

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255233		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2026	
NAME OF PROVIDER OR SUPPLIER AZALEA GARDENS NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 530 HALL ST , WIGGINS, Mississippi, 39577			
(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 8/3/2026 through 8/6/2026. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F812, F583, F584, F656, F657, F692, F693, and F867. The facility had a census of 58 and was licensed for 99 beds.			F0000			
F0812 SS = E	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, interviews, and facility policy review, the facility failed to store and maintain food under sanitary conditions by failing to remove			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 = E	Continued from page 1 produce with visible biological growth from refrigerated storage and by storing an ice scoop directly on consumable ice for one (1) of two (2) kitchen observations. Findings include: A review of the facility's policy titled, "Food Safety Policy," dated Nov 2023, revealed, "...Policy Guidelines: 1. Food safety practices shall be followed throughout the facility's entire food handling process...b. Storage of food in a manner that helps prevent deterioration...6. All equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination..." On 08/03/2026 at 9:51 AM, during an initial kitchen observation and interview with the Dietary Manager (DM), five (5) tomatoes with visible white biological growth were observed in the walk-in cooler. The ice scoop was observed lying directly on top of the ice in the ice bin, with the handle positioned over the consumable ice, creating the potential for hand contact with the ice when retrieving the scoop. The DM acknowledged the tomatoes were not of acceptable quality and were not appropriate for food service. The DM stated she would increase monitoring of refrigerated produce and inspect produce at the time of delivery. The DM acknowledged the ice scoop should not be stored directly on the ice and stated a scoop holder would be installed outside the ice bin. On 08/06/2026 at 10:19 AM, during an interview, the Administrator stated she had been informed of the tomatoes with visible biological growth and the ice scoop being stored directly on the ice. The Administrator stated dietary staff were expected to monitor produce and maintain sanitary food storage practices. She reported staff would begin conducting daily checks of produce for deterioration and confirmed the ice scoop had been relocated to a holder outside the ice bin.			F0812			
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.			F0583			

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F0583 SS = D	Continued from page 2 §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. (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 observations, interviews, record review, and facility policy review, the facility failed to protect residents' rights to personal privacy and confidentiality by failing to provide visual privacy for one resident whose shoulder and a portion of the chest were exposed and visible from the doorway and by posting residents' personal care information on the walls without evidence the residents or their representatives requested the information be displayed, for three (3) of (16) sampled residents (Residents #7, #21, and #52). Findings include: A record review of the facility's policy titled, "Resident Rights Policy," dated Jun2026, revealed, "...Policy Guidelines...11. Staff members are educated on the rights of residents, and the responsibility of the facility is to properly care for its residents..." Resident #21 On 8/3/26 at 12:18 PM, during an observation of	F0583					

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F0583 SS = D	Continued from page 3 Resident #21, the resident was asleep in bed and visible from the doorway because the privacy curtain had not been pulled. The resident's right shoulder and a portion of the chest were exposed. On 8/5/26 at 1:15 PM, during an observation of Resident #21, the privacy curtain was not closed. The resident's right shoulder and a small portion of the chest were visible from the doorway. The resident remained visible for approximately five minutes while the roommate was transferred to bed. On 8/5/26 at 1:38 PM, an interview with Certified Nursing Assistant (CNA #1) for Resident #21 revealed the resident chewed on the right side of the gown because the resident's head remained turned in that direction. CNA #1 reported the gown was removed from that side to reduce the risk of choking and confirmed staff were expected to pull the privacy curtain to maintain the resident's privacy. On 08/06/2026 at 3:15 PM, during an interview, the Administrator stated Resident #21's right shoulder remained uncovered because the resident chewed on clothing and the resident's roommate preferred the privacy curtain remain open to view hallway activity. The Administrator acknowledged Resident #21 depended on staff to protect the resident's privacy because the resident was unable to independently close the privacy curtain or maintain clothing over the exposed area. A record review of the "Admission Record" for Resident #21 revealed the facility admitted the resident on 1/12/2025 with diagnoses including Senile Degeneration of Brain, Not Elsewhere Classified. A record review of the "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 5/10/2026 for Resident #21 revealed cognitive skills for daily decision making were severely impaired. A record review of the "Care Plan Report" for Resident #21 revealed interventions to encourage the resident not to chew clothing. A record review of the "Resident Rights" in-service dated February 16–20, 2026, revealed staff received education regarding resident privacy. The in-service instructed staff to maintain resident privacy by closing room doors, pulling privacy curtains, and providing appropriate clothing or draping to prevent unnecessary exposure of body parts during care. Resident #7			F0583			

