

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/01/2026	
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST , LUCEDALE, Mississippi, 39452			
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F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 6/29/26 through 7/1/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F0812, F0565, F0641, F0644, F0656, F0689, F0695, and F0757. The facility had a census of 50 and was licensed for 59 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: Based on observation, interview, record review, and facility policy review, the facility failed to procure, store, and maintain food under sanitary conditions			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 by failing to ensure opened food items were properly covered, labeled, dated, and discarded in accordance with facility policy and by failing to remove moldy and deteriorated fresh produce from refrigerated storage, with the potential to affect all residents who received food prepared by the dietary department. Findings include: A review of the facility's policy titled, "Food Storage", revealed "...Procedure...7.c. Date marking should be visible on all high-risk food to indicate the date ...ready-to-eat TCS (time/temperature control for safety) food should be consumed, sold, or discarded...12. Leftover food should be stored in covered containers or wrapped carefully and securely...clearly labeled and dated before being refrigerated. Leftover food must be used within 7 days or discarded as per the 2022 Federal Food Code...13.f. all food should be covered, labeled, and dated, and routinely monitored to assure that foods (including leftovers) will be consumed by their use by dates...or discarded...g. All foods should be stored to allow air circulation." On 06/28/2026 at 10:27 AM, during an observation and interview on the initial kitchen tour with the Dietary Manager (DM) #1, the following observations were made: one (1) opened pound cake, dated 06/19/2026, was stored with the food product exposed, was not repackaged or covered, and had not been discarded in accordance with the facility's seven-day policy after opening, Five (5) containers of fresh blueberries with visible mold were stored in a case that restricted adequate air circulation, and (1) one-pound container of strawberries contained visible mold on the fruit. DM #1 observed the above findings and acknowledged the produce was deteriorated. During an interview, DM #1 stated dietary staff were responsible for monitoring opened food items to ensure they were properly covered, labeled, dated, and discarded in accordance with facility policy. She further stated dietary staff were responsible for monitoring fresh produce and removing spoiled items from storage. On 07/01/2026 at 2:36 PM, during a follow-up interview, DM #1 stated all food items were expected to be covered, labeled, dated, and discarded in accordance with facility policy. She stated responsibility for monitoring food storage was shared among dietary staff and acknowledged accountability had not been consistently maintained. She reported plans to provide re-education and monitor staff compliance.			F0812			

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F0812 SS = F	Continued from page 2 On 07/01/2026 at 3:23 PM, during an interview, the Administrator stated the facility expected food items to be properly covered, labeled, dated, stored, and discarded in accordance with facility policy to maintain sanitary conditions and reduce the risk of foodborne illness. A record review of dietary staff in-service records dated 10/28/2025 and 10/31/2025 revealed staff received education regarding foodborne illness prevention, cross-contamination, food storage, and leftover food handling.	F0812					
F0565 SS = D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in	F0565					

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F0565 SS = D	Continued from page 3 the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to resolve and provide follow-up regarding grievances brought forward by the Resident Council related to food quality and cleanliness of resident rooms for six (6) of (12) months of Resident Council meetings reviewed. Findings include: A review of the facility's policy, "Resident and Family Grievances," revised 2/1/26 revealed It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal, or fear of discrimination or reprisal. The grievance official would take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. Steps to resolve the grievance may involve forwarding the grievances to the appropriate department manager for follow-up. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the grievance official. Prompt efforts include acknowledgement of complaint/grievance and actively working toward a resolution of that complaint/grievance. The grievance official, or designee, will keep the resident appropriately appraised of progress towards resolution of the grievances. The grievance official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include, at minimum, the date the grievance was received, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions. statement as she was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of grievance, and the date written decision was issued. The facility will make prompt efforts to resolve grievances. A review of the facility's policy, "Resident Council Meetings," revised 12/17/25 revealed the facility Shall act upon concerns and recommendation of the Council, make attempts to accommodate recommendations to the extent practical, and communicate its decisions to the Council. The Activity Director, or designated Liaison, shall assist the Resident Council with scheduling of meetings and meeting topics, upon request by the Council.	F0565					

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F0565 SS = D	Continued from page 4 A record review of the "Resident Council Meeting Minutes" dated January 1, 2026, revealed the breakfast and supper were cold. The chicken breast and chicken legs are not cooked all the way. The fried chicken was cooked hard. The dietary resolution for January was a cook, and a defective base heater was replaced. The staff was in-serviced to temp (check the temperature) of the chicken at the thickest part of the chicken. February 2026, The Residents complained that the resolution for January was not effective because the food continues to be over and undercooked in February 2026. The resolution for February from dietary revealed they have instructed the staff to recommend an alternate from the "always available menu," if the residents have concerns about fried food. March 2026, Residents complained they are not getting the correct food that they ordered from always available menu. Example, if they order a ham sandwich, they will receive a hamburger. The dietary resolution is that the residents can choose from the regular menu or the always available menu. May 2026, the residents complained that the resolutions are not effective because the chicken is overcooked and they are not receiving what they ordered from the always available menu. The Dietary manager stated that he talked to the cooks about the cooking time for chicken tenders. June 2026 revealed residents repeatedly voiced concerns regarding food quality, food temperature. The residents stated their complaints have not been resolved because the food is terrible. In the meeting the minutes the residents also expressed concerns about room cleanliness, and housekeeping services March 2026, The housekeeping resolution revealed the resident's rooms will be cleaned and trash taken out daily for April 2026, and June 2026. The residents' state this has not been resolved because the staff do not clean their rooms are take out the trash on weekends. The meeting minutes revealed the same concerns that were discussed during multiple meetings. The records revealed interventions were discussed and corrective actions were implemented, but follow-up with the resident council to see if interventions put in place resolved the issues. On 6/29/26 at 3:00 PM, during an interview with Resident Council members attended by the Administrator, Residents reported they routinely complained during resident council meetings about cold food, poor food quality, and unclear and the rooms. The residents also reported the food was either undercooked or overcooked. Residents provide examples that baked chicken was undercooked and fried chicken was cooked too hard.			F0565			

