| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255344 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/30/2026 |
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| **QUITMAN COUNTY HEALTH & REHAB LLC** | **350 GETWELL DRIVE , MARKS, Mississippi, 38646** |

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| F0000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an Annual Re-certification survey along with one (1) Complaint Investigation (CI MS#3095226) at the facility on 7/28/26 through 7/30/26. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F689 for CI MS#3095226 related to Accident Hazards. The SA also cited F868, F641, F644, F646, F755, and F759.<br><br>The census at the time of the survey was 49 and the facility is licensed for 60 beds. | F0000 | | |
| F0689<br>SS = G | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that -<br><br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, record review, resident and staff interview, and facility policy review, the facility failed to ensure a resident was transported safely and that appropriate safety devices were used to prevent an accident for one (1) of two (2) resident reviewed for accidents, Resident #11. Resident #11 was transported in a wheelchair that was not secured with a wheelchair restraint/securement system, resulting in the resident rolling backward out of the van when the lift gate was lowered, striking his head on the ramp and sustaining a laceration on his arm and head that required emergency-room evaluation.<br><br>Findings Include: | F0689 | | |

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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| F0689 SS = G | Continued from page 1<br><br>Review of the facility policy titled “Safety and Supervision of Residents” revealed “Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities...”<br><br>Record review of “Emergency Physician Record” dated 7/13/26 revealed Chief Complaint: “Fall” under context: “Presents to emergency department (ED) with complaint of (c/o) headache (HA) and left (LT) elbow injury that started after being dropped in his wheelchair (w/c) during a transfer.” Under “Clinical Impression: Head contusion and left arm contusion.” Under Subjective/Objective Assessment: “Patient sent from the nursing home with c/o fall from w/c with head injury and skin tear to left elbow and small laceration to posterior head...”<br><br>During an interview on 7/28/2026 at 1:42 PM, Resident #11 revealed he fell out of the van upon returning from dialysis. He stated his wheelchair was backed up to the lift gate and Certified Nursing Assistant (CNA) #1 lowered the gate and began walking toward the front of the van. Resident #11 stated, “I rolled out backward; I hit my head hard on the ramp and got a cut on my arm.” He further stated he was taken to the emergency room and did not return to the facility until approximately 9:30 PM later that night.<br><br>During an interview on 7/28/2026 at 1:50 PM, the Administrator revealed she had reviewed camera footage of the incident and observed CNA #1 turn her back after lowering the lift gate, at which time Resident #11 fell backward out of the van.<br><br>During an interview and observation on 7/28/2026 at 3:05 PM, CNA #1 revealed she was transportation staff and recalled transporting Resident #11 after his dialysis appointment. She stated she had already picked up another resident whose wheelchair was secured in the van and decided to also pick up Resident #11 because she knew he was finishing dialysis and did not want him to wait. She revealed, "I'm going to be honest with you, even if it gets me in trouble," and further stated, "he was wedged against the gate lift in the back of the van, and his wheelchair was not secured with a safety buckle." CNA #1 revealed she didn't think he could go anywhere because he was wedged in but apparently when she put the lift gate down, he rolled out because he was not secured. An observation of the | F0689 | | |

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| F0689 SS = G | Continued from page 2<br>transportation van revealed a minivan with two bucket seats and two safety harness buckles on the floor in between the seats. No wheelchair securement buckle was observed for a second wheelchair.<br><br>During an interview on 7/29/2026 at 8:28 AM, the Housekeeping Supervisor revealed he was responsible for the upkeep of the facility vehicles. He confirmed the transportation van was designed to transport one wheelchair, although additional securement could be installed for a second wheelchair. He confirmed Resident #11 was not properly secured during transport and stated, “I can see how when CNA #1 let the gate down and then turned her back it would be easy for the resident to come out.”<br><br>Record review of the "Admission Record" revealed Resident #11 was admitted to the facility on 02/05/2026 with diagnoses that included Chronic Kidney Disease, Stage 4, and Hemiplegia, unspecified affecting left nondominant side.<br><br>Record review of Resident #11's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of May 6, 2026 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident is cognitively intact. | F0689 | | |
| F0868 SS = E | QAA Committee<br><br>CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(iv) The infection preventionist.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, | F0868 | | |

