

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255179		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/27/2026	
NAME OF PROVIDER OR SUPPLIER LEAKESVILLE REHABILITATION AND NURSING CENTER, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MELODY LANE , LEAKESVILLE, Mississippi, 39451			
(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 08/24/2026 through 08/27/2026. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F880, F628, F641, F656, F657, F684, F695, and F947. The facility had a census of 46 and was licensed for 60 beds.			F0000			
F0880 SS = E	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			F0880			

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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F0880 SS = E	Continued from page 1 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. 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, interviews, record review, and facility policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) by failing to wear required Personal Protective Equipment (PPE), including a gown, while providing tracheostomy care for one (1) of four (4) care observations. Resident #40.	F0880					

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F0880 SS = E	Continued from page 2 Findings include: A record review of the facility's policy titled, "Enhanced Barrier Precautions" with reviewed date of 09/01/2024 revealed "... It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms ... "Enhanced barrier precautions" (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities ... High-contact resident care activities include: ... device care or use: ... tracheostomy ..." During an observation and interview on 08/25/2026 at 10:20 AM, Resident #40 was observed lying in bed with the head of the bed elevated. A tracheostomy with an oxygen collar was in place. Resident #40 stated tracheostomy care was completed daily. During an interview on 08/25/2026 at 10:55 AM, Certified Nurse Aide (CNA) #1 stated the yellow star by Resident #40's name near the door indicated the resident was on EBP related to having a tracheostomy. She explained when providing any close contact care staff is to wear Personal Protective Equipment (PPE) to prevent spread of infection. During an interview on 08/25/2026 at 11:25 AM, Licensed Practical Nurse (LPN) #1 stated a Respiratory Therapist (RT) was working that day, and tracheostomy care was provided by the RT or Registered Nurse (RN) supervisor. She stated the yellow star by the resident's name indicated the resident was on Enhanced Barrier Precautions and PPE was to be worn when providing care for the resident. During an observation and interview on 08/25/2026 at 3:30 PM, the RT provided tracheostomy care to Resident #40 while wearing gloves but no gown. The RT stood on the left side of the resident's bed and reached across the resident to remove the existing tracheostomy dressing. During the care, the RT's clothing contacted the resident's bed linens, bedrail, and gown. The RT stated he did not believe a gown was necessary because he stood to the side of the bed and believed there was no risk of contamination from the resident. When asked about EBP, the RT stated the precautions applied when a risk of contamination was present.	F0880					

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F0880 SS = E	Continued from page 3 During an interview on 08/26/2026 at 2:00 PM, LPN #5, reported the facility practiced EBP, the yellow star identified residents on EBP, PPE was available, and a gown should have been worn during Resident #40's tracheostomy care. During an interview on 08/26/2026 at 3:30 PM, the Director of Nursing (DON) stated PPE was required while providing tracheostomy care and that staff were expected to wear the required PPE while providing high-contact care to residents on EBP. During an interview on 08/26/2026 at 3:45 PM, the Administrator, reported that she expects all staff to follow infection control practices and to wear required PPE while providing high-contact care, including tracheostomy care, for residents on EBP. A record review of Resident #40's "Admission Record" revealed the facility admitted the resident on 12/16/2025 with diagnoses including Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation and Tracheostomy Status. A record review of Resident #40's "Order Summary Report," with active orders as of 08/26/2026, revealed orders to assess tracheostomy status every two hours; change the drain sponge to the tracheostomy site every shift; change the Shiley 5 XLT Distal inner cannula daily; change tracheostomy ties daily; implement Enhanced Barrier Precautions every day and night shift; and provide tracheostomy site care every shift. A record review of Resident #40's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/13/2026 revealed a Brief Interview for Mental Status (BIMS) Summary Score of 11, indicating moderate cognitive impairment. Section O revealed resident had a tracheostomy and received respiratory therapy.	F0880			
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.	F0628			

