

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255164		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2026	
NAME OF PROVIDER OR SUPPLIER JEFFERSON COUNTY NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 910 MAIN STREET , FAYETTE, Mississippi, 39069			
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F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 7/27/27 through 7/30/26. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F693 and F880. The facility had a census of 49 and was licensed for 60 beds.		F0000				
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)-		F0656				

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 reverse for further 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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F0656 SS = D	Continued from page 1 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to replace an enteral feeding syringe daily as ordered and care planned for one (1) of four (4) resident reviewed for enteral feedings. Resident #9. Findings Include: Record review of the facility policy "Comprehensive Care Plan Policy" with an effective date of January 2020 revealed, "... Jefferson County Nursing Home shall develop, implement, evaluate, and revise an individualized care plan for every resident..." Record review of the Care Plan Report revealed "Focus: The resident requires tub feeding per peg tube...Interventions/Task...Change enteral syringe daily on night shift..." On 7/27/26 at 11:20 AM, Resident #9 was observed in bed receiving Isosource enteral formula at 50 milliliters per hour. The resident's head of bed was elevated. The enteral syringe was dated 7/26/26 and had not been replaced as ordered and care planned. During an interview on 7/27/26 at 11:28 AM, Licensed Practical Nurse (LPN) #1 observed the syringe and confirmed it was dated 7/26/26 and had not been replaced. LPN #1 stated the night-shift nurse should have replaced the syringe with a new one. LPN #1 stated the syringe was changed daily to reduce the resident's risk of infection. LPN # 1 acknowledged she should have identified the outdated syringe during her morning rounds. LPN #1 stated that if the night-shift nurse failed to replace	F0656					

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F0656 SS = D	Continued from page 2 the syringe, it became her responsibility to replace it. During an interview on 7/29/26 at 1:54 PM, the Director of Nursing (DON) confirmed the enteral syringe should have been changed during the midnight shift. The DON stated the syringe required daily replacement to reduce the possibility of infection. The DON stated the day-shift nurse should check the enteral feeding equipment during the first morning round to ensure the syringe was properly dated and changed. The Director of Nursing stated she expected all staff to follow the resident's physician orders, care plan, and facility procedures to ensure resident safety. During an interview on 7/29/26 at 2:10 PM, the Minimum Data Set (MDS) and Care Plan Nurse stated the comprehensive care plan directed staff regarding each resident's individualized care needs. The Care Plan Nurse confirmed nursing staff failed to follow Resident #9's care plan when they did not replace the enteral syringe daily. The Care Plan Nurse stated she expected staff to follow residents' comprehensive care plans while providing care. A record review of Resident #9's "Admission Record" revealed the resident was admitted on 3/13/25 with diagnoses that included Dysphagia and Alzheimer's disease. A record review of Resident #9's Minimum Data Set assessment (MDS), with an Assessment Reference Date (ARD) of 6/3/26, revealed the resident was severely cognitively impaired. A record review of Resident #9's "Order Summary Report" revealed orders dated 4/21/26 for Isosource 1.5 enteral formula at 50 milliliters per hour with a 200-milliliter water flush every four hours. The orders directed staff to change the enteral syringe daily and to label the formula container, syringe, and administration set with the resident's name, date, time, and nurse's initials.	F0656					
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F0693					

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F0693 SS = D	Continued from page 3 §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure a resident with a feeding tube received appropriate treatment and services, as evidenced by failure to replace an enteral feeding syringe daily as ordered for one (1) of four (4) residents reviewed for enteral feeding. Resident #9. Findings Include: A record review of the facility policy, "Policy and Procedure: Percutaneous Endoscopic Gastrostomy (PEG) and Gastrostomy Management" with a review date of January 2026 revealed, "...To establish standardized procedure for the safe care, effective and individualized enteral nutrition therapy for residents requiring PEG or Gastrostomy (G)-tubes..." During an observation on 7/27/26 at 11:20 AM, Resident #9 was observed in bed receiving Isosource enteral formula at 50 milliliters per hour. The resident's head of bed was elevated. The enteral syringe was dated 7/26/26 and had not been replaced as ordered. During an interview on 7/27/26 at 11:28 AM, Licensed Practical Nurse (LPN) #1 observed the syringe and confirmed it was dated 7/26/26 and had not been replaced. LPN #1 stated the night-shift nurse should have replaced the syringe with a new one. LPN #1 stated the syringe was changed daily to reduce the resident's risk of infection. LPN # 1 acknowledged she should have identified the outdated syringe during her morning rounds. LPN #1 stated that if the night-shift nurse failed to replace the syringe, it became her responsibility to replace	F0693					

