

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255220	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET PO BOX 279, ROLLING FORK, Mississippi, 39159	
(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 6/8/26 through 6/11/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F756, F851, F578, F583, F585, F604, F641, F656, F657, F689, F700, and F868. The facility had a census 50 and was licensed for 54 beds.	F0000		
F0756 SS = F	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F0756		

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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F0756 SS = F	<p>Continued from page 1 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview, record review, and consultant pharmacist job description review the facility failed to ensure a monthly medication regimen review (MMR) was conducted by the consultant pharmacist for residents residing in the facility for twelve (12) of (12) months reviewed, with the potential to affect all 50 residents residing in the facility.</p> <p>Findings include:</p> <p>A review of the facility's, "Consultant Pharmacist Job Description," revealed, "...The Consultant Pharmacist is responsible for overseeing and monitoring the pharmaceutical services provided to residents...The Consultant Pharmacist ensures compliance with federal and state regulations, promotes safe medication practices, conducts monthly medication regimen reviews, and serves as a resource to the interdisciplinary healthcare team to optimize resident outcomes and quality of care...Essential Duties and Responsibilities Medication Regimen Review Conduct monthly drug regimen reviews (DRR) for all residents as required by federal and state regulations... Complete monthly drug regimen reviews with required timeframes..."</p> <p>A review of the facility's records revealed there were no documented MMRs completed by the Consultant Pharmacist for residents in the facility from June 2025 through June 2026.</p> <p>On 6/10/26 at 10:00 AM, during an interview, the Director of Nursing (DON) reviewed the facility's records and confirmed the facility did not have documentation to verify the consultant pharmacist conducted the required MMRs for the past year.</p> <p>On 6/10/26 at 10:15 AM, during an interview with the Pharmacy Consultant, he stated that he has not been to the facility to do MMRs since the facility was</p>	F0756		

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F0756 SS = F	Continued from page 2 re-opened from the tornado that occurred in May of 2023. He explained the facility was closed for 16 to 17 months and his license for that software used to complete MMRs had expired during that time. The pharmacist stated that he went to renew his license for the software, but it was no longer available. He stated that he was looking for another type of software to provide the pharmacy reviews for the facility, however, he has not been able to find one at this time. On 6/11/26 at 10:30 AM, during an interview, the Administrator confirmed the facility did not have MMR documentation by the pharmacist for a twelve-month period. The Administrator reported MMRs were expected to occur in accordance with regulatory requirements.	F0756		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical	F0851		

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F0851 SS = F	<p>Continued from page 3 nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);</p> <p>(ii) Resident census data; and</p> <p>(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).</p> <p>§483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.</p> <p>§483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.</p> <p>§483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.</p> <p>This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to submit Payroll-Based Journal (PBJ) staffing data to the Centers for Medicare & Medicaid Services (CMS) for one (1) of (1) quarter reviewed. (Fiscal Year Quarter 2 2026)</p> <p>Findings include: A review of the facility's, "Payroll-Based Journal (PBJ) Reporting Policy and Procedure" undated revealed, "...Purpose To establish standardized procedures for the accurate collection, verification, maintenance, and submission of Payroll-Based Journal. (PBJ) staffing data in compliance with CMS requirements. This policy ensures accurate reporting of staffing information and supports compliance with federal regulations governing long term care facilities...shall accurately collect and electronically submit staffing and census information through the CMS Payroll-Based Journal (PBJ) system as required by federal regulations. All staffing</p>	F0851		

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F0851 SS = F	<p>Continued from page 4 information submitted to CMS must be complete, accurate, supported by documentation and submitted by established CMS deadlines. Failure to submit accurate PBJ data may negatively impact the facility's Five-Star Quality Rating, survey outcomes, and regulatory compliance status."</p> <p>A record review of the "PBJ Staffing Data Report" for Fiscal Year Quarter 2, 2026, revealed the facility failed to submit Payroll Based Journal staffing data for the reporting period of January 1, 2026, through March 31, 2026.</p> <p>On 6/9/26 at 1:00 PM, during an interview, the Chief Financial Officer (CFO) responsible for payroll reporting confirmed the facility failed to submit the second quarter PBJ data for the period January 1, 2026, through March 31, 2026. The CFO reported the facility experienced a tornado in 2023 and payroll records were maintained manually for a period of time due to nonfunctioning time clocks. The CFO reported she was responsible for payroll processing for the hospital, nursing home, two clinics, and administrative staff. The CFO explained that due to time constraints she did not complete and submit the required PBJ data. The CFO reported time clocks were reinstalled in January 2026 and she anticipated future PBJ submissions would be completed timely.</p> <p>On 6/9/26 at 1:30 PM, during an interview, the Administrator confirmed the facility failed to submit PBJ data to CMS for the second quarter of 2026. The Administrator reported she had previously been informed by the CFO that the PBJ submission had been completed. The Administrator reported the CFO later acknowledged the submission had not been completed due to time constraints. The Administrator reported the facility had experienced PBJ submission issues prior to this reporting quarter and had discussed transferring responsibility for PBJ submission to facility staff; however, corporate leadership elected to continue assigning the responsibility to the CFO.</p> <p>On 6/9/26 at 2:00 PM, during an interview, the Chief Executive Officer (CEO) reported he expected PBJ data to be submitted to CMS in accordance with CMS requirements. The CEO reported he was unaware the second quarter PBJ data had not been submitted and had been informed the submission was completed. The CEO reported measures would be implemented to ensure future PBJ submissions were completed timely.</p>	F0851		

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<p>F0578 SS = D</p>	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir</p> <p>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on staff interview, record review, and Admission Package review, the facility failed to ensure residents or their Resident Representatives (RRs) were informed of their rights regarding Advance Directives (ADs), including whether an AD existed and whether they wished to receive</p>	<p>F0578</p>		

