

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255320		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2026	
NAME OF PROVIDER OR SUPPLIER LANDMARK NURSING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 100 LAUREN DRIVE , BOONEVILLE, Mississippi, 38829			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey at the facility from 08/03/26 through 08/06/26. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies F583, F645, F656, F658, F690, F697, and F761. The census at the time of the survey was 67 and facility was licensed for 80 beds.			F0000			
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.			F0583			

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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F0583 SS = D	Continued from page 1 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to ensure a resident's right to personal privacy during a blood glucose check and insulin administration for one (1) of four (4) care opportunities observed. (Resident #24). Findings Include: Record review of facility policy titled "Resident Rights and Responsibilities" with a revision date of 10/10/2022 revealed "...7. Privacy and confidentiality...a. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident..." Observation on 8/5/2026 at 11:17 AM revealed Licensed Practical Nurse (LPN) #2 assisted Resident #24 from the dining room to the area by the nurses' station. LPN #2 checked the resident's blood glucose, which was 251 mg/dL (milligrams/deciliter). LPN #2 then prepared six (6) units of insulin and administered the insulin into the back of the resident's right upper arm. During the blood glucose check and insulin administration, at least two (2) facility staff members walked past the nurses' station and opened the unit doors. Additionally, three (3) hospice personnel approached and remained at the nurses' station while LPN #2 administered the insulin injection. During an interview on 8/5/2026 at 2:40 PM, LPN #2 stated Resident #24 should have been taken to her room for privacy during the blood glucose check and insulin administration. LPN #2 acknowledged performing the procedures by the nurses' station was a dignity issue. During an interview on 8/6/2026 at 1:31 PM, the Director of Nursing (DON) confirmed Resident #24 should have been provided privacy during the blood glucose check and insulin administration. The DON stated the procedures should not have been performed in an open area where other individuals were present.			F0583			

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F0583 SS = D	Continued from page 2 Record review of "Admission Record" revealed Resident #24 was admitted to facility on 4/25/2024 and had diagnoses of Alzheimer's Disease and Type 2 Diabetes Mellitus with Diabetic Polyneuropathy. Record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/17/2026 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 10, indicating Resident #24 was moderately cognitively impaired.	F0583					
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.	F0645					

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F0645 SS = D	Continued from page 3 §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to accurately complete the Level I Preadmission Screening and Resident Review (PASARR) screening, resulting in the failure to refer a resident with documented mental illness for a PASARR Level II evaluation, for one (1) of two (2) residents reviewed for PASRR. Resident #7 Findings Include: Review of the facility policy titled "Admission to Facility," revised 5/20/20, revealed under PASARR:			F0645			

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F0645 SS = D	Continued from page 4 "This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening..." Record review of the "Admission Record" revealed the facility admitted Resident #7 on 7/28/25 with a primary diagnosis of Hypertensive Heart and Chronic Kidney Disease with Heart Failure. Other medical diagnoses included Bipolar Disorder, Obsessive-Compulsive Disorder, and Unspecified dementia. Record review of Resident #7's PASARR, dated 7/31/25, revealed the resident had a history of mental illness and took mood stabilizers and antidepressants. Section M, "PASARR level II Categorical Determination Criteria," asked: "a. Does "proper first name of the resident" have a primary diagnosis of Alzheimer's /Dementia?" The facility marked "Yes," although Resident #7 did not have a primary diagnosis of Alzheimer's/Dementia. This inaccurate response resulted in a screening outcome of "PASARR Activity Required: No." Therefore, the resident was not referred for a PASARR Level II evaluation despite documented diagnoses of bipolar disorder and obsessive-compulsive disorder. An interview and record review with Social Services (SS) on 8/4/26 at 1:20 PM revealed she was responsible for PASARR submissions. SS confirmed the resident was not referred for a Level II evaluation and stated she thought that was unusual because the resident had bipolar disorder. SS acknowledged Resident #7 did not have a primary diagnosis of dementia. After reviewing the question in Section M, SS confirmed she completed the PASARR inaccurately because she thought the question asked whether the resident had any diagnosis of dementia. SS confirmed the Level I was completed inaccurately and did not represent the resident's true status, which could alter the state mental health authority's findings. An interview with the Director of Nursing (DON) on 8/4/26 at 2:03 PM revealed Resident #7 was admitted to the facility following a hip fracture. The DON confirmed the resident had dementia, but dementia was not the resident's primary diagnosis. She further acknowledged the inaccurate information	F0645			

