

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255141		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
NAME OF PROVIDER OR SUPPLIER PICAYUNE REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 READ ROAD , PICAYUNE, Mississippi, 39466			
(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 and Complaint Investigation (CI MS #3034554) at the facility from 7/6/26 through 7/9/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. CI MS #3034554 was investigated related to abuse, neglect, quality of care/treatment and injury of unknown origin and no deficiency was cited. During the recertification survey, F812, F880, F550, F578, F656, and F679 were cited. The facility had a census of 99 and was licensed for 120 beds.			F0000			
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:			F0812			

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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F0812 SS = F	Continued from page 1 Based on observation, staff interviews, and record review the facility failed to maintain sanitary conditions in the dietary department by failing to ensure dishes washed in a low-temperature dishwasher were sanitized with the required chlorine concentration prior to reuse and by failing to wash and sanitize used beverage pitchers before returning them to refrigerated storage for two (2) of three (3) days of kitchen observations. Findings include: On 07/07/2026 at 10:40 AM, during an observation and interview with Dietary Aide (DA) #1, observed DA #1 was operating the low-temperature dishwasher. DA #1 used a chlorine test strip to verify the sanitizer concentration. The test strip remained white, indicating no detectable chlorine sanitizer. DA #1 asked whether she should notify the District Manager (DM) and then informed the DM that the test strip did not register any chlorine. The DM observed the test strip and confirmed no chlorine was present. During the interview, DA #1 stated she routinely tested the chlorine level during each wash cycle but was unsure why the sanitizer was not registering. She confirmed the chlorine test strip measured 10, 50, 100, and 200 parts per million (ppm) and acknowledged documenting chlorine values such as 61 and 62 ppm represented her estimate of the closest reading. On 07/07/2026 at 3:30 PM, during observation and interview, DA #2 was observed washing dishes in the low-temperature dishwasher. During interview in the presence of the DM, DA #2 confirmed she had not checked the chlorine sanitizer concentration before washing the dishes. She stated she had been trained by the previous Dietary Manager to wash all dishes before checking the sanitizer concentration. She further stated she usually did not document the chlorine level because the dietary aide working earlier had already completed the dishwasher log for the dinner meal. During an interview at the same time, with the DM, she reported that the Eco Lab representative had been notified. The DM confirmed that the kitchen staff have continued to use the dishwasher after observing the chlorine test strip showed no detectable sanitizer. She stated staff were expected to notify her of any dishwasher malfunction and acknowledged the dishwasher should have been producing adequate chlorine sanitizer during operation. She further stated the varying chlorine values documented on the dishwasher log reflected staff estimating the sanitizer concentration rather than recording actual			F0812			

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F0812 SS = F	Continued from page 2 readings. On 07/07/2026 at 4:07 PM, during an interview, the Dishwasher Manufacturer Representative (DMR) stated the minimum acceptable chlorine concentration was 50 ppm and the minimum rinse temperature was 120°F. He explained that staff should record only the actual chlorine concentration indicated on the test strip. He confirmed entries such as 57 ppm and 66 ppm were not valid readings and indicated staff were estimating the sanitizer concentration rather than documenting the actual test strip result. On 07/08/2026 at 10:36 AM, during an observation and interview with DA #3, DA #3 was observed to bring in three (3) beverage pitchers that had been used on the resident care unit. DA #3 placed the used pitchers containing remaining beverage back into the kitchen refrigerator without emptying, washing, or sanitizing them. An interview with DA #3 revealed it is her standard practice to place pitchers that are at least half filled back into the refrigerator after bringing them back into the kitchen after meal service. An interview with the District Supervisor (DS) revealed she observed the used beverage pitchers in the refrigerator. The DS confirmed used beverage pitchers returned from the resident care units should be emptied, washed, and sanitized before being placed back into refrigeration. On 07/09/2026 at 3:31 PM, during an interview, the Administrator stated she expected dietary staff to maintain sanitary food service practices, including ensuring dishes were properly sanitized and used beverage pitchers were washed before reuse. She stated additional education would be provided regarding sanitation, food safety, and proper operation of the low-temperature dishwasher. A review of the "Dish Machine Log – Low Temperature (Chemical Sanitizer)" for July 2026 revealed chlorine concentrations ppm's were documented as 57 through 63 ppm. These documented values were inconsistent with the manufacturer's test strip, which only measured chlorine concentrations of 10, 50, 100, or 200 ppm.	F0812					
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide	F0880					

