

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255260		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/13/2026	
NAME OF PROVIDER OR SUPPLIER HILLTOP MANOR HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 101 KIRKLAND STREET , UNION, Mississippi, 39365			
(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 re-certification survey at the facility from 8/11/26 through 8/13/26. During the survey, the SA determined that the facility was not in compliance with the Medicare and Medicaid regulations for participation and cited regulatory deficiencies F565, F689, F550, F584, F656, F658, F677, and F761. Census at the time of survey was 53 and the facility is licensed for 60.			F0000			
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.			F0565			

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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F0565 SS = E	Continued from page 1 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review the facility failed to act upon and resolve repeated Resident Council grievances related to food quality, staff attitudes, unanswered call lights, delayed assistance with care, housekeeping services, and the availability of ice water for eight (8) of 12 residents in the Resident Council meeting. Resident #13, Resident #15, Resident #17, Resident #23, Resident #32, Resident #38, Resident #41, and Resident #49 Findings Include: Review of the facility policy titled "Resident and Family Grievances" revised 11/14/25 revealed under, "Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal...Policy Explanation and Compliance Guidelines: ... 2. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; ... 4. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC (long term care) facility stay..." Record review of the "Resident Council Minutes" dated 7/8/26 revealed, "Food is pointless to talk about this topic because nothing ever changes, flavor, smell, presentation, everything in general is horrible, nasty. According to the residents, the shift from 11 PM to 7 AM sleep by the vending machines. Residents reported that the CNA's enter their rooms, turn off the call light, and inform them that they will return in 1 (one) minute to provide assistance. However, residents stated that CNAs never come back. (Resident #38)stated that the CNAs never change her bed. (Resident #23) stated that the CNAs do not help her with her bath. She also stated that			F0565			

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F0565 SS = E	Continued from page 2 when they do assist her, they have a bad attitude toward her during care. Residents report that bathrooms are not cleaned daily and items are not moved when sweeping or mopping. Residents report that all trash cans in their rooms need to be cleaned." There was no indication the facility addressed the residents' concerns. During the Resident Council meeting held on 8/12/26 at 12:10 PM, residents stated they knew how and with whom to file a grievance and they confirmed that they have told everyone about their concerns and nothing gets done. Resident #15 stated, "It doesn't do any good to file a grievance, you might as well be talking to that T.V. on the wall," as she pointed to the television. Residents #13, #15, #23, #38, and #49 stated they met monthly for council meetings, but their concerns were never addressed or resolved, stating, "Nothing ever gets done." All stated they believed their concerns would remain unresolved after the meeting. Residents #15, #17, #32, and #38 stated the aides had attitudes when asked to provide assistance. Resident #17 stated, "They treat us poorly acting really nasty toward us and not willing to help us." Resident #38 stated, "Nobody ever comes to my room to check on me; I could be lying dead in my bed." She stated, "I do everything for myself; I can't even get them to change my sheets." She added, "They haven't been changed in three (3) weeks." Resident #13 stated the aides did not enter her room to check on her and that she changed her own sheets. She stated this was becoming more difficult because she had trouble moving around the bed and bending to apply the fitted sheet. Resident #13 stated she wanted the aides to change her sheets, but they would not. Residents #13 and #15 stated call lights remained on for hours. Resident #13 stated she activated the call light for her roommate, who required assistance, but no one came. She stated call lights took 30 to 45 minutes or longer to be answered and stated, "It's terrible; We can't get any aides or nurses on that end (of the building) when we need them." She stated her roommate waited almost an hour for staff to clean her and change her brief. Resident #15 stated the aides "Are ridiculous" and stated none of them "Are worth a d***; You will see them one time at the beginning of the shift and you'll never see them again." She stated staff repeatedly turned off her call light and told her, "It will be a minute," but did not return. Resident #15 stated she remained wet for more than an hour because staff did not respond to her call light. She stated these concerns had been discussed during prior council meetings, but nothing happened and these things did not get resolved. Resident #17			F0565			

