

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255349		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/25/2026	
NAME OF PROVIDER OR SUPPLIER PEARL RIVER CO NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 305 WEST MOODY STREET PO BOX 392, POPLARVILLE, Mississippi, 39470			
(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 a Complaint Investigation (CI MS #3170245) at the facility from 8/24/26 through 8/25/26. CI MS #3170245 was investigated related to neglect, accidents, and quality of care. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F656 and F689 related to the CI. The facility held a license for 105 beds, with a census of 87.			F0000			
F0656 SS = G	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.			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 = G	Continued from page 1 (iv) In consultation with the resident and the resident's representative(s)- (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 interviews, record review, and facility policy review, the facility failed to implement a comprehensive person-centered care plan by failing to provide the care-planned assistance of two staff members during a resident transfer for one (1) of five (5) residents reviewed for transfers. (Resident #1). Findings include: A review of the facility's policy titled, "Using the Care Plan," revised August 2006, revealed, "Policy Statement: The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident..." A record review of Resident #1's "Admission Record" revealed the facility admitted the resident on 06/03/26, with an initial admission date of 10/15/24, with diagnoses including cellulitis of the right lower limb. A record review of the "Order Summary Report," as of 08/07/26, revealed an order dated 04/25/25 requiring extensive assistance of two (2) staff members for transfers. A record review of Resident #1's "Care Plan Report" revealed a focus area for an Activities of Daily Living (ADL) self-care performance deficit related to requiring assistance with ADLs, multiple sclerosis,	F0656					

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F0656 SS = G	Continued from page 2 and a history of falls, revised on 01/20/25. Interventions included "extensive assist times two (2) with transfers," initiated on 06/11/26, and "Hoyer lift as needed for transfers times two (2) assist," initiated on 12/03/25. A record review of the computerized Certified Nursing Assistant (CNA) Kardex revealed that on 08/07/26, Resident #1's transfer status was documented as "extensive assistance with two plus persons physical assist." A record review of Nursing Assistant (NA) #1's written statement revealed she was unaware Resident #1 required assistance of two staff members for transfers when she transferred the resident from the wheelchair to the bed on 08/07/26. NA #1 positioned the resident's wheelchair at an angle facing the bed, stood in front of the resident, and assisted the resident to stand and transfer onto the bed. NA #1 then bent down to monitor the resident's catheter. After NA #1 stood back up and moved the wheelchair, she heard a "pop" and observed blood "everywhere." A record review of the facility's "Incident Report" revealed that on 08/07/26 at 6:15 PM, NA #1 reported that while transferring Resident #1 from the wheelchair to the bed, she heard a "pop" and observed bleeding from the resident's right lower leg. A record review of the "Emergency Department Encounter" revealed that on 08/07/26 at 6:38 PM, Resident #1 presented with a right leg injury. The resident and facility staff reported that while the resident was being transferred to the bed with assistance, her legs began to give out, and she struck her right leg on the side rail, resulting in a large laceration. The Emergency Department documented a large laceration across the anterior surface of the right leg with an obvious open fracture. Distal sensation and pulse were intact. Resident #1 was subsequently transferred to another hospital for further evaluation and treatment. A record review of the portable right tibia/fibula X-ray dated 08/07/26 at 6:22 PM revealed, "Impression: Marked generalized osteopenia. Significant soft tissue defect along the anterior aspect of the proximal right tibia without evidence of acute bony injury. Postop change otherwise noted." A record review of the "Emergency Department Encounter" revealed that on 08/08/26 at 1:18 AM, the medical record documented that Resident #1	F0656			