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F0880 SS = F	Continued from page 3 a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880					

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F0880 SS = F	Continued from page 4 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to implement appropriate Contact Precautions in accordance with Centers for Disease Control and Prevention (CDC) guidelines by failing to provide designated disposal containers for contaminated personal protective equipment (PPE), contaminated linens, and other contaminated materials in resident rooms, resulting in contaminated PPE, linens, and other contaminated materials being discarded with routine waste and laundry for two (2) of five (5) residents reviewed for infection prevention and control (Residents #4 and #110). Findings include: A record review of the facility's policy titled, "Infection Prevention and Control Program" with review date 3/03/2026 revealed "... An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Policy Interpretation and Implementation... 11. Prevention of Infection a. Important facets of infection prevention include: ... 7. Implementing appropriate isolation precautions when necessary; and 8. Following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC)." A record review of the "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Setting (2007)) last updated September 2024 revealed "... III.B.1. Contact Precautions. Contact precautions are intended to	F0880					

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F0880 SS = F	Continued from page 5 prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment... Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission... Healthcare personnels caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE (Personal Protective Equipment) upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination...". On 07/06/2026 at 10:45 AM, during an observation and interview with Certified Nursing Assistant (CNA) #1, the State Agency (SA) observed Contact Isolation signage and PPE available outside Resident #110's room. CNA #1 stated Resident #110 had been admitted on Contact Precautions related to a urinary tract infection (UTI) and staff were required to wear PPE when providing care. On 07/06/2026 at 11:24 AM, during an observation and interview with Resident #110, the SA observed a bedside commode lined with clear plastic bags. No designated biohazard waste container or designated contaminated linen receptacle was observed in the resident's room or bathroom. On 07/06/2026 at 12:15 PM, during an observation, the SA observed Contact Isolation and Enhanced Barrier Precautions signage and PPE available outside Resident #4's room. Resident #4's wife stated the resident remained on Contact Precautions due to an infected wound on his right foot/toe. On 07/06/2026 at 2:45 PM, during an observation and interview with Resident #4, the SA observed no designated disposal containers for contaminated PPE, linens, or other contaminated materials in the resident's room. Resident #4 reported drainage had periodically leaked from his wound onto his sock prior to the dressing being changed. On 07/07/2026 at 11:05 AM, during an observation and interview with Resident #4, Contact Isolation signage and PPE remained in place; however, no designated disposal containers were observed in the resident's room or bathroom. Resident #4 stated	F0880			

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F0880 SS = F	Continued from page 6 staff wore gowns and gloves while providing care and discarded the PPE in the regular trash container located in the room. On 07/07/2026 at 2:25 PM, during an interview, Licensed Practical Nurse (LPN) #1 confirmed Resident #4 remained on Contact Precautions following a positive wound culture for Methicillin-resistant Staphylococcus aureus (MRSA). LPN #1 stated staff were required to wear PPE whenever providing direct care. On 07/07/2026 at 2:40 PM, during an observation and interview with Resident #4, resident observed sitting up in his high back wheelchair with right foot observed with dressing dry and intact. No designated disposal containers were observed in his room. On 07/07/2026 at 3:42 PM, during an interview, LPN #2 stated Resident #110 was admitted on Contact Precautions for Extended-Spectrum Beta-Lactamase (ESBL) in the urine. She stated staff were required to don (put on) PPE before entering the room and remove and discard PPE before exiting the room. LPN #2 reported PPE had been discarded in the regular trash container located in the resident's room. On 07/08/2026 at 8:00 AM, during an observation and interview, the SA observed LPN #3 place two designated disposal containers into Resident #110's room. LPN #3 stated she had just been instructed by the Director of Nursing (DON) to place the containers in the room and confirmed no designated disposal containers had been present since the resident's admission on 07/03/2026. On 07/08/2026 at 8:10 AM, during an observation and interview, Registered Nurse (RN) #1 observed donning proper PPE while administering intravenous antibiotics and discarded the PPE in the regular trash container. RN #1 stated Resident #110 had remained on Contact Precautions since his admission on 07/03/26. On 07/08/2026 at 1:00 PM, during an interview, CNA #6 stated no designated disposal containers had been present in Resident #110's room. CNA #6 reported contaminated gowns were placed in routine linen bags with other facility linens, bed linens were placed in the routine laundry, PPE was discarded in the regular trash container, and bedside commode liner bags were discarded in the regular trash after use.	F0880					