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F0628 SS = D	Continued from page 4 (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this	F0628					

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F0628 SS = D	Continued from page 5 section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under	F0628					

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F0628 SS = D	Continued from page 6 the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.			F0628			

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F0628 SS = D	Continued from page 7 §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure transfer notices included an accurate reason for transfer and information in language understandable to the resident and/or Resident Representative (RR) for two (2) of (2) residents reviewed for the discharge process. Residents #3 and Resident #56. Findings include: A review of the facility's policy titled, "Transfer and Discharge (including AMA)," reviewed 08/15/2024, revealed, "...The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language...they can understand...The notice will include...The specific reason and basis for the transfer or discharge..." Resident #3 A record review of Resident #3's "Admission Record" revealed the facility admitted the resident initially on 11/30/2017 and re-entry on 04/22/2026 with diagnoses including atrial fibrillation. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/21/2026 revealed Resident #3 was discharged with return anticipated to a short-term general hospital.			F0628			

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F0628 SS = D	Continued from page 8 A record review of Resident #3's recent Quarterly MDS with an ARD of 07/30/2026 revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. A record review of Resident #3's "Order Details," dated 08/21/2026, revealed an order to "Send to (Proper hospital) ER (Emergency Room) for treatment et evaluation r/t (related to) lethargy/dropping hemaglobin." A record review of Resident #3's "Notice of Facility Initiated Transfer or Discharge," dated 08/21/2026, revealed the facility documented "Sent to ER for evaluation and treatment of: Eval (evaluation) of lethargy" and "Admitting to hospital for treatment of: Abnormal Hgb (Hemoglobin) 8." Resident #56 A record review of Resident #56's "Admission Record" revealed the facility admitted the resident on 06/03/2026 with diagnoses including pneumonia, unspecified organism. A record review of the Discharge MDS, with an ARD of 06/06/2026, revealed Resident #56 was discharged with return anticipated to a short-term general hospital and had a BIMS score of 14, indicating the resident was cognitively intact. A record review of Resident #56's "Order Summary," dated 06/05/2026, revealed an order to "Send out to ER (Emergency Room) to be evaluated for SOB (shortness of breath)." A record review of Resident #56's "Notice of transfer/ Discharge Notice," dated 6/6/2026 revealed "Reason for Discharge or Transfer: Expired". On 08/27/2026 at 8:42 AM, during an interview, the Social Services Designee (SSD) stated she was responsible for completing the Notice of Transfer/Discharge forms. The SSD confirmed Resident #56 was alive when the resident transferred from the facility to the hospital. The SSD stated she incorrectly documented "Expired" on Resident #56's transfer notice because the resident subsequently died at the hospital, and she believed the form should therefore indicate the resident had expired. The SSD stated she was unaware Resident #3's transfer notice contained terminology that might not be easily understood by a lay person. The SSD stated accurate and understandable information was important so the RR would know the reason the resident was transferred.	F0628					

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F0628 SS = D	Continued from page 9 On 08/27/2026 at 12:45 PM, during an interview, the Administrator stated the SSD was responsible for completing the transfer notice and providing information regarding the transfer to the RR. The Administrator stated it was important that the transfer notice contain accurate and understandable information, so the RR understood the reason for the resident's transfer. The Administrator stated she expected the SSD to obtain the correct reason for transfer and document the information on the transfer notice in language that was easily understood.	F0628					
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F0641					