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F0578 SS = D	<p>Continued from page 6 information or assistance in formulating an AD, for two (2) of (16) sampled residents. Resident #11 and Resident #22.</p> <p>Findings included:</p> <p>A record review of the medical records for Resident #11 and Resident #22 revealed there was no documentation that the resident or the Resident Representative (RR) received information regarding formulating an Advance Directive (AD).</p> <p>A record review of the facility's "Admission Package" revealed two (2) separate forms titled "Advance Directive Consent," which included language regarding the level of treatment, including code status, and an "Acknowledgement of Advance Directives," which provided documentation regarding advance directive rights and whether an advance directive existed.</p> <p>On 6/8/26 at 4:13 PM, during an interview and record review of Resident #11's medical record with the Director of Nursing (DON), she reported that she was not exactly sure about Advance Directive forms. The DON stated each resident should have a code status in the chart and there should be an Acknowledgement Form completed on admission for all residents.</p> <p>On 6/9/26 at 9:20 AM, during an interview with Social Services #1, she confirmed she was responsible for completing the "Admission Package" with residents and family members upon admission. Social Services #1 reported the facility used the "Advance Directive Consent" forms in the package because she felt the Advance Directive Consent form contained the same information and more, and the "Acknowledgement of Advance Directives" form was not used. After reviewing the forms, Social Services #1 and the DON confirmed the forms contained different information. The Advance Directive Consent form did not include information regarding whether the resident had an Advance Directive or whether the resident wished to receive information regarding formulating an Advance Directive, Living Will, or Power of Attorney.</p> <p>On 6/11/26 at 1:37 PM, during a phone interview with the Administrator, she reported she thought the Advance Directive Consent forms were to be completed upon admission.</p> <p>On 6/11/26 at 2:00 PM, during an interview with the DON, she reported the facility did not have a policy regarding Advance Directives.</p>	F0578		

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F0578 SS = D	Continued from page 7 Resident #11 A record review of the "Admission Record" revealed the facility admitted Resident #11 on 11/17/25 with diagnoses including nontraumatic subarachnoid hemorrhage from right carotid siphon and bifurcation. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/26 revealed Resident #11 had a Brief Interview for Mental Status (BIMS) Summary Score of 00, which indicated the resident was severely cognitively impaired. Resident #22 A record review of the "Admission Record" revealed the facility admitted Resident #22 on 11/1/24 with diagnoses including hemiplegia and hemiparesis. A record review of the Quarterly MDS with an ARD of 3/21/26 revealed Resident #22 had a BIMS Summary Score of 7, which indicated the resident was severely cognitively impaired.	F0578		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F0583		

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F0583 SS = D	<p>Continued from page 8</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to personal privacy for one (1) of (16) sampled residents reviewed for resident rights, as evidenced by posting of identifying personal care directions including Nothing by Mouth (NPO), Keep Head of Bed (HOB) elevated at 45 degrees, safe swallow precautions, and elevate my legs while in bed. Resident #33.</p> <p>Findings included:</p> <p>A review of the facility's policy "Resident Rights" undated, revealed "... It is the policy of this facility to ensure that the rights of the residents residing at this facility upheld in the highest regard. Staff will be trained on resident rights upon hire and at a minimum annually thereafter... Resident's Rights ... 13. Each resident has the right to personal privacy and the right to privacy in written communication as evidenced by the following: ... f. Medical record maintained confidentially ..."</p> <p>On 6/8/26 at 11:53 AM, during an observation, Resident #33 was lying in bed with eyes closed. There were five (5) signs above Resident #33's headboard that included "Family will do laundry, NPO (Nothing by Mouth), Keep HOB elevated at 45 degrees, safe swallow precautions, and turn schedule. Another sign was observed on the wall by the window that stated to elevate my legs while in bed."</p> <p>On 6/8/26 at 1:15 PM, during an interview with Certified Nurse Aide (CNA) #2, she reported Resident #33 has a percutaneous endoscopic gastrostomy (PEG) tube and eats nothing by mouth, and that is why the signs are posted to alert all staff. CNA #2 stated she works agency and has been coming to the facility for eight (8) months. She did not know how long the signs had been posted on the wall.</p>	F0583		

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F0583 SS = D	<p>Continued from page 9</p> <p>CNA #2 further explained that the information regarding NPO status and keeping the head of the bed elevated is documented on the Kardex and care plan to inform staff how to care for Resident #33.</p> <p>On 6/8/26 at 1:55 PM, during an interview with Registered Nurse (RN) #1, she reported Resident #33 is NPO and receives bolus tube feedings every six (6) hours. RN #1 stated the posted resident information is included on the physician orders, Medication Administration Record (MAR), Treatment Administration Record (TAR), and care plan.</p> <p>On 6/9/26 at 11:05 AM, during an observation, Resident #33 had a visitor in his room. All signs containing personal care information remained on the wall intact and visible.</p> <p>On 6/9/26 at 2:15 PM, during an interview with Licensed Practical Nurse (LPN) #1, she reported the signage on Resident #33's wall was posted by the Minimum Data Set (MDS) nurse and the social worker. LPN #1 stated the facility uses agency staffing and the signs were posted to remind staff of the precautions necessary to prevent complications, but she was unsure when the signs were posted. LPN #1 reported the information displayed on the wall included care information that was also available in Resident #33's chart, Kardex, and care plan.</p> <p>On 6/10/26 at 3:15 PM, during an interview with RN #2, she confirmed that she and social services placed the signs on Resident #33's wall to inform staff of the precautions and included personal care information regarding Resident #33's NPO status, swallow precautions, and the need to elevate the resident's legs. RN #2 stated this information was also available on Resident #33's care plan, Kardex, and physician orders. RN #2 reported she was not aware the facility could not post signs containing resident care information on the walls.</p> <p>On 6/10/26 at 3:30 PM, during an interview with the Director of Nursing (DON), she reported that signage on a resident's wall regarding personal care information is a dignity issue and a resident rights concern. The DON stated she expects all staff to honor resident rights at all times and not post personal or care information where others can see it.</p> <p>A record review of the "Admission Record" revealed the facility admitted Resident #33 on 10/6/25 with diagnoses including Aphasia Following Cerebral Infarction.</p>	F0583		

