STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING B. WING	**10/29/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	**78 HOSPITAL RD , MACON, Mississippi, 39341**

(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 along with a Complaint Investigation (CI MS #3159683) at the facility on 10/27/2026 through 10/29/2026. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F605, F637, and F641. The SA investigated CI MS #3159683 and no deficiencies were cited. The census at the time of the survey was 57 and the facility was licensed for 60 beds.	F0000		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical	F0605		

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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F0605 SS = D	Continued from page 1 symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless	F0605		

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F0605 SS = D	Continued from page 2 the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, and facility policy review, the facility failed to ensure a resident receiving an antipsychotic medication received a gradual dose reduction (GDR), unless clinically contraindicated, for one (1) of three (3) residents reviewed for antipsychotic medications. Resident #2 Findings Include: A record review of facility policy titled, "Use of Psychotropic Medications," revealed "...Adequate indications for use...For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use in inadequate...10. Residents who use psychotropic drugs shall receive gradual dose reductions (GDR), unless clinically contraindicated in an effect to discontinue these drugs..." Record review revealed Resident #2's had an active physician order with a start date of 07/31/2025 for olanzapine 2.5	F0605		

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F0605 SS = D	Continued from page 3 milligrams (mg) twice daily. Review of the resident's medical records revealed no documented GDR attempts had been documented since that beginning order date. Record review of Consultant Pharmacist Recommendations dated 01/15/2026 and 03/08/2026 revealed recommendations to attempt reductions of Resident #2's olanzapine dosage. The physician indicated disagreement with both recommendations but did not document a clinical rationale supporting the decision. Record review of a Consultant Pharmacist Recommendation dated 07/31/2026 revealed another recommendation to reduce olanzapine. The physician selected, "No, do not change the current orders," and indicated the drug, dose, duration, and indications were clinically appropriate. However, the physician did not complete the section requesting the rationale for why reductions were contraindicated. During an interview on 10/28/2026 at 2:45 PM, the Interim Director of Nursing confirmed Resident #2 had not received a GDR since starting the medication and that there was not a rationale as to why the GDR should not be attempted. During an interview on 10/28/2026 at 4:40 PM, the Administrator stated the physician had been asked previously to provide clinical rationales for declining GDR recommendations but continued to decline recommendations without providing the requested rationales. A record review of the Quarterly Minimum Data Set Assessment (MDS), with an Assessment Reference Date (ARD) of 9/30/2026, revealed resident was scored as rarely or never understood and the Brief Interview for Mental status (BIMS) score was not conducted. A record review of "Face Sheet" revealed that the facility admitted Resident #2 on 04/25/2024 with a diagnosis of Dementia.	F0605		
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major	F0637		

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F0637 SS = D	Continued from page 4 decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews and facility policy review, the facility failed to complete a significant-change assessment following improvement in a resident’s condition, for one (1) of 35 residents reviewed, Resident #4. Findings Include: A record review of a statement on facility letterhead dated 10/29/26 and signed by the Administrator indicated that the facility does not have a policy for Minimum Data Set (MDS) significant change. A review of the facility policy titled “Conducting an Accurate Resident Assessment” revealed, “The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas.” During an interview on 10/27/2026 at 10:45 AM, Resident #4 reported the wounds had healed and the urinary catheter had been discontinued “a while back.” A record review revealed Resident #4’s admission MDS assessment, with an Assessment Reference Date (ARD) of 08/28/2026, documented a Stage III pressure ulcer and an indwelling urinary catheter. Record review of the Order Information for: Urinary Catheter Care and Order Information for: Wound Care revealed the catheter and treatment for the Stage III pressure ulcer were discontinued on 09/25/2026 and no subsequent MDS assessment was identified. During an interview on 10/30/2026 at 8:30 AM, the MDS nurse confirmed the wound had healed and no additional wound treatments were ordered as of 09/25/2026 and the catheter was discontinued after the wounds healed. The MDS nurse acknowledged these improvements warranted a significant-change MDS assessment and confirmed she had failed to complete the assessment.	F0637		

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F0637 SS = D	Continued from page 5 A record review of the Admission MDS with an ARD of 8/28/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15 indicates that the resident is cognitively intact. A record review of "Face Sheet" revealed that the facility admitted Resident #4 on 8/19/2026 with a diagnosis of Congestive Heart Failure.	F0637		
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. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews and facility policy review, the facility failed to accurately code	F0641		

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F0641 SS = D	Continued from page 6 weight loss on the Minimum Data Set (MDS) assessment for one (1) of 35 residents reviewed, Resident #8. Findings Include: A review of the facility policy titled “Conducting an Accurate Resident Assessment” revealed, “The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas...” Record review of Resident #8’s Quarterly MDS assessment, with an Assessment Reference Date (ARD) of 07/15/2026, revealed "Section K0300" was coded to indicate weight loss of 5% or more in the last month or 10% or more in the last six months. A record review of the resident’s weight records revealed weights of 117 pounds on 01/23/2026, 124 pounds on 06/24/2026, and 125 pounds on 07/15/2026. These weights reflected weight gain rather than weight loss and did not support the coding in Section K0300. An interview on 10/28/2026 at 2:00PM with the Dietary Manager agreed that the coding was incorrect and that she should have marked it as a weight gain instead of weight loss. An interview with the MDS nurse on 10/29/2026 at 9:00 AM revealed that weight loss should not have been coded after reviewing the weights and it was marked inaccurately and did not reflect the current condition of the resident. A record review of "Face Sheet" revealed that the facility admitted Resident #8 on 08/18/2008 with a diagnosis of Cerebrovascular Accident. Record review of the MDS with an ARD of 07/15/2026 Item C1000 revealed Cognitive Skills for Daily Decision Making was coded as moderately impaired.	F0641		