STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255340	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE HEALTH & REHABILITATION	**211 WINDMILL DRIVE , MERIDIAN, Mississippi, 39305**

(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 08/11/2026 through 08/13/2026. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F558, F803 and F880. The facility had a census of 55 and was licensed for 60 beds.	F0000		
F0558 SS = E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to reasonably accommodate residents' needs by ensuring call lights were accessible and within reach for three (3) of (15) sampled residents. Resident #10, #12 and #29. Findings Include: Record review of the facility's "Dignity and Respect" undated, revealed "You have the right to dignity and respect in the care you receive and the settings you live in... It also means you have a right to expect care and a residential setting that: promotes your quality of life… aims to reach or maintain for you the highest achievable level of physical, mental and social well-being, consistent with a comprehensive assessment of your needs and your plan of care..." Resident # 10 On 08/11/2026 at 11:30 AM, during an observation, Resident #10 was observed sitting in the recliner.	F0558		

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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F0558 SS = E	Continued from page 1 Resident #10 stated “who is there?” It is obvious Resident #10 has vision impairment. She states she uses call light when it is near, but if not, she just yells out for staff come sees what she needs. On 08/11/26 at 1:11 PM, an observation and interview with Resident #10 stated sometimes she drops the call light and must yell out for help. An observation of the call light revealed the call light was not in reach but wrapped around bed rail. She stated she sometimes gets frustrated when she does not have call light and must yell for help. She stated they do not always place call light within reach of her. On 08/12/26 at 1:28 PM, in an interview and observation with Certified Nursing Assistant (CNA)# 2 confirmed the call light was not within reach and was wrapped around the bed rail. She stated she forgot to make sure it was in reach. She stated she usually lets Resident #10 know that call light is within reach. She stated that when Resident #10 yells out for help the staff goes to see what she needs. Record review of Resident #10 "Admission Record” revealed an admission date of 4/20/26 with diagnoses that included of unqualified visual loss, both eyes. Record review of Resident #10’s Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/21/26 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicates moderate cognitive impairment. Resident # 12 On 08/12/26 during random observations of call lights revealed Resident #12 was in the wheelchair close to the window. The call light was observed on the opposite side of the bed and wrapped around bed rail and was not in reach. On 08/13/26 at 11:48 AM, during an observation revealed Resident #12 was in the wheelchair close to the window. The call light was observed on the opposite side of the bed and wrapped around bed rail and was not in reach. On 08/13/2026 at 11:50 AM, an observation revealed Resident #12 sitting in a wheelchair on the right side of the bed. The call light was observed wrapped around the bed rail and was not in reach. CNA#3 confirmed the call light was not in reach and unwrapped it and placed it on the wheelchair. She	F0558		

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F0558 SS = E	Continued from page 2 stated she assisted resident in the wheelchair and "forgot" to give the resident the call light. She stated residents could get injured if call lights are not in place. She stated that call light should always be in reach for all residents to use for assistance. Record review of Resident #12's "Admission Record" revealed an admission date of 1/13/25 and diagnoses that included unspecified abnormalities of gait and mobility and unspecified lack of coordination. Record review of Resident #12's MDS with an ARD of 6/17/26, revealed a BIMS score of 14, indicating the resident was cognitively intact. Resident # 29 On 08/11/26 at 07:50 AM, an observation of Resident #29 was sitting in the recliner eating breakfast. The call light was observed on the opposite side of the room wrapped around the bed rail with the cord for the bed remote. On 08/11/2026 at 9:09 AM, in an interview and observation, Resident #29 stated they do not always give her call light when they place her in the recliner. An observation revealed the call light was wrapped around bed remote and attached to the bed on the opposite side of the chair where the resident was sitting. Resident #29's daughter who was at the bedside untangled the call light and gave it to the resident. The residents' daughter confirmed that the call light was not in reach and was difficult to untangle. She stated call lights should be in reach. On 08/13/2026 at 1:22 PM, in an interview with Corporate Compliance Nurse who was also acting as the Director of Nursing (DON), stated residents call light should be in reach. She stated she expects staff to answer call lights in a timely manner and place them in reach. She started residents trying to get help without call lights could fall. She stated she expects staff to follow policy, care plans and assessments. Record review of Resident #29's "Admission Record" revealed an admission date of 01/20/26 with diagnoses that included unspecified osteoarthrosis, unspecified site and unspecified abnormalities of gait and mobility. Record review of Resident #29's MDS with an ARD of 7/22/26 revealed a BIMS score of 12 which indicated moderate cognitive impairment.	F0558		

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F0803 SS = D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to identify, document, and accommodate food preferences and failed to ensure a resident knew that a substitute meal was available for one (1) of (15) sampled residents. Resident #33. Findings Include: Record review of the facility policy “Tray Identification Cards Tickets “undated revealed, “…Special needs, request and preferences of each individual resident is documented...” During Resident Council meeting at 10:21 AM on 08/11/26, Resident #33 revealed that the dietary staff consistently gave her meals that she did not like, for example, she stated she “absolutely hates” tuna	F0803		