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F0565 SS = E	Continued from page 3 stated she was not receiving showers and had waited up to one hour and 30 minutes to be changed. Resident #49 stated he received a shower because he completed it himself. He stated the aides gave him trouble and did not want to assist him, so he showered independently. Resident #38 stated call lights were not answered at night because the aides slept near the drink machines at the end of the hall. Residents #13, #17, and #38 stated aides also pulled chairs into the hallway near therapy, placed their legs in wheelchairs, and slept. Resident #38 stated ice water was not passed on any shift. Other residents agreed this concern had been discussed during previous council meetings and continued to be a problem. Residents #13, #15, #23, #38, and #49 stated the food was awful. Residents #13 and #23 stated the food was always cold, and Resident #17 stated food served in her room was also often cold. Resident #15 stated the facility repeatedly served the same foods. Resident #23 stated mashed potatoes were served seven days a week and that hot dogs were served without condiments. Resident #41 stated, "I don't like to eat breakfast because the bacon and sausage are too greasy and the grease is all on the plate." Resident #38 stated the kitchen sent burnt food and expected residents to eat it. Resident #23 stated housekeeping did not properly clean resident rooms, empty the trash, or fully mop the floors. An interview with the Activities Director on 8/12/26 at 1:50 PM confirmed she was aware of the Resident Council concerns and that they had been complaining to her in each meeting. She stated residents also told her they believed nothing was ever going to get done. She stated call lights, extended wait times for care, staff attitudes, and food were the primary recent concerns. The Activities Director stated she reviewed all concerns from the meeting with the Administrator and provided a copy of the minutes to each department. She stated each department was responsible for addressing the concerns. She stated the dietary department usually attended the meetings but missed the previous meeting. She confirmed the residents' concerns had not been addressed due to changes in administration and that their concerns were still ongoing. The Activity Director confirmed that the previous Resident Council meeting minutes prior to the 07/08/26 date do not reflect the concerns that the residents have voiced but she did confirm that they have told her about these same concerns for months. She confirmed that it was her job to get the grievances to the appropriate departments in order to get these grievances resolved.			F0565			

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F0565 SS = E	Continued from page 4 An interview with the Dietary Manager on 8/12/26 at 3:01 PM revealed she usually attended Resident Council meetings to address food concerns. She stated Residents #13 and #15 were picky eaters and that nothing she did would please them, stating, "I have tried." She stated the facility followed an ordering guide and menu, and many residents could not have certain foods or spices. She stated she had a budget she could not exceed and sometimes modified menu items. The Dietary Manager stated money was an issue and it was impossible to make 60 people happy. She stated alternate meals were available and staff would prepare foods residents liked if the foods were available. An interview with the Administrator on 8/13/26 at 1:40 PM revealed she was aware of the residents' concerns from the meeting. She stated she had been in the position for only a few months and that the Director of Nursing and Assistant Director of Nursing left the facility without notice. She stated the new Director of Nursing began work on Monday, and she was waiting to address the nursing concerns with the new Director of Nursing. The Administrator confirmed the residents' concerns should be acted upon and resolved timely and should not be recurring problems during monthly meetings and that they had failed to do that. Record review of the "Admission Record" revealed the facility admitted Resident #13 on 12/10/25 with medical diagnoses that included Parkinson's Disease, History of Falling, Tremor, and Need for Assistance with Personal Care. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/3/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #13 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #15 on 12/11/25 with medical diagnoses that included Bipolar Unspecified, Other Specified Disorders of Bladder, and Presence of Right Artificial Hip Joint. Record review of the MDS with an ARD of 6/15/26 revealed under section C, a BIMS summary score of 15, indicating Resident #15 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #17 on 4/15/26 with medical diagnoses that included Guillain-Barre Syndrome.	F0565					

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F0565 SS = E	Continued from page 5 Record review of the MDS with an ARD of 7/10/26 revealed under section C, a BIMS summary score of 15, indicating Resident #17 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #23 on 1/19/26 with medical diagnoses that included Parkinson's Unspecified. Record review of the MDS with an ARD of 7/06/26 revealed under section C, a BIMS summary score of 15, indicating Resident #23 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #32 on 4/13/23 with medical diagnoses that included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. Record review of the MDS with an ARD of 5/14/26 revealed under section C, a BIMS summary score of 15, indicating Resident #32 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #38 on 4/01/26 with medical diagnoses that included Chronic Obstructive Pulmonary Disease. Record review of the MDS with an ARD of 5/11/26 revealed under section C, a BIMS summary score of 15, indicating Resident #38 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #41 on 5/15/26 with medical diagnoses that included Hydrocephalus Unspecified. Record review of the MDS with an ARD of 7/14/26 revealed under section C, a BIMS summary score of 15, indicating Resident #41 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #49 on 6/10/25 with medical diagnoses that included Chronic Obstructive Pulmonary Disease with Acute Exacerbation. Record review of the MDS with an ARD of 7/20/26 revealed under section C, a BIMS summary score of 15, indicating Resident #49 was cognitively intact.	F0565					
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689					

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F0689 SS = E	Continued from page 6 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide a safe smoking environment by failing to ensure protective smoking aprons were worn during smoking activities for two (2) residents reviewed for smoking safety (Resident #4 and Resident #45) for three (3) of four (4) smoking activities observed. Findings Include: Record review of the facility policy titled, "Policies and Procedures" under "Subject: Smoking-Supervised" with an effective date of 6/1/2025 revealed, "The Center will provide a safe, designated smoking area for residents. ...The Center will have safety equipment safety equipment available in designated smoking areas including; ...smoking aprons ... 2. If a resident is identified during the smoking evaluation to require assistance or supervision with smoking, the Center will include the appropriate information in the care plan... 4. ...During designated smoking times staff will be assigned to assist or supervisor residents whose care plans indicate assistance or supervision is required while smoking..." Resident #4 An observation on 8/11/26 at 4:00 PM revealed Resident #4 was seated in the designated smoking area and was smoking without wearing a smoking apron. Record review of the "Admission Record" revealed the facility admitted Resident #4 on 7/29/24 with medical diagnoses that included Alzheimer's Disease, muscle wasting and atrophy, and unspecified lack of coordination. 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 03,	F0689					