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F0583 SS = D	Continued from page 4 On 08/03/2026 at 12:25 PM, during an observation of Resident #7, the State Agency (SA) observed a sign posted on the wall above the resident's bed that read, "Keep Head of Bed elevated as tolerated." On 08/04/2026 at 10:53 AM, during an observation of Resident #7, the sign stating, "Keep Head of Bed elevated as tolerated," remained posted on the wall above the resident's bed. On 08/05/2026 at 3:22 PM, during a telephone interview, Resident #7's Resident Representative (RR) stated she was unaware of the sign posted above the resident's bed directing staff to keep the head of the bed elevated. The RR stated the resident's tube-feeding care information should be maintained in the medical record rather than posted on the wall. A record review of Resident #7's "Admission Record" revealed the facility admitted the resident on 12/21/2022 with the diagnoses of Senile Degeneration of Brain, Not Elsewhere Classified, Unspecified Dementia, Unspecified Severity, With Other Behavioral Disturbance and Gastrostomy Status. A record review of Resident #7's "Order Summary Report," with active orders as of 08/06/2026, revealed orders for NPO (nothing by mouth) diet, Percutaneous Endoscopic Gastrostomy (PEG) tube feeding, use of an abdominal binder, PEG site care, and Head of bed (HOB) elevated above 30 degrees. A record review of Resident #7's "Significant Change MDS," with an ARD of 06/03/2026, revealed the Staff Assessment for Mental Status identified short- and long-term memory problems and cognitive skills for daily decision-making as severely impaired. Section K identified the resident as having a feeding tube and receiving 51% or more of total calories through parenteral or tube feeding. Resident #52 On 08/03/2026 at 12:25 PM, during an observation of Resident #52's room, the SA observed a sign posted on the wall above the resident's bed that stated, "NPO." On 08/03/2026 at 3:19 PM, during an interview, Resident #52 stated she did not know who posted the NPO sign above her bed or how long it had been displayed. Resident #52 stated she did not like the sign because it informed others that she could not	F0583					

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F0583 SS = D	Continued from page 5 receive food or fluids by mouth. On 08/04/2026 at 10:10 AM, during an observation with Registered Nurse (RN) #2 of Resident #52, the "NPO" sign remained posted on the wall above the resident's bed. On 08/05/2026 at 10:10 AM, during an interview, RN #2 stated staff were aware that signs containing residents' personal care or medical information were not to be posted in residents' rooms due to privacy concerns. On 08/05/2026 at 1:20 PM, during an observation and interview, RN #1 confirmed the "Keep Head of Bed elevated as tolerated" sign remained posted above Resident #7's bed and the "NPO" sign remained posted above Resident #52's bed. RN #1 confirmed the information displayed on the signs was available in the residents' medical records. On 08/06/2026 at 10:19 AM, during an interview and observation, the Director of Nursing (DON) confirmed the signs remained posted above Residents #7's and #52's beds. The DON acknowledged the signs communicated personal care information that was available in the residents' medical records and stated the information should not have been posted on the walls. The DON removed the signs during the observation and stated she expected staff to protect residents' privacy. On 08/06/2026 at 3:15 PM, during an interview, the Administrator stated residents' personal health information was expected to remain private and staff were expected to protect each resident's privacy. A record review of Resident #52's "Admission Record" revealed the facility admitted the resident on 10/07/2024 with diagnoses including Traumatic Subdural Hemorrhage Without Loss of Consciousness, Subsequent Encounter and Gastrostomy Status. A record review of Resident #52's "Order Summary Report" revealed active physician orders dated 8/6/26 for NPO diet NPO texture, NPO consistency, for dysphagia and Enteral Feed four times a day. A record review of Resident #52's "Quarterly MDS," with an ARD of 05/10/2026, revealed a Brief Interview for Mental Status (BIMS) Summary Score of 11, indicating moderate cognitive impairment. Section K identified the resident as having a PEG tube and receiving 51% or more of total calories through parenteral or tube feeding.			F0583			