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F0880 SS = F	Continued from page 7 On 07/08/2026 at 2:30 PM, during an interview, CNA #2 stated Resident #4 had no designated disposal containers in the room throughout the weekend. She reported contaminated linens were placed in routine laundry bags with other facility linens because no designated contaminated linen receptacle was available. PPE was discarded in the regular trash container. On 07/08/2026 at 3:05 PM, during an interview, CNA #3 confirmed no designated disposal containers were present in Resident #4's room during her shift. She reported PPE worn while providing care was discarded in the regular trash container. On 07/08/2026 at 4:30 PM, during an interview, RN #2 stated residents placed on Contact Precautions were expected to have Contact Isolation signage, PPE, and two designated disposal containers in the room, including one container for contaminated linens and one container for biohazardous waste. RN #2 confirmed neither Resident #4 nor Resident #110 had designated disposal containers until 07/08/2026. RN #2 stated that without designated disposal containers, contaminated PPE, linens, and other contaminated materials could be discarded with routine waste or laundry, increasing the risk for transmission of organisms such as MRSA and Extended-Spectrum Beta-Lactamase (ESBL). On 07/09/2026 at 2:00 PM, during an interview, the DON confirmed residents on Contact Precautions were expected to have designated disposal containers for contaminated linens and biohazardous waste placed in their rooms. The DON stated staff were expected to follow Contact Precaution procedures to prevent the transmission of infectious organisms and confirmed any nursing staff member could obtain and place the required disposal containers in the resident room. On 07/09/2026 at 3:00 PM, during an interview, the Administrator stated she expected staff to follow CDC Contact Precaution guidelines, including ensuring resident rooms were properly equipped with required infection control supplies and promptly reporting missing equipment needed to safely implement Contact Precautions. Resident #4 A record review of Resident #4's "Admission Record" revealed the facility admitted the resident on 11/25/2025 with the diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Type 2			F0880			

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F0880 SS = F	Continued from page 8 Diabetes Mellitus with Diabetic Peripheral Angiopathy Without Gangrene, and Peripheral Vascular Disease, Unspecified. A record review of Resident #4's "Order Details" with order date 06/25/2026 revealed order for "obtain wound culture and sensitivity r/t (related to) rt (right) foot 2nd toe wound drainage. one time only ..." A record review of Resident #4's "Order Details" with order date 06/30/2026 revealed order for "contact isolation r/t MRSA wound every shift for 8 (eight) days ..." A record review of Resident #4's "Order Summary Report" revealed orders for "... contact isolation r/t MRSA wound every shift for 1 Month with start date 07/09/2026 and stop date 08/09/2026 ... Wound #3 arterial ulcer R (right) 2nd toe; clean with wound cleanser, paint with betadine, apply dry dressing, change 3 times a week and PRN (as needed), start date 7/8/26 ... Bactrim DS Oral Tablet 800-160 milligrams (mg) ... Give 1 tablet by mouth two times a day for wound infection/MRSA/RT (right) foot 2nd toe for 7 days with start date 07/08/2026 ..." A record review of Resident #4's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/26/2026 revealed Brief Interview for Mental Status (BIMS) Summary Score of 15, which indicated cognitively intact. A record review of Resident #4's "View Progress Notes" with effective date 6/25/2026 12:41 PM revealed "... During wound care rounds resident's Right 2nd toe wound noted to have purulent drainage on bed and sock. Notified (Proper Name) Wound Care Service's Nurse Practitioner new order to obtain wound culture. Wound culture obtained and sent to lab ..." A record review of Resident #4's "Wound Culture" with resulted date 06/29/2026 revealed 3+ Staphylococcus Aureus MRSA (Methicillin-resistant Staphylococcus aureus) a group of bacteria that causes infection. Resident #110 A record review of Resident #110's "Admission Record" revealed the facility admitted the resident on 07/03/2026 with the diagnosis of Acute Cystitis with Hematuria. A record review of Resident #110's "Order Summary	F0880					