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F0689 SS = E	Continued from page 7 indicating Resident #4 was severely cognitively impaired. Resident #45 During an observation and interview on 8/11/26 at 9:46 AM, Resident #45 was seated in his wheelchair and was wearing sweatpants with visible burn holes. Resident #45 acknowledged he was a smoker and stated he did not wear a smoking apron over his clothes when smoking. An observation on 8/11/26 at 4:00 PM revealed Resident #45 was seated in the designated smoking area and was smoking without wearing a smoking apron. Record review of the "Admission Record" revealed the facility admitted Resident #45 on 5/21/25 with medical diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and lack of coordination. Record review of the MDS with an ARD of 5/26/26 revealed under Section C, a BIMS summary score of 15, indicating Resident #45 was cognitively intact. During an interview and observation on 8/11/26 at 4:10 PM, Certified Nurse Aide (CNA) #1 acknowledged she was responsible for the smoke break that day and Resident #4 and Resident #45 were smoking without wearing smoking aprons. During an observation and interview on 8/12/26 at 10:32 AM, Resident #4 and Resident #45 were seated in the designated smoking area and were wearing smoking aprons. CNA #2 stated she put smoking aprons on all the residents to ensure they did not burn themselves. Unsamped Resident #1 stated, "I only wear an apron if you put one on me, which isn't all the time." During an interview on 8/12/26 at 1:05 PM, the Director of Nursing (DON) stated the unit manager was responsible for completing smoking assessments upon admission and quarterly. The DON stated the smoking assessments evaluated the residents' ability to hold a cigarette, dispose of ashes, and whether the resident needed to wear a smoking apron for safety. The DON stated she was unaware of any incidents or accidents involving Resident #4 or Resident #45 while smoking. During an interview on 8/12/26 at 1:25 PM, Registered Nurse (RN) #1 stated she was one of the unit managers and was responsible for conducting	F0689					

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F0689 SS = E	Continued from page 8 smoking assessments upon a resident's admission and quarterly. RN #1 stated all residents were required to wear smoking aprons for their safety, so they did not burn themselves. RN #1 stated Resident #4 and Resident #45 were supposed to wear smoking aprons for their safety. RN #1 further stated Resident #45 was slow to flick his ashes and that it was "a big safety concern for him." During a subsequent observation and interview on 8/13/26 at 2:34 PM, Resident #4 and Resident #45 were seated in the designated smoking area and were smoking without wearing smoking aprons. CNA #2 and RN #3 were present and confirmed the residents were not wearing smoking aprons.	F0689					
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F0550					

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F0550 SS = D	Continued from page 9 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure residents were treated with respect and dignity by providing reasonable accommodation for residents' needs and preferences related to incontinence care and protection of their beds, wheelchairs, and recliners for three (3) of 20 sampled residents. Resident #13, Resident #15, and Resident #49 Findings Include: Record review of the facility policy titled "Resident Rights" revealed under, "...4. Respect and Dignity: The resident has a right to be treated with respect and dignity, including: ... c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences..." An observation and interview with Resident #13 on 8/11/26 at 10:39 AM revealed she was lying in bed. Resident #13 stated she was incontinent at times, especially at nighttime, although she did not require assistance from staff because she did everything on her own. She stated the facility no longer allowed residents to have incontinence pads to use at night due to the cost. Resident #13 stated residents received only an incontinent brief and a sheet. She stated the briefs were thin and did not hold up, allowing urine to leak throughout the night and it soaked her bed sheets and mattress. Because the facility no longer allowed incontinent bed pads, she cut up garbage bags and placed it under her fitted sheet to prevent the mattress from getting wet. Resident #13 stated she had to change her own sheets if they became wet because the aides never entered her room to do anything. She stated the facility sometimes ran out of sheets, and she had to use regular flat sheets instead of fitted sheets. Resident #13 stated she was told the company was no longer purchasing the incontinent pads and she had to make do the best way she could. Observations of the laundry carts on 8/11/26 and 8/12/26 revealed there were no washable or			F0550			