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F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide a	F0584					

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F0584 SS = D	Continued from page 7 safe and homelike environment by failing to ensure an overhead bed light pull cord was accessible to a resident with limited mobility, resulting in the resident requiring staff assistance to operate the light while in bed for one (1) of (16) residents reviewed for environment. (Resident #6). Findings include: A review of the facility's policy titled, "Safe and Homelike Environment Policy," dated Oct. 2024 revealed, "...Policy Guidelines...6. The facility will provide and maintain adequate and comfortable lighting levels in all areas..." On 08/03/2026 at 11:28 AM, during an observation and interview, Resident #6 requested assistance turning off the overhead bed light. The overhead light pull cord was observed outside the resident's reach while she was in bed. Resident #6 stated the pull cord was too short for her to reach and reported the light frequently remained on until staff were available to turn it off. On 08/05/2026 at 1:12 PM, during an observation, a Physical Therapist Assistant (PTA) returned Resident #6 to bed following therapy. Resident #6 requested the PTA turn off the overhead light because she could not reach the pull cord from the bed. On 08/05/2026 at 1:15 PM, during an interview, Resident #6 stated she routinely requested staff assistance to turn the overhead light on or off because she could not reach the pull cord while in bed. On 08/06/2026 at 10:18 AM, during an interview, the Administrator stated she was unaware Resident #6 could not reach the overhead light pull cord from the bed. She stated another resident had an extended overhead light pull cord that could be reached from the bed and acknowledged the same accommodation could have been provided for Resident #6. On 08/06/2026 at 12:05 PM, during an interview, Housekeeping/Maintenance (HM #1) stated the overhead bed light pull cord was extended after notification from the Administrator. On 08/06/2026 at 3:15 PM, during a post-exit interview, the Administrator stated Resident #6 had occupied the room for approximately two weeks following the room change and acknowledged the overhead light pull cord could have been adjusted during that time.			F0584			

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F0584 SS = D	Continued from page 8 A record review of the "Admission Record" for Resident #6 revealed the facility admitted the resident on 8/21/2022 with the diagnoses including aftercare following joint replacement surgery. A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/21/2026 for Resident #6 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. Section GG revealed the resident required substantial/maximal assistance with mobility. A record review of Resident #6's "Care Plan Report" revealed interventions to ensure the resident's room had adequate lighting and to keep personal items within reach.			F0584			
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)-			F0656			

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F0656 SS = D	Continued from page 9 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to develop and implement a comprehensive, person-centered care plan that addressed hospice services for one (1) of (16) residents sampled. (Resident #9). Findings include: A review of the facility's policy titled, "Comprehensive Care Plan Policy" dated Oct 2023 revealed, "...Policy Guidelines 1. The care planning process will include an assessment of the resident's...needs... 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..." On 08/06/2026 at 11:15 AM, during an interview, Licensed Practical Nurse (LPN) #1, Minimum Data Set (MDS) Coordinator, stated she was responsible for developing resident care plans at the facility. LPN #1 acknowledged she had not developed a hospice care plan for Resident #9. She explained Resident #9 had experienced two recent significant changes in condition, which contributed to the hospice care plan being overlooked. LPN #1 stated the hospice care plan was used to identify the care and services provided by the facility and those provided by the hospice provider. LPN #1 stated she would ensure all residents receiving hospice services had a hospice care plan. On 08/06/2026 at 11:19 AM, during an interview, the Director of Nursing (DON) confirmed Resident #9's	F0656					