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F0880 SS = F	Continued from page 9 Report" revealed orders for "... Isolation Precautions: Contact precautions R/T (related to) ESBL (Extended-Spectrum Beta-Lactamases) UTI (Urinary Tract Infection) every shift until 07/10/2026 start date 07/03/2026 ... Ertapenem Sodium Injection Solution Reconstituted (Ertapenem Sodium) ... Use 1 (one) gram intravenously one time a day related to Acute Cystitis with Hematuria for 5 (five) Days start date 07/04/2026 ..."	F0880					
F0550 SS = D	A record review of Resident #110's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/09/2026 revealed a Brief Interview for Mental Status (BIMS) Summary Score of 15, which indicated cognitively intact. A record review of Resident #110's "Urine Culture" with resulted date 06/27/2026 revealed greater than 100,000 CFU/ml (Cetrimide, Fucidin, and Cephalosporin per milliliters) Klebsiella Pneumoniae ESBL (Extended-Spectrum Beta-Lactamases) a group of bacteria that causes infections.	F0550					
	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her						

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F0550 SS = D	Continued from page 10 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on resident interviews, staff interviews, record review, and facility policy review, the facility failed to promote resident self-determination and honor resident rights by failing to allow residents to choose their dining location on weekends, requiring residents to receive meals in their rooms for three (3) of (20) residents reviewed for Resident Rights. (Residents #63, #75, and #77). Findings include: A record review of the facility's policy titled, "Resident Rights" with a revised date of 4/2017, revealed "...a. Be encouraged in the exercise of their...rights, benefits or privileges guaranteed by the constitution of the United States and the constitution of the state of Louisiana including the right to be free of discrimination or segregation based upon race, sex, handicap, religion, creed, national background or ancestry with respect to residency, b. Be treated as individuals in a manner that supports their dignity, c. Be assured choice and privacy and the opportunity to act autonomously, take risks to enhance independence, and share responsibility for decisions...e. Receive care and services that are adequate, appropriate, and in compliance with contractual terms of residency, relevant federal and state laws, rules and regulations and shall include the right to refuse such care and services..." On 07/06/2026 at 11:29 AM, during an interview, Resident #63 stated residents eat breakfast, lunch, and dinner in their rooms on weekends because they don't have enough staff. On 07/07/2026 at 11:45 AM, during an interview, Resident #75 stated residents are not allowed to eat breakfast, lunch, or dinner in the dining room on	F0550					