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F0550 SS = D	Continued from page 10 disposable incontinence pads. An interview with Certified Nurse Aide (CNA) # 4 on 8/12/26 at 8:24 AM revealed the facility removed all washable bed pads some time ago, but she was unsure why. She stated the aides folded a sheet and placed it under residents for positioning. CNA #4 stated some residents were heavily incontinent with urine and staff might have to change the entire bed and the mattress might be soaked. She stated many residents were unhappy about the removal of the incontinent pads, but there was nothing anyone could do. An interview with Registered Nurse (RN) #2 on 8/12/26 at 8:49 AM revealed the company discontinued the incontinent pads that the staff and residents used for their beds and wheelchairs to protect them from urine, but she was unsure why, stating, "If I had to guess it would be the cost." She confirmed residents had voiced concerns about not having the incontinent pads and stated, "They would rather have them." An observation and interview with Resident #15 on 8/12/26 at 11:54 AM revealed she was sitting in her wheelchair in the hallway on a thick, white, folded blanket. Resident #15 stated she used the folded blanket because the briefs provided by the facility leaked urine. She stated the facility no longer purchased reusable or disposable incontinent pads, so she used the blanket to protect her wheelchair from urine. An interview with Resident #49 on 8/12/26 at 12:06 PM revealed he regularly sat and watched television in his recliner and slept in it at night. Resident #49 stated he was incontinent at times and required protection under him to prevent soiling the recliner from urine. He stated the facility stopped purchasing the incontinent pads to reduce costs, so he had to purchase his own disposable pads for the recliner, stating "You can't get them here." An interview with the Housekeeping/Laundry Supervisor on 8/12/26 at 2:44 PM revealed he had worked at the facility since December 2025 and was told the facility was no longer purchasing or using incontinence pads. He stated the aides were expected to use briefs and sheets to protect the mattresses and wheelchairs from incontinence. He believed the change occurred after the new company purchased the facility in October 2025. He confirmed the facility did not provide any type of disposable incontinence pads.			F0550			

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F0550 SS = D	Continued from page 11 An interview with the Director of Operations on 8/13/26 at 1:18 PM revealed the company discontinued purchasing washable incontinence pads and did not purchase disposable incontinent pads. He stated the aides should use draw sheets under residents instead. He acknowledged this practice could create a dignity concern for the residents. Record review of the "Admission Record" revealed the facility admitted Resident #13 on 12/10/25 with medical diagnoses that included Parkinson's Disease, History of Falling, Tremor, and Need for Assistance with Personal Care. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/3/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #13 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #15 on 12/11/25 with medical diagnoses that included Bipolar Unspecified, Other Specified Disorders of Bladder, and Presence of Right Artificial Hip Joint. Record review of the MDS with an ARD of 6/15/26 revealed under section C, a BIMS summary score of 15, indicating Resident #15 was cognitively intact. Section H indicated Resident #15 was frequently incontinent of bladder. Record review of the "Admission Record" revealed the facility admitted Resident #49 on 6/10/25 with medical diagnoses that included Chronic Obstructive Pulmonary Disease with Acute Exacerbation. Record review of the MDS with an ARD of 7/20/26 revealed under section C, a BIMS summary score of 15, indicating Resident #49 was cognitively intact.			F0550			
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-			F0584			

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F0584 SS = D	Continued from page 12 §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, staff and resident interviews, record review, and facility policy review, the facility failed to ensure cleaning and disinfection of resident wheelchairs was completed for three (3) of 20 sampled residents reviewed. Resident #23, Resident #29, and Resident #43 Findings include: Record review of policy titled, "Cleaning and Disinfection of Resident-Care Equipment," with a revision date of 11/13/2025 revealed "...c. direct care staff are responsible for cleaning single-resident equipment when visibly soiled and according to routine schedule..." An observation on 08/11/2026 at 9:42 AM, and again on 08/12/2026 at 9:30 AM revealed Resident #29's	F0584					

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F0584 SS = D	Continued from page 13 wheelchair was noted to have a thick brown substance on bilateral rear wheels, spokes, entire wheelchair frame, and brakes. An observation on 08/11/2026 at 9:44 AM and again on 08/12/2026 at 10:00 AM revealed Resident #43's wheelchair was noted to have a thick brownish gray substance on the entire wheelchair frame and bilateral rear wheels. An observation 08/11/2026 at 11:00 AM and again on 08/12/2026 at 10:55 AM revealed Resident #23's wheelchair was noted to have a thick gray substance and small food particles on the entire wheelchair frame, the bilateral rear wheels, including the spokes. An observation and interview on 08/12/2026 at 1:50 PM revealed Resident #23 sitting in her wheelchair in her room. She revealed that her wheelchair was "filthy" and needed to be cleaned. She further revealed that her daughter had discussed this situation with the previous Director of Nursing (DON) and still nothing had been done. Resident #23 revealed that she had been in the facility for nearly two years and her wheelchair had never been cleaned. Resident #23 further stated, "This wheelchair is awful looking and I want it cleaned." During an observation and interview on 08/12/2026 at 4:22 PM with the DON, she confirmed that Resident #23, Resident #29, and Resident #43's wheelchairs were dirty and needed to be cleaned. She revealed that there was a cleaning schedule posted at the nurse's desk that included cleaning wheelchairs on the night shifts. She revealed that they divided the wheelchairs up between three days so that all wheelchairs were cleaned weekly. She revealed that residents had the right to have a clean environment and this included clean equipment. She stated, "I like to have a clean vehicle, and I know they do too." Record review of the facility, "11-7 Cleaning Schedule" revealed: "Sunday: CNAs (Certified Nursing Assistant) to clean and return south hall wheelchairs and Geri chairs.... Monday: CNAs to clean and return north hall wheelchairs and Geri chairs....Tuesday: CNAs to clean and return middle hall wheelchairs and Geri chairs...." Record review of Resident #23's "Admission Record" revealed an admission date of 07/15/24 with diagnoses that included Unspecified Parkinsonism and Muscle Weakness. Record review of Resident #23's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/06/26 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that she was cognitively intact.			F0584			