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F0641 SS = D	Continued from page 10 This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure a Minimum Data Set (MDS) assessment accurately reflected a resident's medication use by coding the resident as having received an antipsychotic medication during the 7-day look-back period when the resident's antipsychotic medication had been discontinued prior to the look-back period for one (1) of (12) sampled residents reviewed for MDS accuracy. Resident #9. Findings include: A review of the facility's policy titled, "Conducting an Accurate Resident Assessment," reviewed and revised 7/24/2026, revealed, "...3. The appropriate qualified health professional will correctly document the resident's medical, functional, and psychosocial problems...4. A Registered Nurse (RN) will coordinate the RAI (Resident Assessment Instrument) completion process with the appropriate participation of health professionals. The registered nurse is responsible for certifying that the assessment has been completed...7. A registered nurse will sign and certify that the assessment/correction request is complete. Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment..." A record review of the "Admission Record" for Resident #9 revealed the facility admitted the resident on 7/17/2025 with diagnoses including Hypothyroidism, Unspecified, and Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. A record review of Resident #9's "Order Recap Report" revealed an order for Seroquel (quetiapine) 25 mg with a discontinuation date of 07/06/2026. A record review of Resident #9's July 2026 Medication Administration Record (MAR) revealed Seroquel (quetiapine) 25 mg was discontinued on 07/06/2026 and was not administered after that date. A record review of Resident #9's Quarterly MDS with an Assessment Reference Date (ARD) of 07/16/2026, revealed Section N0415A was coded to indicate Resident #9 received an antipsychotic medication during the applicable 7-day look-back period of 07/10/2026 through 07/16/2026.	F0641					

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F0641 SS = D	Continued from page 11 On 08/26/2026 at 12:08 PM, during an interview, Registered Nurse (RN) #2, the MDS Nurse, confirmed Resident #9 did not receive an antipsychotic medication during the applicable 7-day look-back period. RN #2 confirmed the MDS was incorrectly coded to indicate Resident #9 received an antipsychotic medication during the look-back period.	F0641					
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)- (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,	F0656					

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F0656 SS = D	Continued from page 12 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 develop comprehensive person-centered care plans that addressed identified and individualized care needs for three (3) of (12) sampled residents reviewed for comprehensive care plans. Resident #3, Resident #6, and Resident #9. Findings include: A review of the facility's policy titled, "Comprehensive Care Plans," implemented 09/30/2025, revealed, "...it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights, that include measurable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality..." Resident #3 A record review of Resident #3's "Care Plan Report" revealed a focus for behavior problems with no specific goals or interventions. The care plan contained a focus for anticoagulant therapy; however, the focus contained no interventions. The care plan also contained a focus related to the resident's wishes for the provision of spiritual care while residing in the facility; however, the focus contained no goal or interventions addressing the identified focus. A record review of Resident #3's "Admission Record" revealed the facility admitted the resident on 04/22/2026 with diagnoses including Unspecified Atrial Fibrillation. A record review of Resident #3's Quarterly MDS with an ARD of 07/30/2026 revealed a BIMS score of 11, indicating moderate cognitive impairment.			F0656			

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F0656 SS = D	Continued from page 13 Resident #6 A record review of Resident #6's "Care Plan Report" revealed a focus for disturbed thought processes that identified chlorpromazine as a psychotropic medication and included an action for the medication related to dementia/behaviors. The care plan did not contain individualized goals or interventions addressing Resident #6's severe cognitive impairment associated with dementia. A record review of Resident #6's "Admission Record" revealed the facility admitted the resident on 08/05/2016 with diagnoses including Unspecified Intracranial Injury with Loss of Consciousness status unknown, and Dementia in Other Diseases Classified Elsewhere, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/11/2026 for Resident #6 revealed a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. A record review of Resident #6's "Order Review History Report" revealed an order dated 5/14/26 for chlorpromazine HCl 10 mg (milligrams) administered via gastrostomy tube twice daily related to dementia. Resident #9 A record review of Resident #9's "Care Plan Report" revealed the care plan focus for "...impaired cognitive function r/t psychiatric disorder as evidence by ...impaired memory...depression..." The care plan contained no goal associated with the focus. The care plan included an action for sertraline 50 mg for depression. A record review of the "Admission Record" for Resident #9 revealed the facility admitted the resident on 07/17/2025 with diagnoses including Hypothyroidism, Unspecified, and Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. A record review of Resident #9's "Order Summary Report" with active orders as of 07/01/2026 revealed an active physician order for sertraline 50 mg with a start date of 05/15/2026. A record review of Resident #9's July 2026 Medication Administration Record (MAR) revealed	F0656					