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<p>F0583 SS = D</p>	<p>Continued from page 10 A record review of the "Order Summary Report" revealed Resident #33 had physician orders for "... NPO diet, NPO texture, NPO consistency May have small pleasure pureed snack in between meals (dated 4/27/26) ... Bolus Jevity 1.5 237 cc (cubic centimeter) q (every) 6h (hours) (dated 5/29/62)... Elevate head of bed at least 45 degrees at all time to prevent aspiration (dated 11/20/25) ... Enteral Bolus Give Jevity 1.5 237cc q6h (4 times a day) via peg tube every 6 hours related to GASTROSTOMY STATUS (dated 5/29/26) ... head of bed up 45 degrees (dated 10/6/25) ... Off load heels while in bed (dated 4/10/26)"</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/12/26 revealed Resident #33 had a Brief Interview for Mental Status (BIMS) Summary Score of 00, which indicated her cognition was severely impaired. Section K, K0520, Nutritional Approaches revealed Feeding tube (e.g., nasogastric or abdominal) (PEG).</p>	<p>F0583</p>		
<p>F0585 SS = D</p>	<p>Grievances</p> <p>CFR(s): 483.10(j)(1)-(4)</p> <p>§483.10(j) Grievances.</p> <p>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:</p>	<p>F0585</p>		

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F0585 SS = D	<p>Continued from page 11</p> <p>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;</p> <p>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;</p> <p>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;</p> <p>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;</p> <p>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if</p>	F0585		

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F0585 SS = D	<p>Continued from page 12 an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interviews, record review, and facility policy review, the facility failed to ensure Resident #34's right to have grievances investigated and resolved by failing to initiate the grievance process after the resident reported three (3) missing clothing outfits for one (1) of (16) sampled residents reviewed.</p> <p>Findings included:</p> <p>A review of the facility's "Grievance Policy," undated, revealed "...It is the policy...that all residents are to be encouraged and assisted if necessary in filing grievance in the event that they have a need to make a concern known...The facility will document all grievances in the electronic health record. The social service department will retain evidence of grievances and actions taken for the required length determined by the retention log. Procedure: 1. Upon receipt of a grievance/complaint the staff receiving the complaint will initiate the Grievance/Complaint Form...5. In all grievance cases, the resident and or legal representative will be informed of the result of the investigation, the recommendations made by the investigating parties, and of the action(s) contemplated by the appropriate Department Head and Administrator."</p> <p>A record review of the handwritten copy of an inventory list, dated 3/27/26 and signed by Licensed Practical Nurse (LPN) #1, revealed Resident #34 had clothing items inventoried and signed upon admission.</p> <p>On 6/9/26 at 3:00 PM, during an interview at the Resident Council meeting, Resident #34 reported (3) outfits were missing after being sent to laundry and had not been returned after reporting the concern to staff. Resident #34 reported the concern had been communicated to staff a few weeks earlier, including Certified Nurse Aide (CNA) #2, and reported being directed to search the laundry room themselves for missing items.</p>	F0585		

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F0585 SS = D	<p>Continued from page 13</p> <p>On 6/9/26 at 4:30 PM, during an interview with the Activities Director (Activities #1), she reported the Administrator was aware of concerns regarding missing clothing. Activities #1 reported clothing identification methods included the use of permanent marker, which may fade or not be visible on dark clothing. Activities #1 further reported clothing labels were available but responsibility for labeling was unclear. Activities #1 reported a large amount of unclaimed clothing was maintained in the laundry room and residents were permitted to search for items. Activities #1 reported she was unaware of a process for replacement of missing clothing items.</p> <p>On 6/10/26 at 9:10 AM, during an interview with CNA #2, she reported Resident #34 and the resident's family had reported missing clothing items. CNA #2 confirmed the items were listed on the inventory sheet and reported searching the laundry area without locating the items.</p> <p>On 6/10/26 at 9:45 AM, during an interview with the Social Services Designee (SS #1), she reported she was unaware of the missing clothing concerns because no formal grievance had been filed. SS #1 reported clothing items generally were not replaced if not documented on the inventory sheet and reported she was unaware of additional missing clothing reports from other residents.</p> <p>On 6/10/26 at 1:10 PM, during an interview with Housekeeping Supervisor (HSK #1), she reported awareness of Resident #34's concerns regarding missing clothing items and stated she had received communication from CNA #2 regarding the missing clothing. HSK #1 reported that when items are missing, staff document the missing items and search the laundry and lost-and-found areas.</p> <p>On 6/10/26 at 1:48 PM, during an observation and interview, there were multiple bags of unidentified clothing and unmatched socks in the laundry area. HSK #1 reported there was no reliable method to identify clothing that was not labeled and confirmed the reported missing clothing items for Resident #34 had not been located.</p> <p>On 6/11/26 at 12:45 PM, during an interview with the Administrator, she reported awareness of the missing clothing for Resident #34 and stated she intended to purchase replacement clothing items the previous week and confirmed replacement had not been completed yet.</p> <p>On 6/11/26 at 1:00 PM, during an interview with the CNA Supervisor, she reported notification had been</p>	F0585		