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F0584 SS = D	Continued from page 14 Record review of Resident #29's "Admission Record" revealed an admission date of 08/25/22 with diagnoses that included Unspecified Heart Failure and Unspecified Muscle Weakness. Record review of Resident #29's MDS with ARD of 08/03/26 under Section C revealed a BIMS score of 15 which indicated that she was cognitively intact. Record review of Resident #43's "Admission Record" revealed an admission date of 08/23/22 with diagnoses that included Primary Generalized Osteoarthritis and Unspecified Heart Failure. Record review of Resident #43's MDS with ARD of 07/13/26 under Section C revealed a BIMS score of 99 which indicated that she was unable to complete the interview.	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 15 (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 resident and staff interviews, record review and facility policy review the facility failed to develop an Activities of Daily living (ADL) care plan for Resident's #24 and #33 and failed to implement care plan interventions for Resident #42's ADL needs and failed to implement smoking aprons required for Resident's #4 and #45, for five (5) of 20 sampled residents reviewed. Findings include: Review of facility policy and procedures, Comprehensive Care Plans, revision date 11/14/2025, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident...to meet a resident's medical, nursing, and mental and psychosocial needs..." Resident #4 Record review of Resident #4's "Care Plan Report" revealed under, "Focus: Smoker – Mr. (Proper last name of the resident' is a smoker)...Interventions/Tasks...He requires a smoking apron while smoking." On 8/11/2026 at 4:00 PM an observation revealed Resident #4 sitting in the smoking area, smoking; the resident was not wearing a smoking apron. Record review of the "Admission Record" revealed	F0656					

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F0656 SS = D	Continued from page 16 the facility admitted Resident #4 on 7/29/24 with medical diagnoses that included Alzheimer's Disease, Muscle wasting and atrophy, and unspecified Lack of Coordination. 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 03, indicating Resident #4 was severely cognitively impaired. On 8/11/2026 at 4:10 PM, during an interview Certified Nurse Aide (CNA) #1 acknowledged she was responsible for the smoke break today. She lit the residents' cigarettes and kept the lighter and cigarettes in a box. An observation revealed that Resident #4 was not wearing a smoking apron. An interview on 8/12/2026 at 1:05 PM, with the Director of Nursing (DON) revealed that the residents' plan of care for safely smoking was not being followed regarding wearing the smoking apron. During an interview on 8/12/2026 at 3:45 PM, the Minimum Data Set (MDS) Coordinator revealed that if Resident #4 was not wearing the smoking apron, then the smoking plan of care for the resident was not being followed. Resident #24 Record review of Resident #24's Activities of Daily Living (ADL) "Care Plan Report" revealed under, "Focus: ADL's – Mr. "Proper last name of the resident" admitted with an ADL deficit R/T (related to) muscle weakness, decreased mobility, lower ext. (extremity) ulcers." The interventions were that the resident was dependent on staff assistance for toileting hygiene. The care plan did not include specific care instructions, such as the transfer method, required equipment, number of staff needed, toileting schedule, clothing and hygiene preferences, or safety measures. During an observation and interview with Resident #24 on 8/11/26 at 10:34 AM, he was sitting in his wheelchair in his room. Resident #24 stated the aides did not take him to the restroom as they were supposed to. He stated staff had to use a lift because he could not stand. He stated he asked staff to take him to the restroom, and stated, "They just will not do it." He stated one of his biggest concerns was being able to use the toilet. He also			F0656			