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| F0868 SS = E | Continued from page 3<br>or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.<br><br>§483.80(c) Infection preventionist participation on quality assessment and assurance committee.<br><br>The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, policy review, and interview, the facility failed to ensure its Quality Assessment and Assurance (QAA) Committee met at least quarterly for two (2) of four (4) quarters reviewed.<br><br>Findings include:<br><br>Review of facility policy titled “Quality Assurance and Performance Improvement (QAPI) – Role of the QAPI Coordinator” undated revealed, “Duties and responsibilities to the QAPI Program includes…2. Meeting with the QAPI Committee monthly to review assessment tools, data reports, and QAPI activities carried out by departments, services, or committees…”<br><br>Review of facility’s Quality Assurance and Performance Improvement (QAPI) Meeting Signature Pages revealed a meeting was held on 1/20/2026 and 6/19/2026.<br><br>During an interview on 7/30/2026 at 2:00 PM, the Administrator confirmed the committee met only on 01/20/2026 and 06/19/2026 and that no other QAA Committee meetings were held or scheduled over the past 12 months. She stated, “That’s all I have. It’s all I could find.” She further confirmed that she was aware the meetings should be held at least quarterly and that they had failed to do that. | F0868 | | |

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| F0641 SS = D | Accuracy of Assessments<br><br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br><br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br><br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br><br>§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.<br><br>§483.20(j) Penalty for Falsification.<br><br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(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.<br><br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on facility policy review, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments accurately reflected a resident's Pre-Admission Screening and Resident Review (PASRR) status for one (1) of 14 residents reviewed for resident assessments. Resident #20.<br><br>Findings include:<br><br>Review of facility policy titled "Resident Assessment Instrument" revised 9/2010 revealed, "…3. The purpose of the assessment is to describe the | F0641 | | |

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| F0641 SS = D | Continued from page 5<br>resident's capability to perform daily life functions and to identify significant impairments in functional capacity. 4. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning…"<br><br>Record review of Resident #20's Level II PASRR, completed 10/7/2025, revealed the State's PASRR determination indicated Resident #20 met the criteria for having a serious mental illness as defined by PASRR. The Level II PASRR identified an Axis I primary diagnosis of schizophrenia.<br><br>Record review of Resident #20's Comprehensive Admission MDS assessment with an Assessment Reference Date (ARD) of 10/16/2025, revealed Section A1500, PASRR, was coded "0," indicating the resident was not considered by the State Level II PASRR process to have serious mental illness, intellectual disability, or a related condition.<br><br>Record review of Resident #20's Significant Change in Status MDS assessment with an ARD of 11/14/2025, revealed Section A1500 was again coded "0," indicating the resident was not considered by the State Level II PASRR process to have serious mental illness, intellectual disability, or a related condition.<br><br>During an interview on 7/29/2026 at 1:45 PM, the Nurse Consultant confirmed Section A1500 was inaccurately coded on both MDS assessments. She stated accurate assessments were important to ensure the assessments reflected residents' needs and that residents received the care and services they required.<br><br>Record review of the Admission Record indicated Resident #20 was admitted to the facility on 10/9/2025 with medical diagnoses that included (Idiopathic) Normal Pressure Hydrocephalus and Schizoaffective Disorder.<br><br>Review of the MDS, with an ARD of 11/14/2025, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 9, indicating Resident #20 had moderate cognitive impairment. | F0641 | | |
| F0644 SS = D | Coordination of PASARR and Assessments<br><br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br><br>A facility must coordinate assessments with the | F0644 | | |

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| F0644 SS = D | Continued from page 6<br>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:<br><br>§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.<br><br>§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.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and staff interview, the facility failed to coordinate Resident #20's assessments with the State Level II Pre-Admission Screening and Resident Review (PASRR) process. The facility failed to incorporate the PASRR recommendations for psychiatric medication evaluation and monitoring, individual therapy, and psychosocial rehabilitation for one (1) of 14 residents sampled. Resident #20<br><br>Findings include:<br><br>Review of a statement on facility letterhead dated 7/30/26 and signed by the Administrator revealed, "We do not have a policy on Behavior Health/Mental Health."<br><br>Review of Level II PASRR completed on 10/7/2025 revealed the Department of Mental Health sent a PASRR notice of nursing facility approval stating Resident #20 was appropriate for nursing home level of care. The notice indicated Resident #20 met criteria for having a diagnosis of mental illness as defined by PASRR, with an Axis I primary: Schizophrenia. The notice goes on to report that Resident #20 would benefit from the specialized services of: Medication evaluation and monitoring by a psychiatrist to evaluate response to psychotropic medications on target symptoms and modify orders, for management of his mental illness; Individual therapy services to develop coping skills to better manage his symptoms of delusions, paranoia, agitation, and refusing care; and to provide an appropriate outlet to express his feelings and emotions; Psychosocial rehabilitation to support and restore community functioning and | F0644 | | |