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F0585 SS = D	Continued from page 14 received from laundry staff that the missing items for Resident #34 could not be located and communication had been made to the nurse who signed the inventory list. The CNA Supervisor stated this occurred the previous month. (May 2026) On 6/11/26 at 1:05 PM, during an interview with Licensed Practical Nurse (LPN) #1, she reported awareness that Resident #34's clothing items could not be located and confirmed no formal grievance was initiated and no follow-up actions were completed. A record review of the "Admission Record" revealed the facility admitted Resident #34 on 3/26/26 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/8/26 revealed Resident #34 had a Brief Interview for Mental Status (BIMS) Summary Score of 15, which indicated the resident was cognitively intact.	F0585		
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §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 physical . . . 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 symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of	F0604		

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F0604 SS = D	<p>Continued from page 15</p> <p>discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical restraints by failing to identify a self-releasing seat belt as a restraint for one (1) of (16) sampled residents, Resident #21, who was unable to independently release the device.</p> <p>Findings included:</p> <p>A review of the facility's "Restraint Reduction and Use Policy," undated, revealed, "Purpose To promote resident dignity, safety, and quality of life through restraint-free care whenever possible and to ensure compliance with federal and state regulations governing restraint use. Policy...is committed to maintaining a restraint-free environment. Physical...restraints shall not be imposed for discipline or staff convenience and shall only be used when medically necessary...Definitions Physical Restraint: Any manual method, device, material, or equipment attached or adjacent to the resident's body that restricts freedom of movement and cannot be easily removed by the resident...Assessment Prior to the use of any restraint, the interdisciplinary team shall assess the resident to identify causes of behaviors, risks, alternatives attempted, and potential consequences. Alternatives The facility shall utilize restraint alternatives whenever possible... Physician Orders Restraints shall only be used pursuant to a physician order when clinically justified..."</p> <p>On 6/8/26 at 10:15 AM, during an observation, Resident #21 was seated in a wheelchair with a self-releasing seat belt secured across the lap. Resident #21 manipulated the buckle but was unable to independently release the seat belt.</p> <p>On 6/8/26 at 10:30 AM, during an interview with Certified Nursing Assistant (CNA) #1, she reported Resident #21 required staff assistance throughout the day and frequently forgot how to perform routine tasks due to dementia.</p> <p>On 6/8/26 at 10:45 AM, during an interview with Registered Nurse (RN) #2, she reported the</p>	F0604		

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F0604 SS = D	<p>Continued from page 16 self-releasing seat belt was utilized for positioning and was not considered a restraint.</p> <p>On 6/8/26 at 11:00 AM, during an interview with Licensed Practical Nurse (LPN) #1, she reported Resident #21 used the self-releasing seat belt to prevent sliding from the wheelchair. LPN #1 was unable to provide documentation demonstrating Resident #21 could independently release the device. LPN #1 further reported Resident #21 was unable to release the self-releasing seat belt due to confusion and dementia.</p> <p>On 6/9/26 at 1:00 PM, during an interview and record review with the Director of Nursing (DON), she reviewed Resident #21's records and confirmed there was no documentation demonstrating Resident #21 had been assessed and determined capable of independently releasing the self-releasing seat belt. The DON acknowledged that if a resident could not independently release the device, the seat belt would be considered a restraint. The DON reported the facility was a restraint-free facility and the seat belt was being utilized for positioning.</p> <p>On 6/10/26 at 4:15 PM, during an observation and interview with the DON and Minimum Data Set (MDS) nurse, Resident #21 was sitting in a wheelchair in the dayroom with the self-releasing seat belt secured across the lap. Resident #21 was asked to stand up and remove the self-releasing seat belt. Resident #21 was unable to recognize that the seat belt needed to be released in order to stand and was unable to release the belt independently.</p> <p>On 6/11/26 at 10:18 AM, during an interview with the Administrator, she reported staff were expected to follow the facility's restraint policy when utilizing any device that could restrict a resident's freedom of movement.</p> <p>A record review of the "Admission Record" revealed the facility admitted Resident #21 on 11/1/24 with diagnoses including Parkinson's Disease.</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/14/26 revealed Resident #21 had a Brief Interview for Mental Status (BIMS) Summary Score of 04, which indicated severely impaired cognition. A review of Section P of the assessment revealed Resident #21 was not coded as having a restraint.</p> <p>A record review of Resident #21's medical record revealed there was no restraint assessment completed for a self-releasing seat belt.</p>	F0604		

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F0641 SS = D	<p>Accuracy of Assessments</p> <p>CFR(s): 483.20(g)(h)(i)(j)</p> <p>§483.20(g) Accuracy of Assessments.</p> <p>The assessment must accurately reflect the resident's status.</p> <p>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>§483.20(i) Certification.</p> <p>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.</p> <p>§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.</p> <p>§483.20(j) Penalty for Falsification.</p> <p>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(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</p> <p>(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.</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, staff interview, and facility policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately completed and coded in accordance with MDS requirements for three (3) of (16) sampled residents reviewed for MDS accuracy, as evidenced by failing to complete discharge assessment and entry assessments (Resident #2 and Resident #56) and inaccurately coding Resident #55's MDS to indicate "Death in Facility" when the resident expired at the hospital.</p>	F0641		

