

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 09/24/2026	
NAME OF PROVIDER OR SUPPLIER SENATOBIA HEALTHCARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 402 GETWELL DR , SENATOBIA, Mississippi, 38668			
(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	
M0000	Initial Comments		M0000				
	The State Agency (SA) conducted an Annual Re-certification survey along with a Complaint Investigation (CI MS#3692885) at facility from 9/22/26 through 9/24/26. 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 M225, M460, M500, M625, M655, M815, M850. The SA investigated CI#3692885 and no deficiencies were cited. The census at the time of the survey was 100 and the facility held a license for 106 beds.						
M0225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility. c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse.		M0225				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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M0225	Continued from page 1 d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of the Payroll-Based Journal (PBJ) Staffing Data Report, staffing records, interview, and facility policy review, the facility failed to meet Mississippi's minimum of 2.80 hours of direct nursing care per resident per 24-hour period on two (2) of 26 weekend days reviewed during Quarter 3 of 2026. The facility reported 2.60 hours per resident on 04/26/2026 and 2.75 hours per resident on 05/03/2026. Findings include: Review of the facility policy titled "Nursing Services and Sufficient Staff," undated, revealed, "Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychological well-being of each resident..." Review of the PBJ Staffing Data Report for Quarter 3	M0225					

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M0225	Continued from page 2 of 2026, April 1 through June 30, revealed the facility triggered for excessively low weekend staffing. Record review of the Staffing Grid for the 26 Saturdays and Sundays in that quarter revealed the facility reported 2.60 hours of direct nursing care per resident on 04/26/2026 and 2.75 hours on 05/03/2026. Both were below the state minimum of 2.80 hours per resident per 24-hour period. During an interview on 09/24/2026 at 1:40 PM, the Workforce Manager reviewed the staffing for 04/26/2026 and 05/03/2026. She stated both dates had staff call-ins and agency staff did not fill the open shifts and confirmed that they were below the state minimum for staffing. She stated she or other staff sometimes cover shifts, but staff do not always come in for a last-minute call-in.			M0225			
M0460	45.16.3 Criminal History Record Checks Criminal History Record Checks. Pursuant to Section 43-11-13, Mississippi Code of 1972, the covered entity shall require to be preformed a disciplinary check with the professional licensing agency, if any, for each employee to determine if any disciplinary action has been taken against the employee by the agency, and a criminal history record check on: 1. Every new employee of a covered entity who provides direct patient care or services and who is employed on or after July 01, 2003, and 2. Every employee of a covered entity employed prior to July 01, 2003, who has documented disciplinary action by his or her present employer. 3. Except as otherwise provided in this paragraph, no employee hired on or after July 01, 2003, shall be permitted to provide direct patient care until the results of the criminal history record check revealed no disqualifying record or the employee has been granted a waiver. Provided the covered entity has documented evidence of submission of fingerprints for the background check, any person may be employed and provide direct patient care on a temporary basis pending the results of the criminal history record check but any employment offer, contract, or arrangement with the person shall be voidable, if he/she receives a disqualifying criminal record check and no waiver is granted.			M0460			

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M0460	Continued from page 3 4. If such criminal history record check discloses a felony conviction; a guilty plea; and/or a plea of nolo contendere to a felony for one (1) or more of the following crimes which has not been reversed on appeal, or for which a pardon has not been granted, the applicant/employee shall not be eligible to be employed at the licensed facility: a. possession or sale of drugs b. murder c. manslaughter d. armed robbery e. rape f. sexual battery g. sex offense listed in Section 45-33-23(g), Mississippi Code of 1972 h. child abuse i. arson j. grand larceny k. burglary l. gratification of lust m. aggravated assault n. felonious abuse and/or battery of vulnerable adult 5. Documentation of verification of the employee ' s disciplinary status, if any, with the employee ' s professional licensing agency as applicable, and evidence of submission of the employee ' s fingerprints to the licensing agency must be on file and maintained by the facility prior to the new employees first date of employment. The covered entity shall maintain on file evidence of verification of the employee ' s disciplinary status from any applicable professional licensing agency and of submission and/or completion of the criminal record check, the signed affidavit, if applicable, and/or a copy of the referenced notarized letter addressing the individual ' s suitability for such employment. 6. Pursuant to Section 43-11-13, Mississippi Code of			M0460			