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F0565 SS = D	Continued from page 5 The residents reported these concerns have been discussed for several months and they were told that if they did not like the meal being served, they could order from the always available menu. The residents further reported that when concerns were brought directly to the Administrator, improvements occurred for a couple of weeks and then conditions returned to the same routine. The residents reported housekeeping staff would clean rooms on the day a complaint was made; however, housekeeping services were not consistently provided on weekends. The residents reported food quality and room cleanliness were worse on weekends. One resident reported requesting soup and receiving a can of soup from the kitchen. Several residents reported garbage cans were overflowing by Monday morning because housekeeping services were not provided on the weekends. On 6/29/26 at 3:15 PM, during an interview with the Activity Director (AD), the AD reported she attended Resident Council meetings and was aware residents had voiced concerns regarding food services and room cleanliness for several months. The AD reported she was unable to provide documentation demonstrating the concerns were resolved. The AD reported she communicated the residents' concerns to the Dietary Director and Housekeeping Director and that residents continued to complain about food quality and room cleanliness. The AD reported concerns were addressed; however, they had not been resolved. The AD further reported she typically read the department heads' responses back to the residents during Resident Council meetings. On 6/30/26 at 09:00 AM, during an interview with the Housekeeping Supervisor, the supervisor acknowledged residents had complained regarding cleanliness of resident rooms. The supervisor reported he believed the concerns had been corrected and focused on the residents who directly complained to him. The supervisor reported he was unaware additional residents continued to have the same concerns. On 6/30/26 at 10:00 AM, during an interview with the Dietary Manager, the Dietary Manager reported he was not aware residents continued to complain about the food. The Dietary Manager reported residents had not complained directly to him in over a year except for one resident who frequently requested menu items that were unavailable. The Dietary Manager reported that residents who did not like the meal being served could order from the always available menu. The Dietary Manager reported	F0565					

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F0565 SS = D	Continued from page 6 he had not attended Resident Council meetings to discuss concerns with residents because he was unaware the concerns continued. On 7/1/16 at 09:00 AM Certified Nursing Assistant (CNA)# 6 explained that the residents have complained about the food being cold and one resident complains they never give him what he orders. If he orders a sandwich with chips. He will get the sandwich and no chips. If he orders two boxes of cereal. He will only get one. CNA #6 also stated that the residents complain about their rooms not being cleaned on the weekends. On 7/1/26 at 9:20AM, interview with CNA #7 explained that the residents have complained about the poor quality of food. The CNA #7 stated the residents complain of not getting what they requested, food is cold (mainly soup) and it's either not done or it's cooked too hard. The residents also complain about their rooms not being cleaned on weekends. The CNA #7 said she thinks the facility does not have enough housekeepers to clean all the rooms. On 7/1/26 at 1:00 PM, during an interview with the Administrator, the Administrator acknowledged the facility was expected to investigate resident grievances, implement corrective actions when indicated, and provide follow-up regarding concerns raised through the Resident Council process. The Administrator confirmed she was aware of the residents complaining about the food and the cleanliness of their rooms. The Administrator said she expected the department heads to resolve the complaints in a timely manner. Record review of Resident council Members: Resident #3 A record review of the facility Admission record revealed the resident was admitted on 12/27/2017 with a DX of Occlusion and Stenosis of right carotid artery. A record review of residents Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/20/26 revealed a Brief Interview for Mental Status(BIMS) score of 15 which indicated cognitively intact. Resident #8A record review of the facility Admission record revealed the resident was admitted on 4/28/25 with a DX of Hypertension, and pain.			F0565			

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F0565 SS = D	Continued from page 7 A record review of residents' Annual MDS with an ARD of 4/22/26 revealed BIMS score of 11 which indicated cognitively intact. Resident #11 A record review of the facility Admission record revealed the resident was admitted on 7/2/2021 with a DX of Chronic Embolism and Thrombosis and Hypertension. A record review of resident's Quarterly MDS with an ARD of 4/1/26 revealed BIMS score of 15 which indicated cognitively intact. Resident #16A record review of the facility Admission record revealed the resident was admitted on 8/6/25 with a DX of Chronic Kidney Disease with stage 1through stage 4 A record review of residents' Quarterly MDS with an ARD of 5/13/26 revealed BIMS score of 15 which indicated cognitively intact. Resident #23 A record review of the facility Admission record revealed the resident was admitted on 4/15/26 with a DX of spastic paraplegia and neurogenic bladder. A record review of residents' admission MDS with an ARD of 4/22/26 revealed BIMS score of 15 which indicated cognitively intact. Resident #24 A record review of the facility Admission record revealed the resident was admitted on 9/13/24 with a DX of Atrial Fibrillation A record review of residents' Quarterly MDS with an ARD of 6/10/26 revealed BIMS score of 15 which indicated cognitively intact. Resident #33 A record review of the facility Admission record revealed the resident was admitted on 2/24/25 with a DX of Paraplegia A record review of residents' Quarterly MDS with an ARD of 3/25/25 revealed BIMS score of 15 which indicated cognitively intact. Resident #40 A record review of the facility Admission record revealed the resident was admitted on 4/17/26 with a DX of Fracture of unspecified part of left clavicle and heart failure. A record review of residents' Quarterly MDS with an ARD of 5/6/26 revealed BIMS score of 14 which indicated cognitively intact.	F0565					