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F0656 SS = G	Continued from page 3 "fell out of the wheelchair," sustaining a laceration to the right proximal tibia/fibula area just below the knee. The laceration to the right lower leg measured 10 centimeters (cm). A record review of the "CT Knee Without Contrast RT," dated 08/08/26 at 2:59 AM, revealed, "Impression: Acute fracture of the proximal tibia extending into the tibial tubercle and medial tibial plateau." On 08/25/2026 at 10:00 AM, during a telephone interview, NA #1 stated she was unaware Resident #1 required a two-person assist for transfers and did not see the two-person-assist requirement documented on Resident #1's Kardex in the computerized charting system. NA #1 confirmed she transferred Resident #1 from the wheelchair to the bed on 08/07/2026 without assistance from a second staff member. On 08/25/2026 at 10:40 AM, during an interview, Registered Nurse/Minimum Data Set (RN/MDS) #1 stated each resident's comprehensive care plan was individualized based on the resident's assessed needs, functional status, and required level of assistance. RN/MDS #1 confirmed Resident #1's comprehensive care plan identified that the resident required extensive assistance of two staff members for transfers. RN/MDS #1 stated nursing staff, CNAs, and NAs were expected to review and follow each resident's individualized care plan, including the identified level of assistance required for transfers. On 08/25/2026 at 1:00 PM, during an interview, the Director of Nursing (DON) stated nursing assistants were expected to follow each resident's individualized care plan when providing care and confirmed residents' transfer requirements were available to nursing assistants through the Kardex. The DON confirmed NA #1 knew how to access the Kardex to identify residents' transfer requirements. The DON stated three other residents assigned to NA #1 required Hoyer-lift transfers and that NA #1 requested assistance with those transfers. The DON confirmed Resident #1's care plan required assistance of two staff members for transfers and NA #1 did not follow the resident's care plan when she transferred Resident #1 without assistance from a second staff member. The DON stated she expected all staff to follow residents' care-planned transfer requirements. On 08/25/2026 at 1:30 PM, during an interview, the Administrator stated all nursing staff were expected to follow each resident's individualized care plan,			F0656			

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F0656 SS = G	Continued from page 4 including transfer requirements. The Administrator stated staff were expected to review a resident's transfer status before providing assistance and obtain additional staff assistance when required by the care plan. The Administrator confirmed Resident #1's care plan required assistance of two staff members for transfers and that the care plan should have been followed during the transfer on 08/07/26.	F0656					
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide the required level of staff assistance during a resident transfer to reduce the risk of an avoidable accident when one staff member transferred a resident who required assistance of two staff members for one (1) of five (5) residents reviewed for accidents. (Resident #1). Findings include: A review of the facility's policy titled, "Accidents/Incidents," revised April 2013, revealed, "Policy Statement: Our facility shall provide a safe and secure environment for staff and residents. Therefore, all accidents or incidents occurring on facility premises...while performing their jobs shall be reported and investigated..." A review of the facility's policy titled, "Safety and Supervision of Residents," revised July 2017, revealed, "Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities..." A record review of Resident #1's "Admission Record" revealed the facility admitted the resident	F0689					

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F0689 SS = G	Continued from page 5 on 06/03/26, with an initial admission date of 10/15/24, with diagnoses including cellulitis of the right lower limb. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/10/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. A record review of the "Order Summary Report," as of 08/07/26, revealed an order dated 04/25/25 requiring extensive assistance of two (2) staff members for transfers. A record review of Resident #1's "Care Plan Report" revealed a focus area for an Activities of Daily Living (ADL) self-care performance deficit related to requiring assistance with ADLs, multiple sclerosis, and a history of falls, revised on 01/20/25. Interventions included "extensive assist times two (2) with transfers," initiated on 06/11/26, and "Hoyer lift as needed for transfers times two (2) assist," initiated on 12/03/25. A record review of the computerized Certified Nursing Assistant (CNA) Kardex revealed that on 08/07/26, Resident #1's transfer status was documented as "extensive assistance with two plus persons physical assist." A record review of Nursing Assistant (NA) #1's "Skills Check Offs" competency revealed the competencies were completed and signed off between 06/10/2026 and 07/10/2026, prior to the incident on 08/07/2026. The competency checkoffs included resident transfers, use of mechanical lifts, and use of the computerized charting system/Kardex to identify resident care needs. A record review of NA #1's "Continuing Education Earned" revealed training was completed between 06/8/26 and 06/23/26. A record review of the facility's "Incident Report" revealed that on 08/07/26 at 6:15 PM, NA #1 reported that while transferring Resident #1 from the wheelchair to the bed, she heard a "pop" and observed bleeding from the resident's right lower leg. The nurse entered the room and observed Resident #1 sitting on the bed with blood running from a large laceration to the right lower leg. The nurse applied pressure to the wound with towels, called for assistance, and the resident was transferred to the adjacent emergency room for evaluation and treatment. The Medical Provider,			F0689			