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M0460	Continued from page 4 1972, the licensing agency shall require every employee of a covered entity employed prior to July 01, 2003, to sign an affidavit stating that he or she does not have a criminal history as outlined in paragraph (3) above. 7. From and after December 31, 2003, no employee of a covered entity hired before July 01, 2003, shall be permitted to provide direct patient care unless the employee has signed an affidavit as required by this section. The covered entity shall place the affidavit in the employee ' s personnel file as proof of compliance with this section. 8. If a person signs the affidavit required by this section, and it is later determined that the person actually had been convicted of or pleaded guilty or nolo contendere to any of the offenses listed herein, and the conviction or pleas has not been reversed on appeal or a pardon has not been granted for the conviction or plea, the person is guilty of perjury as set out in Section 43-11-13, Mississippi Code of 1972. The covered entity shall immediately institute termination proceedings against the employee pursuant to the facility ' s policies and procedures. 9. The covered entity may, in its discretion, allow any employee unable to sign the affidavit required by paragraph (7) of this subsection or any employee applicant aggrieved by the employment decision under this subsection to appear before the covered entity ' s hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed at the covered entity. The covered entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to: (1) age at which the crime was committed; (2) circumstances surrounding the crime; (3) length of time since the conviction and criminal history since the conviction; (4) work history; (5) current employment and character references; and (6) other evidence demonstrating the ability of the individual does not pose a threat to the health or safety of the patients in the licensed facility. 10. The licensing agency may charge the covered entity submitting the fingerprints a fee not to exceed Fifty Dollars (\$50.00).			M0460			

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M0460	Continued from page 5 11. Should results of an employee applicant ' s criminal history record check reveal no disqualifying event, then the covered entity shall, within two (2) weeks of the notification of no disqualifying event, provide the employee applicant with a notarized letter signed by the chief executive officer of the covered entity, or his or her authorized designee, confirming the employee applicant ' s suitability for employment based on his or her criminal history record check. An employee applicant may use that letter for a period of two (2) years from the date of the letter to seek employment at any covered entity licensed by the Mississippi State Department of Health without the necessity of an additional criminal record check. Any covered entity presented with the letter may rely on the letter with respect to an employee applicant ' s criminal background and is not required for a period of two (2) years from the date of the letter to conduct or have conducted a criminal history check as required in this subsection. 12. For individuals contacted through a third party who provide direct patient care as defined herein, the covered entity shall require proof of a criminal history record check. 13. Pursuant to Section 43-11-13, Mississippi Code of 1972, the licensing agency, the covered entity, and their agents, officer, employees, attorneys, and representatives, shall be presumed to be acting in good faith for any employment decision or action taken under this section. The presumption of good faith may be overcome by a preponderance of the evidence in any civil action. No licensing agency, covered entity, nor their agents, officers, employees, attorneys and representatives shall be held liable in any employment discrimination suit in which an allegation of discrimination is made regarding an employment decision authorized under this section. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on personnel record review, facility policy review, staffing schedule/time record review, and staff interviews, the facility failed to ensure criminal background checks were completed for three (3) of five (5) employees reviewed who worked in the facility. Employees #1, #2, and #3 Findings include: Review of the facility's policy titled "Background	M0460					

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M0460	Continued from page 6 Investigations" with no revision date revealed, "Policy: Job reference checks, drug screenings, licensure verifications and criminal conviction record checks are conducted on all personnel making application for employment with this company..." Record review of Employee #1's personnel record on 9/24/2026 at 12:30 PM revealed a hire date of 8/17/2026. Review of Employee #1's Individual Employee Time Card revealed a statement signed by the Administrator, "Employee is salaried and does not clock in. He started on 8/17/26 and works Monday – Friday 8:30 AM – 5:30 PM." Employee #1 worked during the period of 8/17/26 through 9/24/2026. No documentation of a completed criminal background check was identified in the records reviewed. Record review of Employee #2's personnel record on 9/24/2026 at 2:35 PM revealed a hire date of 9/07/2026. Review of Employee #2's Individual Employee Timecard records revealed Employee #2 worked the following dates: 9/07/26, 9/09/2026, 9/10/2026, 9/13/2026, 9/14/2026, 9/15/2026, 9/16/26, 9/19/2026, 9/21/2026, and 9/22/2026. No documentation of a completed criminal background check was identified in the records reviewed. Record review of Employee #3's personnel record on 9/24/26 at 2:40 PM revealed a hire date of 8/31/2026. Review of timecards revealed Employee #3 worked 8/31/2026, 9/01/2026, 9/02/2026, 9/03/2026, 9/05/2026, 9/06/2026, 9/07/2026, 9/08/2026, 9/11/2026, 9/13/2026. Employee #3 has not worked since 9/13/2026. No documentation of a completed criminal background check was identified in the records reviewed. During an interview with the Administrator on 9/24/26 at 12:46 PM, he revealed there is no full-time Human Resources employee, and the facility was unable to locate criminal background checks for Employee #1, #2, #3. On 9/24/2026 at 1:00 PM, the Director of Nursing stated she was unaware criminal background checks had not been completed. She stated that background checks were important to determine whether employees were suitable to work with residents and whether they had criminal histories that would make them ineligible for such employment.			M0460			