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F0565 SS = D	Continued from page 8 Resident #44 A record review of the facility Admission record revealed the resident was admitted on 4/17/26 with a DX of Chronic Obstructive Pulmonary Disease (COPD). A record review of residents' Admission MDS with an ARD of 4/24/26 revealed BIMS score of 15 which indicated cognitively intact.	F0565					
F0641 SS = D	Resident #47 A record review of the facility Admission record revealed the resident was admitted on 11/01/24 with a DX of heart failure and Hypertension. A record review of residents' Quarterly MDS with an ARD of 5/6/26 revealed BIMS score of 15 which indicated cognitively intact. Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money	F0641					

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F0641 SS = D	Continued from page 9 penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure a Minimum Data Set (MDS) assessment accurately reflected the Resident's nutritional status by coding the resident as receiving tube feeding when the resident had no feeding tube, did not receive enteral nutrition during the assessment reference period, and had an active physician order for a regular diet, affecting one (1) of (16) residents reviewed for MDS accuracy. (Resident #24). Findings include: A review of facility's policy titled, "MDS 3.0 Completion", with a revised date of 12/17/25, revealed, "...Policy...Residents are assessed...to identify care needs...Policy Explanation and Compliance Guidelines...1...conducts...comprehensive, accurate...assessment of each resident's functional capacity..." A record review of the "Admission Record" revealed Resident #24 was admitted by the facility on 9/13/24 with diagnoses including Unspecified Atrial Fibrillation. A record review of Resident #24's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/2026 revealed Section K0520, Nutritional Approaches, Item B (Feeding tube [e.g., nasogastric or abdominal (PEG)] while a resident), was coded "Yes," indicating the resident received tube feeding during the assessment reference period. A record review of Resident #24's "Registered Dietitian (RD) Assessment," with an effective date of 03/10/2026, revealed the resident's current diet order was a regular diet. The effective date of the assessment fell within the MDS assessment reference period for the Quarterly MDS with an ARD of 03/11/2026.			F0641			

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F0641 SS = D	Continued from page 10 A record review of Resident #24's "Order Summary Report" revealed an active physician's order, dated 09/13/2024, for a regular diet with regular texture and regular/thin liquid consistency. The order remained active during the Quarterly MDS assessment reference period with an ARD of 03/11/2026. A record review of Resident #24's "Intake and Output" report for the month of March 2026, which included the Quarterly MDS assessment reference period with an ARD of 03/11/2026, revealed the resident consumed meals by mouth, with meal intake documented as the percentage consumed for each meal. The Intake and Output report contained no documentation indicating the resident received enteral nutrition or nutrition administered by feeding tube during the assessment reference period. A record review of Resident #24's clinical record revealed no physician orders, assessments, progress notes, dietary documentation, or other medical record documentation indicating the resident had a feeding tube or received enteral nutrition during the Quarterly MDS assessment reference period with an ARD of 03/11/2026. On 06/30/2026 at 3:47 PM, during an interview with Licensed Practical Nurse (LPN) #2, she stated she was responsible for completing MDS assessments. She reported that medical records, including physician orders, progress notes, therapy documentation, and dietary records, are reviewed to determine the appropriate MDS coding. She confirmed that tube feeding should not have been coded on the Quarterly MDS with an ARD of 03/11/2026. On 07/01/2026 at 12:30 PM, during an interview with the Director of Nursing (DON), she confirmed the MDS with an ARD of 03/11/2026 had been coded incorrectly to indicate the resident had a feeding tube. She stated the resident had never had a feeding tube or received enteral nutrition while residing at the facility. The DON further stated her expectation was that MDS assessments be completed accurately and reflect the resident's actual status during the assessment reference period. On 07/01/26 at 1:18 PM, during an interview with the Administrator, she stated that Resident #24 did not have a feeding tube and had not received enteral nutrition. She confirmed the Quarterly MDS with an ARD 3/11/26 was coded inaccurately. She stated her expectation was that the MDS be completed			F0641			

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F0641 SS = D	Continued from page 11 accurately and reflect the resident's status during the assessment reference period.	F0641					
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure Preadmission Screening and Resident Review (PASRR) Level I screenings were completed accurately and residents received appropriate referral for PASRR Level II evaluation in accordance with PASRR requirements, affecting two (2) of (2) residents reviewed for PASRR requirements. (Residents #2 and #8). Findings Include: A review of the facility's policy, "Resident Assessment- Coordination with PASARR program" with revision date 10/30/25, revealed "Policy: the facility coordinates assessments with the preadmission screening and resident review program under Medicaid to ensure that individuals with a mental disorder (MD), intellectual disability (ID), or related condition receives care and services in the most integrated setting appropriate to their needs...Policy Explanation and Compliance Guidelines...5. a. The facility must screen the individual using the State's Level 1 screening process and refer any resident who has or may have MD, ID, or a related condition to the appropriate	F0644					