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F0645 SS = D	Continued from page 5 could alter whether the resident was referred to the mental health authority for a Level II evaluation.	F0645					
F0656 SS = D	Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #7 was cognitively intact. 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. (C) Discharge plans in the comprehensive care plan,						

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F0656 SS = D	Continued from page 6 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 implement a pain care plan for one (1) of 19 care plans reviewed. Resident #7 Findings Include: Review of the facility policy titled "Comprehensive Plan of Care" revised 2/17/25 revealed under, "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality." Record review of Resident #7's "Care Plan Report" revealed under, "Focus: 'proper first name of resident' has pain r/t (related to) arthritis, OA (osteoarthritis), RA (rheumatoid arthritis), and history of hip fx (fracture)." The care plan also revealed under, "Interventions: Observe for s/s (signs and symptoms) of pain every shift." On 8/3/26 at 11:35 AM, during a telephone interview with the Resident Representative (RR), she revealed Resident #7 had rheumatoid arthritis and had fractured both hips in the past. The RR stated the resident talked about pain, especially pain in her right hip, and reported the pain was unbearable at times. The RR stated the facility gave the resident Tylenol for pain, which the resident told her, "Is just like taking water" and did nothing for the pain. During an observation and interview with Resident #7 on 8/3/26 at 2:46 PM, she was sitting on the edge of her bed with her right hand positioned under her right hip. She stated she had pain in her neck, lower back, and right hip. She explained that she had fallen in the past and fractured both hips, which required surgical repair. The resident stated her right hip had caused pain since the surgery. She	F0656					

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F0656 SS = D	Continued from page 7 stated she felt a nodule in the hip region and the pain increased with movement. She stated she was participating in therapy and had to ride the bicycle, stating, "It absolutely kills me." The resident revealed she propped her hand under her right thigh to relieve the pain. She stated she had Voltaren gel and Tylenol for pain, but "It does not do much of anything." The resident stated she complained of pain during therapy, but it did not do any good, so she pushed through to complete the therapy. Record review of Resident #7's "Physical Therapy (PT) Evaluation and Plan of Treatment," dated 2/16/26, revealed under "Patient goals," "Decrease pain in order to walk around place and socialize with everyone." The evaluation also revealed under "Current Referral: Referred to physical therapy following insidious onset of R (right) hip and leg pain.... she has had an onset of pain in her R (right) hip that limits her function. She is unable to provide a date, but pt (patient) has had her R (right) hip replaced prior to admission to this facility. Pt (patient) states that her pain is 0/10 at best and 8/10 at worst w/ (with) worsening symptoms during activity and ambulation." Record review of the "Progress Notes" for Resident #7, dated 4/21/26, revealed, "Complained of continued and increasing pain to right hip. Requested 'Something Done.' Charge nurse made aware." During an interview with the Rehab Director on 8/4/26 at 1:58 PM revealed she had been working with Resident #7 in occupational therapy (OT) and the resident complained of right hip pain, but not consistently. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/14/26 revealed under section J, "How much of the time have you experienced pain or hurting over the last 5 days?" Frequently was indicated. Under "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" Occasionally was indicated. Further review of the MDS with an ARD of 7/15/26 revealed under section J, "How much of the time have you experienced pain or hurting over the last 5 days?" Almost constantly was indicated. Under "Over the past 5 day, how often have you limited your day-to-day activities because of pain?" Frequently was indicated. During an observation and interview with Resident #7 on 8/5/26 at 8:29 AM, she was sitting in a chair in her room. She explained that she received Tylenol			F0656			

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F0656 SS = D	Continued from page 8 around 5:00 PM the previous evening and stated, "It may have helped some; my hip hurt real bad last night." Record review of Resident #7's July and August 2026 MARs revealed no indication that the resident's pain was monitored every shift. An interview with the MDS Nurse on 8/6/26 at 11:42 AM revealed that the purpose of the care plan was to inform staff how to care for residents. She confirmed Resident #7's pain care plan was not followed. Record review of the "Admission Record" revealed the facility admitted Resident #7 on 7/28/25 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Rheumatoid Arthritis, and Pain Unspecified. Record review of the MDS with an Assessment Reference Date (ARD) of 7/15/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #7 was cognitively intact.	F0656					
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to follow physician orders for a resident with a Percutaneous Endoscopic Gastrostomy (PEG) tube medication administration for one (1) of four (4) residents observed for medication administration (Resident #5). Findings Include: Record review of facility policy titled "Medication Administration," revised on 3/30/2026, revealed, "Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection."	F0658					