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NAME OF PROVIDER OR SUPPLIER PICAYUNE REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 READ ROAD , PICAYUNE, Mississippi, 39466			
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F0550 SS = D	Continued from page 11 weekends. Resident #75 stated the dining room doors are usually closed on the weekend except for a 30-minute activity on Saturdays periodically. On 07/07/2026 at 12:00 PM, during an interview, Resident #77 stated he enjoys eating meals in the dining room because it allows him to socialize with other residents. He stated that on weekends he doesn't get out of bed because he is required to eat breakfast, lunch, and dinner in his room and is not permitted to eat in the dining room. On 07/09/2026 at 9:00 AM, during an interview, Certified Nursing Aide (CNA) #6 stated residents routinely eat all meals in their rooms on weekends because there are not enough staff to supervise and assist residents in the dining room. CNA #6 stated that residents are occasionally permitted to eat in the dining room on Saturdays if staffing permits; however, residents do not eat in the dining room on Sundays because the dining room remains closed. On 7/9/26 at 9:10 AM during an interview, Licensed Practical Nurse (LPN) # 6 stated that the residents eat in their rooms on the weekends because there are not enough staff to cover the residents or to assist the residents with their meals in the dining room. LPN #6 also stated that at times the facility is down two (2) nurses or (2) CNA's which prevent them from assisting the residents in the dining room, she states that they try to meet the residents' basic needs. On 7/9/26 at 9:25 AM during an interview CNA # 7 confirmed residents routinely receive meals in their rooms on Saturdays and Sundays due to staffing shortages. She stated residents may occasionally eat in the dining room on Saturdays if staffing allows; however, residents are never permitted to eat in the dining room on Sundays. On 07/09/2026 at 9:45 AM, during an interview, the Director of Nursing (DON) stated he attempted to provide residents with dining services on weekends to the best of the facility's ability. He stated there may be circumstances in which residents were unable to dine in the dining room; however, staff were encouraged to provide residents with a positive dining experience. The DON stated he was not aware residents were routinely receiving breakfast, lunch, and dinner in their rooms on weekends rather than being afforded the opportunity to dine in the dining room. On 07/09/2026 at 10:00 AM, during an interview, the Administrator stated she was unaware residents	F0550					

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F0550 SS = D	Continued from page 12 routinely received meals in their rooms on weekends. She confirmed residents have the right to choose where they eat their meals and stated staff are expected to honor resident choice regarding dining location. Resident # 63 A record review of Resident #63's "Admission Record" revealed the resident was admitted to the facility on 5/5/26 with diagnoses including Unspecified Fracture of unspecified Lumbar Vertebra and Type 2 Diabetes Mellitus without complication. A record review of residents' Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/11/26 revealed Brief Interview Mental Status (BIMS) score of 14 which indicated cognitively intact. Resident #75 A record review of Resident #75's "Admission Record" revealed the resident was admitted to the facility on 8/28/17 with diagnoses including Paranoid Schizophrenia and Borderline Intellectual Functioning. A record review of the Annual MDS with an ARD of 5/19/26 revealed a BIMS score of 15, which indicates cognitively intact. Resident #77 A record review of Resident #77's "Admission Record" revealed the resident was admitted to the facility on 7/6/23 with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side and Reduced Mobility. A record review of residents' Annual MDS with an ARD of 5/28/26 revealed BIMS score of 11 which indicated moderate cognitive impairment.	F0550			
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §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. §483.10(c)(8) Nothing in this paragraph should be	F0578			

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F0578 SS = D	Continued from page 13 construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (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. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (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. (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. (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. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure residents who had not executed an Advance Directive were informed of their right to formulate an Advance Directive and were offered assistance in establishing an Advance Directive for two (2) of (20) residents reviewed for Advance Directives. (Residents #11 and #75). Findings include: A review of the facility's policy titled, "Advance Directives Policy", with no date, revealed, "...The resident has the right to make his or her own decisions concerning medical care, including the right to accept or refuse medical or surgical	F0578					

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F0578 SS = D	Continued from page 14 treatment and the right to formulate advance directives. Our facility acknowledges the resident's right to provide written Advance Directives, as required under the Patient Self-Determination Act of 1990, which communicates preference for treatment and care (allowed by the state) in the event he or she becomes incapacitated and unable to express his or her wishes..." A review of the facility's policy titled, "Advance Directives," revised in Aug 2023, revealed, "Advance directives will be respected in accordance with state law and facility policy. Policy Interpretation and Implementation, 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical treatment and to formulate an advanced directive if he or she chooses to do so. 2. Written information will include a description of the facility's policies to implement advance directives and applicable state law... 6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, ...family members, ...and/or...legal representative about the existence of any written advance directives. 7. Information about whether or not the resident has executed advance directives shall be displayed in the medical record. 8. If the resident indicates he or she has not established advance directives, facility staff will offer assistance in establishing advance directives. a. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. b. Facility staff will document the offer in the patient's record to include acceptance/ denial..." A record review of the clinical records for Residents #11 and #75 revealed no documentation the residents or their Resident Representatives (RR) received written information regarding the right to formulate an Advance Directive (AD) or were offered assistance in establishing an AD. On 07/06/2026 at 11:08 AM, during an interview, Licensed Vocational Nurse (LVN) #1 stated the Social Services Director (SSD) was responsible for providing residents and RR information regarding Advance Directives and maintaining the documentation in the electronic medical record. LVN #1 confirmed no Advance Directive documentation was available for Residents #11 or #75. On 07/09/2026 at 2:32 PM, during an interview, the Administrator stated the SSD was responsible for educating residents and RRs regarding Advanced Directive and maintaining the required documentation in the resident's medical record. The	F0578					

