

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/10/2026	
NAME OF PROVIDER OR SUPPLIER STONE COUNTY REHABILITATION AND NURSING CTR INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1436 EAST CENTRAL AVENUE , WIGGINS, Mississippi, 39577			
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M0000	Initial Comments The State Agency (SA) conducted an annual re-licensure survey at the facility from 9/8/26 to 9/10/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M065, M0815, and M1570. .		M0000				
M0000	Initial Comments The State Agency (SA) conducted an annual re-licensure survey at the facility from 9/8/2026 through 9/10/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operations for Alzheimer's Disease/Dementia Care Unit and cited M065. The census at the time of the survey was 19 with a bed capacity of 20.		M0000				
M0065	50.3.2 Care Plans Care Plans. Individual care plans shall be developed by the staff for each resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to revise a resident's comprehensive person-centered care plan following a fall resulting in a fracture of the proximal right femur by failing to develop additional or revised interventions addressing the resident's risk for falls and injury, for one (1) of (15) residents reviewed for comprehensive care plans. Resident #9. Findings Include: A record review of the facility's policy titled "Comprehensive Care Plan" revision date of 05/01/2026 revealed "...Policy Explanation and Compliance Guidelines...5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6...Alternative		M0065				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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M0065	Continued from page 1 interventions will be documented, as needed..." A record review of Resident #9's "Care Plan Report" revealed a focus addressing the resident's risk for falls and injury; however, the care plan did not contain additional or revised interventions following the resident's 06/01/2026 fall resulting in a fracture of the proximal right femur. A record review of Resident #9's "Admission Record" revealed the facility admitted the resident on 03/01/2022 with diagnoses including Fracture of Unspecified Part of Neck of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing. A record review of Resident #9's "Comprehensive Minimum Data Set (MDS)" with Assessment Reference Date (ARD) of 06/11/2026 revealed the resident was severely impaired for Cognitive Skills for Daily Decision Making. A record review of Resident #9's "Incident Report," dated 06/01/2026, revealed the resident sustained a witnessed fall and was sent to the hospital for evaluation. A record review of Resident #9's staff written statement related to the fall, dated 06/01/2026, revealed the resident sustained a witnessed fall and was sent to the hospital. A record review of Resident #9's "Computed Tomography (CT) Scan," dated 06/01/2026, revealed a fracture of the proximal right femur. On 09/08/2026 at 12:31 PM, during an interview, Registered Nurse (RN) #1 stated Resident #9 sustained a witnessed fall and fractured the right hip. On 09/10/2026 at 3:44 PM, during an interview, Licensed Practical Nurse (LPN) #2, Care Plan Nurse, confirmed Resident #9's comprehensive care plan had not been updated following the fall resulting in the right hip fracture. LPN #2 stated she was aware of the resident's fall with injury and confirmed the care plan should have been updated. LPN #2 stated the purpose of updating the care plan was to implement interventions to prevent further falls. LPN #2 further stated she became the Care Plan Nurse after the fall in late June 2026. On 09/10/2026 at 3:49 PM, during an interview, the Director of Nursing (DON) confirmed Resident #9's comprehensive care plan should have been updated			M0065			

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M0065	Continued from page 2 following the fall. The DON stated that at the time of the fall, the facility was undergoing a transition in care-plan responsibilities because he had been promoted and was training another nurse to assume his previous responsibilities. The DON stated the comprehensive care plan was used by all staff to guide the resident's care and acknowledged the care-plan update was missed during the transition.			M0065			
M0815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to store food in accordance with professional standards for food service safety by failing to label and date food brought into the facility for a resident and failing to discard milk that was past its expiration date, during one (1) of two (2) kitchen observations. Findings include: A review of the facility's policy titled "Food Receiving and Storage" revised 07/2014 revealed, "...Policy Interpretation and Implementation...13...b. All foods belonging to residents must be labeled with the resident's name, the item, and the "use by" date..." On 09/08/2026 at 10:08 AM, during the initial kitchen tour, an observation of refrigerator #2 revealed one bowl of food brought into the facility by a resident's family that was not labeled or dated and one (1) unopened gallon of milk with an expiration date of 09/01/2026. During an interview at that time, the Cook stated kitchen staff were responsible for labeling and dating food and maintaining the freshness of food stored in the kitchen and were expected to discard expired items. The Cook stated unlabeled, undated, or expired food could be consumed and could cause someone to become ill. The Cook further stated staff should do a better job of labeling food and knowing when to remove expired items from the food supply. On 09/09/2026 at 11:06 AM, during an interview, the Dietary Manager (DM) stated the cooks were responsible for checking food labeling and dating			M0815			