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F0656 SS = D	Continued from page 10 comprehensive care plan did not address the resident's hospice services. The DON stated the comprehensive care plan was used to direct staff regarding the resident's care needs and that she expected residents receiving hospice services to have those services addressed in their comprehensive care plans. A record review of the facility's "Admission Record" revealed the facility admitted Resident #9 on 11/09/2018 with diagnoses including Peripheral Vascular Disease. A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/21/2026 revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. Section O0110, K1, Hospice Care, was coded "Yes." A record review of Resident #9's "Order Summary Report" revealed an active physician order dated 05/15/2026 to admit the resident to (Proper name initials for hospice company). A record review of Resident #9's "Care Plan Report" revealed no care plan focus, goals, or interventions addressing the resident's hospice services.			F0656			
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their			F0657			

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NAME OF PROVIDER OR SUPPLIER AZALEA GARDENS NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 530 HALL ST , WIGGINS, Mississippi, 39577			
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F0657 SS = D	Continued from page 11 resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to revise comprehensive care plans to reflect changes in residents' care needs related to percutaneous endoscopic gastrostomy (PEG) tube replacement with placement of sutures and significant weight loss, for two (2) of (16) sampled residents. (Residents #7 and #44). Findings include: A record review of the facility's policy titled, "Care Plan Revisions Upon Status Change" with date of Oct 2023 revealed, "... The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. ... f. Care plans will be modified as needed by the MDS (Minimum Data Set) Coordinator or other designated staff member..." Resident #7 A record review of Resident #7's "Admission Record" revealed the facility admitted the resident on 12/21/2022 with diagnoses including Gastrostomy Status and Senile Degeneration of the Brain. A record review of Resident #7's Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/03/2026, revealed the Staff Assessment for Mental Status identified short- and long-term memory problems and cognitive skills for daily decision-making as severely impaired. Section K identified the resident as having a feeding tube and receiving 51% or more of total calories through parenteral or tube feeding. A record review of Resident #7's hospice "Physician Order" dated 07/16/2026 revealed, "patients Peg			F0657			

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F0657 SS = D	Continued from page 12 tube displaced. Facility to send patient out to hospital to have Peg replaced." A record review of Resident #7's "Emergency Documentation" with service date 07/16/2026 revealed "... Peg tube replacement procedure ... The peg tube was sewed in with some 4.0 (Proper Name) sutures. 2 stitches placed..." A record review of Resident #7's "General Emergency Department Discharge Instructions" dated 07/16/2026 revealed "... follow up with your primary care physician within 1 week..." A record review of Resident #7's "Care Plan Report" revealed a focus for "High Risk for altered nutrition" related to the resident's PEG tube and documented the PEG tube dislodgement on 07/15/2026. The care plan was not revised following the resident's return from the emergency department on 07/16/2026 to reflect the PEG tube replacement and the presence of two sutures placed to secure the PEG tube. Resident #44 A record review of Resident #44's "Admission Record" revealed the facility admitted the resident on 12/13/2024 with the diagnoses including Alzheimer's Disease, Unspecified, Personal History of Malignant Neoplasm of Bone, and Personal History of Other Malignant Neoplasm of Skin/Personal History of Malignant Neoplasm of Breast. A record review of Resident #44's "Order Summary Report" revealed an active physician order for a nutritional supplement, 120 cubic centimeters (cc) or four ounces (oz), three times daily for nutritional support, with a start date of 01/17/2026. A record review of Resident #44's Quarterly MDS, with an ARD of 07/20/2026, revealed a BIMS summary score of 2, indicating severe cognitive impairment. Section K documented a weight of 140 pounds, weight loss of 5% or more in the last month or 10% or more in the last six months, and use of a mechanically altered diet. A record review of Resident #44's "Care Plan Report" revealed a focus for high risk for altered nutrition related to gastroesophageal reflux disease (GERD), dysphagia, mechanically altered diet, gastroparesis with vomiting, and significant unplanned weight loss in July 2026. The care plan did not include new or revised interventions addressing the resident's significant weight loss	F0657					