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F0658 SS = D	Continued from page 9 Record review of the "Order Summary Report" revealed an order dated 5/27/25, "Enteral Feed Order every shift Flush PEG tube with 30 milliliters (ml) of water before and after medication administration and 5 ml between meds." During a medication administration observation on 8/5/2026 at 9:30 AM, Licensed Practical Nurse (LPN) #1 removed Aspirin, Loratadine, Azithromycin, Linzess, and Hydrocodone from the medication cart. LPN #1 placed all five (5) medications together in one medication crushing pouch and crushed them at the same time. LPN #1 added a small amount of water to the combined crushed medications. LPN #1 also removed Docusate Sodium Liquid and measured the appropriate amount into a medication cup. Prior to administering the medications, LPN #1 verified placement of Resident #5's PEG tube and flushed the PEG tube with 30 ml of water. LPN #1 then administered the five (5) combined crushed medications through the PEG tube, followed by 5 ml of water. LPN #1 then administered the liquid Docusate Sodium, followed by 30 ml of water. LPN #1 did not administer the five (5) crushed medications separately with five (5) ml of water between each medication as ordered by the physician. During an interview on 8/5/2026 at 9:55 AM, LPN #1 confirmed that when administering medications through a PEG tube, each medication should be crushed and administered separately with 5 ml of water between each medication and that she had failed to do that. During an interview on 8/6/2026 at 1:23 PM, the Director of Nursing (DON) acknowledged that physician orders indicated how medications are to be administered. The DON confirmed that the physician order for Resident #5 was not followed and stated that the medications should have been administered according to the physician order. Record review of "Admission Record" revealed Resident #5 was admitted to facility on 3/25/2025 with diagnoses including Dysphagia Following Cerebral Infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/10/2026 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #5 was cognitively intact.	F0658					

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F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interview, record review, and facility policy review, the facility failed to implement a scheduled toileting program for urinary incontinence after repeated assessments identified the resident as a candidate for scheduled toileting for one (1) of two (2) residents reviewed for urinary incontinence. Resident #10 Findings Include: Review of the facility policy titled "Bladder and Bowel Habits, Urinary Incontinence and Catheter Care" revised 9/15/22, revealed under, "Policy: It is	F0690					

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F0690 SS = D	Continued from page 11 the policy of this facility to re-establish a program of independent bladder and bowel control." Also revealed under, "Urinary Incontinence: ... A resident who is incontinent of bladder shall receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Each resident who is incontinent of urine is identified, assessed, and provided treatment and services to achieve or maintain as much normal urinary function as possible..." An interview with Resident #10 on 8/4/26 at 9:50 AM revealed she was usually continent of urine during the day but occasionally had accidents. She stated, during the night, she was incontinent of urine, and staff came into her room and changed her brief. Record review of Resident #10's Minimum Data Sets (MDS) with Assessment Reference Dates (ARD) of 1/13/26, 4/7/26, and 7/8/26 revealed under Section H-Bladder and Bowel item H0300 that the resident was frequently incontinent. The MDS also revealed under item H0200, "Urinary Toileting Program A. Has a trial of a toileting program (scheduled toileting, prompted voiding, or bladder retraining) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?" No was indicated. Record review of the "Bowel and Bladder Evaluation" dated 1/8/26, 4/5/26, and 7/4/26 revealed the resident was alert and oriented and had urinary incontinence "Not always, but at least daily." The evaluations reflected scores ranging from 12 to 13, which indicated the resident was a candidate for scheduled toileting (timed voiding). Each evaluation reflected, "Will not proceed with bladder retraining program," with no additional comments. An interview with the Director of Nursing (DON) on 8/5/26 at 2:42 PM revealed the night shift charge nurse was responsible for completing the bowel and bladder evaluations quarterly. She stated that if staff identified an issue during the evaluation, the night shift charge nurse was to notify the day shift charge nurse, who would contact the physician for orders, such as an order to check the resident's urine for a urinary tract infection. The DON confirmed the facility did not provide bladder retraining programs for urinary incontinence. She also stated Resident #10's bowel and bladder evaluations identified the resident as a candidate for scheduled toileting; however, a program was not implemented to address the resident's urinary incontinence.			F0690			