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F0641 SS = D	<p>Continued from page 18 Findings include:</p> <p>A review of the facility's "Minimum Data Set (MDS) Assessment and Completion Policy," undated, revealed "... Purpose To establish procedures for the timely, accurate, and comprehensive completion of Minimum Data Set (MDS) assessments in accordance with CMS (Center for Medicare and Medicaid Services) requirements ... state regulations, and facility standards... Responsibilities The MDS Coordinator is responsible for scheduling assessments, coordinating IDT (interdisciplinary team) input, coding assessments, ensuring timely completion and transmission, monitoring validation reports, and maintaining records. The Director of Nursing (DON) will ensure nursing documentation supports MDS coding and care planning... Assessment Schedule The facility will complete assessments as required by CMS ... Documentation Requirements ... Documentation must be accurate, objective, complete, timely, and consistent across disciplines..."</p> <p>Resident #2</p> <p>A record review of the "Admission Record" revealed the facility admitted Resident #2 on 10/15/25 with diagnoses including Cerebral Ischemia.</p> <p>A record review of Resident #2's "Progress Note" dated 05/14/2026 at 2:14 PM revealed "... Sent out via ambulance..."</p> <p>A record review of Resident #2's "Progress Note" dated 05/19/2026 at 6:55 PM revealed "... returned from several days stay at (Proper Name) Hospital ..."</p> <p>A record review of the clinical electronic health record "MDS" tab revealed Resident #2 had a "Discharge Return Anticipated" (5/14/26), an "Entry" (5/19/26), and a "Medicare-5 Day" (5/26/26) with a "Status" of "In Progress," indicating the assessments had not been completed and transmitted to CMS.</p> <p>Resident #56</p> <p>A record review of the "Admission Record" revealed the facility admitted Resident #56 on 12/09/24 with diagnoses including Chronic Obstructive Pulmonary Disease, Unspecified.</p> <p>A record review of Resident #56's "Progress Notes" dated 04/29/2026 at 6:25 PM revealed "...sent to...ER (Emergency Room) via ambulance..."</p>	F0641		

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<p>F0641 SS = D</p>	<p>Continued from page 19 A record review of Resident #56's "Progress Notes" dated 5/5/2026 12:10 PM revealed "... returned from several days admit ..."</p> <p>A record review of Resident #56's "Progress Notes" dated 5/23/2026 at 8:37 AM revealed "... the resident departed the facility by ambulance..."</p> <p>A record review of Resident #56's "Progress Notes" dated 5/28/26 at 6:59 PM revealed, "...Returned from several days in hospital..."</p> <p>A record review of the clinical electronic health record "MDS" tab revealed Resident #56 had an "Entry" (5/5/26), and a "Discharge Return Anticipated" (5/23/26) with a "Status" of "In Progress," indicating the assessments had not been completed and transmitted to CMS. There was no "Entry" created for 5/28/26 when the resident returned from the hospital.</p> <p>Resident #55</p> <p>A record review of the "Admission Record" revealed the facility admitted Resident #55 on 09/24/25 with diagnoses including Chronic Obstructive Pulmonary Disease, Unspecified.</p> <p>A record review of Resident #55's "Progress Notes" dated 03/24/2026 at 3:52 PM revealed "... EMS (Emergency Medical Services) arrive to facility to transport resident to emergency room ..."</p> <p>A record review of Resident #55's "Progress Notes" dated 04/07/2026 at 9:35 AM revealed "... residents RP (Responsible Party) contacted facility and notified that resident passed away last night ..."</p> <p>A record review of the "Discharge" MDS with an ARD of 03/24/2026 for Resident #55 revealed "... Section A0310 Type of Assessment ... F. Entry/discharge reporting ... Discharge-return anticipated ... A2105. Discharge Status ... Short-term General Hospital ..."</p> <p>A record review of the "Death in Facility" MDS with an ARD of 04/06/2026 for Resident #55 revealed "... Section A0310 Type of Assessment ... F. Entry/discharge reporting ... Death in Facility ..." which indicated Resident #55 expired in the facility and not an acute care hospital.</p> <p>On 06/09/2026 at 2:36 PM, during an interview with the Director of Nursing (DON), she explained that Resident #55 was sent out to the hospital for respiratory distress and he never came back to the</p>	<p>F0641</p>		

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F0641 SS = D	<p>Continued from page 20 facility. He was in the hospital for several weeks until he died at the hospital.</p> <p>On 06/09/2026 3:33 PM, during an interview with Registered Nurse (RN) #2, she confirmed that she completes all the MDS assessments and transmissions. She confirmed that the resident's recent MDS was death in the facility, but he died at the hospital that he was discharged to. She explained that the resident was discharged to the hospital on 03/24/26 and later died at the hospital on 04/06/26. She confirmed that the MDS was coded inaccurately due to resident died weeks after being discharged to the hospital.</p> <p>On 06/09/2026 at 4:11 PM, during a follow up interview with RN #2, she reported that she is aware that some of the residents' MDS assessments are not up to date. She reported that she has been working the cart and assisting the new DON with getting systems in place and doing other duties in the facility. She is aware of the timeframe for the completion of the MDS and she tries to complete all the assessments in the required timeframes.</p> <p>On 06/11/2026 at 1:29 PM, during a follow up interview with the DON, she reported that she was not aware that the residents' assessments were not submitted timely. She stated she expected all residents' MDS assessments to be completed accurately and submitted timely and confirmed that she had not been conducting any record checks to ensure the assessments were submitted timely.</p> <p>On 06/11/2026 at 1:37 PM, during a phone interview with the Administrator, she reported that she expects staff to complete the required duties of their job and complete the tasks daily. She was not aware that the residents' MDS assessments were not being completed accurately or timely.</p>	F0641		
F0656 SS = D	<p>Develop/Implement Comprehensive Care Plan</p> <p>CFR(s): 483.21(b)(1)(3)</p> <p>§483.21(b) Comprehensive Care Plans</p> <p>§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 -</p>	F0656		