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F0656 SS = D	Continued from page 17 stated he had to wait hours for help and staff did not want to help him and stated, "I have a hard time getting someone to help me." An interview with the MDS Nurse on 8/13/26 at 2:10 PM revealed she was unsure how often Resident #24 was toileted, how he transferred, or how much assistance he required and would have to ask the aides. She confirmed the ADL care plan was copied from the MDS section GG assessment and lacked the individualized, person-centered approaches needed to instruct staff how to care for Resident #24. She confirmed the care plan was not developed so that anyone could review it and know how to care for him. Record review of the "Admission Record" revealed the facility admitted Resident #24 on 11/29/25 with medical diagnoses that included History of Falling, Reduced Mobility, and Stiffness of Right and Left Knee. Record review of the MDS with an ARD of 6/3/26 revealed under section C, a BIMS summary score of 15, indicating Resident #24 was cognitively intact. Resident #33 Record review of Resident #33's ADL "Care Plan Report" revealed under, "Focus: ADL's – Mr. 'Proper last name of the resident' has an ADL self-care performance deficit R/T dementia." The care plan listed Resident #33 as independent with showering/bathing and personal hygiene. Although the care plan identified an ADL self-care deficit, the interventions consisted of the copied section GG functional status entries from the MDS and did not instruct staff how to ensure Resident #33 received assistance with bathing, hair care, and other personal hygiene needs. Under "Interventions," the care plan indicated "Weekly nail care." During an observation of Resident #33 on 8/11/26 at 9:44 AM, he was lying on his bed with his head at the foot of the bed and his eyes closed. A foul body odor was noticeable in the hallway outside his room. After a knock on the door, Resident #33 sat on the edge of his bed and appeared disheveled and unkempt. He had a foul body odor; his hair was oily, greasy, and slicked down to his scalp; and he was barefoot. His fingernails and toenails were approximately one-half (1/2) to three-fourths (3/4) inch long. During an observation and interview with CNA #4 on 8/13/26 at 9:26 AM, she confirmed Resident #33			F0656			

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F0656 SS = D	Continued from page 18 had long nails, oily hair, and a foul body odor. CNA #4 indicated Resident #33 had not been showered. An interview with the MDS Nurse on 8/13/26 at 2:20 PM revealed Resident #33 refused his showers; however, she was unable to provide documentation from the nurses or aides showing that he refused. She stated Resident #33 was independent with bathing according to section GG. However, after the MDS Nurse questioned CNA #6, she indicated Resident #33 required cueing and supervision while showering and was never left unattended. The MDS Nurse confirmed the ADL care plan was copied from the MDS section GG assessment and lacked the individualized, person-centered approaches needed to instruct staff how to care for Resident #33. She also confirmed that his nail care plan was not followed. Record review of the "Admission Record" revealed the facility admitted Resident #33 on 10/10/24 with medical diagnoses that included Unspecified Dementia and Autistic Disorder. Record review of the MDS, with an ARD of 6/15/26, revealed under Section C, a BIMS summary score of 15, indicating Resident #33 was cognitively intact. Resident #42 Record review of "Care Plan Report", revealed "ADL self-care performance deficit related to Muscle Wasting and Atrophy of Bil (bilateral) arm, L(Left) side weakness/impairment, needs assist with ADL's." During an observation and interview on 08/11/2026 at 9:41 AM revealed Resident #42 sitting up in his wheelchair with a full one-half inch beard. Resident #42 stated that staff have not shaved him in 2-3 weeks and that he does not wish to grow a beard. He also revealed that he could not shave himself if he tried due to decrease use of his arms. Resident #42 stated that he had required assistance with his shaving and other care since he was admitted to the facility, and he revealed that he wanted to be shaved. On 08/12/2026 at 12:30 PM an interview Registered Nurse (RN) #2, revealed that shaving was part of Resident #42's personal hygiene and grooming needs and should be addressed on bath or shower days three times a week and as needed.			F0656			

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F0656 SS = D	Continued from page 19 An interview on 08/13/2026 at 9:07 AM with MDS nurse revealed person centered care plan should tell how to take care of the resident. She stated that he did need assistance with ADLs to include shaving and if it was not done then his care plan was not followed. Record review of Resident #42's "Admission Record" revealed an admission date of 08/25/2023 with diagnoses Muscle Wasting and Atrophy of Right and left Upper Arm and Need for Assistance with Personal Care. Record review of Resident #42's MDS with ARD of 06/09/26 revealed a BIMS score of 15 which indicated that he was cognitively intact. Resident #45 Record review of Resident #45's "Care Plan Report" revealed under, "Focus: Smoker – Mr. "Proper last name of the resident" is a smoker" under "Interventions/Tasks.... Revealed, "Observe clothing and skin for signs of cigarette burns. ... Resident requires a smoking apron while smoking." On 8/11/2026 at 9:46 AM, during an observation and interview it was noted that Resident #45, was seated in his wheelchair, was wearing sweatpants with visible burn holes. Resident #45 acknowledged he was a smoker and did not wear a smoking apron over his clothes when smoking. On 8/11/2026 at 4:00 PM an observation revealed Resident #45 sitting in the smoking area, smoking; the resident was not wearing a smoking apron. Record review of the "Admission Record" revealed the facility admitted Resident #45 on 5/21/25 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, and Lack of Coordination. Record review of the MDS with an ARD of 5/26/26 revealed under section C, a BIMS summary score of 15, indicating Resident #45 was cognitively intact. An interview on 8/12/2026 at 1:05 PM, the DON revealed that the residents' plan of care for safely smoking was not being followed regarding wearing the smoking apron. During an interview on 8/12/2026 at 3:45 PM, the			F0656			