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| F0644 SS = D | Continued from page 7<br>well-being to promote recovery in the community and to incorporate independent community living due to a discharge anticipated. Recommendations for Placement Needs Specialized Services: Psychosocial Rehabilitation Medication Evaluation and Monitoring Individual Therapy.<br><br>Record review of a Social Services note dated 11/11/25, documented, “Referral emailed to (Proper name of company providing psychiatric services).”<br><br>During an interview on 7/29/26 at 3:45 PM, the Registered Nurse (RN) Nurse Consultant stated that the facility contacted (Proper Name) Health Services, the company used by the facility to provide psychiatric services, and they had no record that Resident #20 had received a psychiatric evaluation or treatment from them. The clinical record similarly contained no evidence that a psychiatric provider evaluated or treated Resident #20 following his 10/9/25 admission.<br><br>Record review of Resident #20’s Psychotropic Evaluation dated 7/21/26, revealed, “…Resident is feeling or appearing down, depressed or hopeless >/= (less than or equal to) two weeks…Resident will cry at times but usually easily redirected. Usually happy when out of his room. Family and/or staff believe that depression is consistently contributing to impaired quality of life…”<br><br>Review of the Admission Record indicated Resident #20 was admitted to the facility on 10/9/2025 with medical diagnoses that included (Idiopathic) Normal Pressure Hydrocephalus and Schizoaffective Disorder.<br><br>Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/2025, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 9, indicating Resident #20 had moderate cognitive impairment. | F0644 | | |
| F0646 SS = D | MD/ID Significant Change Notification<br><br>CFR(s): 483.20(k)(4)<br><br>§483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.<br><br>This REQUIREMENT is NOT MET as evidenced by: | F0646 | | |

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| F0646 SS = D | Continued from page 8<br>Based on observation, record review, and staff interview, the facility failed to notify the State Mental Health Authority of a significant change in a resident's mental condition following inpatient psychiatric admissions for one (1) of two (2) Preadmission Screening and Resident Review (PASRR) reviewed, Resident #45.<br><br>Findings Include:<br><br>The facility provided a statement on letterhead that read, “We do not have a policy on PASSR (pre-admission screening and resident review) change in status request.”<br><br>An observation of Resident #45 on 7/30/26 at 1:04 PM revealed he was sitting in his wheelchair outside his room. The resident was alert to name and displayed facial frowning and a blunt affect.<br><br>Record review of the “Admission Record” revealed the facility admitted Resident #45 on 9/30/24 with medical diagnoses that included Schizoaffective Disorder, Catatonic Schizophrenia, Bipolar Disorder, Major Depressive Disorder, and Anxiety Disorder.<br><br>Record review of Resident #45’s “Pre-Admission Screening and Resident Review,” completed upon admission to the facility, revealed under “Level II Outcome Comments,” dated 10/3/24, “Due to a (suspected or confirmed) level II diagnosis of an Intellectual Disability, an onsite Level II will be initiated. A level II will not be initiated for a serious mental illness (SMI) due to the individual’s current orientation and medical condition.”<br><br>Record review of the “Department of Mental Health" determination letter, dated 10/3/24, revealed, “(Resident #45) was referred to the Department of Mental Health for an Intellectual Developmental Disabilities (IDD) level II. (Resident #45) is sixty-one years old, has numerous medical conditions: Anxiety Disorder, Major Depressive Disorder and Catatonic Schizophrenia. Resident #45 is a high risk for institutionalization, extensive medical and personal care needs and may need daily services and supports, he is approved for nursing home placement.”<br><br>Record review of Resident #45’s progress notes dated 10/25/25 through 7/30/26 revealed recurring anxiety, paranoia, hallucinations, verbal aggression, threatening statements, physical aggression, resistance to redirection, attention-seeking behaviors, and episodes of intentionally lowering himself to the floor: | F0646 | | |

