did not use a basin of clean water, did not rinse the washcloth between uses, did not rinse soap from the resident's skin, did not perform hand hygiene during care, and did not wear gowns despite physician orders requiring Enhanced Barrier Precautions during hygiene care. Following completion of care, the CNAs removed their gloves and performed hand hygiene in the hallway. On 06/16/26 at 2:47 PM, during an interview, CNA #3 confirmed perineal care was not completed correctly. CNA #3 stated she was nervous and forgot the proper procedure. CNA #3 acknowledged the deficient care placed the resident at risk for infection On 06/16/26 at 2:50 PM, during an interview, CNA #2 confirmed she and CNA #3 did not wear gowns, did not use a barrier, did not use a basin, and did not perform hand hygiene before or during care. CNA #2 stated she believed Resident #45 did not have a basin available. CNA #2 acknowledged that peri-care was not completed according to facility policy and confirmed soap was not rinsed from the resident's skin. On 06/16/26 at 2:59 PM, an observation of Resident #45's closet with CNA #2 and CNA #3 revealed a basin was present. CNA #2 stated she was unaware the resident had a basin. CNA #2 acknowledged the basin should have been used and stated the care provided exposed Resident #45 to cross contamination and infection. CNA #2 again stated she was nervous and forgot the proper procedure. On 06/17/26 at 2:34 PM, during an interview, Licensed Practical Nurse (LPN) #3/ Infection Preventionist, stated staff should have used a basin during care and should have rinsed soap from the resident's skin before drying. LPN #3 stated the CNAs failed to follow facility policy throughout the			M0620			

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M0620	Continued from page 8 procedure. LPN #3 stated the resident was placed at risk for infection, including urinary tract infection, and that failure to wear gowns during Enhanced Barrier Precaution care increased the risk of cross contamination to other residents. LPN #3 stated the care provided placed Resident #45 at increased risk for infection. On 06/17/26 at 3:10 PM, during an interview, Registered Nurse (RN) #1, Case Manager, stated staff should have used a basin to properly provide care. RN #1 stated hand hygiene should have been performed before, during, and after care. RN #1 stated the washcloth should have been rinsed before continued use and soap should have been rinsed from the resident's skin before drying. RN #1 stated staff failed to follow facility policy during the entire procedure. RN #1 stated the deficient practice placed the resident at risk for urinary tract infection, skin irritation, and skin breakdown. RN #1 stated her expectation was that all staff provide care according to facility policy and accepted standards of practice. Record review of the "Face Sheet" revealed an admission date of 11/13/23 with diagnoses that included Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease Affecting Left Non-Dominant side and encounter for attention to colostomy. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/1/26 revealed a Brief Interview for Mental Status (BIMS) score of 1, which indicated severe cognitive impairment. Record review of the "Order Summary Report" with active orders as of 6/17/26 revealed an order dated 1/17/26 "Enhanced Barrier Precautions- gown and gloves to be worn during high contact resident care activities...hygiene, changing briefs...Clean stoma with soap and water pat dry wipe skin around stoma with skin prep..."			M0620			
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases.			M1570			

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M1570	Continued from page 9 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review and facility policy review the facility failed to prevent the possibility of spreading infection during perineal for one (1) of four (4) care observations. Resident #45 Record review of the facility policy "Hand Hygiene" with a revision date of 01/24 revealed " Purpose: To cleanse hands to prevent transmission of infection or other conditions. To provide clean health environment for residents, staff and visitors...Procedure... 2. Hand hygiene should be performed between all contacts with residents or when entering and exiting a resident's room. 3. Before and after procedures 3. Before and after applying gloves...." Record review of the facility's "Enhanced Barrier Precaution" signage revealed "EVERYONE MUST Clean their hands, including before entering and when leaving the room. Wear gloves and a gown for the following high contact Resident Care Activities... Changing briefs or assisting with toileting..." Record review of the facility policy "Enhanced Barrier Precautions (EBP)" with a revision date of 3/24 revealed "... EBP involves gown and gloves use during high-contact resident care activities for residents known to be colonized ...For resident for whom EBP are indicated, EBP is employed when performing the following...Changing briefs or assisting with toileting..." During an observation on 06/16/26 at 2:40 PM,			M1570			