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F0656 SS = D	Continued from page 14 sertraline 50 mg was administered as ordered. A record review of the Quality Assurance and Performance Improvement (QAPI) meeting documentation dated 05/27/2026 revealed the facility identified a goal for care plans to be updated and signed as care-plan reviews were completed. A record review of the QAPI meeting documentation dated 08/19/2026 revealed the facility identified a goal for all care plans to be reviewed, corrected, and updated with current orders to accurately reflect residents' plans of care. On 08/25/2026 at 3:54 PM, during an interview, Registered Nurse (RN) #3/MDS Nurse, stated she returned to the facility after an approximately two-year absence and began using PointClickCare (PCC) for care planning. RN #3 stated she believed she had been regularly updating residents' care plans; however, the updates were not being entered into the electronic system correctly. RN #3 stated the problem was identified on 05/27/2026 and addressed during a QAPI meeting. RN #3 further stated she completed an audit on 08/19/2026 and determined care-plan updates continued to be entered incorrectly. RN #3 stated the facility subsequently conducted another QAPI meeting and continued working to update and revise residents' comprehensive care plans. On 08/26/2026 at 3:13 PM, during a follow-up interview, RN #3 stated the purpose of the comprehensive care plan was to provide staff with a tool containing the information necessary to consistently provide care to residents. RN #3 stated comprehensive care plans were developed at baseline and reviewed following quarterly and annual assessments. RN #3 stated she had previously believed PCC automatically updated the comprehensive care plans as resident information was entered into the electronic system but subsequently learned the system did not automatically make those care-plan updates.	F0656			
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F0657			

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F0657 SS = D	Continued from page 15 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to revise a comprehensive care plan to reflect a change in a resident's medication regimen by failing to remove antipsychotic medication interventions after Seroquel (quetiapine) was discontinued for one (1) of (12) sampled residents reviewed for comprehensive care-plan revisions. Resident #9. Findings include: A record review of Resident #9's "Care Plan Report" revealed focuses, goals, and interventions instructing staff to observe the resident for side effects associated with antipsychotic medication use. The care plan continued to contain interventions related to antipsychotic medication use after the physician's order for Seroquel (quetiapine) was discontinued on 07/06/2026. A record review of the "Admission Record" for Resident #9 revealed the facility admitted the resident on 07/17/2025 with diagnoses including Hypothyroidism, Unspecified, and Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety.	F0657					

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F0657 SS = D	Continued from page 16 A record review of Resident #9's "Order Recap Report" revealed an order for Seroquel (quetiapine) 25 mg with a discontinuation date of 07/06/2026. A record review of Resident #9's July 2026 Medication Administration Record (MAR) revealed Seroquel (quetiapine) 25 mg was discontinued on 07/06/2026 and was not administered after that date. A record review of Quality Assurance and Performance Improvement (QAPI) meeting documentation dated 05/27/2026 revealed the facility identified a goal for care plans to be updated and signed as care-plan reviews were completed. A record review of the QAPI meeting documentation dated 08/19/2026 revealed the facility identified a goal for all care plans to be reviewed, corrected, and updated with current physician orders to accurately reflect residents' plans of care. During an interview on 08/25/2026 at 3:54 PM, Registered Nurse (RN) #3, Minimum Data Set (MDS)/Care Plan Nurse, stated she returned to the facility after an approximately two-year absence and began using PointClickCare (PCC) for care planning. RN #3 stated she believed she had been regularly updating residents' care plans; however, the updates were not being entered into the electronic system correctly. RN #3 stated the issue was identified on 05/27/2026 and addressed during a QAPI meeting. RN #3 further stated she completed an audit on 08/19/2026 and determined care-plan updates continued to be entered incorrectly. RN #3 stated the facility subsequently conducted another QAPI meeting and continued working to update and revise residents' comprehensive care plans. During a follow-up interview on 08/26/2026 at 3:13 PM, RN #3 stated the purpose of the comprehensive care plan was to provide staff with a tool containing the information necessary to consistently provide care to residents. RN #3 stated care plans could be updated daily based on changes in residents' conditions and physician orders. RN #3 stated she had previously believed PCC automatically updated the comprehensive care plans as information was entered into the electronic system but subsequently learned the system did not automatically update the care plans.	F0657					
F0684 SS = D	Quality of Care CFR(s): 483.25	F0684					