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F0657 SS = D	Continued from page 13 and did not include the physician-ordered nutritional supplement initiated on 01/17/2026. A record review of Resident #44's "Weights and Vitals Summary" revealed that on 07/10/2026, the resident weighed 140.2 pounds, reflecting an 18-pound (11.4%) weight loss from the comparison weight of 158.2 pounds documented on 01/10/2026. The record further revealed that on 04/10/2026, the resident weighed 145.6 pounds, reflecting a 26.4-pound (15.3%) weight loss from the comparison weight of 172 pounds documented on 11/10/2025. On 08/06/2026 at 12:00 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated she was responsible for completing MDS assessments and care plans. LPN #1 stated the facility used a working care plan that was reviewed and updated as changes occurred. She confirmed Resident #7 returned from the emergency department with sutures securing the PEG tube and acknowledged the care plan was not revised to address the PEG tube site or sutures. LPN #1 further confirmed Resident #44 experienced significant weight loss in April and July 2026; however, no new interventions were added to the care plan in response to the weight loss. She also confirmed the nutritional supplement ordered in January 2026 had not been added to the care plan and stated she had missed adding the intervention. LPN #1 stated the purpose of the care plan was to direct staff in providing care and should include interventions addressing each resident's identified needs. On 08/06/2026 at 2:12 PM, during an interview, the Director of Nursing (DON) stated comprehensive care plans were used to direct resident care and were expected to remain current and reflect each resident's assessed care needs. On 08/06/2026 at 3:15 PM, during an interview, the Administrator stated she expected comprehensive care plans to be revised in accordance with facility policy when a resident experienced a change in condition or care needs.	F0657					
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral	F0692					

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F0692 SS = D	Continued from page 14 fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to identify, assess, and respond to significant weight loss documented in the medical record for one (1) of two (2) residents reviewed for nutritional status. Resident #44. Findings include: A record review of the facility's policy titled, "Aberrant Weight Policy" dated December 2018 revealed "... Based on the resident's comprehensive assessment, the facility will strive to ensure that all residents maintain acceptable parameters of nutritional status ... Policy Guidelines: ... 2. Monthly, weekly and daily weights will be monitored for abnormalities at the time they are obtained or as soon as possible. 3. All weights will be monitored by the Quality Assessment and Assurance Nurse and the Interdisciplinary Team. 4. Aberrant weights will be rechecked before they are recorded in the clinical record. 5. Significant weight changes will require interventions implemented, monitored, and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals, and current professional standards to maintain acceptable parameters of nutritional status." A record review of Resident #44 "Admission Record" revealed the facility admitted the resident on 12/13/2024 with diagnoses including Alzheimer's Disease, Unspecified, Personal History of Malignant Neoplasm of Bone, and Personal History of Other Malignant Neoplasm of Skin/Personal History of Malignant Neoplasm of Breast.			F0692			