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| F0646 SS = D | Continued from page 9<br><br>On 11/11/25, the resident sat in the lobby and called out to staff members as they walked past. He either did not respond when staff spoke to him or stated that he was scared. The resident fidgeted with his hands and displayed pronounced facial grimacing.<br><br>On 11/13/25, the resident began trembling while walking in the hallway and threw himself toward a nurse. The nurse lowered him to the floor. The resident then got up independently and denied pain or injury.<br><br>On 11/14/25, the resident appeared anxious, stated that no one wanted to care for him, walked with a shuffling gait, and threw himself onto several employees throughout the day. Staff documented no improvement in his symptoms following an increase in Clonazepam.<br><br>On 11/18/25, the resident stood in the hallway and refused to move forward or backward. He stated that staff and other residents were trying to kill him, wrung his hands, displayed pronounced facial grimacing, and exhibited periods of catatonia. He denied suicidal or homicidal thoughts but stated that he was afraid of everyone. The resident refused his medication because he was afraid of staff. Later, he grabbed toward a nurse's arm and stated, "You could at least help me". The nurse practitioner was notified and ordered a psychiatric consultation. The resident was transferred to “Proper name of inpatient behavior facility” on 11/18/25 and returned to the facility on 12/2/25 with an increase in Risperdal to 4 milligrams twice daily.<br><br>Record review of the proper name of the inpatient Geri-psych facility’s “History of Present Illness,” dated 11/19/25, revealed, “Pt (patient) reportedly has been refusing med. Thinks staff/resident there are trying to kill him. Wringing his hands and has deep grimace on face. Threatening other residents.”<br><br>On 12/17/25, the resident was observed crying in bed, fidgeting with his hands, making crying sounds, and displaying pronounced facial grimacing. The resident stated that he did not know what to do and did not know why no one liked him.<br><br>On 3/3/26, the resident was observed grimacing, whining, fidgeting, and making multiple physical complaints.<br><br>Record review of Resident #45’s “Psych Progress Note,” dated 3/4/26, revealed, “Pleasant and cooperative with assessment. Sleep and appetite | F0646 | | |

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| F0646 SS = D | Continued from page 10<br>"Good". Mood "okay". Denies negative mood s/sx (signs and symptoms). Pt (patient) is compliant with medications. Staff does not report any behavioral concerns." Further review revealed, "Seems to be stable."<br><br>On 3/5/26, the resident walked throughout the hallway repeatedly stating that no one was paying attention to him and that staff were trying to kill him. Later that morning, the resident stated that no one liked him, people wanted to hurt him, and everyone wanted him to die. He yelled in the hallway, stopped in the middle of the hallway and would not move. The nurse practitioner was notified and ordered a psychiatric consultation. The resident was transferred to "Proper name of inpatient behavior facility" on 3/5/26 and returned to the facility on 3/17/26.<br><br>Record review of Resident #45's proper name of inpatient Geri-psych facility "History of Present Illness," dated 3/6/26, revealed, "He is unsure why he is here. He admits to seeing things. Stuff happening in front of me that ain't there." Also admits to feeling depressed lately. "I go off the deep end and get angry sometimes." "I can be outside and hear something that ain't there. Not voices, I just hear certain things. I get scared at nighttime."<br><br>Record review of Resident #45's Nurse Practitioner (NP) "Nursing Home Visit," dated 3/24/26, revealed, "The patient was seen today. He returned from Geri Psyche on 3/17/26. They increased his Seroquel at night from 600 to 800 mg (milligrams). They decreased his Klonopin to 0.5 mg (milligrams) bid (twice daily)."<br><br>On 3/31/26, the resident experienced an episode of anxiety during which he cried and breathed rapidly.<br><br>On 4/1/26, the resident stood and urinated on the bedroom floor while staff attempted to redirect him to sit down due to his risk of falling.<br><br>On 4/2/26, the resident was observed sitting in his doorway, grimacing, wringing his hands, and speaking in a child-like manner.<br><br>On 4/6/26, the resident hollered at staff, attempted to make himself vomit, stated he could not walk, and remained noncompliant after staff provided him with a wheelchair.<br><br>On 4/10/26, the resident propelled his wheelchair into the medication cart, hollered at the nurse, and continued the behavior despite redirection. Later that | F0646 | | |