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F0644 SS = D	Continued from page 12 state designated authority for Level II PASARR evaluation..." Resident #2 A record review of the "Admission Record" revealed Resident #2 was admitted to the facility on 10/18/2024 with diagnoses including Type 2 Diabetes Mellitus with Unspecified Complications, Major Depressive Disorder, Recurrent, Unspecified, and Schizoaffective Disorder, Depressive Type. A record review of the "Order Summary Report" for Resident #2 revealed active physician orders for Quetiapine Fumarate 25 mg daily with start date 10/18/24 and Sertraline HCL 50 mg daily with start date 1/30/26. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/29/2026 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Review of Section I revealed a diagnosis of schizophrenia. A record review of Resident #2's clinical record revealed a PASRR Level I assessment was present; however, no PASRR Level II evaluation was located in the medical record. Further review of the "Pre-Admission Screening (PAS) Application for Long Term Care" revealed Section IX, Federal PASRR, was marked "No" for a diagnosis of major mental illness. Review of the "LTSS Mississippi Screening Questionnaire" revealed Section I (Medications) contained no documented medications, and Section J (Diagnosis 1) identified Acute Respiratory Failure with Hypoxia as the resident's diagnosis, although the clinical record documented an active diagnosis of schizoaffective disorder. On 6/29/26 at 3:13 PM, an interview with the Director of Nursing (DON) for Resident #2 revealed a PASRR Level II evaluation had not been completed. On 06/30/2026 at 11:27 AM, during an interview, Social Services Director (SS #1) stated a PASRR Level I assessment was completed upon admission. She confirmed a PASRR Level II evaluation had not been completed. She stated a diagnosis change typically prompt a PASRR Level II review and confirmed no PASRR Level II evaluation was in Resident #2's medical record. On 06/30/2026 at 12:44 PM, during an interview with the Director of Nursing (DON), she stated the facility submits PASRR Level I assessments upon	F0644					

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F0644 SS = D	Continued from page 13 admission and relies on the appropriate state designated authority to identify residents requiring a PASRR Level II evaluation. She acknowledged the facility did not follow up when the PASRR Level I assessment was completed incorrectly and did not trigger a PASRR Level II evaluation. After reviewing Resident #2's PASRR Level I assessment, the DON confirmed inaccurate information had been entered in Section I and Section J and acknowledged the inaccurate information could prevent a PASRR Level II evaluation from being initiated. She further stated staff are expected to complete PASRR Level I assessments accurately. Resident #8 A record review of Resident #8's "Admission Record" revealed the resident was admitted to the facility on 04/28/2025 with diagnoses including unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The record revealed a diagnosis of schizoaffective disorder was added on 06/30/2025 following the resident's admission. A record review of the "Pre-Admission Screening (PAS) Application for Long Term Care" for Resident #8 revealed Section IX. Federal PASRR was marked "yes" for a diagnosis of Alzheimer's/dementia and "no" for diagnosis of a major mental illness. No documentation was identified showing the updated psychiatric diagnosis of schizoaffective disorder had been submitted to the appropriate state-designated PASRR authority for review. A record review of the "Order Summary Report" for Resident #8 revealed orders for Aricept Oral Tablet 10 MG (Donepezil Hydrochloride) with a start date 4/28/25 and Zyprexa Oral Tablet 2.5 MG (Olanzapine) with a start date 11/20/25. A record review of the Annual MDS with an ARD of 4/22/2026 for Resident #8 revealed a BIMS score of 11, indicating moderately impaired cognition. Review of Section I revealed a diagnosis of schizophrenia. On 6/30/26 at 1:51 PM, an interview with the Social Services Designee (SS #2) for Resident #8 revealed no significant behavioral concerns had been reported, and no PASRR Level II evaluation had been initiated following the addition of the schizoaffective disorder diagnosis. On 07/01/2026 at 9:16 AM, during an interview with Registered Nurse (RN) #1, she confirmed the diagnosis of schizoaffective disorder documented for			F0644			

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F0644 SS = D	Continued from page 14 Resident #8 on 06/30/2025 should have prompted the facility to submit the updated diagnosis for PASRR review following the resident's admission. On 07/01/2026 at 2:55 PM, during a post-exit interview, the Administrator acknowledged the facility failed to submit the required PASRR referrals for Level II evaluation for Residents #2 and #8. The Administrator stated there was no rebuttal to the findings.	F0644					
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 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.	F0656					