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F0693 SS = D	Continued from page 4 it. During an interview on 7/29/26 at 1:54 PM, the Director of Nursing (DON) confirmed the enteral syringe should have been changed during the midnight shift. The DON stated the syringe required daily replacement to reduce the possibility of infection. The DON stated the day-shift nurse should check the enteral feeding equipment during the first morning round to ensure the syringe was properly dated and changed. The Director of Nursing stated she expected all staff to follow the resident's physician orders, care plan, and facility procedures to ensure resident safety. A review of Resident #9's "Admission Record" revealed the resident was admitted on 3/13/25 with diagnoses that included Dysphagia and Alzheimer's disease. A review of Resident #9's Minimum Data Set assessment (MDS) with an Assessment Reference Date (ARD) of 6/3/26, revealed the resident was severely cognitively impaired. A review of Resident #9's "Order Summary Report" revealed orders dated 4/21/26 for Isosource 1.5 enteral formula at 50 milliliters per hour with a 200-milliliter water flush every four hours. The orders directed staff to change the enteral syringe daily and to label the formula container, syringe, and administration set with the resident's name, date, time, and nurse's initials.	F0693					
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F0880					

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F0880 SS = D	Continued from page 5 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F0880					

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F0880 SS = D	Continued from page 6 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation interview, facility policy review, and record review, the facility failed to follow infection prevention guidelines for one (1) of one (1) residents observed for catheter care. Resident # 4 Findings include : A record review of facility policy titled "Catheter Care for Male Policy", undated revealed, "It is the policy of this facility to provide catheter care to prevent infection of the resident's urinary tract..." A record review of facility policy titled "Infection Prevention and Control Program" revealed, "This facility has developed and maintains an infection prevention and control program that provides a safe, sanitary, and comfortable environment to help prevent the development and transmission of infection..." A review of the facility policy titled " Hand Hygiene Policy" reviewed 2/2017 revealed, "Policy: Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors...3. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to the attached hand hygiene table... Condition: After handling contaminated objects... Before and after handling clean or soiled dressings, linens, etc. After handling items potentially contaminated with blood, body fluids, secretions, or excretions, after assistance with personal body functions (e.g., elimination, hair grooming, smoking) ..." During an observation on 7/29/26 at 1:41 PM, Resident #4 was observed receiving urinary catheter care from Registered Nurse (RN) #1. RN #1 cleaned the catheter using three soap-soaked gauze pads, rinsed the area using three water-soaked gauze pads, and dried the area with a washcloth. RN #1 did not remove her gloves or perform hand hygiene during or after the procedure. While wearing the same soiled gloves used to handle the catheter, RN #1 pulled up the resident's bed covers, touched the bed remote control, and adjusted the bed's height. During an interview on 7/29/26 at 1:44 PM, RN #1 acknowledged she should have removed her gloves	F0880					

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F0880 SS = D	Continued from page 7 and performed hand hygiene before transitioning from the wet gauze to the washcloth used to dry the resident. RN #1 stated this was necessary to prevent cross-contamination. RN #1 further acknowledged that touching the catheter area and then touching the resident's bed remote control with the same gloves could have caused cross-contamination. RN #1 confirmed that failing to change gloves, failing to perform hand hygiene, and touching clean items with soiled gloves increased the risk of spreading infection within the facility. During an interview on 7/30/26 at 9:35 AM, the Director of Nursing (DON) stated the facility's catheter care policy did not specifically direct staff to change gloves at a particular point during the procedure. However, the facility's infection prevention policy directed staff to prevent cross-contamination by removing soiled gloves before touching clean objects, including the resident's bed linens and bed remote control. The DON stated she expected staff to follow the facility's infection prevention policies when providing catheter care. During an interview on 7/30/26 at 9:42 AM, the Infection Control Nurse stated that wearing soiled gloves and touching objects in a resident's room increased the risk of spreading organisms from the catheter area to other surfaces through cross-contamination. The Infection Control Nurse stated the treatment nurse had called in on 7/29/26, which required RN #1, the charge nurse, to perform care usually completed by the treatment nurse. The Infection Control Nurse stated all licensed nursing staff had demonstrated competency in the procedure and were capable of performing the care. The Infection Control Nurse stated she expected staff to follow infection prevention policies to prevent the transmission of infection to residents. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/1/26 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 5 which indicated severe mental impairment. A review of the "Admission Record" revealed the resident was admitted on 9/16/25 with diagnoses that included unspecified dementia, unspecified severity, without behavioral disturbance psychotic disturbance, mood disturbance and anxiety.			F0880			