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| F0646 SS = D | Continued from page 11<br>day, the resident hollered from his room and made statements about someone shooting the wrong person and staff not caring about him.<br><br>On 5/22/26, the resident threatened a staff member by stating, "You're stupid. I will knock you out." He then entered the hallway among staff and other residents and stated, "All ya'll stupid I'm about to knock somebody out." Another resident reported hearing him state, "I'm going to hit that sorry a** b***h." The physician was notified, and the resident was transferred to “Proper name of inpatient psychiatric facility” on 5/22/26. He returned to the facility on 5/30/26 with a medication change.<br><br>Record review of Resident #45’s proper name of inpatient Geri-psych facility “Discharge Summary Report,” dated 5/30/26, revealed, “He has been showing symptoms of delusion, agitation, and physical aggression. Symptoms were unable to be treated on an outpatient basis which required this Geri-psych admission.”<br><br>On 6/13/26, the resident was observed lying stiff in bed with his arms extended and legs stiff. After getting out of bed, he accused a nurse aide of hitting him, although the nurse documented directly observing that the nurse aide did not hit him. Later that morning, the resident stood in the hallway, began rocking, and lowered himself to the floor. He remained on the floor for several minutes before getting up independently and sitting in a wheelchair. The physician was notified, and staff attempted to locate psychiatric placement.<br><br>On 7/5/26, the resident stood in the middle of the hallway with his hands clenched into fists and accused a nurse aide of attempting to hit him. He moved to his room after staff redirected him.<br><br>On 7/7/26, the resident became verbally argumentative and aggressive toward other residents. He grabbed a nurse aide's arm as the nurse aide walked past him. Staff separated the resident from others; however, he continued making inappropriate and confrontational comments despite redirection.<br><br>On 7/13/26, the resident intentionally lowered himself to the floor, rolled on the floor, and then got up independently without assistance.<br><br>On 7/15/26, the psychiatric nurse practitioner reported the resident stated he was experiencing hallucinations at night that caused him to feel afraid. The physician was notified, and the resident's | F0646 | | |

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| F0646 SS = D | Continued from page 12<br>Risperdal was increased from 2 milligrams twice daily to 4 milligrams twice daily.<br><br>Record review of Resident #45's "Psych Progress Note," dated 7/15/26, revealed, "Resident #45 is sitting in chair in the hallway and declines to go elsewhere for privacy. Pt (patient) is aggravated. He is rambling and speaking in incomplete thoughts, doesn't give direct answers to questions, Staff reports patient had episode of inappropriate behaviors. Pt reports AVH (auditory and visual hallucinations). "It's really scared me. I don't know what it is."<br><br>Overall, the record showed recurring behavioral symptoms from 11/11/25 through 7/15/26, including three transfers for inpatient behavioral-health treatment, continued threatening or aggressive behavior following his returns, repeated accusations that staff intended to harm him, hallucinations, paranoia, and medication adjustments.<br><br>An interview with Social Services (SS) on 7/30/26 at 1:04 PM revealed Resident #45 displayed frequent behaviors and was routinely seen by psychiatric services at the facility. She confirmed the resident had multiple psychiatric stays and medication adjustments during the past year. SS stated she did not submit a significant change in status to the mental health authority following any of the resident's three inpatient Geri-psych stays. She stated that she did not know she was required to submit the information and stated, "I am learning as I go."<br><br>An interview with the Administrator (ADM) on 7/30/26 at 2:21 PM revealed she was not aware that the facility was required to submit a change in status to the mental health authority when a resident with a mental illness or intellectual disability experienced a significant change. She stated that the corporate nurse informed her of the requirement several months earlier. She confirmed SS was responsible for submitting the information to the mental health authority and stated, "She did not know to do it either; she found out the same time I did we were supposed to be doing those." The ADM confirmed the submission was required to ensure Resident #45 received all required services in the appropriate setting.<br><br>Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/4/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident #45 was moderately cognitively impaired. | F0646 | | |

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| F0755 SS = D | Pharmacy Srvcs/Procedures/Pharmacist/Records<br><br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, interview, and facility policy review, the facility failed to ensure a prescribed medication was available for timely administration and failed to implement its medication-acquisition process when the medication was unavailable for one (1) of five (5) residents reviewed for medication availability. Resident #20<br><br>Findings include:<br><br>Review of facility policy titled “Adverse Consequences and Medication Errors” undated revealed, “Policy statement: The interdisciplinary team monitors medication usage to prevent and detect medication-related problems… 2. The staff and | F0755 | | |