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F0656 SS = D	Continued from page 20 MDS Coordinator revealed that if Resident #45 was not wearing his smoking apron, then the smoking plan of care for the resident was not being followed.	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, staff interview, record review, and facility policy review, the facility failed to administer enteral flushes according to physician orders for one (1) of seven (7) residents reviewed during medication administration observations. Resident #50 Findings Include: Review of the facility policy titled "Medication Administration via Enteral Tube," revised 11/7/25, revealed "Policy: It is the policy of this facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practice guidelines...Procedure a. Verify physician orders for medication and enteral tube flush amount..." Record review of Resident #50's August 2026 "Medication Administration Record (MAR)" revealed an order dated 8/30/24, "Enteral feed order every shift flush with 60 cc (cubic centimeters) of water before and after meds." During an observation of a medication pass with Registered Nurse (RN) #4 on 8/11/26 at 4:36 PM, RN #4 crushed and administered Resident #50's evening medications through the feeding tube. RN #4 did not flush the tube with the ordered 60 cc of water before or after administering the medications. When asked whether the resident's tube should have been flushed with water before and after the medications, RN #4 replied, "I think its 30 before and after meds." RN #4 confirmed she did not give the flush. She stated the resident was NPO (nothing by mouth) and received all fluids from nursing staff through the feeding tube. RN #4 acknowledged the resident could become dehydrated if the ordered amount of water was not given.	F0658					

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NAME OF PROVIDER OR SUPPLIER HILLTOP MANOR HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 101 KIRKLAND STREET , UNION, Mississippi, 39365			
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F0658 SS = D	Continued from page 21 An interview with the Director of Nursing (DON) on 8/12/26 at 10:40 AM revealed she expected nurses to read the MAR and know the flush orders before entering the resident's room. This would ensure the resident received the physician ordered flush amount. Record review of the "Admission Record" revealed the facility admitted Resident #50 on 8/30/24 with medical diagnoses that included Other Paralytic Syndrome following Cerebral Infarction Affecting Left Non-Dominant Side, Gastrostomy Status, and Unspecified Protein-Calorie Malnutrition. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/18/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 13, indicating Resident #50 was cognitively intact.			F0658			
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure residents requiring assistance received the necessary activities of daily living (ADL) care. This was evidenced by failure to provide timely toileting assistance (Resident #24), shower and nail care (Resident # 33) and facial shaving (Resident #42) for three (3) of the 53 residents reviewed for activities of daily living. Findings include: Review of facility policy titled, "Activities of Daily Living (ADL's)" with a revision date of 11/07/2025, revealed, "...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene..." Resident #24 An observation and interview with Resident #24 on 8/11/26 at 10:34 AM revealed he was sitting in his			F0677			

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F0677 SS = D	Continued from page 22 wheelchair in his room. Resident #24 stated the aides did not take him to the restroom as they were supposed to. He stated staff had to use a lift because he could not stand. He stated he asked staff to take him to the restroom, but, "They just will not do it." He stated one of his biggest concerns was being able to use the toilet. He also stated he had to wait hours for help and staff did not want to help him. An observation on 8/11/26 at 11:38 AM revealed Resident #24 was sitting in his wheelchair in his room. His covered lunch meal was in front of him, and he was not eating. When asked why he was not eating lunch, Resident #24 stated, "I am waiting on the trays to be passed and picked up so I can go to the bathroom." He stated staff told him they could not assist him to the toilet while meal trays were out. He stated he had been waiting for assistance and added, "This is all the time; I have a hard time getting someone to help me." An interview on 8/11/26 at 11:41 AM with Certified Nurse Aide (CNA) #3 revealed staff knew Resident #24 needed assistance. CNA #3 stated staff could not assist residents to the toilet while meal trays were out and confirmed Resident #24 was told he would have to wait. An interview with the Director of Nursing (DON) on 8/11/26 at 11:46 AM revealed she expected staff to assist Resident #24 with toileting when needed. She confirmed the resident should not have to wait during a meal or until he had an accident. She stated this was an unacceptable practice and residents who needed assistance during mealtimes should receive the required care. An observation and interview with Resident #24 on 8/12/26 at 9:33 AM revealed he was sitting in his wheelchair in the hallway. He stated he had been waiting 30 minutes to use the bathroom. He stated, "A girl with a nose ring" walked by, and he told her he needed to use the bathroom. He stated she said "OK" and walked away. Resident #24 stated, "It's like this every day, I can't get anyone to help me." An interview with the DON on 8/12/26 at 10:02 AM, she was notified that Resident #24 continued to wait for toileting assistance. The DON went into the hallway to find someone to assist him. Resident #24 was taken to the shower room and assisted to the toilet. The DON confirmed the aide who was initially notified of Resident #24's need should have stopped and obtained help to assist him. She confirmed all staff, including nurses, should address his needs			F0677			