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F0692 SS = D	Continued from page 15 A record review of Resident #44's "Order Summary Report" revealed active physician orders for regular diet, mechanical soft with ground meat texture, honey consistency with order date 4/20/26 and nutritional supplement three times a day 120 cc (cubic centimeters) or 4 oz (ounces) supplement for nutrition support with order date 1/17/26. A record review of Resident #44's "Quarterly Minimum Data Set (MDS)", with an Assessment Reference Date (ARD) of 07/20/2026, revealed a Brief Interview for Mental Status (BIMS) summary score of 2, which indicated severe cognitive impairment. Section K documented a weight of 140 pounds, weight loss of 5% or more in the last month or 10% or more in the last six months, and use of a mechanically altered diet. A record review of Resident #44's "Weights and Vitals Summary" revealed that on 07/10/2026, the resident weighed 140.2 pounds, reflecting an 18-pound (11.4%) weight loss from the comparison weight of 158.2 pounds documented on 01/10/2026. The record further revealed that on 04/10/2026, the resident weighed 145.6 pounds, reflecting a 26.4-pound (15.3%) weight loss from the comparison weight of 172 pounds documented on 11/10/2025. A record review of Resident #44's "Nutrition Quarterly" assessments dated 04/15/2026 and 07/14/2026 revealed no documentation addressing the significant weight loss identified in the resident's weight record. The 04/15/2026 assessment documented a weight of 145.6 pounds, and the 07/14/2026 assessment documented a weight of 140.2 pounds. A record review of Resident #44's "Nutritional Evaluation" dated 01/14/2026 revealed the resident weighed 158.2 pounds and had poor-to-fair intake. The assessment identified a weight change and documented initiation of a nutritional supplement three times daily. A record review of Resident #44's "Physician's Progress Notes" dated 05/21/2026, 06/04/2026, and 07/30/2026 revealed no documentation addressing the resident's significant weight loss. A record review of Resident #44's "Progress Note" dated 07/19/2026, completed by the Care Plan Nurse, revealed no documentation addressing the resident's significant weight loss. On 08/04/2026 at 12:29 PM, during an interview, the			F0692			

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F0692 SS = D	Continued from page 16 Director of Nursing (DON) stated Resident #44 had experienced a decline in condition and weight loss several months earlier. The DON stated the resident's appetite varied and reported the Registered Dietitian (RD) assessed residents annually and when significant weight loss occurred. On 08/04/2026 at 2:15 PM, during an interview, Dietary Department #3 confirmed an RD assessment was not completed when Resident #44 experienced significant weight loss in April or July 2026. She stated the resident's last RD assessment was completed in January 2026 and acknowledged the resident was missed for follow-up evaluation. On 08/04/2026 at 3:30 PM, during an interview, the DON stated Resident #44 should have been assessed by the RD when significant weight loss occurred. The DON reviewed the resident's medical record and confirmed the April and July nutritional assessments did not address the significant weight loss and she could not identify documentation that the RD, Nurse Practitioner (NP), or physician assessed or addressed the significant weight loss. On 08/05/2026 at 11:00 AM, during an interview, Dietary Department #1 stated significant weight loss was expected to be documented in the nutritional evaluation and communicated to the interdisciplinary team, including the physician or NP, RD, nursing staff, Quality Assurance nurse, and DON. She confirmed Resident #44's April and July quarterly nutritional assessments did not identify the significant weight loss and acknowledged the resident was missed for RD evaluation. On 08/06/2026 at 11:45 AM, during a telephone interview, Dietary Department #2 stated she had recently begun completing quarterly nutritional assessments and used the resident's medical record, including the most recent weight and physician orders, to complete the assessments. She stated she was unaware significant weight loss was required to be included in the nutritional assessment. On 08/06/2026 at 12:00 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated resident weights were obtained from the weight section of the electronic medical record and that she used information available in the medical record when completing Resident #44's comprehensive assessment. LPN #1 confirmed Resident #44 had significant weight loss documented in the medical record and acknowledged the MDS charting note she completed for the quarterly review did not address			F0692			