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F0690 SS = D	Continued from page 12 An interview with the MDS Nurse on 8/5/26 at 2:58 PM revealed the MDS staff reviewed the bowel and bladder evaluations but did not implement interventions when concerns related to urinary incontinence were identified. She confirmed the facility had never implemented a scheduled toileting program for any resident. The MDS Nurse stated Resident #10 preferred to wear a brief at night and chose to be incontinent; however, she acknowledged the facility had not attempted a scheduled program in which staff toileted the resident at night. An interview with Certified Nurse Aide (CNA) #1 on 8/5/26 at 3:12 PM revealed that at night, staff entered Resident #10's room and changed her brief every two hours but did not offer to toilet her. CNA #1 stated, "We just change her." Record review of the "Admission Record" revealed the facility admitted Resident #10 on 1/25/25 with medical diagnoses including Spinal Stenosis. Record review of the MDS with an ARD of 7/8/26 revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 14, indicating Resident #10 was cognitively intact.			F0690			
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to ensure pain was adequately assessed, monitored, and managed. The facility failed to complete a comprehensive pain evaluation and reassess and monitor Resident #4 following pain management interventions; and failed to consistently monitor Resident #7's pain and notify the provider for evaluation of the resident's pain management regimen when the resident experienced persistent pain that interfered with daily activities for two (2) of three (3) residents reviewed for pain.			F0697			

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F0697 SS = D	Continued from page 13 Findings Include: Review of the facility policy titled "Pain Management," revised 3/10/2025, revealed, "The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. ... The facility will use a pain assessment tool ... Assessment of pain shall include location, duration, radiation, precipitating and alleviating factors. Re-assessment shall be performed after each method of pain relief is tried to assess the effectiveness of the method. Attempts to control pain shall be employed until the resident reaches an acceptable comfort level..." During an interview on 8/3/26 at 11:25 AM, Resident #4 stated, "I have pain at times to my bottom and my knees, but I'm not having any pain at this time." Record review of Resident #4's "Visit Note Report: Registered Nurse (RN) Hospice Subsequent Visit," dated 8/3/26 at 4:05 PM, revealed under "Pain: Patient Response," "Are you uncomfortable because of pain? No." The narrative documentation revealed, "Patient states that she is sore from being in the bed; however, denied needing pain medication at time of visit." Record review of Resident #4's "Order Summary Report" revealed an order for Fentanyl Patch 72 Hour 25 micrograms/hour (MCG/HR), apply one patch transdermally every 72 hours for pain, and an order for Morphine Sulfate (Concentrate) Oral Solution 20 milligrams/milliliter (MG/ML), give 0.2 ML by mouth every four hours as needed for pain. Record review of Resident #4's nursing "Progress Note" dated 8/3/26 revealed the resident's family reported that Resident #4 complained of leg pain and requested administration of the as-needed Morphine Sulfate. There was no documented comprehensive assessment of Resident #4's reported leg pain, including the location, duration, radiation, precipitating factors, or alleviating factors, prior to administration of the as-needed Morphine Sulfate. Record review of Resident #4's Medication Administration Record (MAR) revealed that on 8/3/26 at 5:00 PM, Resident #4 received Morphine Sulfate Oral Solution 20 MG/ML, 0.2 ML, as needed for pain. The MAR reflected a pain level of 5 associated with the administration. A Fentanyl			F0697			

