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 **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
M0000	Initial Comments The State Agency (SA) conducted an annual re-licensure survey at the facility from 6/8/26 to 6/11/26. 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 M500, M640, and M710.	M0000		
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	M0500		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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M0500	Continued from page 1 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 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;	M0500		

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M0500	Continued from page 2 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 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: Based on observation, interview, record review, and	M0500		

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M0500	Continued from page 3 facility practice review, the facility failed to ensure residents' rights were promoted and protected by failing to ensure Resident #21's right to be free from physical restraints, Resident #34's right to have grievances investigated and resolved, Residents #11 and #22's rights to receive information and assistance regarding Advance Directives (ADs), and Resident #33's right to personal privacy for five (5) of (16) sampled residents reviewed (Residents #21, #34, #11, #22, and #33). Findings included: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 …” 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 knowns…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.” 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	M0500		

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M0500	Continued from page 4 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…" Resident #21 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. 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. On 6/8/26 at 10:45 AM, during an interview with Registered Nurse (RN) #2, she reported the self-releasing seat belt was utilized for positioning and was not considered a restraint. 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. On 6/9/26 at 1:00 PM, during an interview 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. 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	M0500		

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M0500	Continued from page 5 belt needed to be released in order to stand and was unable to release the belt independently. 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. A record review of the "Admission Record" revealed the facility admitted Resident #21 on 11/1/24 with diagnoses including Parkinson's Disease. 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. A record review of Resident #21's medical record revealed there was no restraint assessment completed and no physician's order for the self-releasing seat belt. Resident #34: 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. A record review of the handwritten copy of an inventory list, dated 3/27/26 and signed by LPN #1, revealed Resident #34 had clothing items inventoried and signed upon admission. On 6/9/26 at 3:00 PM, during an interview at the Resident Council meeting, Resident #34 reported three (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. On 6/9/26 at 4:30 PM, during an interview with the Activities Director (Activities #1), she reported the	M0500		

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M0500	Continued from page 6 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. 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. 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. 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. 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. On 6/11/26 at 1:00 PM, during an interview with the CNA Supervisor, she reported notification had been 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 2025) On 6/11/26 at 1:05 PM, during an interview with LPN #1, she reported awareness that Resident #34's clothing items could not be located and confirmed	M0500		

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M0500	Continued from page 7 no formal grievance was initiated and no follow-up actions were completed. On 6/11/26 at 12:45 PM, during a post-exit 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. Resident #11 and #22 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). 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. On 6/8/26 at 4:13 PM, during an interview and record review of Resident #11's medical record with the 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. 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. 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	M0500		

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M0500	Continued from page 8 completed upon admission. 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. 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 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/21/26 revealed Resident #22 had a BIMS Summary Score of 7, which indicated the resident was severely cognitively impaired. Resident #33 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.” On 6/8/26 at 1:15 PM, during an interview with 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. 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	M0500		

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M0500	Continued from page 9 staff how to care for Resident #33. On 6/8/26 at 1:55 PM, during an interview with 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. 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. On 6/9/26 at 2:15 PM, during an interview with 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. 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. On 6/10/26 at 3:30 PM, during an interview with the 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. A record review of the “Admission Record” revealed the facility admitted Resident #33 on 10/6/25 with diagnoses including Aphasia Following Cerebral Infarction. 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	M0500		

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M0500	Continued from page 10 (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) ......" 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).	M0500		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE 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). Findings include: A review of the facility's "Smoking and Smokeless Tobacco Policy," effective 12/31/202 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…"	M0640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0640	Continued from page 11 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. 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. 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. 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. 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 relation to oxygen equipment or policy compliance. The Administrator stated her expectation was for Resident #51 to go outside to vape. A record review of the “Admission Record” revealed the facility admitted Resident #51 on 11/27/25 with diagnoses that included Dementia, Mild. 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. 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	M0640		

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M0640	Continued from page 12 questions specifically regarding vaping safety.	M0640		
M0710	45.24.3 Consultation Consultation. Each facility shall obtain the services of a licensed pharmacist who will be responsible for: 1. Establishing a system of records of receipt and disposition of all controlled drugs and to determine that drug records are in order and that an account of all controlled drugs are maintained and reconciled; 2. Provide drugs regimen review in the facility on each resident every thirty (30) days by a licensed pharmacist; 3. Report any irregularities to the attending physician or nurse practitioner/physician assistant and the director or nursing; and 4. Records must reflect that the consultation pharmacist monthly report is acted upon. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record 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. Findings include: 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 regiment reviews (DRR) for all residents as required by federal and state regulations…" A review of the facility's records revealed there were no documented MMRs completed by the Consultant	M0710		

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M0710	Continued from page 13 Pharmacist for residents in the facility from June 2025 through June 2026. 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. 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 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.	M0710		