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M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for	M0500					

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M0500	Continued from page 8 deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless	M0500					

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M0500	Continued from page 9 medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, record review, facility policy review, and staff and resident interviews, the facility failed to promote and maintain resident's dignity and right to self-determination for four (4) of 104 residents reviewed for residents' rights. Residents #10, #47, #69, #80 Findings Include: Review of the facility policy titled "Resident Rights" revealed, "The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility." Also revealed under, "5. Self-determination: The resident had the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: ... b. The			M0500			

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M0500	Continued from page 10 resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident..." Review of the facility's undated policy titled "Promoting/Maintaining Resident Dignity" with no revision date revealed, "It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity..." Resident #10 During an observation and interview on 9/23/26 at 12:12 PM, Resident #10 was in bed with a wander bracelet on her right ankle. She said she entered the facility for therapy after a hospital stay and had previously lived with her son. She said she made her own decisions, and no one held power of attorney or conservatorship for her. According to the resident, her son told her the previous month that she could not return to his home. She told staff she did not want to remain at the facility and would walk out. She said she became upset and was sent to the hospital after staff reported that she had made a suicidal statement, although she did not recall making that statement. She said paramedics gave her an injection and took her to the hospital against her wishes. Upon her return, staff placed the bracelet on her ankle. The resident stated, "I didn't even know what it was; I had to ask them and was told, If I tried leaving here or tried to go out the door, they would bring me back and would call the police on me. They will not let me leave until I have somewhere safe to go; I can't even get out the doors." She also stated, "I go to the front door and sit but If I get to close it alarms and I have to be moved back." Resident #10 said she did not consent to the bracelet and wanted it removed. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/03/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #10 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #10 on 10/27/25 with medical diagnoses that included Malignant Neoplasm of Unspecified Site of Unspecified Female Breast and Chronic Obstructive Pulmonary Disease. Record review of Resident #10's "Progress Notes" revealed notes dated 8/22/26, "Resident sitting at nurses' station demanding to be let leave the facility. She states she is her own RP (Responsible Party) and she wants to leave. Resident states she	M0500					

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M0500	Continued from page 11 will sleep outside until she finds a place. Attempts made to redirect resident unsuccessful. ... Pt (patient) son visited and told pt she could not live on her own due to safety concerns. Pt became very upset and began telling nursing staff she was leaving the facility and would "walk around until she had the money for a place of her own." Nursing staff notified RP, Admin (Administrator), DON (Director of Nursing), and supervisor as well as called facility psychiatrist when pt stated, "I just don't want to live anymore." Facility psychiatrist as well as on call NP (Nurse Practitioner) gave orders for pt to have psychiatric evaluation done due to suicidal thoughts, Pt was transported via EMS (Emergency Management Services) to 'Proper name of Hospital' after becoming aggressive with EMS and refusing RP, son (Proper name) agreed for pt to be seen for psych evaluation." Also revealed under, "Behavior Note: Resident verbalized to staff "I don't want to live anymore." Resident noted to be in emotional distress and attempting to leave the facility AMA (against medical advice)..." Record review of Resident #10's "Hospital Discharge Summary" dated 8/27/26 revealed, "Presents to the ED (emergency department) with aggressive and agitation with concerns of suicidal statements. Patient resides in a nursing home; this morning, she was aggressive to the nursing home staff and was reported that she had suicidal statements for which she required chemical and physical restraints in the nursing home. Upon interview, patient denies reporting suicidal statements. In the ED, vital signs concerning for tachycardia with labs remarkable for AKI (Acute Kidney Injury), Hypercalcemia (high calcium) and UA (urinalysis) concerning for bacteriuria. She received IV (intravenous) abx (antibiotics) and was admitted to medicine for further management. Pt was evaluated by psychiatry and started on Zoloft and Seroquel. Her UTI (Urinary Tract Infection) was treated with merrem (antibiotic). She was deemed stable for d/c (discharge) back to SNF (skilled nursing facility) on 8/27/26." Record review of Resident #10's "Order Details" showed an order dated 8/27/26: "Wander Guard to right ankle to alert staff to exit seeking. Check placement and function q (every) shift." Record review of Resident #10's "Elopement Evaluation," dated 8/27/26, identified the resident as a wanderer because she expressed a desire to go home or stayed near an exit door. The evaluation showed no history of elopement or attempts to leave without notifying staff.			M0500			