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F0697 SS = D	Continued from page 14 72-Hour 25 MCG/HR transdermal patch was applied on 8/3/26 at 5:02 PM. Further record review revealed no completed Pain Evaluation for Resident #4 in accordance with the facility's pain management process and no documented comprehensive pain assessment addressing the location, duration, radiation, precipitating factors, and alleviating factors associated with the resident's reported leg pain. The record also contained no documented reassessment of Resident #4's pain or monitoring for adverse effects following administration of the as-needed Morphine Sulfate. Observations on 8/4/26 at 12:55 PM and again at 2:40 PM revealed Resident #4 lying in bed asleep. During an interview on 8/4/26 at 2:55 PM, RN #1 stated, "I've been off work for a week and don't know why she does not have a pain assessment completed." During an observation and interview on 8/4/26 at 3:00 PM, Resident #4 was observed awake and lying in bed. Resident #4 stated, "I've been sleeping a lot; they gave me pain medicine." Resident #4 denied pain at the time of the interview and stated that when she experienced pain, it was usually located in her knees and bottom. During an interview on 8/4/26 at 3:55 PM, the Director of Nursing (DON) confirmed that a Pain Evaluation had not been completed for Resident #4 and that the resident's pain had not been comprehensively assessed prior to administration of the as-needed Morphine Sulfate on 8/3/26. The DON confirmed that the hospice nurse's documentation from the 8/3/26 visit at 4:05 PM revealed Resident #4 denied being uncomfortable because of pain and denied needing pain medication at the time of the visit. The DON confirmed that following the hospice nurse's visit, the resident's family reported that Resident #4 complained of leg pain and requested the as-needed Morphine Sulfate. The Morphine Sulfate was subsequently administered, followed by application of the Fentanyl patch. The DON further confirmed that Resident #4 was not reassessed or monitored for adverse reactions following administration of the as-needed Morphine Sulfate. The DON stated, "This is concerning to me because the resident could have become overly sedated, and this could have resulted in a bad outcome." During an interview on 8/4/26 at 4:20 PM, the Medical Director confirmed that prior to			F0697			

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F0697 SS = D	Continued from page 15 administration of as-needed pain medication, a resident's pain should be assessed, and the resident should be monitored following administration for effectiveness and adverse effects. The physician confirmed that failure to assess and monitor the resident could result in adverse consequences, including sedation. Record review of the "Admission Record" revealed the facility admitted Resident #4 on 5/25/26 with medical diagnoses that included Chronic Systolic (Congestive) Heart Failure and Major Depressive Disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/25/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #4 was cognitively intact. Resident #7 A telephone interview with the Resident Representative (RR) on 8/3/26 at 11:35 AM revealed Resident #7 had rheumatoid arthritis and had fractured both hips in the past. The RR stated the resident talked about pain, especially pain in her right hip, and reported the pain was unbearable at times. The RR stated the facility gave the resident Tylenol for pain, which the resident told her, "Is just like taking water" and did nothing for the pain. An observation and interview with Resident #7 on 8/3/26 at 2:46 PM revealed she was sitting on the edge of her bed with her right hand positioned under her right hip. She stated she had pain in her neck, lower back, and right hip. She explained that she had fallen in the past and fractured both hips, which required surgical repair. The resident stated her right hip had caused pain since the surgery. She stated she felt a nodule in the hip region and the pain increased with movement. She stated she was participating in therapy and had to ride the bicycle, stating, "It absolutely kills me." The resident revealed she propped her hand under her right thigh to relieve the pain. She stated she had Voltaren gel and Tylenol for pain, but "It does not do much of anything." The resident stated she complained of pain during therapy, but it did not do any good, so she pushed through to complete the therapy. Record review of Resident #7's "Physical Therapy (PT) Evaluation and Plan of Treatment," dated 2/16/26, revealed under "Patient goals," "Decrease pain in order to walk around place and socialize with			F0697			

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F0697 SS = D	Continued from page 16 everyone." The evaluation also revealed under "Current Referral: Referred to physical therapy following insidious onset of R (right) hip and leg pain.... she has had an onset of pain in her R (right) hip that limits her function. She is unable to provide a date, but pt (patient) has had her R (right) hip replaced prior to admission to this facility. Pt (patient) states that her pain is 0/10 at best and 8/10 at worst w/ (with) worsening symptoms during activity and ambulation..." Record review of the "Progress Notes" for Resident #7, dated 4/21/26, revealed, "Complained of continued and increasing pain to right hip. Requested 'Something Done.' Charge nurse made aware." Record review of the August 2026 Medication Administration Record (MAR) revealed an order dated 4/21/26 for "Voltaren arthritis pain external gel 1% (percent) apply to lower back/bilateral hip topically every evening shift for hip pain/low back pain and every 8 (eight) hours as needed." The MAR also revealed an order dated 8/4/25 for "Tylenol oral tablet 325 MG (milligrams) give 2 (two) tablets by mouth every 6 (six) hours as needed for pain related to generalized osteoarthritis." An interview with the Rehab Director on 8/4/26 at 1:58 PM revealed she had been working with Resident #7 in occupational therapy (OT), but the resident had plateaued. The Rehab Director stated the resident complained of right hip pain, but not consistently, and she had not modified the treatment plan because of the pain. Record review of the "Occupational Therapy Progress Notes," dated 6/25/26 through 7/13/26, revealed no documentation that the resident experienced pain during the treatment sessions. Record review of the MDS with an ARD of 4/14/26 revealed under section J, item J0410 "How much of the time have you experienced pain or hurting over the last 5 days?" Frequently was indicated. Under item J0510 "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" Occasionally was indicated. Further review of the MDS with an ARD of 7/15/26 revealed under section J, item J0410 "How much of the time have you experienced pain or hurting over the last 5 days?" Almost constantly was indicated. Under item J0530 "Over the past 5 day, how often have you limited your day-to-day activities because of pain?" Frequently was indicated.			F0697			