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F0684 SS = D	Continued from page 17 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure a resident received necessary care and services consistent with professional standards of practice by failing to ensure timely follow-up for removal of (23) surgical staples following repair of a right femur fracture, which resulted in the staples remaining in place for more than 30 days after admission for one (1) of (12) sampled residents reviewed for quality of care. Resident #1. Findings include: A record review of the facility's policy "Provision of Quality Care" with reviewed date 08/15/2024 revealed "... Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices ... Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being ... All employees are responsible for following established policies and procedures ..." A record review of Resident #1's "Admission Record" revealed the facility admitted the resident on 07/20/2026 with the diagnoses of Encounter for Other Specified Surgical Aftercare and Displaced Intertrochanteric Fracture of Right Femur. A record review of Resident #1's "Admission Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/27/2026 revealed a Brief Interview for Mental Status (BIMS) Summary Score of 7, which indicated severe cognitive impairment. Section M revealed a surgical wound. A record review of Resident #1's "Order Summary Report" with active orders as of 08/26/2026 revealed Surgical incision site to Right Hip: Cleanse with			F0684			

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F0684 SS = D	Continued from page 18 wound cleanser, pat dry and cover with dry dressing daily and as needed start date 08/14/2026, Surgical site to right hip: Monitor staples (23 total) for s/s (signs and symptoms) infection daily start date 08/14/2026. A record review of Resident #1's July 2026 "Treatment Administration Record (TAR)" revealed an order to cleanse R (right) hip incision site with wound cleanser, pat dry, and cover with bandage Q (every) day and PRN (as needed) with start date 07/21/2026 and D/C (discontinued) date 08/14/2026. The TAR further revealed an order to monitor the staples to the right hip surgical site for S/S (signs and symptoms) of infection every day and night shift with start date of 07/20/2026 and D/C date 08/14/2026". A record review of Resident #1's August 2026 "Treatment Administration Record (TAR)" revealed an order to cleanse the right hip surgical incision site with wound cleanser, pat dry, and cover with a dressing daily and as needed, with a start date of 08/14/2026 and discontinuation date of 08/26/2026. The TAR further revealed an order to monitor the 23 staples to the right hip surgical site for signs and symptoms of infection daily, with a start date of 08/14/2026 and discontinuation date of 08/26/2026. A record review of Resident #1's "Progress Notes" with effective date 08/25/2026 completed via the nurse practitioner revealed "... monitor right lateral hip incision for erythema, warmth, drainage, dehiscence, staple status, and delayed healing; continue current surgical-site monitoring ..." On 08/25/2026 at 3:15 PM, during an interview and observation with Licensed Practical Nurse (LPN) #2, Resident #1's right upper outer thigh was observed with two (2) bandages dated 08/24/2026. LPN #2 stated Resident #1 still had staples in place from the surgical incision present when the resident was admitted to the facility. LPN #2 removed the bandages, and three (3) surgical incision sites were observed with a total of 23 staples remaining in place. The superior incision had loosened staples and dried scabs, with a scant amount of blood noted on the old dressing. The two (2) smaller incisions had staples loosened from the incision sites with dried scabs. LPN #2 stated the sites had been monitored daily and dressing changes had been completed. On 08/25/2026 at 3:30 PM, during an interview, Registered Nurse (RN) #5 stated Resident #1 was scheduled for an orthopedic follow-up appointment			F0684			