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F0656 SS = D	<p>Continued from page 21</p> <p>(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</p> <p>(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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on staff interview, record review, and facility policy review, the facility failed to develop a comprehensive, person-centered care plan related to hospice services for Resident #41 and for all care and services for Resident #42 for two (2) of (16) sampled residents.</p> <p>Findings include:</p> <p>A review of the facility's "Comprehensive Care Plan Policy" undated, revealed "... Purpose To establish a standardized process for developing...comprehensive person-centered care plans that address each</p>	F0656		

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F0656 SS = D	<p>Continued from page 22 resident's physical, psychosocial, emotional, dietary, functional, and spiritual needs in accordance with federal and state regulations... Responsibilities The MDS (Minimum Data Set) Coordinator shall coordinate the care planning process, schedule care plan meetings, and ensure care plans are developed and updated timely...Development of Care Plans A Comprehensive care plan shall be developed within seven (7) days after completion of the comprehensive assessment..."</p> <p>Resident #41</p> <p>A record review of the "Admission Record" revealed the facility admitted Resident #41 on 4/10/26 with the diagnoses including Chronic Obstructive Pulmonary Disease.</p> <p>A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/20/2026 revealed Resident #41 had a Brief Interview for Mental Status (BIMS) summary score of 15, indicating cognitively intact.</p> <p>A record review of the "Order Details" revealed Resident #41 had a Physician's Order, dated 4/13/26, to admit to hospice (04/10/26).</p> <p>A record review of the "Progress Notes" revealed Resident #41 had a "Nurses Note", dated 6/10/26 at 11:47 PM for "...Resident remains on hospice..."</p> <p>A record review of the "Comprehensive Care Plan" for Resident #41 revealed there was no care plan developed with a focus, goals, or interventions related to hospice services.</p> <p>On 6/9/26 at 3:24 PM, an interview with MDS/Care Plan Nurse (RN #2) revealed Resident #41 currently received hospice services and confirmed the care plan did not reflect hospice services, goals, or interventions. RN #2 reported the care plan should be consistent with physician orders to guide nursing staff in providing care and reported the care plan was reviewed daily, quarterly, annually, and as needed when changes occur.</p> <p>On 6/10/26 at 11:20 AM, an interview with Social Services Designee (SS #1) revealed Resident #41 was admitted to the facility on hospice services.</p> <p>Resident #42</p> <p>A record review of the "Admission Record" revealed Resident #42 was admitted by the facility on 4/14/26</p>	F0656		

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F0656 SS = D	<p>Continued from page 23 with diagnoses including Encephalopathy, Type 2 Diabetes Mellitus, and Unspecified Dementia.</p> <p>A record review of the Admission MDS with an ARD of 04/21/2026 revealed Resident #42 had a BIMS Summary Score of 2, which indicated severely cognitively impaired.</p> <p>A review of the clinical record for Resident #42 revealed there was no comprehensive care plan, only a "Baseline Care Plan" dated 4/14/26.</p> <p>On 06/09/2026 at 4:11 PM, during an interview with Registered Nurse (RN)#2, she explained she was facility's MDS and care plan nurse. She reported that she is aware that she is behind on developing resident comprehensive care plans and explained that she has been assisting the new Director of Nursing (DON). She reported that the purpose of the care plan is to tell staff how to care for the residents and without a care plan, the resident may not receive the correct care.</p> <p>On 06/11/2026 at 1:29 PM, during an interview with the DON, she reported that she was not aware that the residents' care plan was not developed. She expects all residents to have a person-centered care plan developed, implemented, and revised per guidelines.</p> <p>On 06/11/2026 at 1:37 PM, during a phone interview with the Administrator, she stated that she expects staff to complete the required duties of their job and complete the tasks daily. She was not aware that the residents' care plans were not developed.</p>	F0656		
F0657 SS = D	<p>Care Plan Timing and Revision</p> <p>CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans</p> <p>§483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p>	F0657		

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F0657 SS = D	<p>Continued from page 24</p> <p>(D) A member of food and nutrition services staff.</p> <p>(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.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interviews, record review, and the facility policy review the facility failed to revise a resident's care plan for two (2) of (16) sampled residents related to significant weight loss and pressure injuries (Resident #2) and changes in psychotropic medication (Resident #13).</p> <p>Findings include:</p> <p>A record review of the facility's "Comprehensive Care Plan Policy" undated, revealed "... Purpose To establish a standardized process for...reviewing, and revising comprehensive person-centered care plans that address each resident's physical, psychosocial, emotional, dietary, functional, and spiritual needs in accordance with federal and state regulations... Responsibilities The MDS (Minimum Data Set) Coordinator shall coordinate the care planning process, schedule care plan meetings, and ensure care plans are developed and updated timely. The Director of Nursing (DON) shall oversee nursing participation and implementation of care plan interventions... Review and Revision Care plans shall be reviewed and revised: Following comprehensive assessments ... upon significant change in condition ... following accidents, incidents, or adverse events when indicated ... Whenever resident needs, preferences, or services change. Revisions shall be documented and communicated to appropriate staff. Documentation Care plan documentation shall accurately reflect resident needs, goals, interventions, and outcomes. All updates, revisions, and interdisciplinary participation shall be documented in the medical record..."</p> <p>Resident #2</p>	F0657		