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F0656 SS = D	Continued from page 15 (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 observation, interview, record review, and facility policy review, the facility failed to develop and implement individualized comprehensive care plan interventions that addressed residents' assessed needs and physician-prescribed treatment regimens, for three (3) of (16) residents reviewed for comprehensive care planning. (Residents #6, #7, and #55). Findings include: A review of the facility's policy titled, "Comprehensive Care Plans" revised on 2/1/26, revealed "It is the policy of the facility to develop and implement a comprehensive person centered care plan for each resident consistent with residents rights that include measurable objectives and time frames to meet a resident's medical, nursing and mental and psychosocial needs and ALL services that are identified in resident's comprehensive assessment to meet professional standards of quality...Policy Explanation and Compliance Guidelines...3. The comprehensive care plan will describe...a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being". Resident #6 A record review of Resident #6's " Care Plan Report " revealed a pain-related focus and interventions that included administration of prescribed pain medication; however, the care plan did not include individualized interventions directing staff how to manage the resident's pain during activities of daily living (ADLs), repositioning, or turning, despite documentation and staff reports that the resident experienced pain during these care activities. On 6/29/26 at 2:29 PM, during an interview with Resident #6, the resident reported experiencing pain during turning, repositioning, movement, and dressing and reported not routinely being offered	F0656					

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F0656 SS = D	Continued from page 16 pain medication prior to bathing or ADL care. On 6/30/26 at 2:30 PM, an interview with Certified Nursing Assistant (CNA #4) for Resident #6 revealed the resident verbalized pain during repositioning, transfers, and ADL care and reported notifying nursing staff when pain was reported. On 6/30/26 at 2:35 PM, an interview with Registered Nurse Charge Nurse (RN #3) for Resident #6 revealed nursing staff received reports of the resident experiencing pain and reported the resident complained of pain during bathing, repositioning, and turning. On 6/30/26 at 3:50 PM, an interview with Minimum Data Set (MDS)/Care Plan and Admissions Nurse (RN #1) for Resident #6 revealed the care plan should include individualized interventions based on MDS findings and nursing input. During review of the care plan, RN #1 confirmed individualized interventions addressing pain during ADLs and repositioning were not included. A record review of the "Admission Record" for Resident #6 revealed the facility admitted the resident on 5/1/2026 with the diagnoses of CHRONIC COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGESTIVE) HEART FAILURE. A record review of the "Order Details" for Resident #6 revealed a physician order for Hydrocodone-Acetaminophen Oral Tablet 10-325 MG (milligrams) every eight (8) hours PRN (as needed). A record review of the Annual MDS with an Assessment Reference Date (ARD) of 5/8/2026 for Resident #6 revealed Section J indicated frequent pain and a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired. Resident #7 A record review of Resident #7's "Care Plan Report" revealed a focus of "At risk for injury/falls," r/t (related to) Hemiplegia, Dementia, Epilepsy, Muscle Weakness, and Poor Safety Awareness. Interventions included keeping the resident's call light within reach. The care plan also included a separate focus of "At risk for abnormal bleeding related to med (medication) usage," initiated on 07/17/2024. Interventions under this focus directed staff to observe for bruising, nosebleeds, hematuria (blood in the urine), bloody stools, bleeding gums, and petechiae (tiny pinpoint red, purple, or brown spots caused by bleeding under the skin), and to report	F0656		

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F0656 SS = D	Continued from page 17 signs and symptoms of abnormal bleeding to MD (Medical Doctor). On 06/29/2026 at 2:35 PM, during an observation of Resident #7, the resident was lying in bed. The call light was wrapped around the overhead bed light fixture above the head of the bed, placing it beyond the resident's reach. On 06/30/2026 at 11:30 AM, during an interview with RN #2, she stated Resident #7 did not refuse medications or treatments. After reviewing Resident #7's Medication Administration Record (MAR), RN #2 confirmed there was no documentation of monitoring for potential adverse consequences associated with the resident's psychotropic or anticoagulant medications. She further stated there was no designated area on the MAR to document monitoring for potential adverse consequences. On 06/30/2026 at 2:00 PM, during an interview and observation of Resident #7, resident was in the dining room interacting with activities. Resident reported that he wasn't sure what types of medications he is on, but the staff give him his medications daily. On 07/01/2026 at 9:09 AM, during an observation of Resident #7's room while the resident was out of the room, the call light remained wrapped around the overhead bed light fixture in the same inaccessible position observed on the previous two survey days. On 7/1/26 at 9:33 AM, an interview with Certified Nursing Assistant Supervisor (CNA #1) for Resident #7 revealed staff received training on call light placement and resident safety. During the interview, the call light remained in the same inaccessible position observed on the previous survey days. CNA #1 stated the call light should only be temporarily moved out of reach while cleaning the room or making the bed and should otherwise remain within the resident's reach. On 7/1/26 at 3:15 PM, an interview with the Administrator for Residents #6 and #7 revealed expectations were for staff to ensure each resident's comprehensive care plan was individualized and implemented with interventions addressing identified needs, including pain management and safety. A record review of Resident #7's "Admission Record" revealed the facility initially admitted the resident on 7/28/22 with the diagnoses of Hemiplegia and Hemiparesis Following Cerebral	F0656					