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F0677 SS = D	Continued from page 23 timely. An interview with the Long-Term Care District Ombudsman on 8/13/26 at 11:02 AM revealed Resident #24 had voiced care concerns to her during previous visits to the facility. She stated Resident #24 reported that staff would not help him get dressed and that he experienced extended wait times for care. The Ombudsman stated she spoke with the Administrator and notified her of Resident #24's concerns. Record review of the "Admission Record" revealed the facility admitted Resident #24 on 11/29/25 with medical diagnoses that included History of Falling, Reduced Mobility, and Stiffness of Right and Left Knee. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/3/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #24 was cognitively intact. Section GG revealed he was dependent with toileting. Resident #33 An observation of Resident #33 on 8/11/26 at 9:44 AM revealed he was lying on his bed with his head at the foot of the bed and his eyes closed. A foul body odor was noticeable in the hallway outside his room. After a knock on the door, the resident sat on the edge of his bed and appeared disheveled and unkempt. The resident had a foul body odor; his hair was oily, greasy, and slicked down to his scalp; and he was barefoot. His fingernails and toenails were approximately one-half (1/2) to three-fourths (3/4) inch long. An observation and interview with CNA #4 on 8/13/26 at 9:26 AM revealed Resident #33 was on the 3-11 PM shift shower schedule and should receive a shower on Monday, Wednesday, and Friday. CNA #4 confirmed the resident had long nails, oily hair, and a foul body odor. An observation and interview with Registered Nurse (RN) #2 on 8/13/26 at 9:48 AM confirmed that Resident #33 was not receiving showers or nail care. RN #2 stated any staff member could provide nail care because the resident was not diabetic. She stated long nails could cause a skin injury if the resident scratched himself. An interview with CNA #6 on 8/13/26 at 10:02 AM			F0677			

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F0677 SS = D	Continued from page 24 revealed the 3-11 PM shift was not providing showers to any residents and that this had been happening for a while. An interview with the DON on 8/13/26 at 10:16 AM revealed she expected residents to receive showers on their scheduled days and staff to provide nail care when needed. Record review of the "Admission Record" revealed the facility admitted Resident #33 on 10/10/24 with medical diagnoses that included Unspecified Dementia and Autistic Disorder. Record review of the MDS, with an ARD of 6/15/26, revealed under Section C, a BIMS summary score of 15, indicating Resident #33 was cognitively intact. Resident #42 An observation and interview on 08/11/2026 at 9:41 AM revealed Resident #42 sitting up in his wheelchair with a full one-half inch beard. Resident #42 stated that staff have not shaved him in two to three weeks and that he does not wish to grow a beard. He also revealed that he could not shave himself if he tried due to decrease use of his arms. Resident #42 stated that he had required assistance with his shaving and other care since he was admitted to the facility, and he revealed that he wanted to be shaved. An interview on 08/12/2026 at 12:30 PM with RN #2, revealed that shaving was part of Resident #42's personal hygiene and grooming needs and should be addressed on bath or shower days three times a week and as needed. An interview on 08/12/2026 at 12:50 PM with the DON revealed that Resident #42 should have been shaved at least once a week but should be offered a shave on his regular scheduled bath or shower days. She revealed that not receiving his scheduled care was unacceptable and she would address this issue and ensure improved care. She further stated that she wanted these residents to be clean and feel good about themselves and that they would come up with a plan to ensure this wasn't missed again. Record review of Resident #42's "Admission Record" revealed an admission date of 08/25/2023 with diagnoses that included Muscle Wasting and			F0677			

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F0677 SS = D	Continued from page 25 Atrophy of Right Hand, Right and Left Upper Arm and Need for Assistance with Personal Care.	F0677					
F0761 SS = D	Record review of Resident #42's MDS with an ARD of 06/09/26 under Section C revealed a BIMS score of 15 which indicated that he was cognitively intact. 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, staff interview, and facility policy review the facility failed to ensure that medication carts were locked and secured while unattended for one (1) of two (2) medication carts observed. North Hall Findings include: Record review of facility policy titled "Medication Storage", revised 11/7/25 revealed "...1. a. All drugs and biologicals will be stored in locked compartment (i.e., medication carts, cabinets, drawers, refrigerators, medication room) ..." An observation on 8/12/26 at 12:45 PM revealed a medication cart on the North Hall that was unlocked	F0761					

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F0761 SS = D	Continued from page 26 and unattended. An observation on 08/12/2026 at 12:50 PM revealed Registered Nurse (RN) #2 exit ed Room #116B and approached her unlocked medication cart. An interview at that time with RN #2 confirmed that the medication cart was not locked and stated it was important to keep it locked when she was away from it to prevent residents or others from getting medications out of cart which could possibly harm them. RN #2 revealed that she normally kept the medication cart locked when she was away from it but had forgotten. An interview on 08/12/2026 at 12:50 PM with the Director of Nursing (DON) revealed that all medications should be locked in the medication carts when unattended by staff. She revealed that by not storing medications properly, anyone could walk up to the cart and take what they wanted. DON also confirmed that they had wandering residents and those with Dementia who could have taken medications they did not need, and her number one goal was to keep these residents safe.			F0761			