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F0657 SS = D	<p>Continued from page 25</p> <p>A record review of the Comprehensive Care Plan revealed the care plan with a "Focus" of "Nutritional Status General" was not revised to reflect Resident #2's weight loss or pressure injury.</p> <p>A record review of the "Order Summary Report" revealed Resident #2 had Physician's Orders for a House Supplement after meals for Weight Management (Order date: 06/05/2026), Prostat 30 ml (milli liters) by mouth twice a day two times for to promote wound healing (Order date: 04/09/2026), and to clean deep tissue injury to left heel with normal saline, pat dry, place foam with silver dressing daily until resolved every shift and as needed (Order date: 5/22/26).</p> <p>On 06/09/2026 at 4:11 PM, during an interview with Registered Nurse (RN)#2, she explained that she is behind on revising and updating resident care plans. She reported that the purpose of the care plan is to tell staff how to care for the resident and without the care plan in place, the resident may not receive the correct care.</p> <p>A record review of the "Admission Record" revealed the facility admitted Resident #2 on 10/15/25 with diagnoses including Cerebral Ischemia.</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/26/2026 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) Summary score of 12, which indicated moderate cognitive impairment. Section K0300 revealed yes to weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. Section M0210 revealed one (1) unhealed pressure ulcer/injury.</p> <p>Resident #13</p> <p>A record review of the "Comprehensive Care Plan" for Resident #13 revealed a "Focus" of "...receives antipsychotic medication..." with "Interventions/Tasks" including "Administer Psychotropic medication: quetiapine Fumerate 20 mg..."</p> <p>A record review of the "Order Details" revealed Resident #13 had a current Physician's Order, dated 12/16/25 for Quetiapine Fumarate tablet 50 milligrams (mg) daily.</p> <p>A record review of the Medication Administration Record (MAR) for May 2025" for Resident #13</p>	F0657		

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F0657 SS = D	Continued from page 26 revealed the resident was administered 50 mg of Quetiapine Fumarate daily. A record review of the "Admission Record" revealed the facility admitted Resident #13 on 5/15/25 with diagnoses including Parkinson's Disease. On 6/9/26 at 3:24 PM, an interview with MDS/Care Plan Nurse (RN #2) revealed Resident #13 currently received Seroquel (Quetiapine Fumarate) 50 mg and confirmed the care plan interventions reflected 20 mg. She explained that the care plan interventions had not been revised to reflect the resident's current orders. RN #2 reported the care plan should be consistent with physician orders to guide nursing staff in providing care. On 06/11/2026 at 1:29 PM, during an interview with the Director of Nursing (DON), she reported that she was not aware that the residents' care plan was not revised to accurately reflect residents' care and services. She stated she expected resident care plans to be revised per guidelines. On 06/11/2026 at 1:37 PM, during a phone interview with the Administrator, she stated she expected staff to complete the required duties of their job and complete the tasks daily. She was not aware that the residents' care plans were not being revised.	F0657		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure smoking and vaping activities were assessed, supervised, and conducted in accordance with facility policy and resident safety requirements for one (1) of three (3) residents reviewed for accident/hazards. (Resident #51).	F0689		

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F0689 SS = D	<p>Continued from page 27 Findings include:</p> <p>A review of the facility's "Smoking and Smokeless Tobacco Policy," effective 12/31/17 revealed, "...It is the policy...to endure precautions are taken for the resident's individual safety, as well as the safety of others in the facility. Residents are able to participate in novelty activities such as smokeless tobacco and e-cigarettes...A Smoking Safety Evaluation will be completed upon admission for all residents...Safety measures must be followed in order to participate in smoking activities...No...e-cigarettes...may be kept in the resident's rooms...Smoking times are daily at 7:00 AM, 9:00 AM, 11:00 AM, 1:00 PM, 3:00 PM, 5:00 Pm, and 7:00 PM. Residents will be accompanied by a staff member at each smoking time..."</p> <p>On 6/8/26 at 1:40 PM, during an interview, Resident #51 reported vaping in the room, keeping the vape device in the room, and receiving vape supplies from the resident's daughter.</p> <p>On 6/9/26 at 3:48 PM, during an interview with the Director of Nursing (DON), she reported she was unaware that Resident #51 was vaping in the room.</p> <p>On 6/9/26 at 4:59 PM, during an observation, Resident #51 demonstrated use of a vape device in the room prior to dinner. Resident #51 reported not being informed that vaping was prohibited in the room, reported using the vape device only in the room, and reported keeping the vape device on the resident's person at all times. Resident #51 reported never going outside during designated smoking times. An oxygen concentrator was present in the room near Resident #51's chair.</p> <p>On 6/10/26 at 9:45 AM, during an interview with the Social Services Director (SS #1), she reported smoking assessments were completed upon admission and quarterly and that vaping products should be treated the same as tobacco and not used inside the facility. SS #1 reported she was unaware that Resident #51 was vaping in the room and had observed Resident #51 wearing the vape device around the resident's neck.</p> <p>On 6/11/26 at 2:45 PM, during an interview with the Administrator, she reported there had been prior discussion with Resident #51's family regarding the smoking policy and believed Resident #51 was aware of the policy. The Administrator reported Resident #51 had access to scheduled smoking times outside but acknowledged Resident #51 reported vaping in the room and had not considered vaping use in</p>	F0689		

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<p>F0689 SS = D</p>	<p>Continued from page 28 relation to oxygen equipment or policy compliance. The Administrator stated her expectation was for Resident #51 to go outside to vape.</p> <p>A record review of the "Admission Record" revealed the facility admitted Resident #51 on 11/27/25 with diagnoses that included Dementia, Mild.</p> <p>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/29/26 revealed Resident #51 had a Brief Interview for Mental Status (BIMS) Summary Score of 15, which indicated she was cognitively intact.</p> <p>A record review of the "Smoking Safety Evaluation," dated 4/14/26, revealed Resident #51 had "Follow the facility's policy on location and time of smoking" marked as "Yes." There were no other questions specifically regarding vaping safety.</p>	<p>F0689</p>		
<p>F0700 SS = D</p>	<p>Bedrails</p> <p>CFR(s): 483.25(n)(1)-(4)</p> <p>§483.25(n) Bed Rails.</p> <p>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident with bed rails had an entrapment</p>	<p>F0700</p>		