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M0500	Continued from page 12 During an interview on 9/23/26 at 12:30 PM, the DON revealed she had worked at the facility for about three weeks. She said staff applied the wander bracelet because Resident #10 threatened to walk across the parking lot and go home. The DON confirmed that the resident did not have dementia, was cognitively intact, and did not have a power of attorney for decision-making. During an interview on 9/23/26 at 4:37 PM, Social Services (SS) revealed Resident #10 demanded to leave after her son told her she could not return to his home. SS stated nursing staff then applied the wander bracelet. During an interview on 9/24/26 at 9:20 AM, the Administrator (ADM) revealed the bracelet was applied for safety. He referred to an incident several years earlier in which he stated another cognitively intact resident left the facility and police were called. He said residents were no longer allowed on the front porch and the facility used wander bracelets for residents who might leave. He said he told Resident #10 she could not leave because she had nowhere to stay and was at high risk for self-harm. He confirmed she had not attempted to go out the door but had threatened to leave and said she would sleep in a ditch. He revealed he told her he would call the police and Adult Protective Services (APS) if she left. The ADM acknowledged that Resident #10 was cognitively intact and should be able to make decisions about her care, but stated, "I can't allow her to leave." When asked whether she had consented to the bracelet, he stated, "I was told she did." After being informed that the resident wanted it removed, he stated, "We can't take it off because she has not been back from the hospital 30 days yet," and described this as facility protocol. During an interview on 9/24/26 at 10:05 AM, Certified Nurse Aide (CNA) #1 revealed Resident #10 had never tried to leave through the doors. The CNA stated staff applied the wander bracelet after the resident said she wanted to leave the facility. During a telephone interview on 9/24/26 at 11:10 AM, Registered Nurse (RN) #1 revealed she was instructed to apply the wander bracelet when Resident #10 returned from the hospital because the resident had expressed a desire to go home. Resident #47 Resident #69	M0500					

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M0500	Continued from page 13 Resident #80 During an observation of residents in the dayroom of the 200 Hall on 9/22/2026 at 10:26 AM, Resident #47, Resident #69, and Resident #80 were observed sitting in the dayroom with seven (7) other residents. A sign was taped to the back of the residents' wheelchairs that stated, "I'M READY FOR BED!" On 9/22/2026 at 10:30 AM, Licensed Practical Nurse (LPN) #1, assigned to the 200 Hall stated, "Today was the first time I have witnessed signs on the wheelchairs. I'm not sure who put them on the wheelchairs or why." During an interview with the DON on 9/22/2026 at 11:00 AM, she stated she was unaware of signs on the wheelchairs and would not have agreed to the use of signage on the back of a resident's wheelchair. During an interview on 9/22/2026 at 11:05 AM with the Administrator, he stated a staff member had placed the signs on the wheelchairs to remind CNAs which residents needed to be assisted to bed. The Administrator stated residents' rights and signage had previously been addressed with staff, and he was not in agreement with signage being placed on the back of the residents' wheelchairs. Record review of a copy of the signage provided to the surveyor read, "IM READY FOR BED!" On 9/23/2026 at 3:36 PM, RN #1, stated she had typed the note to inform CNAs which residents needed assistance getting to bed. She stated she had not intended the signs to be harmful or malicious. She confirmed that residents have a right to dignity and respect and signs on the back of residents' wheelchairs should not have been used. Record review of the "Admission Record" revealed the facility admitted Resident #47 on 11/23/2023 with medical diagnoses that included Unspecified Dementia. Record review of the MDS with an ARD of 8/28/26 revealed under section C, a BIMS of 4, which			M0500			

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M0500	Continued from page 14 indicated Resident #47 had severe cognitive impairment. Record review of the "Admission Record" revealed the facility admitted Resident #69 on 5/15/2026 with medical diagnoses that included Dementia. Record review of the MDS with an ARD of 8/18/2026 revealed under section C, a BIMS of 3, which indicated Resident #69 had severe cognitive impairment. Record review of the "Admission Record" revealed the facility admitted Resident #80 on 10/11/2023 with medical diagnoses that included Vascular Dementia. Record review of the MDS with an ARD of 8/14/2026 revealed under section C, a BIMS of 3, which indicated Resident #80 had severe cognitive impairment.	M0500					
M0625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, interview, record review and facility policy review, the facility failed to provide physician ordered services to prevent the likelihood of worsening of contractures for 1 (one) of 2 (two) residents reviewed for Range of Motion (ROM), Resident #16 Findings Include: Review of the facility policy "Prevention of Decline in Range of Motion" revealed under "Policy Explanation Compliance Guidelines: 1. The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systemic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventative care..." An observation on 09/22/26 at 11:00 AM revealed Resident #16 lying in bed and she had bilateral hand contractures. Her right hand was closed tightly in a fist with her fingernails touching the palm of her	M0625					