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F0692 SS = D	Continued from page 17 the significant weight loss. On 08/06/2026 at 1:15 PM, during a telephone interview, the NP stated she could not recall being notified of Resident #44's significant weight loss and confirmed her progress notes did not address the weight loss. The NP stated she expected facility staff to notify her or the physician of changes in the resident's condition. On 08/06/2026 at 2:12 PM, during an interview, the DON stated she believed some of Resident #44's documented weights may have been entered incorrectly. The DON stated staff were expected to notify the interdisciplinary team of weight discrepancies and obtain a reweight and that new interventions were expected when significant weight loss was identified. On 08/06/2026 at 2:25 PM, during an interview, Registered Nurse (RN) #3 stated Resident #44 was receiving weekly weights related to weight loss; however, the weekly weights were maintained in a separate book and were not entered into the electronic medical record. RN #3 confirmed the weights documented in the electronic medical record were available for providers and staff to review. RN #3 stated weight changes greater than two pounds were expected to be reported to the physician and RD. On 08/06/2026 at 3:15 PM, during an interview, the Administrator stated she was aware of Resident #44's weight loss and believed some documented weights may have been entered incorrectly. The Administrator stated she expected staff to follow facility policy, notify the interdisciplinary team and provider of significant weight loss, and document the identified change.			F0692			
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical			F0693			

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F0693 SS = D	Continued from page 18 condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure appropriate care and clinical follow-up for a resident's percutaneous endoscopic gastrostomy (PEG) tube site after sutures were placed during PEG tube replacement, including obtaining clarification regarding suture monitoring and removal, for one (1) of one (1) resident reviewed for tube feeding. Resident #7. Findings include: A record review of the facility's policy titled, "Gastrostomy Site Care Policy" with date Oct 2023 revealed "It is the policy of this facility to perform gastrostomy site care as ordered. Policy Guidelines: 1. Verify there is a physician order for gastrostomy site care ... 24. Report any complications promptly to the physician, and supervisor." On 08/05/2026 at 1:20 PM, during an observation and interview with Registered Nurse (RN) #1, two sutures were observed securing the external PEG tube bumper to the resident's abdomen. Yellow-brown dried material was observed at the suture sites, the surrounding skin appeared pink, and scant serosanguineous drainage was observed on the removed dressing. RN #1 stated Resident #7 had returned from the emergency department following PEG tube replacement with sutures securing the tube and stated she believed the sutures had been present for more than two weeks. RN #1 stated PEG site care was performed daily by nursing staff or the hospice nurse and acknowledged she expected the sutures would have been addressed during that period. On 08/06/2026 at 1:15 PM, during a telephone interview, the Nurse Practitioner (NP) stated she was unaware sutures had been placed when Resident #7's PEG tube was replaced and stated facility staff			F0693			

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F0693 SS = D	Continued from page 19 had not notified her of the sutures. The NP stated sutures were generally removed within approximately 14 days and should be monitored for signs of infection and removed when clinically appropriate. The NP stated she would need to assess the PEG site to determine whether the remaining sutures were ready for removal. On 08/06/2026 at 1:45 PM, during an interview, the Director of Nursing (DON) stated she was aware Resident #7 returned from the emergency department with sutures securing the PEG tube. The DON stated the facility did not remove sutures and the resident returned without specific instructions addressing suture care; however, she confirmed facility staff had not obtained follow-up or clarification from the physician or NP regarding monitoring or removal of the sutures. The DON stated she had reviewed the emergency department documentation, which identified two sutures as having been placed. The DON stated the NP, or physician would assess the PEG site as soon as possible. A record review of Resident #7's "Admission Record" revealed the facility admitted the resident on 12/21/2022 with diagnoses including Gastrostomy Status. A record review of Resident #7's "Significant Change Minimum Data Set (MDS)", with an Assessment Reference Date (ARD) of 06/03/2026, revealed the Staff Assessment for Mental Status identified short- and long-term memory problems and cognitive skills for daily decision-making as severely impaired. Section K identified the resident as having a feeding tube and receiving 51% or more of total calories through parenteral or tube feeding. A record review of Resident #7's "Emergency Documentation" with service date 07/16/2026 revealed the resident underwent PEG tube replacement and documented, "...The peg tube was sewed in with some 4.0 (Proper Name) sutures. 2 stitches placed..." A record review of Resident #7's "General Emergency Department Discharge Instructions" dated 07/16/2026 revealed instructions to follow up with the resident's primary care physician within one week. A record review of Resident #7's "Order Summary Report," with active orders as of 08/06/2026, revealed orders for PEG tube feeding, use of an abdominal binder, and PEG site care. No physician	F0693			