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F0656 SS = D	Continued from page 18 Infarction Affecting Left Non-Dominant Side, Vascular Dementia, Mild, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety, And Other Seizures. A record review of Resident #7's "Order Summary Report" with active orders as of 6/30/26 revealed physician orders for Duloxetine HCl Enteric Coated Pellets Cap 30 MG (milligram) Give 1 caplet orally one time a day for Pain (dated 07/01/2024), Rexulti Oral Tablet 0.5 MG Give 1 tablet by mouth one time a day for Dementia with agitation (dated 07/29/2025), Trazodone HCl Oral tablet Give 25 mg by mouth at bedtime for Depression/Insomnia (dated 01/26/2026), and Xarelto Oral Tablet 15 MG Give 1 tablet orally one time a day related to Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris (dated 07/01/2024). The resident was receiving an antipsychotic, antidepressant, and anticoagulant, all of which require monitoring for potential adverse consequences. There were no orders for monitoring the side effects of the medications. A record review of Resident #7's Quarterly MDS with an ARD of 04/08/26 revealed a BIMS score of 12, indicating moderately impaired cognition. Section GG revealed impairment on one side. A review of Section N revealed he was administered antipsychotic, antidepressant, and anticoagulant medications. A record review of Resident #7's medical records, including the MAR, revealed there was no documentation that the resident was monitored for the side effects of the medications. Resident #55 A record review of Resident #55's "Care Plan Report" revealed a focus of "At risk for altered level of comfort," r/t (related to) Parkinsons disease. Interventions directed staff to observe for adverse side effects to medications such as increased lethargy, slurred speech, sedation or confusion and notify physician. On 06/30/2026 at 11:00 AM, during an interview and observation with Resident #55, resident observed lying in her bed watching television. Resident reported that she is on medications that she doesn't think she needs. She reported that she doesn't know why she is at the facility except for therapy. On 06/30/2026 at 11:50 AM, during an interview with RN #2, she stated Resident #55 had been admitted	F0656					

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F0656 SS = D	Continued from page 19 to the facility approximately two (2) weeks earlier and had adjusted well. She reported that the resident took her medications without difficulty. RN #2 stated she had administered a PRN (as needed) medication on one occasion for increased anxiety after the resident reported seeing men in her bathroom. RN #2 further stated there was no designated place on the MAR to document monitoring for potential adverse consequences of Resident #55's medications. On 06/30/2026 at 3:05 PM, during an interview, the Director of Nursing (DON) stated residents receiving psychotropic medications, anticoagulants, and anti-anxiety medications were expected to be monitored for potential adverse consequences each shift. After reviewing the Medication Administration Records for Residents #7 and #55, the DON confirmed there was no documentation demonstrating monitoring for adverse consequences. The DON stated that if there was no designated place to document medication monitoring, staff were expected to notify management so the issue could be corrected. A record review of Resident #55's "Admission Record" revealed the facility admitted the resident on 06/17/2026 with the diagnoses of Parkinson's Disease Without Dyskinesia, Without Mention of Fluctuations, Anxiety, and Depression. A record review of Resident #55's "Order Summary Report" with active orders as of 7/1/26 revealed orders for Aripiprazole Oral Tablet 5 mg Give 1 tablet by mouth one time a day related to Anxiety Disorder (dated 6/18/26), Fluoxetine HCL Oral Tablet 40 mg Give 1 capsule by mouth one time a day related to Depression ((dated 6/18/26), Hydroxyzine HCL Oral Tablet 25 mg Give 1 tablet by mouth every 8 hours as needed for anxiety (dated 6/30/26), and Trazadone HCL Oral Tablet 100 mg Give 1 tablet by mouth one time a day related to Insomnia (dated 6/18/26). The resident was receiving an antipsychotic, antidepressants, and anxiolytic medication requiring monitoring for potential adverse consequences. There were no orders identified for monitoring the side effects of the medications. A record review of Resident #55's Admission MDS with an ARD of 06/24/2026 revealed in progress with BIMS Score of 12, indicating moderately impaired cognition. A review of Section N revealed she was administered antipsychotic and antidepressant medications. A record review of Resident #55's medical records,	F0656					

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F0656 SS = D	Continued from page 20 including the MAR, revealed there was no documentation that the resident was monitored for the side effects of the medications.	F0656					
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, staff interviews, record review, and facility policy review, the facility failed to ensure the resident environment remained as free of accident hazards as possible by maintaining Resident #7's call light within reach, consistent with the resident's assessed fall risk, left-sided hemiplegia, need for assistance with mobility and toileting, and comprehensive care plan interventions, affecting one (1) of (16) residents reviewed for accident prevention. (Resident #7). Findings include: A review of the facility's policy titled, "Call Lights-Accessibility and Timely Response," with revision date 2/1/26 revealed, "Staff will ensure the call light is within reach of the resident and secured as needed." A record review of Resident #7's "Fall Risk Evaluation" dated 4/10/26 identified the resident as being at risk for falls due to balance problem while standing, decreased muscular coordination, and requires use of assistive devices. On 06/29/2026 at 2:35 PM, during an observation of Resident #7, the resident was lying in bed. The call light was wrapped around the overhead bed light fixture above the head of the bed, placing it beyond the resident's reach. On 06/30/2026 at 2:45 PM, during an observation of Resident #7's room while the resident was out of the room, the call light remained wrapped around	F0689					