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M0625	Continued from page 15 hand and her left hand was closed and she had the ability to flex and extend her left index finger and there were no hand devices in use. Follow-up observations on 09/23/26 at 8:35 AM and at 11:10 AM and on 09/24/26 at 8:13 AM revealed Resident #16 lying in her bed with bilateral hand contracture and no devices were in place inside of her hands. There were three carrot hand devices on top of her nightstand next to her bed. Resident #16 had severe cognitive deficits and was dependent on staff to meet her needs. An interview on 09/23/26 at 2:30 PM with Certified Nursing Assistant (CNA) #4, revealed that Resident #16 did not have hand devices to be placed in her hands, and she confirmed that she had never observed anything placed in her hands. CNA #4 entered Resident #16's room and confirmed the three soft carrot hand devices located on her nightstand next to her bed and not in use in resident's hands. CNA #4 revealed that the application of hand devices was not listed on her Kardex/task list, so she didn't know to do it. An interview on 09/24/26 at 8:35 AM with Licensed Practical Nurse (LPN) #5 revealed that Resident #16 was assigned to her and she took care of her often. She revealed that Resident #16 was bedbound and dependent on staff to care for her. LPN #5 revealed that Resident #16 had bilateral hand contractures and confirmed that she had observed the carrots in her hands a few times before but not every day and further confirmed that if hand splints or devices were placed in her hands, the resident would not be able to remove them. LPN #5 confirmed the three soft hand carrots on her nightstand and confirmed she was not wearing them today. At that time LPN #5 reviewed Resident #16's physician orders on the computer, confirmed the order for the carrots to be placed for six hours a day and stated, "I didn't know about the order" and confirmed that she had not been making sure they were in place. She further revealed that the use of hand splints was often put in place to help keep the hands open to prevent fingernails from cutting into the skin causing possible breakdown and infection. An interview on 09/24/26 at 8:45 AM with the Director of Nursing (DON) revealed that there were no excuses for the carrot devices not to be in place in Resident #16's contracted hands as ordered. She revealed that the carrot devices should be placed in resident's hands every day for six hours to help prevent her fingernails from touching her hands which could cause skin breakdown and worsening of			M0625			

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M0625	Continued from page 16 contractures. She revealed that her expectation was for all nurses and CNAs to follow the orders located on the Task list and on her care plan. She revealed that she had recently printed all the resident tasks off and reviewed with staff of the importance of following the care assigned to each resident. The DON confirmed the order for the hand splints to be applied daily for 6 hours and stated she would have to make adjustments to ensure this was completed. Record review of Resident #16's "Admission Record" revealed an admission date of 02/18/10 with diagnoses that included Unspecified Dementia and Need for Assistance with Personal Care. Record review of Resident #16's Physician order dated 05/28/26 revealed order to place carrot in both hands every morning for six (6) hours per day and for nurse to remove every 2 hours and as needed for skin and circulation checks. Record review of Resident #16's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/13/26 under Section GG revealed that she had upper extremity impairment on both sides. Record review of Resident #16's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/13/26 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 99 which indicated that she had severe cognitive deficits.			M0625			
M0655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observations, interviews, record review, and facility policy review, the facility failed to coordinate dialysis-related fluid management with the dialysis provider and attending practitioner to ensure that daily fluid restrictions were being adhered to and monitored for two (2) of 23 sampled residents. Resident #11 and Resident #12 Findings include: Review of the facility policy titled "Hemodialysis,"			M0655			