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| F0755 SS = D | Continued from page 14<br>practitioner strive to minimize adverse consequences by: a. Following relevant clinical guidelines.... for use, dose, administration.... of the medication..."<br><br>Record review of Resident #20's May 2026 Medication Administration Record (MAR) revealed an order for Haldol Decanoate 100 mg/mL (milligrams/milliliter), inject 150 mg intramuscularly on the 14th of each month for schizoaffective disorder. On 05/14/2026 at 4:58 PM, nursing documented, "MEDICATION NOT IN FACILITY." Further review revealed the scheduled 05/14/2026 dose was never administered. The medical record contained no documented evidence that nursing contacted the pharmacy to obtain the medication, notified the prescribing practitioner of the unavailable and omitted dose, or obtained instructions for administering or rescheduling the missed injection.<br><br>During an interview on 7/30/2026 at 1:58 PM, the Administrator confirmed Resident #20 did not receive the Haldol Decanoate injection scheduled for 05/14/2026. The Administrator confirmed the medical record contained no evidence that the nurse contacted the pharmacy to obtain the medication or notified the prescribing practitioner that the medication was unavailable and the dose had been omitted. She stated, "The nurse should have contacted the pharmacy and notified the physician."<br><br>Record review of the Admission Record indicated Resident #20 was admitted to the facility on 10/9/2025 with medical diagnoses that included (Idiopathic) Normal Pressure Hydrocephalus and Schizoaffective Disorder.<br><br>Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/2025, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 9, indicating Resident #20 had moderate cognitive impairment. | F0755 | | |
| F0759 SS = D | Free of Medication Error Rts 5 Prcnt or More<br><br>CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br><br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br><br>This REQUIREMENT is NOT MET as evidenced by: | F0759 | | |

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| F0759 SS = D | Continued from page 15<br><br>Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the medication error rate was five (5) percent (%) or less for two (2) of 27 medication opportunities. Medication error rate of 7.41%<br><br>Findings include:<br><br>The facility provided a document titled “Procedure Guideline for Ensuring the Six Rights of Medication Administration,” which revealed under, “2. To prevent medication errors, keep in mind the six rights of medication administration each time you prepare to administer a drug; right medication, right dose, right patient, right route, right time, and right documentation.” The document further revealed under, “5. Observe the six rights of medication administration: A. right medication: (1) Check the medication label against the MAR (medication administration record) three times:”<br><br>Record review of room 111-B MAR revealed an order dated 7/18/25, “Aspirin Oral Tablet 325 MG (milligrams) give 1 (one) tablet via (by) gastrostomy tube (G-tube) one time a day for Cerebrovascular Accident (CVA).”<br><br>During an observation of a medication pass with Licensed Practical Nurse (LPN) #2 on 7/29/26 at 6:21 AM, she removed one acetaminophen (Tylenol) 325-milligram tablet from the medication bottle and crushed it for administration to room 111-B instead of preparing the ordered Aspirin 325-milligram tablet. After entering the resident’s room, but before administering the medication, LPN #2 was stopped and informed that she had prepared Tylenol instead of Aspirin. LPN #2 confirmed she had made an error and stated she was nervous and did not read the medication label as she was supposed to. LPN #2 stated that giving Tylenol instead of aspirin would not provide the intended effect for stroke and clot prevention.<br><br>Record review of room 118-B MAR revealed an order dated 10/18/25, “Thiamine HCL (hydrochloride) Oral Tablet 250 MG give 1 tablet by mouth one time a day for alcohol abuse.”<br><br>During a medication pass observation with LPN #1 on 7/29/26 at 8:30 AM, she prepared and administered one 100-milligram thiamine tablet to room 118-B instead of the ordered 250-milligram dose.<br><br>During an interview on 7/29/26 at 9:30 AM, LPN #1 | F0759 | | |

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| F0759 SS = D | Continued from page 16<br>confirmed she had made an error. After reviewing the physician's order, LPN #1 stated she should have administered two and one-half tablets to equal the ordered 250-milligram dose. LPN #1 stated the resident received thiamine for alcoholism and confirmed that failure to receive the correct dose could result in a low thiamine level and nutritional deficits.<br><br>During an interview on 7/29/26 at 10:27 AM, the Interim Director of Nursing stated she expected nurses to check the medication and dosage against the order on the MAR three times before administration to prevent medication errors.<br><br>Record review of the "Admission Record" revealed the facility admitted room 118-B on 10/17/25 with medical diagnoses that included Metabolic Encephalopathy and Alcohol Abuse.<br><br>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/1/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 14, which indicated room 118-B was cognitively intact.<br><br>Record review of the "Admission Record" revealed the facility admitted room 111-B on 7/29/21 with medical diagnoses that included Cerebral Infarction, Vascular Dementia, and Gastrostomy Status.<br><br>Record review of the MDS with an ARD of 5/27/26 revealed under section C, a BIMS summary score of 4, which indicated room 111-B was severely cognitively impaired. | F0759 | | |