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F0693 SS = D	Continued from page 20 orders addressing monitoring or removal of the PEG tube sutures were identified. A record review of Resident #7's "Treatment Administration Records (TARs)" for July and August 2026 revealed no documentation of monitoring specific to the PEG tube sutures. A record review of Resident #7's "Progress Notes" from 07/01/2026 through 08/06/2026 revealed an entry dated 07/16/2026, completed by Registered Nurse (RN) #4, which documented, "...Resident returned to facility...peg tube to left abdomen intact with 4 sutures, site without bleeding, insertion site pink, no dressing present on arrival, abdominal binder in place..." No subsequent progress-note documentation addressing monitoring, provider notification, follow-up, or removal of the sutures was identified. On 08/06/2026 at 2:00 PM, during an interview, RN #4 stated she was working when Resident #7 returned from the emergency department following PEG tube replacement on 07/16/2026 and documented the presence of sutures at the PEG tube site. RN #4 stated the resident returned without orders addressing suture care. RN #4 acknowledged she did not obtain clarification regarding care or removal of the sutures and could not recall notifying the physician or NP of their presence. On 08/06/2026 at 3:15 PM, during an interview with the Administrator, she reported that she expects all staff to follow the facility's policy and procedures and expects to notify the interdisciplinary team and the NP or primary physician of any change in a resident's status.	F0693					
F0867 SS = D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and	F0867					

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(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	
F0867 SS = D	Continued from page 21 resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.	F0867					

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F0867 SS = D	Continued from page 22 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, 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: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by:	F0867					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F0867 SS = D	Continued from page 23 Based on record review and staff interview, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of a previously cited deficiency; specifically, the facility was cited for failing to maintain food under sanitary conditions related to produce with visible white biological growth during the 2025 annual recertification survey and was cited again for the same deficient practice during the current 2026 annual recertification survey, demonstrating the QAPI program failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of eight (8) deficiencies cited (F812). Findings include: Record review of the "Provider History Report" revealed the facility received a citation during the annual recertification survey for "F0812 - Food Procurement, Store/Prepare/Serve-Sanitary." A record review of the facility's 2025 Statement of Deficiencies (CMS Form 2567) revealed the facility was cited during the 2025 annual recertification survey for deficient food storage practices in the Dietary Department, which included produce with visible white biological growth stored in a refrigerator. A record review of the facility's Plan of Correction dated 03/10/2025 revealed the Certified Dietary Manager (CDM) or Administrator would inspect fresh produce three times per week for four weeks. The Plan of Correction further revealed the Registered Dietitian or Administrator would conduct weekly audits of food storage areas for four weeks beginning 04/07/2025, with audit findings presented to the Quality Assessment and Assurance (QAA) Committee beginning 04/10/2025 and reviewed by the committee for two months. On 08/03/2026 at 9:51 AM, during an observation of the Dietary Department as part of the current annual recertification survey, five (5) tomatoes with visible white biological growth were observed in the walk-in cooler. On 08/06/2026 at 3:15 PM, during an interview, the Administrator acknowledged the facility had received a repeat finding related to food storage practices in the Dietary Department. She stated that following the 2025 annual recertification survey, the facility implemented weekly dietary audits for a specified period and reduced the frequency to monthly audits after the monitoring period was completed. The			F0867			

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F0867 SS = D	Continued from page 24 Administrator stated the facility attempted to identify and correct concerns identified through the audit process; however, based on the repeat finding identified during the current survey, the Dietary Department would resume weekly audits. The Administrator further stated the facility planned to revise its food storage practices by storing tomatoes in dry storage rather than the cooler to improve air circulation and reduce moisture accumulation.			F0867			