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M0655	Continued from page 17 undated, revealed, "...The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include...Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services...3. The facility will coordinate and collaborate with the dialysis facility to assure that: a. The resident's needs related to dialysis treatments are met...d. There is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff..." Record review of facility policy titled "Fluid Restriction" revealed, "It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders..." Resident #11 During an observation and interview on 09/23/2026 at 12:20 PM, following Resident #11's dialysis treatment, the resident's bedside table held a water pitcher, an unopened 16-ounce bottle of carbonated beverage, and an unopened eight-ounce bottle of a carbonated beverage. Resident #11 stated, "They just filled up my water pitcher." When questioned about fluid restrictions, Resident #11 stated, "I'm not supposed to have over 32 ounces a day." Review of Resident #11's Order Summary Report for 04/01/2026 through 09/23/2026 revealed no active or discontinued order for a fluid restriction. The Order Summary Report included an active order dated 07/20/2026 that directed staff to "Offer eight (8) ounces (oz) water with medications to promote urinary health every shift; may offer water flavor/enhancers if no allergy to red dye." During an observation on 09/23/2026 at 1:02 PM, Resident #11's lunch tray included an (8) eight-ounce glass of tea. During an interview on 09/23/2026 at 2:26 PM, the Director of Nursing (DON) stated, "I have only been here three weeks, and I have yet to meet the Registered Dietitian." When questioned regarding Resident #11's fluid restriction, the DON reviewed the resident's orders and confirmed there was no order for a fluid restriction and no documentation that nursing staff monitored the resident's fluid intake. The DON stated she had been told the Registered Dietitian visited the facility weekly. The DON reviewed Resident #11's admission history and physical and confirmed someone had written "fluid			M0655			

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M0655	Continued from page 18 restriction?" on the front page; however, she found no documentation that the question had been clarified or addressed. The DON reviewed the facility Registered Dietitian's notes dated 04/23/2026, 05/14/2026, 06/26/2026, and 07/27/2026 and confirmed the dietitian had documented that Resident #11 was not on a fluid restriction. During a telephone interview on 09/23/2026 at 2:40 PM, a Registered Nurse (RN) at (proper name) Dialysis center, confirmed Resident #11 was on a 32-ounce-per-24-hour fluid restriction. The RN stated, "I'm sure he goes above that; he comes in above his dry weight." The RN confirmed Resident #11 had not required additional dialysis treatment days to remove excess fluid since admission to the nursing facility. During a telephone interview on 09/23/2026 at 2:50 PM, the facility's Registered Dietitian stated Resident #11 was not on a fluid restriction. She stated that, based on her communication with the Registered Dietitian at the dialysis center, she understood that Resident #11 was not on a fluid restriction. The facility Registered Dietitian stated, "If she makes any changes, she will notify me, and she has not notified me." During a telephone interview on 09/23/2026 at 2:55 PM, the Registered Dietitian at the dialysis center confirmed Resident #11 was on a fluid restriction and stated, "I keep him on 32 ounces." Record review of Resident #11's documented Fluid Intake with Meals was 1,200 milliliters on 09/15/2026 and 1,560 milliliters on 09/17/2026. Both amounts were greater than 32 ounces, approximately 946 milliliters. The record did not establish the total fluid consumed during either 24-hour period because fluids at medication pass, between meals, and in the resident's, room were not documented. Record review of Resident #11's Admission Record revealed the resident was admitted to the facility on 4/17/2026 with medical diagnoses that included End Stage Renal Disease and Dependence on Renal Dialysis. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/27/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 15 under Section C, which indicated Resident #11 was cognitively intact. Resident #12			M0655			

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M0655	Continued from page 19 Record review of Resident #12's Medication Administration Record (MAR) revealed an order for a "1,000 milliliter (mL) fluid restriction, Breakfast 4 oz (ounces) (120 cc (cubic centimeters)) juice, 6 oz. (180 cc) coffee, 8 oz. (240 cc) milk, Lunch 4 oz (120 cc) tea or water, Supper 4 oz. (120 cc) tea or water TOTAL 26 oz. (780 cc) fluids, Nursing Service should deliver the remaining 8 oz (240 cc)". Further review of the resident's allotted fluids for meals and medication administration revealed the amounts totaled 1,020 mL over a 24-hour period, exceeding the ordered fluid restriction by 20 ml. Record review of Resident #12's fluid intake documentation and medication administration documentation revealed fluid intake was documented separately for meals and medication administration; however, there was no documentation of a cumulative 24-hour fluid intake to demonstrate Resident #12's total fluid consumption was monitored in accordance with the 1,000 ml fluid restrictions. An observation on 9/22/2026 at 12:26 PM revealed Resident #12 had eight (8) ounces of unsweet tea on her lunch tray. During an interview on 9/22/2026 at 12:30 PM, Certified Nursing Assistant (CNA) #4 confirmed Resident #12 had 240 ml of unsweet tea on her meal tray. CNA #4 stated she had set up Resident #12's meal tray and did not check the meal ticket. CNA #4 reviewed the meal ticket and confirmed it indicated Resident #12 was on a 1,000 mL fluid restriction and should have received four (4) ounces of unsweet tea with the meal. CNA #4 stated she did not know how many ounces equals 240 mL and asked, "It's not four?" During an interview on 9/24/2026 at 10:17 AM, Licensed Practical Nurse (LPN) #6 confirmed Resident #12 was on a 1,000 ml fluid restriction. LPN #6 stated she did not track the amount of fluids Resident #12 consumed throughout the day or the resident's total fluid intake over a 24-hour period. She stated she provided Resident #12 with 240 mL of fluid each day during medication administration. During an interview on 9/24/2026 at 12:20 PM, the DON confirmed Resident #12 was on a 1,000 ml fluid restriction and that the resident's total fluid intake over 24 hours was not monitored or documented. The DON stated it was her expectation that the resident's fluid restriction be followed. She stated the error with the amount of fluid provided on the meal tray originated in the kitchen; however, she			M0655			