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F0689 SS = G	Continued from page 6 Director of Nursing (DON), and Resident Representative (RR) were notified. A record review of NA #1's written statement, undated, revealed she was unaware Resident #1 required assistance of two staff members for transfers when she transferred the resident from the wheelchair to the bed on 08/07/26. NA #1 positioned the resident's wheelchair at an angle facing the bed, stood in front of the resident, and assisted the resident to stand and transfer onto the bed. NA #1 then bent down to monitor the resident's catheter. After NA #1 stood back up and moved the wheelchair, she heard a "pop" and observed blood "everywhere." A record review of the "Emergency Department Encounter" revealed that on 08/07/26 at 6:38 PM, Resident #1 presented with a right leg injury. The resident and facility staff reported that while the resident was being transferred to the bed with assistance, her legs began to give out, and she struck her right leg on the side rail, resulting in a large laceration. The Emergency Department documented a large laceration across the anterior surface of the right leg with an obvious open fracture. Distal sensation and pulse were intact. Resident #1 was subsequently transferred to another hospital for further evaluation and treatment. A record review of the portable right tibia/fibula X-ray dated 08/07/26 at 6:22 PM revealed, "Impression: Marked generalized osteopenia. Significant soft tissue defect along the anterior aspect of the proximal right tibia without evidence of acute bony injury. Postop change otherwise noted." A record review of the "Emergency Department Encounter" revealed that on 08/08/26 at 1:18 AM, the medical record documented that Resident #1 "fell out of the wheelchair," sustaining a laceration to the right proximal tibia/fibula area just below the knee. The laceration to the right lower leg measured 10 centimeters (cm). A record review of the "CT Knee Without Contrast RT," dated 08/08/26 at 2:59 AM revealed, "Impression: Acute fracture of the proximal tibia extending into the tibial tubercle and medial tibial plateau." On 08/25/2026 at 10:00 AM, during a telephone interview, NA #1 stated that on 08/07/2026, she was working at the facility as a Nursing Assistant (NA) and was scheduled to test for CNA certification on 08/08/2026. NA #1 stated she was assigned to			F0689			

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F0689 SS = G	Continued from page 7 provide care for six residents and was instructed to ask other CNAs for assistance with transfers, Hoyer lifts, and repositioning residents, as needed. NA #1 stated she was unaware Resident #1 required a two-person assist for transfers and did not see the two-person-assist requirement documented on Resident #1's Kardex in the computerized charting system. NA #1 confirmed she transferred Resident #1 from the wheelchair to the bed on 08/07/2026 without assistance from a second staff member. NA #1 stated she did not observe an injury during the transfer. After moving the wheelchair away from Resident #1, she observed bleeding from the resident's right leg and immediately called for assistance. NA #1 confirmed that prior to the incident, she had received education on the facility's computerized charting system and was aware that each resident had a Kardex containing resident-specific care information. NA #1 further stated she was responsible for providing care to other residents who required Hoyer-lift transfers and confirmed she obtained assistance from other staff members when transferring those residents. On 08/25/26 at 10:20 AM, during a telephone interview, CNA #2 confirmed she worked the same shift as NA #1 on 08/07/26. CNA #2 stated the charge nurse instructed CNAs and NAs to be responsible for their assigned residents during the shift. CNA #2 stated she personally assisted NA #1 with several resident transfers during the shift that required Hoyer lifts and confirmed NA #1 requested and received assistance from other staff when assistance was required. On 08/25/26 at 1:00 PM, during an interview, the DON confirmed that prior to being assigned residents, NAs were required to complete classroom education and skills competency checkoffs, including education on the facility's computerized charting system and how to access the Kardex to identify each resident's care needs and transfer requirements. The DON confirmed NA #1 knew how to access the Kardex to identify residents' transfer requirements. The DON stated three other residents assigned to NA #1 required Hoyer-lift transfers and that NA #1 requested assistance with those transfers. The DON confirmed Resident #1's care plan required assistance of two staff members for transfers and NA #1 did not follow the resident's care plan when she transferred Resident #1 without assistance from a second staff member. The DON stated she expected all staff to follow residents' care-planned transfer requirements. On 08/25/2026 at 1:30 PM, during an interview, the			F0689			

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F0689 SS = G	Continued from page 8 Administrator stated all nursing staff were expected to follow each resident's individualized care plan, including transfer requirements. The Administrator stated staff were expected to review a resident's transfer status before providing assistance and obtain additional staff assistance when required by the care plan. The Administrator confirmed Resident #1's care plan required assistance of two staff members for transfers and that the care plan should have been followed during the transfer on 08/07/26.			F0689			