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M1570	Continued from page 10 Certified Nursing Assistant (CNA) #2, assisted by CNA #3, was observed providing peri-care to Resident #45. Prior to care, CNA #2 obtained supplies from a linen cart in the hallway including a lift pad, brief, and towels. Either of the CNAs did not perform hand hygiene before initiating care or during the procedure. During care, CNA #2 turned on the faucet while wearing gloves, wet a hand towel, and applied soap. CNA #3 lowered the bed linens and removed the residents' brief. CNA #3 cleansed the residents' left and right thigh areas using a single front-to-back stroke with the same soapy washcloth. CNA #3 then cleansed the vaginal area one time without folding the washcloth or using a clean portion of the cloth for each stroke. After cleansing the vaginal area, the CNAs failed to rinse soap from the resident's skin and immediately dried the resident with a towel. CNA #3 then turned the resident onto her left side. CNA #2 flipped the same wet soapy washcloth over one time and cleansed the buttocks area using a single front-to-back stroke before drying the area. The CNAs did not use a basin of clean water, did not rinse the washcloth between uses, did not rinse soap from the resident's skin, did not perform hand hygiene during care, and did not wear gowns despite physician orders requiring Enhanced Barrier Precautions during hygiene care. Following completion of care, the CNAs removed their gloves and performed hand hygiene in the hallway. During an interview on 06/16/26 at 2:47 PM, CNA #3 confirmed peri-care was not completed correctly. CNA #3 stated she was nervous and forgot the proper procedure. CNA #3 acknowledged the deficient care placed the resident at risk for infection. During an interview on 06/16/26 at 2:50 PM, CNA #2 confirmed she and CNA #3 did not wear gowns, did not use a barrier, did not use a basin, and did not perform hand hygiene before or during care. CNA #2 stated she believed Resident #45 did not have a basin available. CNA #2 acknowledged that peri-care was not completed according to facility policy and confirmed soap was not rinsed from the resident's skin. During an observation on 06/16/26 at 2:59 PM, of Resident #45's closet with CNA #2 and CNA #3 revealed a basin was present. CNA #2 stated she was unaware the resident had a basin. CNA #2 acknowledged the basin should have been used and stated the care provided exposed Resident #45 to cross contamination and infection. CNA #2 again stated she was nervous and forgot the proper			M1570			

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/18/2026	
NAME OF PROVIDER OR SUPPLIER LAWRENCE CO NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 700 JEFFERSON STREET SOUTH PO BOX 398, MONTICELLO, Mississippi, 39654			
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M1570	Continued from page 11 procedure. During an interview on 06/17/26 at 2:34 PM, Licensed Practical Nurse (LPN) #3/ Infection Preventionist, stated staff should have used a basin during care and should have rinsed soap from the resident's skin before drying. LPN #3 stated the CNAs failed to follow facility policy throughout the procedure. LPN #3 stated the resident was placed at risk for infection, including urinary tract infection, and that failure to wear gowns during Enhanced Barrier Precaution care increased the risk of cross contamination to other residents. LPN #3 further stated contaminated linens should have been bagged and not placed against staff uniforms. LPN #3 stated the care provided placed Resident #45 at increased risk for infection. During an interview on 06/17/26 at 3:10 PM, Registered Nurse (RN) #1, Case Manager, stated staff should have used a basin to properly provide care. RN #1 stated hand hygiene should have been performed before, during, and after care. RN #1 stated the washcloth should have been rinsed before continued use and soap should have been rinsed from the resident's skin before drying. RN #1 stated staff failed to follow facility policy during the entire procedure. RN #1 stated the deficient practice placed the resident at risk for urinary tract infection, skin irritation, and skin breakdown. RN #1 stated her expectation was that all staff provide care according to facility policy and accepted standards of practice. Record review of the "Face Sheet" revealed an admission date of 11/13/23 with diagnoses that included Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease Affecting Left Non-Dominant side and encounter for attention to colostomy. Record review of the "Order Summary Report" with active orders as of 6/17/26 revealed an order dated 1/17/26 " Enhanced Barrier Precautions- gown and gloves to be worn during high contact resident care activities...hygiene, changing briefs...Clean stoma with soap and water pat dry wipe skin around stoma with skin prep..." A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 6/1/26 revealed a Brief Interview for Mental Status (BIMS) score of 1, which indicates severe cognitive impairment.			M1570			