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NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST , LUCEDALE, Mississippi, 39452		
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F0689 SS = D	Continued from page 21 the overhead bed light fixture above the head of the bed in the same inaccessible position observed on 06/29/2026. On 7/1/26 at 9:05 AM, an interview with Certified Nursing Assistant (CNA) #2 for Resident #7 revealed staff were trained to ensure the resident's call light was within reach, offer hydration, and address resident needs prior to exiting the room. On 07/01/2026 at 9:09 AM, during an observation of Resident #7's room while the resident was out of the room, the call light remained wrapped around the overhead bed light fixture in the same inaccessible position observed on the previous two survey days. On 7/1/26 at 9:19 AM, during an interview with CNA #3, she reported Resident #7 required limited assistance with mobility due to left-sided paralysis, required assistance with transfers and toileting, had an unsteady gait, and was able to communicate needs. She stated staff were expected to ensure the call light and other necessary items remained within the resident's reach before leaving the room. On 7/1/26 at 9:33 AM, an interview with CNA #1 for Resident #7 revealed staff received training on call light placement and resident safety. During the interview, the call light remained in the same inaccessible position observed on the previous survey days. CNA #1 stated the call light should only be temporarily moved out of reach while cleaning the room or making the bed and should otherwise remain within the resident's reach. On 07/01/2026 at 2:56 PM, during an interview, the Administrator stated staff were expected to ensure residents' call lights remained within reach at all times. A record review of the "Admission Record" revealed Resident #7 was admitted to the facility on 07/28/2022 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/2026 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Section GG documented impairment affecting one side of the resident's body. A record review of the Comprehensive Care Plan for	F0689			

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F0689 SS = D	Continued from page 22 Resident #7 revealed a focus of at risk for injury/falls r/t (related to) Hemiplegia, Dementia, Epilepsy, Muscle Weakness, Poor Safety Awareness. An intervention directed staff to keep the residents' call light within reach. A record review of "In-service Training Topics" dated 3/2/26 revealed call light placement was included as an educational topic with no concerns noted.			F0689			
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure required oxygen cautionary signage was posted for a resident receiving oxygen therapy, affecting one (1) of two (2) residents reviewed for respiratory care. (Resident #12). Findings include: A review of the facility's policy titled, "Oxygen Administration," implemented and revised 02/04/2026, revealed, "...Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences... Policy Explanation and Compliance Guidelines...6. Oxygen warning signs must be placed on the door of the resident's room where oxygen is in use..." On 06/29/2026 at 10:35 AM, during an observation and interview, Resident #12 was observed lying in bed receiving oxygen via nasal cannula at 2 liters/minute (L/min). The resident stated she was recovering from pneumonia, continued to have a cough, felt weak, and experienced shortness of breath. No oxygen cautionary signage was observed on the resident's door or door frame.			F0695			

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F0695 SS = D	Continued from page 23 On 06/29/2026 at 2:05 PM, during a follow-up observation, Resident #12 remained in bed receiving oxygen via nasal cannula at 2 L/min. No oxygen cautionary signage was observed on the resident's door or door frame. On 06/30/2026 at 9:40 AM, during an observation, Resident #12 was not in the room; however, oxygen remained in use at 2 L/min from the wall outlet. No oxygen cautionary signage was observed on the resident's door or door frame. On 06/30/2026 at 9:55 AM, during an interview, Certified Nurse Aide (CNA) #5 stated Resident #12 had experienced weakness since returning from the hospital following treatment for pneumonia and wore oxygen most of the time while in her room, removing it only when leaving the room. On 06/30/2026 at 10:40 AM, during an interview and observation, Licensed Practical Nurse (LPN) #1 stated Resident #12 had been using oxygen as needed since returning from the hospital with pneumonia. LPN #1 stated residents receiving oxygen should have an oxygen caution sign posted on the door frame to indicate oxygen was in use. During the observation, LPN #1 confirmed no oxygen cautionary signage was present. LPN #1 further stated responsibility for placing the signage was not assigned to a specific staff member. On 06/30/2026 at 4:00 PM, during an interview, the Director of Nursing (DON) confirmed an oxygen cautionary sign should have been posted near the entrance of Resident #12's room, typically on the door frame, to alert staff and visitors that oxygen was in use. The DON stated the purpose of the signage was to promote resident and staff safety and confirmed staff were expected to place the sign whenever oxygen was in use. A record review of Resident #12's "Admission Record" revealed the resident was admitted to the facility on 02/06/2025 with diagnoses including non-ST elevation myocardial infarction (NSTEMI)(Heart Attack). A record review of Resident #12's "Order Summary Report" revealed a physician's order for oxygen at 2 L/min via nasal cannula as needed for complaints of dyspnea or oxygen saturation less than 92 percent, with a start date of 06/16/2025. A record review of Resident #12's Quarterly Minimum Data Set (MDS) with an Assessment			F0695			

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F0695 SS = D	Continued from page 24 Reference Date (ARD) of 05/06/2026 revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact.	F0695					
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure residents receiving psychotropic and high-risk medications, including anticoagulants, were monitored for potential adverse consequences in accordance with professional standards of practice and facility policy, affecting two (2) of five (5) residents reviewed for unnecessary medications. (Residents #7 and #55). Findings include: A record review of the facility's policy titled, "Unnecessary Drugs" with revision date of 2/1/26, revealed "Policy: It is the facility's policy that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the	F0757					