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F0803 SS = D	Continued from page 4 fish. She said she has not asked them for a substitute, she just simply does not eat her lunch that day. On 08/11/2026 at 10:32 AM, in an interview with Resident #33 she stated sometimes she gets food on her tray that she dislikes. She stated they gave her tuna the other day and she does not like tuna. She stated she was admitted here earlier this year, and no one has come around asking her about likes and dislikes relating to food. She stated did not know she could get something else to eat. On 08/12/26 at 11:58 AM, during an observation of lunch is being served in the dining room revealed various unsampled residents' meal tickets were marked N/A (not applicable) for likes and dislikes. On 08/12/26 at 2:37 PM, in an interview with the Certified Dietary Manager (CDM) he stated he visits new admissions within 1-2 hours after admission to discuss dietary like and dislikes. He stated he does it only once unless there is a problem then he will adjust likes and dislikes. He stated it is important to find out, and document residents' likes and dislikes, so they can have a choice of what they want to eat. He stated when residents are served food they do not like they can lose weight. On 08/12/26 at 3:55 PM, during an interview with the CDM, he stated that he added a dislike of black pepper to Resident #33 meal ticket today because someone told him she does not like black pepper. He stated he should have done a one on one with her to confirm all of Resident #33 likes and dislikes. On 08/13/2026 at 1:32 PM, in an interview with Nursing Home Administrator (NHA) stated the CDM should review likes and dislikes upon admission and quarterly. She stated there is a possibility of Resident #33 not eating at all, weight loss and a decline in health. She stated her expectations are for residents to have their food choices. She stated it's very important that they receive what they like to eat and enjoy eating. She stated she expects the CDM to accommodate residents' food needs and choices. Record review of Resident #33's "Admission Record" revealed an admission date of 01/08/26 with diagnoses that included anxiety disorder. Record review of Resident #33's "Order Summary Report" revealed an order 1/8/26 for NAS (No Added Salt) diet, Regular texture, Regular liquids consistency.	F0803		

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F0803 SS = D	Continued from page 5 Record review of Resident #33's Minimum Data Set (MDS)with an Assessment Reference Date (ARD) of 7/7/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicates cognitively intact. Record review of Resident #33's meal ticket dated 08/11/26 for breakfast, lunch and dinner revealed N/A for likes and dislikes. Record review of Resident #33's meal ticket given on 8/12/26 revealed black pepper as a dislike.	F0803		
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 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	F0880		

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F0880 SS = D	Continued from page 6 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. 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, record review, and facility policy review, the facility failed to follow infection prevention guidelines when performing perineal/incontinent care for one (1) of two (2) care observations during survey. (Resident #8). Findings include: Record review of the facility policy "Perineal Care Policy" revised 1/2010 revealed, “It is the policy of this facility to provide perineal cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition…4. Always change gloves when moving from a dirty to a clean environment…”	F0880		

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F0880 SS = D	Continued from page 7 On 8/13/26 at 10:29 AM, Certified Nursing Assistant (CNA) #1 was observed providing incontinent care for Resident #8. The resident's brief contained urine and a small amount of feces (bowel movement). CNA #1 removed the resident's brief, turned the resident onto her side, and cleaned bowel movement from the resident's buttocks while wearing gloves. CNA #1 then turned the resident onto her back and performed urinary perineal care while wearing the same gloves used to clean the bowel movement. CNA #1 did not change gloves or perform hand hygiene between cleaning the resident's buttocks and urinary perineal area. During an interview on 8/13/26 at 10:36 AM, CNA #1 confirmed she cleaned bowel movement from Resident #8's buttocks before performing urinary perineal care while wearing the same gloves. CNA #1 stated staff should clean the perineal area first and proceed from clean to dirty areas to prevent transferring bacteria from bowel movement to the urinary perineal area. CNA #1 stated bacteria transferred to the urinary perineal area could cause a urinary tract infection. CNA #1 further stated gloves should be changed when moving from one area to another because wearing the same soiled gloves could result in cross-contamination. During an interview on 8/13/26 at 11:19 AM, the Interim Director of Nursing (IDON) stated CNA #1 should have cleaned the urinary perineal area before cleaning the resident's buttocks to follow the practice of moving from clean to dirty areas. The IDON stated CNA #1 should have removed the contaminated gloves, performed hand hygiene, and applied clean gloves before moving from the resident's buttocks to the urinary perineal area. She stated the failure could transfer bacteria, including Escherichia coli, to the resident's urinary perineal area and cause a urinary tract infection. She stated staff were expected to provide care according to infection prevention practices and facility policies. During an interview on 8/13/26 at 12:42 PM, the Infection Preventionist (IP) stated CNA #1 should have changed gloves and performed hand hygiene before moving from the resident's buttocks to the urinary perineal area. The IP stated CNA #1 should have cleaned the urinary perineal area before cleaning the resident's buttocks to reduce the risk of a urinary tract infection. The IP stated staff were expected to follow perineal care procedures and hand hygiene recommendations to prevent infection. A record review of Resident 8's "Progress Notes" revealed the resident was treated for a Urinary Tract	F0880		

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F0880 SS = D	Continued from page 8 Infection (UTI) on 5/22/2026. A record review of Resident #8's “Admission Record” revealed she was admitted on 7/25/22 with diagnoses that included Alzheimer's disease. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 5/29/26 revealed a Brief Interview for Mental Status (BIMS) score of 00 which indicates severe cognitive impairment. A record review of Inservice Records dated 6/22/26 revealed the CNA #1 attended an in-service and skills competency on perineal/incontinent care.	F0880		