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F0578 SS = D	Continued from page 15 Administrator acknowledged residents and RRs were expected to receive information regarding the residents' right to formulate an Advanced Directive and, if an Advanced Directive had not been established, to be offered assistance in establishing an Advanced Directive. The Administrator further acknowledged documentation of the Advanced Directive provided, and any offer of assistance was expected to be maintained in the resident's medical record. The Administrator confirmed the facility was unable to provide documentation demonstrating Resident #11 or Resident #75 received information regarding the right to formulate an Advanced Directive or were offered assistance in establishing an Advanced Directive. Resident #11 A record review of the "Admission Record" for Resident #11 revealed the resident was admitted to the facility on 9/16/21 with diagnoses including Alzheimer's Disease, Unspecified, Major Depressive Disorder, Recurrent Severe Without Psychotic Features, and Schizoaffective Disorder, Unspecified. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/17/26 revealed Resident #11 had a Brief Interview Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. Resident #75 A record review of the "Admission Record" for Resident #75 revealed the resident was admitted to the facility on 8/28/17 with diagnoses including Paranoid Schizophrenia and Borderline Intellectual Functioning. A record review of the Annual MDS with an ARD of 5/19/26 revealed Resident #75 had a BIMS score of 15, which indicated intact cognition.	F0578					
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §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	F0656					

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F0656 SS = D	Continued from page 16 comprehensive assessment. The comprehensive care plan must describe the following - (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 (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). (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. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to develop and implement an individualized comprehensive person-centered care plan for a resident requiring mechanical lift transfer assistance for one (1) of (20) sampled residents. (Resident #107). Findings Include: A review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered" reviewed	F0656					

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F0656 SS = D	Continued from page 17 6/2/2025, revealed "...a comprehensive person-centered care plan...is developed and implemented for each resident. Policy Interpretation and Implementation...8. a. include measurable objectives and timeframes; b. describe the services that are to be furnished to attain...the resident's highest practicable physical, mental, and psychosocial well-being..." A review of the facility's policy titled, "Resident Rights" with a revised date of 4/2017, revealed, "...b. be treated as individuals in a manner that supports their dignity...e. receive care and services that are adequate, appropriate, and in compliance with...relevant federal and state laws..." A record review of Resident #107's "Care Plan Report" revealed no individualized interventions directing staff to utilize a Hoyer (mechanical) lift, identifying the required sling type or size, or describing resident-specific transfer techniques or precautions related to the resident's metastatic bone disease. The care plan lacked individualized guidance for staff to safely transfer the resident while mechanical lift assistance was required. On 07/07/2026 at 2:34 PM, during an interview, the Minimum Data Set (MDS)/Care Plan Nurse/Registered Nurse (RN) #5 stated the comprehensive care plan is intended to communicate each resident's individualized care needs to staff and should include resident-specific transfer interventions for residents requiring mechanical lift assistance. RN #5 stated care plans should provide specific instructions describing how staff are to safely transfer residents. On 07/07/2026 at 3:06 PM, during an interview, the Rehabilitation Director confirmed Resident #107's comprehensive care plan contained no interventions identifying Hoyer (mechanical) lift use, sling type, sling size, or resident-specific transfer precautions. The Rehabilitation Director stated Resident #107 had complained of neck pain before hospitalization, which was later determined to be associated with a cervical fracture. On 07/08/2026 at 10:05 AM, during an interview and record review, Charge Nurse (RN #4) reviewed the electronic medical record and confirmed there was no physician order identifying Hoyer lift transfers, no therapy documentation identifying sling type or size, and no care plan interventions directing staff regarding Hoyer lift use or sling requirements. RN #4 stated therapy may have provided recommendations; however, no such documentation			F0656			