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F0757 SS = D	Continued from page 25 resident's highest practicable mental, physical, and psychosocial well-being free from unnecessary drugs ... "Adverse consequence" refers to unwanted, unintended, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. It may include various types of adverse drug reactions and interactions ... Policy Explanation and Compliance Guidelines ... 3... d. Adequate monitoring for efficacy and adverse consequences; e. Preventing, identifying and responding to adverse consequences ..." Resident #7 A record review of Resident #7's "Admission Record" revealed the facility admitted the resident on 10/03/25 with the diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Vascular Dementia, Mild, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety, And Other Seizures. A record review of Resident #7's "Order Summary Report" with active orders as of 6/30/26 revealed physician orders for Duloxetine HCl Enteric Coated Pellets Cap 30 MG (milligram) Give 1 caplet orally one time a day for Pain (dated 07/01/2024), Rexulti Oral Tablet 0.5 MG Give 1 tablet by mouth one time a day for Dementia with agitation (dated 07/29/2025), Trazodone HCl Oral tablet Give 25 mg by mouth at bedtime for Depression/Insomnia (dated 01/26/2026), and Xarelto Oral Tablet 15 MG Give 1 tablet orally one time a day related to Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris (dated 07/01/2024). The resident was receiving an antipsychotic, antidepressant, and anticoagulant, all of which require monitoring for potential adverse consequences. There were no orders for monitoring the side effects of the medications. A record review of Resident #7's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/26 revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. A review of Section N revealed he was administered antipsychotic, antidepressant, and anticoagulant medications. A record review of Resident #7's medical records, including the Medication Administration Record (MAR), revealed there was no documentation that the resident was monitored for the side effects of the	F0757					

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F0757 SS = D	Continued from page 26 medications. On 06/30/2026 at 11:10 AM, during an interview with Certified Nurse Aide (CNA) #4, she stated Resident #7 became agitated several times per week and, on occasion, used profane language toward staff. On 06/30/2026 at 11:30 AM, during an interview with Registered Nurse (RN) #2, she stated Resident #7 did not refuse medications or treatments. After reviewing Resident #7's MAR, RN #2 confirmed there was no documentation of monitoring for potential adverse consequences associated with the resident's psychotropic or anticoagulant medications. She further stated there was no designated area on the MAR to document monitoring for potential adverse consequences. On 06/30/2026 at 2:00 PM, during an interview and observation of Resident #7, resident was in the dining room interacting with activities. Resident reported that he wasn't sure what types of medications he is on, but the staff give him his medications daily. Resident #55 A record review of Resident #55's "Admission Record" revealed the facility admitted the resident on 06/17/2026 with the diagnoses of Parkinson's Disease Without Dyskinesia, Without Mention of Fluctuations, Anxiety, And Depression. A record review of Resident #55's "Order Summary Report" with active orders as of 7/1/26 revealed orders for Aripiprazole Oral Tablet 5 mg Give 1 tablet by mouth one time a day related to Anxiety Disorder (dated 6/18/26), Fluoxetine HCL Oral Tablet 40 mg Give 1 capsule by mouth one time a day related to Depression ((dated 6/18/26), Hydroxyzine HCL Oral Tablet 25 mg Give 1 tablet by mouth every 8 hours as needed for anxiety (dated 6/30/26), and Trazadone HCL Oral Tablet 100 mg Give 1 tablet by mouth one time a day related to Insomnia (dated 6/18/26). The resident was receiving an antipsychotic, antidepressants, and anxiolytic medication requiring monitoring for potential adverse consequences. A record review of Resident #55's "Admission MDS" with an ARD of 06/24/2026 revealed in progress with BIMS Score of 12, which indicated moderate cognitive impairment. A review of Section N revealed she was administered antipsychotic and antidepressant medications.			F0757			

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F0757 SS = D	Continued from page 27 A record review of Resident #55's medical records, including the MAR, revealed there was no documentation that the resident was monitored for the side effects of the medications. On 06/30/2026 at 11:00 AM, during an interview and observation with Resident #55, resident observed lying in her bed watching television. Resident #55 reported that she is on medications that she doesn't think she needs. She reported that she doesn't know why she is at the facility except for therapy. On 06/30/2026 at 11:30 AM, during an interview with CNA #4, she stated Resident #55 had been admitted to the facility approximately two (2) weeks earlier. She reported the resident was cooperative with care and had not exhibited behavioral concerns. However, she stated the resident experienced increased confusion during the afternoon and evening hours. On 06/30/2026 at 11:50 AM, during an interview with RN #2, she stated Resident #55 had been admitted to the facility approximately (2) weeks earlier and had adjusted well. She reported that the resident took her medications without difficulty. RN #2 stated she had administered a PRN (as needed) medication on one occasion for increased anxiety after the resident reported seeing men in her bathroom. RN #2 further stated there was no designated place on the MAR to document monitoring for potential adverse consequences of Resident #55's medications. On 06/30/2026 at 3:05 PM, during an interview and record review, the Director of Nursing (DON) stated residents receiving psychotropic medications, anticoagulants, and anti-anxiety medications were expected to be monitored for potential adverse consequences each shift. After reviewing the MARs for Residents #7 and #55, the DON confirmed there was no documentation demonstrating monitoring for adverse consequences. The DON stated that if there was no designated place to document medication monitoring, staff were expected to notify management so the issue could be corrected. On 07/01/2026 at 3:23 PM, during an interview with the Administrator, she stated that she expects all staff to document care and duties required for their shift following regulatory requirements.			F0757			