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F0700 SS = D	<p>Continued from page 29 assessment and consent completed for the use of bed rails for one (1) of (16) sampled residents. Resident #42.</p> <p>Findings included:</p> <p>A review of the facility's policy "Bed Rail" undated, revealed "... It is the policy...that each resident and resident responsible party be informed of the benefits and risks of all bed rails when applicable ... A consent form will be signed by resident representative (RR) prior to new bed rails are installed if deemed by evaluation for side rail installation ... Procedure At the time of admission, bed rail policy, side rail consent form, and side rail assessment form are to be reviewed by resident responsible party and/or self. The facility representative will assist in the explanation of the policy and perform the side rail use assessment form... The facility will ensure that each resident has a bed rail consent when a bed rail is in use ..."</p> <p>On 6/8/26 at 11:23 AM, during an observation, Resident #42 was lying in bed. There were four (4) half bed rails raised.</p> <p>On 6/9/26 at 11:21 AM, during an observation, Resident #42 was lying in bed. There were two (2) half bed rails raised at the top of the bed.</p> <p>On 6/9/26 at 1:45 PM, during an interview with Certified Nursing Assistant (CNA) #2, she reported Resident #42 required limited assistance with turning and transfers and that the top bed rails were always raised because the resident used them to assist with turning and repositioning. CNA #2 confirmed Resident #42 had (2) bed rails raised at all times while in bed to prevent falls but should not have had (4) bed rails raised.</p> <p>On 6/9/26 at 2:30 PM, during an interview with Licensed Practical Nurse (LPN) #2, she confirmed Resident #42 used the bed rails to assist with moving and rolling over. LPN #2 stated she had observed the top (2) bed rails raised but did not know why the bottom rails would be raised. LPN #2 reported Resident #42 had a history of seizures but had not experienced seizures since admission to the facility.</p> <p>On 6/9/26 at 4:11 PM, during an interview with Registered Nurse (RN) #2, she confirmed Resident #42 had bed rails in use, but there was no bed rail consent or other supporting documentation. RN #2 stated consents should be obtained after bed rail assessments are completed. RN #2 confirmed that</p>	F0700		

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NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET PO BOX 279, ROLLING FORK, Mississippi, 39159	
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F0700 SS = D	<p>Continued from page 30 residents with bed rails in use should have an entrapment assessment and consent completed.</p> <p>On 6/11/26 at 1:29 PM, during an interview with the Director of Nursing (DON), she reported she was unaware that Resident #42's bed rail assessment and consent had not been completed. The DON stated all residents with bed rails in use are required to have a bed rail assessment and consent completed upon admission.</p> <p>On 6/11/26 at 1:37 PM, during a phone interview with the Administrator, she reported she was unaware that bed rail consents and assessments had not been completed and expected staff to complete their assigned duties.</p> <p>A record review of the "Admission Record" revealed the facility admitted Resident #42 on 4/14/26 with diagnoses including Encephalopathy, Type 2 Diabetes Mellitus, and Unspecified Dementia.</p> <p>A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/21/26 revealed Resident #42 had a Brief Interview for Mental Status (BIMS) Summary Score of 2, which indicated the resident was severely cognitively impaired.</p> <p>A record review of Resident #42's medical record revealed there was no documentation of a bed rail assessment, entrapment assessment, or consent related to the use of bed rails.</p>	F0700		
F0868 SS = D	<p>QAA Committee</p> <p>CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)</p> <p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:</p> <p>(i) The director of nursing services;</p> <p>(ii) The Medical Director or his/her designee;</p> <p>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and</p> <p>(iv) The infection preventionist.</p>	F0868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255220	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2026
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F0868 SS = D	<p>Continued from page 31</p> <p>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:</p> <p>(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.</p> <p>§483.80(c) Infection preventionist participation on quality assessment and assurance committee.</p> <p>The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interviews, record review, and facility policy review, the facility failed to ensure that all required members participated in the facility's Quality Assessment and Assurance (QAA)/Quality Assurance and Performance Improvement (QAPI) meetings, as evidenced by the absence of the Medical Director from five (5) of (5) QAPI meetings reviewed.</p> <p>Findings included:</p> <p>A review of the facility's policy "Quality Assurance and Performance Improvement Plan (QAPI), revised 12/31/18 revealed "... It is the policy...to have a written QAPI plan provides guidance to all employees, all departments, and all service providers... all employees will participate in ongoing QAPI efforts which support the facilities mission focused on customer service, operational efficiency, and employee satisfaction... Procedure...all departments are involved...quality improvement..."</p> <p>A record review of the facility's "Quality Assurance Meeting" sign-in sheets dated 6/30/25, 10/14/25, 1/21/26, 3/7/26, and 5/21/26 revealed the Medical Director was not present at any of the last five (5) QAPI meetings.</p>	F0868		

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F0868 SS = D	Continued from page 32 On 6/11/26 at 12:00 PM, during an interview with the Director of Nursing (DON), she stated she had been employed at the facility since January 2026. The DON reported that the Medical Director had not attended the QAPI meeting she had participated in and had not attended either in person or by telephone. On 6/11/26 at 12:45 PM, during an interview with the Medical Director, he stated he had not attended a QAPI meeting in a long time. He reported the last QAPI meeting he attended was under the previous administration and stated the facility did not inform him of the meetings or discuss the information reviewed during the meetings. On 6/11/26 at 1:37 PM, during an interview with the Administrator, she stated she had served in her current position for four (4) years and had previously been the Business Office Manager. The Administrator reported the facility conducted QAPI meetings quarterly during the month following each quarter and stated she was unaware that the Medical Director was required to attend the meetings.	F0868		