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M0655	Continued from page 20 acknowledged the Certified Nursing Assistant (CNA) serving the meal tray should have identified the error and should have known that 240 mL was more than four (4) ounces indicated on the meal ticket. The DON also confirmed that the 240 mL of fluid documented during medication administration exceeded the amount ordered. Record review of "Admission Record" revealed Resident #12 was admitted to the facility on 5/18/2026 with diagnoses of End Stage Renal Disease and Dependence on Renal Dialysis.		M0655				
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: Level II Pattern Based on observation, interview, and facility policy review, the facility failed to ensure food was stored and dishware was sanitized in accordance with established food safety requirements. This failure was evidenced by the facility's low-temperature dishwasher operating below the required 120°F wash temperature, with temperatures of 106°F and 110°F observed after multiple cycles, and by multiple ready-to-eat and time/temperature control for safety foods stored in the kitchen refrigerator without required date marking. These failures affected one (1) of two (2) kitchen tours and had the potential to result in inadequate sanitization of dishware and utensils and the service of food of unknown storage duration, increasing the risk for foodborne illness to residents. Findings Include: Review of the facility policy titled "Food Safety Requirements" revealed under, "Policy: Food will be stored, prepared, distributed and served in accordance with professional standards for food service safety..." Review of the facility policy titled "Dishwasher Temperature" revealed under, "Policy: It is the policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions.... 4. For low temperature dishwashers (chemical sanitization): a. The wash temperature shall be 120 F (Fahrenheit). b. The sanitizing solution shall be 50ppm (parts per		M0815				

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M0815	Continued from page 21 million) hypochlorite (chlorine) on dish surface in final rinse..." Review of the facility policy titled "Date Marking for Food Safety" revealed under, "Policy: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food.... 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared..." Observation during the initial kitchen tour on 9/22/26 at 10:06 AM revealed Dietary Staff #2 running dirty dishes through the low temperature dishwasher. During an interview, Dietary Staff #2 said she did not know whether the dishwasher was a low or high temperature machine. When asked what wash temperature was required, she stated, "I don't know." She said she did not know where the temperature gauge was located, that she was supposed to check it, or that she was supposed to check the sanitizing solution. She said she had worked in the kitchen for only a few months and had not been trained to run the dishwasher. Dietary Staff #3 stated her position was for the tray line, but that staff had been asked to help with the dishes. After several cycles, the dishwasher wash temperature was 106 degrees Fahrenheit. Observation and interview with the Dietary Manager (DM) on 9/22/26 at 10:28 AM revealed he was in his second day of employment at the facility. He confirmed the dishwasher was a low temperature machine and that the wash temperature should reach 120 degrees Fahrenheit. After several more cycles, the gauge rose only to 110 degrees Fahrenheit. The DM stated he did not know how long the machine had operated below the required temperature. During an interview on 9/22/26 at 10:33 AM, Dietary Staff #3 revealed he normally ran the dishwasher when he worked and that the wash temperature must reach 70 degrees. When asked how to check the chlorine concentration of the sanitizing solution, he could not demonstrate the process. The DM then instructed him how to check the concentration. The test result was 100 parts per million (PPM). Observation of the kitchen refrigerator with the DM on 9/22/26 at 10:40 AM revealed the following items without dates: eight ham and turkey sandwiches in a rectangular metal container; one gallon of vegetable soup in a clear plastic container; half of a sliced tomato; chicken noodle soup in a square metal pan; an open package of crackers; and one slice of luncheon meat in a clear sandwich bag. A	M0815					