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F0656 SS = D	Continued from page 18 was present in the medical record. On 07/09/2026 at 3:40 PM, during an interview, the Administrator stated she expected each resident's comprehensive care plan to accurately reflect individualized care needs and include resident-specific interventions to guide staff in providing safe care, including safe transfer techniques when mechanical lift assistance is required. A record review of Resident #107's Discharge MDS with an Assessment Reference Date (ARD) of 06/03/2026 revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Section GG revealed the resident utilized a manual wheelchair at the time of discharge. A record review of the "Admission Record" for Resident #107 revealed the resident was re-admitted to the facility on 05/04/2026 with a diagnosis of Pathological Fracture in Neoplastic Disease Other Specified Site, Sequela. A record review of the "Order Summary Report" for Resident #107 revealed an active order for therapy evaluation and treatment, dated 3/18/26.	F0656					
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide an ongoing program of activities designed to meet the interests, preferences, and psychosocial well-being of residents by failing to implement scheduled weekend activities and provide activity opportunities for bedbound residents for two (2) of (2) residents reviewed for activities. (Residents #13 and #63).	F0679					

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F0679 SS = D	Continued from page 19 Findings include: A review of the facility's policy titled, "Resident Rights", revised 04/2017, revealed, "...Residents shall...n. Have choices about participation in community activities and in preferred activities..." A review of the facility's policy titled, "Activity Programs", Revision Date June 2018, revealed, "...Activity programs are designed to meet the interests of and support the...psychological well-being of each resident...5...activity programs are designed to encourage maximum individual participation and are geared to the individual resident's need. 6. Activities are scheduled 7 (seven) days a week..." A review of the facility's July 2026 activity calendar revealed scheduled activities on Saturdays and Sundays. On 07/06/2026 at 11:40 AM, during an interview, Resident #63 stated the facility did not provide activities on weekends, leaving residents with nothing to do for two days. The resident reported that on Saturday's staff occasionally played a movie in the dining room for residents who wished to watch and were able to attend. The resident stated no other structured activities were offered during the remainder of the weekend. Resident #63 further stated residents can't wait for the weekends to end because they become bored with nothing to do. On 07/09/2026 at 4:00 PM, during an interview, the Activities Director (AD) stated the monthly activity calendar listed multiple activities for Saturdays and Sundays; however, the Activities Department was only present on Saturdays for approximately 30 minutes to conduct one activity for residents able to attend the activity room. The AD confirmed staff did not conduct room-to-room activities for bedbound residents on Saturdays and could not confirm bedbound residents received activities during Sunday church visits. On 07/09/2026 at 4:15 PM, during an interview, Resident #13 stated she remained in bed most of the time and was not offered activities on weekends. The resident stated having nothing to do on weekends bothered her because she became bored and would like to be offered activities to keep her busy. On 07/09/2026 at 4:38 PM, during an interview, the Administrator was informed the Activities			F0679			

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F0679 SS = D	Continued from page 20 Department was not implementing all scheduled weekend activities and that bedbound residents were not being offered weekend activities. The Administrator stated she felt it was important for bedbound residents to have weekend activities and expected bedbound residents to start having consistent weekend activities. Resident #13 A record review of the facility's "Admission Record" revealed the facility admitted Resident #13 on 01/15/2026 with diagnoses including Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1 through Stage 4 chronic kidney disease, or Unspecified Chronic Kidney Disease. A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/7/2026 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. Resident #63 A record review of the facility's "Admission Record" revealed the facility admitted Resident #63 on 05/05/2026 with diagnoses including Unspecified Fracture of Unspecified Lumbar Vertebrae, Sequela. A record review of the Admission MDS with an ARD of 05/11/2026 revealed Resident #63 had a BIMS score of 14 indicating cognitively intact.			F0679			