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M0815	Continued from page 3 and discarding expired food. The DM stated unlabeled, undated, or expired food stored in the refrigerator could result in foodborne illness if consumed by a resident. The DM stated he expected kitchen staff to check food storage and discard expired items and properly label and date food. The DM further stated he planned to implement a flow chart to assist with maintaining food quality. On 09/10/2026 at 1:39 PM, during an interview, the Administrator stated he was aware of the unlabeled and undated food and expired milk identified in the kitchen. The Administrator stated the potential hazard of maintaining the food in the kitchen was that it could be provided to a resident. The Administrator stated he expected kitchen staff to routinely monitor food storage to maintain food freshness.			M0815			
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to perform hand hygiene prior to donning gloves			M1570			

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M1570	Continued from page 4 during resident care to reduce the risk for transmission of infection for two (2) of eight (8) medication administration observations. Residents #4 and #14. Findings include: A record review of the facility's policy titled "Hand Hygiene," revised 09/01/2024, revealed "...all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility...The use of gloves does not replace hand hygiene. If your task requires gloves perform hand hygiene prior to donning gloves..." Resident #4 A record review of Resident #4's "Admission Record" revealed the facility admitted the resident on 06/29/2026 with diagnoses including Other Acute Osteomyelitis, Right Femur. A record review of Resident #4's "Order Summary Report" revealed an active physician's dated 9/9/26 for Vancomycin HCl Intravenous Solution 1500 milligrams (mg)/300 milliliters (mL), one (1) dose intravenously one time a day related to Other Acute Osteomyelitis, Right Femur, through 09/15/2026. On 09/09/2026 at 11:25 AM, during an observation, Registered Nurse (RN) #2 failed to perform hand hygiene prior to donning gloves before disconnecting Resident #4's intravenous (IV) line, cleaning the tubing connection, and flushing the IV with normal saline and heparin. On 09/09/2026 at 11:32 AM, during an interview, RN #2 confirmed she did not perform hand hygiene upon entering the resident's room and stated she should have performed hand hygiene prior to donning gloves. RN #2 stated she placed the resident at risk for infection. Resident #14 A record review of Resident #14's "Admission Record" revealed the facility admitted the resident on 12/13/2023 with diagnoses including Type 2 Diabetes Mellitus with Diabetic Neuropathy. A record review of Resident #14's "Order Summary Report" revealed an active physician's order dated 1/12/24 for Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro), inject as per sliding scale.			M1570			

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M1570	Continued from page 5 On 09/09/2026 at 11:05 AM, during a medication administration observation, RN #1 failed to perform hand hygiene prior to donning gloves before performing a blood glucose check for Resident #14 to determine whether sliding-scale insulin was required. On 09/09/2026 at 11:11 AM, during an interview, RN #1 confirmed she did not perform hand hygiene upon entering the resident's room or prior to performing the blood glucose check. RN #1 stated she placed the resident at risk for infection and the spread of bacteria. On 09/10/2026 at 3:53 PM, during an interview, the Director of Nursing (DON) stated staff should perform hand hygiene before providing resident care and were expected to follow facility policies and procedures. The DON stated failure to perform hand hygiene increased the risk for residents developing infections.			M1570			