Mississippi State Department of Health

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NAME OF PROVIDER OR SUPPLIER SENATOBIA HEALTHCARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 402 GETWELL DR , SENATOBIA, Mississippi, 38668			
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M0815	Continued from page 22 five-pound plastic container of mustard potato salad had a use-by date of 8/23/26. The DM confirmed the items were not dated and said he could not determine how long they had been in the refrigerator. He said the items would have to be discarded because their storage time could not be verified. He confirmed the items could cause foodborne illness if served to residents. He said the crackers and luncheon meat appeared to belong to a staff member and should not have been stored in the kitchen refrigerator.			M0815			
M0850	45.30.6 Modified Diets Modified Diets. Modified diets which are a part of medical treatment shall be prescribed in written orders by the physician or nurse practitioner/physician assistant. All modified diets shall be planned in writing and posted along with regular menus. Liberalized Geriatric Diets are encouraged for elderly residents when there is a need for moderate diet therapy. A current diet manual shall be available to personnel. The dietitian shall approve all modified diet menus and the diet manual used in the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, staff and resident family interviews, record review, and facility policy review the facility failed to ensure a resident received her prescribed therapeutic diet to include nectar thick liquids for 1 (one) of 10 (ten) residents observed for dining. Resident #19 Findings Include: Review of the facility policy "Thickened Liquids" revealed that "The facility provides commercially prepared thickened liquids, as prescribed, to residents who require them..." An observation and interview conducted on 09/23/26 at 12:30 PM revealed Resident #19 sitting upright in bed while being fed by her Resident Representative (RR). RR reported that Resident #19 was dependent on staff for feeding and required assistance with meals and stated, "I just want my mother to be taken care of." RR further reported that while visiting Resident #19, she received her lunch meal tray, which included a cup of regular, thin-consistency tea. She stated that Resident #19 had an order for thickened liquids due to increased coughing episodes during meals. She reported that Resident #19 had begun coughing during meals prior to admission to the facility and had been evaluated by Speech-Language Pathology (SLP), with the primary concern being the risk of aspiration and potential			M0850			

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M0850	Continued from page 23 development of pneumonia. An observation of Resident #19's meal tray confirmed the presence of a four-ounce cup of regular, thin-consistency brown liquid. Review of Resident #19's lunch meal ticket dated Wednesday, 09/23/26 documented, "Diet ... Thick Fluids - Nectar." During an observation and interview on 09/23/26 at 12:40 PM, Licensed Practical Nurse (LPN) #5 confirmed that Resident #19 had received regular-consistency tea on her meal tray and that the meal ticket indicated an order for nectar-thickened fluids. LPN #5 stated that providing regular, thin-consistency fluids to a resident with an order for thickened liquids could result in choking or aspiration and potentially lead to pneumonia. LPN #5 stated that she would address the issue immediately. An interview with the Director of Nursing (DON) on 09/23/26 at 12:50 PM revealed that Resident #19 had an order for thickened liquids for a specific clinical reason and that the incorrect beverage should have been identified before the tray was delivered to the resident. DON identified multiple opportunities for the error to have been recognized and corrected, including by the three kitchen staff members working on the tray line and the Certified Nursing Assistant (CNA) who delivered the tray to Resident #19. The DON stated that the situation was concerning and that residents were expected to receive their prescribed diets and fluid consistencies to prevent potential complications. An interview with Dietary Aide #4 on 09/23/26 at 1:00 PM revealed that she was the last staff member on the meal line and was responsible for placing beverages on the meal trays. Dietary Aide #4 stated that she was required to compare the beverages with the meal ticket to ensure that residents received the prescribed consistency. She acknowledged that she was "going so fast" while placing beverages on the trays and failed to identify the incorrect beverage on Resident #19's tray. She confirmed that it was important for residents to receive the prescribed diet and fluid consistency to prevent potential complications. An interview with the Dietary Manager (DM) on 09/23/26 at 1:08 PM revealed that it was important for residents to receive their prescribed therapeutic diets. DM stated that his expectation was for kitchen staff to follow the diet and fluid consistency documented on each meal ticket.			M0850			

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M0850	Continued from page 24 An interview with Speech-Language Pathologist on 09/24/26 at 10:45 AM revealed that Resident #19 had recently been discharged from the SLP caseload following treatment for swallowing difficulty. The SLP confirmed that Resident #19 had a dietary order for nectar-thickened liquids and stated that the order should be followed to ensure the resident's safety. The SLP explained that providing regular, thin-consistency fluids to Resident #19 could result in coughing and increase her risk for aspiration. The SLP further explained that thickened liquids for a resident with dysphagia slow the swallowing process and may help reduce the risk of complications. Record review of Resident #19's "Order Summary Report" revealed an order effective 08/30/26 for No Added Salt (NAS) diet Regular texture, Nectar consistency. Record review of Resident #19's "Admission Record" revealed an admission date of 07/08/26 and that she had a diagnosis of Dysphagia, Record review of Resident #19's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/15/26 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 02 which indicated that she had severe cognitive deficits.			M0850			