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F0684 SS = D	Continued from page 19 the following morning. RN #5 confirmed this was the resident's first orthopedic follow-up appointment and stated she did not know why the appointment had not occurred earlier. RN #5 stated the resident was supposed to have orthopedic follow-up within one (1) to two (2) weeks after admission and confirmed she could not locate documentation of an earlier appointment. A review of the resident's progress notes did not identify documentation of previous orthopedic follow-up. On 08/26/2026 at 8:30 AM, during an observation, Resident #1 was not in her room. LPN #3 stated the resident had left the facility earlier that morning for the orthopedic appointment. On 08/26/2026 at 1:10 PM, during an interview, LPN #4 stated Resident #1 had returned from the orthopedic appointment and the orthopedic provider had removed the staples. LPN #4 stated the staples had remained in place since the resident's admission on 07/20/2026. On 08/26/2026 at 3:35 PM, during an interview with the Director of Nursing (DON), she confirmed staples should be removed within 7–14 days and staff should notify providers if staples remain longer or if concerns arise. On 08/26/2026 at 3:45 PM, during an interview with the Administrator, she reported that she expects staff to follow standards of practice, notify providers of concerns, and document follow-up. On 08/26/2026 at 4:10 PM, during an observation and interview with Certified Nurse Aide (CNA) #5, Resident #1's right upper thigh/hip surgical sites were observed with redness and scars at the staple marks. No open areas or dressings were observed. CNA #5 stated the resident had staples in place since admission and the sites had been covered daily. CNA #5 stated this was the first time she had observed the sites without dressings and staples. On 08/26/2026 at 4:20 PM, during a telephone interview with staff from Resident #1's orthopedic office, the staff member stated Resident #1 was seen on 08/26/2026 for the first orthopedic follow-up appointment and that no previous appointments had been scheduled or missed. On 08/26/2026 at 4:50 PM, during a telephone interview, the facility's Nurse Practitioner stated she was aware Resident #1 had staples in place upon admission but had not reassessed the staples. The NP stated she had not been notified that the staples			F0684			

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F0684 SS = D	Continued from page 20 remained in place for more than 30 days. The NP stated staples are generally removed within 14 days and prolonged retention can lead to dehiscence, infection, and impaired healing.	F0684					
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure respiratory care services were provided in accordance with professional standards of practice by failing to: 1) perform tracheostomy care using appropriate technique; and 2) appropriately monitor a resident during administration of a nebulizer treatment and turn off the nebulizer machine when medication delivery was complete, for one (1) of two (2) residents sampled for respiratory care. Resident #40. Findings include: A record review of the facility's policy titled, "Tracheostomy Care" revealed "...The purpose of this procedure is to guide tracheostomy care...Clean the Removable Inner Cannula...4. Maintaining sterile field, pour ½ (half) hydrogen peroxide and ½ sterile saline in one compartment of opened kit. Pour sterile saline in another compartment...Site and Stoma Care:... 2. Clean the stoma with peroxide-soaked...cotton tipped applicators (using a single sweep for each side). 3. Rinse the stoma with saline-soaked...cotton tipped applicators (using a single sweep for each side). 4. Wipe with dry gauze (using a single sweep for each side)..." A record review of the facility's policy titled, "Nebulizer Therapy," with a reviewed date of 05/06/2026 revealed, "...It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions...Policy	F0695					