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F0697 SS = D	Continued from page 17 Record review of the July 2026 MAR revealed Resident #7 received Tylenol 325 milligrams (two) tablets on the following dates and times. The nurses documented the medication was effective on follow-up: 7/10/26 at 1352 (1:52 PM) for a pain score of 5; 7/25/26 at 1330 (1:30 PM) for a pain score of 6; 7/27/26 at 1726 (5:26 PM) for a pain score of 5; 7/29/26 at 1045 (10:45 AM) for a pain score of 5; and 7/31/26 at 0830 (8:30 AM) for a pain score of 4. Record review of the August 2026 MAR revealed Resident #7 received Tylenol 325 milligrams (two) tablets on 8/3/26 at 8:33 AM for a pain score of 5. Documentation indicated the medication was effective for pain. An interview with the MDS Nurse on 8/5/26 at 8:20 AM revealed Resident #7 complained of right hip pain, had arthritis pain, and saw a rheumatologist. When asked about the most recent MDS pain assessment dated 7/15/26, which indicated the resident experienced almost constant pain that interfered with her day-to-day activities, the MDS Nurse stated, "It's nothing new, she has arthritis pain and has Tylenol when needed." She denied that the resident's report of constant pain should have been reported to the physician for review of the pain regimen. An observation and interview with Resident #7 on 8/5/26 at 8:29 AM revealed she was sitting in a chair in her room. She explained that she received Tylenol around 5:00 PM the previous evening and stated, "It may have helped some; my hip hurt real bad last night." Record review of Resident #7's July and August 2026 MARs revealed no indication that the resident's pain was monitored every shift. An interview with the Director of Nursing on 8/6/26 at 9:52 AM revealed she expected nurses to monitor residents for pain every shift. She confirmed this was not done for Resident #7. She further revealed the provider should have been notified immediately when the MDS assessment indicated Resident #7 was experiencing constant pain. The DON stated she expected the nurses to follow up after pain	F0697					

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F0697 SS = D	Continued from page 18 medication was given, and if the medication was ineffective, the provider should be notified to alter the pain regimen. Record review of the "Admission Record" revealed the facility admitted Resident #7 on 7/28/25 with medical diagnoses that included Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Rheumatoid Arthritis, and Pain Unspecified. Record review of the MDS with an ARD of 7/15/26 revealed under section C, a BIMS summary score of 15, indicating Resident #7 was cognitively intact.	F0697					
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and facility policy review, the facility failed to ensure controlled substances were securely stored in one (1) of two (2) medication room refrigerators observed by failing to permanently affix the locked narcotic storage box inside the refrigerator.	F0761					

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F0761 SS = D	Continued from page 19 Findings Include: Review of the facility policy titled "Medication Storage" dated 04/26/2023 revealed under "Policy explanation and compliance Guidelines: ...2. Narcotics and Controlled Substances: a. Schedule II drugs and back-up stock of Schedule III, IV and V medications are stored under double-lock and key. b. Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment...such as in the refrigerator..." Observation and interview on 08/06/2026 at 9:06 AM revealed the medication storage room contained a refrigerator identified by Registered Nurse (RN) #1 as being used to store controlled substances. The refrigerator was observed to be unlocked. Inside the refrigerator was a locked black medication box that was not permanently affixed to the refrigerator. The locked box contained Lorazepam Intensol Oral Concentrate 2 milligram (mg)/milliliter (ml) which is a schedule IV-controlled substance. RN #1 stated, "It's always been like this." During an interview on 8/06/2026 at 10:30 AM, the Director of Nurses (DON) confirmed the medication lock box located inside the refrigerator is required to be permanently affixed and acknowledged it was not.			F0761			