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NAME OF PROVIDER OR SUPPLIER LEAKESVILLE REHABILITATION AND NURSING CENTER, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MELODY LANE , LEAKESVILLE, Mississippi, 39451			
(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	
F0695 SS = D	Continued from page 21 Explanation and Compliance Guidelines...14. Observe resident during the procedure for any change in condition. 15. When medication delivery is complete, turn the machine off. Treatment may be considered complete with the onset of nebulizer sputtering." On 08/24/2026 at 11:34 AM, during an observation and interview, Resident #40 was observed sitting up in bed wearing a nebulizer mask with medication being administered through the nebulizer machine. No staff were present in the room. Resident #40 stated she received nebulizer treatments several times a day and occasionally required suctioning. Resident #40 stated staff would place the medication in the nebulizer and then leave because "they have so much to do." On 08/24/2026 at 11:58 AM, during an observation, Resident #40's nebulizer medication was observed to be completed; however, no staff were present in the room. Resident #40 continued to wear the nebulizer mask and was observed with a dry cough. A staff member delivered the resident's lunch tray. Resident #40 removed the nebulizer mask, placed the mask in the bed, and began eating. On 08/24/2026 at 12:06 PM, during an observation, Resident #40's nebulizer machine continued to run. During an interview, Certified Nurse Aide (CNA) #2 stated no staff were present in the resident's room and confirmed no staff had been present when she previously delivered the resident's lunch tray. CNA #2 stated the resident removed the nebulizer mask after completing the treatment and staff would return to turn off the machine. On 08/24/2026 at 12:16 PM, during an observation, a staff member entered Resident #40's room, turned off the nebulizer machine, auscultated lung sounds, and checked the resident's oxygen saturation. During an interview, Registered Nurse (RN) #5 stated she was performing the Respiratory Therapist (RT) duties that day and was responsible for administering nebulizer treatments and inhalers. RN #5 stated that before and after each nebulizer treatment she was expected to measure the resident's oxygen saturation, auscultate lung sounds, assess the respiratory rate, and monitor how the resident tolerated the treatment. When asked how she monitored the resident's tolerance when she was not present during administration, RN #5 stated she was not supposed to leave during nebulizer administration and confirmed she had not remained present during Resident #40's nebulizer treatment.	F0695					

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F0695 SS = D	Continued from page 22 On 08/25/2026 at 10:20 AM, during an observation and interview, Resident #40 was observed lying in bed with head of bed elevated. A tracheostomy with an oxygen collar was in place. Resident #40 stated tracheostomy care was completed daily. On 08/25/2026 at 11:25 AM, during an interview, Licensed Practical Nurse (LPN) #1 stated a RT was working that day, and tracheostomy care was provided by the RT or RN supervisor. On 08/25/2026 at 3:30 PM, during an observation and interview, the RT stated complete tracheostomy care was performed each shift and included cleaning the tracheostomy site and rinsing the site with normal saline. During the observed care, the RT opened the tracheostomy-care kit, which contained two containers, hydrogen peroxide, normal saline, gauze, and cotton-tipped applicators. The RT was observed pouring the solutions together into one container and leaving the second container empty. The RT then used two cotton-tipped applicators together to repeatedly swab around the tracheostomy site rather than using a single sweep for each side. The RT dried the site with gauze without rinsing the site with saline. During the interview following the care, the RT confirmed he used both cotton-tipped applicators together and repeatedly cleaned the site rather than using one sweep and discarding the applicator. The RT stated he was in a hurry and forgot. The RT also confirmed he did not rinse the site after cleaning and stated he had poured the solutions into one container because he was in a hurry. The RT confirmed the tracheostomy-site care was performed incorrectly. On 08/26/2026 at 3:35 PM, during an interview, the Director of Nursing (DON) stated tracheostomy care was expected to be performed using proper technique and nebulizer treatments were expected to be monitored. A record review of Resident #40's "Order Summary Report" with active physician's orders as of 08/26/2026 revealed orders to assess tracheostomy status every two (2) hours; change the drain sponge to the tracheostomy site every shift; change the Shiley 5 XLT Distal inner cannula daily; change tracheostomy ties daily; and provide tracheostomy-site care by cleaning around the outer cannula and behind the flange of the tracheostomy with 1:1 sterile water and hydrogen peroxide every shift. The report further revealed orders to assess and document lung sounds before administration of DuoNeb nebulizer treatments; assess and document lung sounds and tolerance after administration of	F0695					

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F0695 SS = D	Continued from page 23 DuoNeb nebulizer treatments; and administer Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3 mL, one vial via inhalation every six (6) hours for wheezing related to Chronic Obstructive Pulmonary Disease (COPD) with acute exacerbation. A record review of Resident #40's "Admission Record" revealed the facility admitted the resident on 12/16/2025 with the diagnoses of Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation and Tracheostomy Status. A record review of Resident #40's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/13/2026 revealed a Brief Interview for Mental Status (BIMS) Summary Score of 11, indicating moderate cognitive impairment. Section O revealed resident had a tracheostomy and received respiratory therapy.	F0695					
F0947 SS = D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure Certified Nurse Aides (CNAs) received required annual in-service training. Nine (9) CNAs did not receive	F0947					

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F0947 SS = D	Continued from page 24 required training in resident abuse prevention and dementia management, and four (4) additional CNAs did not receive required training in dementia management for (13) of (36) CNAs reviewed for required annual in-service training. Findings include: A record review of the facility's Certified Nurse Aide (CNA) employee roster revealed the facility employed 36 CNAs. A record review of the facility's annual in-service training records and comparison of the training records to the CNA employee roster revealed 13 of 36 CNAs did not receive all required annual in-service training. Nine (9) CNAs did not receive training in resident abuse prevention and dementia management. Four (4) additional CNAs received resident abuse-prevention training but did not receive training in dementia management. A review of the facility's policy titled, "Continuing Education," reviewed 07/18/2026, revealed, "...employees are expected to complete required trainings within designated time frames..." A record review of the sign-in sheets for the facility's in-services titled, "Abuse, Residents Rights, Hydration," dated 02/04/2026; "Abuse, Dementia, Hydration," dated 02/05/2026; "Abuse and Neglect," dated 03/17/2026; "Yellow Dot - Enhanced Barriers, Expectations, Policy & Procedures on Rounds, CNA Duties, LPN (Licensed Practical Nurse) & RN (Registered Nurse) Expectations, Abuse and Neglect," dated 04/10/2026; and "Abuse & Neglect, Pt (Patient) Rights, Staff Burnout, Dementia," dated 07/30/2026, and comparison of the sign-in sheets to the active CNA employee roster revealed nine (9) CNAs did not have documented attendance at training addressing resident abuse prevention and dementia management, and four (4) additional CNAs did not have documented attendance at training addressing dementia management. On 08/26/2026 at 1:23 PM, during an interview, Registered Nurse (RN) #1, Staff Development Nurse, stated she was responsible for providing in-service training to staff at hire and on an ongoing basis. RN #1 stated she sent alerts to staff phones and posted signs at the time clock to inform staff of upcoming in-services and went to all three (3) shifts to provide training. RN #1 stated ongoing education was important to ensure staff understood what constituted abuse, their role in the process, and why			F0947			

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F0947 SS = D	Continued from page 25 residents with dementia may exhibit certain behaviors. RN #1 stated she would try to develop a method to compel staff to attend the in-services. On 08/26/2026 at 1:30 PM, during an interview, the Director of Nursing (DON) stated the Staff Development Nurse was responsible for providing in-service training to staff. The DON stated ongoing staff training was important to ensure staff were knowledgeable regarding abuse and dementia in order to provide care to residents. The DON stated she would like to use a staff census as a check-off to ensure 100 percent of staff received the in-service training. On 08/26/2026 at 1:33 PM, during an interview, the Administrator stated the Staff Development Nurse was responsible for providing new-hire and ongoing in-service training for staff. The Administrator stated ongoing in-service training was important to properly educate staff so they could care for and protect the facility's residents. The Administrator stated the facility would immediately provide dementia, abuse and neglect, and residents' rights in-services until 100 percent of staff received the training.			F0947			