

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A123		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/13/2026	
NAME OF PROVIDER OR SUPPLIER REGINALD P WHITE NURSING FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1451 NORTH LAKE LAND DRIVE , MERIDIAN, Mississippi, 39307			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 08/11/26 through 08/13/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and F656, F657, F689, F698, and F699. The facility had a census of 61 and was licensed for 70 beds.			F0000			
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			

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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F0656 SS = D	Continued from page 1 (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 included individualized goals and interventions addressing hemodialysis treatment and post-dialysis care, including fistula-site assessment and post-dialysis monitoring, for one (1) of (1) residents reviewed for hemodialysis services. (Resident #31). Findings include: A review of the facility's policy titled, "Interdisciplinary Care Plan," revised August 2024, revealed, "...the purpose of this policy is to establish measurable guidelines for using the assessments to develop a care plan that meets the resident's needs, choices and addresses their strengths, weaknesses and goals in order to enhance the quality of care provided..." A record review of Resident #31's "Physician Order Report" revealed an active physician order for dialysis every Monday, Wednesday, and Friday at 6:30 AM at (Proper Name Dialysis). A record review of the facility's "Protocol for Resident Receiving Dialysis" revealed staff were to assess the fistula site for drainage and color and assess for bruit and thrill following each dialysis visit. A record review of Resident #31's "Care Plan" revealed no individualized problem, goal, or intervention addressing the resident's hemodialysis			F0656			

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F0656 SS = D	Continued from page 2 treatment or post-dialysis monitoring and care. On 08/13/2026 at 11:12 AM, during an interview and review of Resident #31's comprehensive care plan, the Minimum Data Set (MDS)/Care Plan Coordinator stated the comprehensive care plan was used to direct staff regarding how to care for the resident. The MDS/Care Plan Coordinator confirmed the care plan did not contain individualized goals or interventions addressing the resident's hemodialysis treatment or care following return from dialysis. The MDS/Care Plan Coordinator stated the care plan should have included interventions for monitoring the fistula site and obtaining post-dialysis weights and vital signs following dialysis treatments. On 08/13/2026 at 1:30 PM, during an interview, the Director of Nursing (DON) confirmed Resident #31's comprehensive care plan did not contain individualized goals or interventions addressing the resident's hemodialysis treatment or post-dialysis care. The DON confirmed Resident #31 was the only resident currently receiving hemodialysis services at the facility. A record review of Resident #31's "Face Sheet" revealed the facility admitted the resident on 02/11/2025 with diagnoses that included End Stage Renal Disease. A record review of Resident #31's Quarterly MDS with an Assessment Reference Date (ARD) of 07/31/2026, revealed in Section C a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was unable to complete the interview.			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.			F0657			

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F0657 SS = D	Continued from page 3 (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 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, person-centered care plans to reflect residents' identified care needs by failing to incorporate trauma-related triggers and individualized interventions for a resident with Post-Traumatic Stress Disorder (PTSD) and by failing to revise the care plan to address a resident's known behaviors of placing himself on the floor and routinely refusing a physician-ordered protective helmet, for two (2) of (16) sampled residents. (Residents #2 and #25). Findings include: A record review of the facility's policy titled, "Interdisciplinary Care Plan" reauthorized August 2024, revealed, "... It is the policy of (Proper Name) to develop a written individualized care plan that meets the needs and choices of each resident as well as address the strengths, weaknesses, and goals identified by the resident's assessment, reassessments ... The entire health record should be considered the "Plan of Care." ... Procedure ... D. The Interdisciplinary Care Plan will: ... receive updates as care needs change ... E. Care will be provided as planned ... F. The interdisciplinary Care Plan will be reviewed and revised to reflect changes in the resident's condition ... The Care Plan will be revised anytime there is an acute change in condition of the resident..." Resident #2 A record review of Resident #2's "Care Plan" revealed a behavioral symptoms problem with a start			F0657			

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F0657 SS = D	Continued from page 4 date of 05/18/2026. The care plan documented that on 07/12/2026, Resident #2 became nervous, scared, and upset because of inappropriate statements made by his roommate and requested to be moved to another room. The care plan did not identify the resident's trauma-related triggers or include individualized interventions addressing the identified triggers. A record review of Resident #2's "Psychology Progress Notes" dated 07/13/2026 revealed the resident reported his roommate threatened him, used vulgar language, attempted to hit him, and made a sexually threatening statement. The resident reported the incident caused him to feel scared due to his history of sexual assault. A record review of Resident #2's "Clinical Progress Notes" dated 07/13/2026 revealed Resident #2 reported he was scared of his roommate, did not feel safe, and did not want to return to the room with the roommate. On 08/11/2026 at 10:11 AM, during an interview, Resident #2 stated he had experienced multiple traumatic events and identified loud noises as something he did not like. On 08/12/2026 at 10:17 AM, during an interview, Resident #2 discussed his history of trauma and identified being yelled at or cursed at as distressing to him. On 08/12/2026 at 11:26 AM, during an interview, Certified Nursing Aide (CNA) #1 stated Resident #2 had discussed his PTSD and history of sexual trauma with staff. CNA #1 stated she was unaware of identified PTSD triggers or individualized care interventions addressing the resident's trauma history. On 08/12/2026 at 1:34 PM, during an interview, Licensed Practical Nurse (LPN) #3 stated Resident #2 had discussed his PTSD experiences and had become nervous and upset when his former roommate used inappropriate language toward him. LPN #3 stated the resident was subsequently moved to a private room but she was unaware of identified PTSD triggers or individualized interventions addressing the resident's trauma history. On 08/13/2026 at 10:10 AM, during an interview, Resident #2 stated his former roommate had yelled and cursed at him, attempted to hit him, and made a sexually threatening statement that caused him to feel scared and unsafe because of his history of	F0657					

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F0657 SS = D	Continued from page 5 sexual trauma. Resident #2 stated he felt unable to defend himself because he used a wheelchair. The resident stated he felt safe and was doing better since being moved to a private room and reported no further incidents with the former roommate or other residents. A record review of Resident #2's "Face Sheet" revealed the facility admitted the resident on 05/12/2026 with diagnoses including Personal History of Traumatic Brain Injury, Bipolar Disorder, current episode depressed, severe, without psychotic features, and Post-Traumatic Stress Disorder (PTSD). A record review of Resident #2's Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/18/26, revealed Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. Section I Active Diagnoses revealed the diagnoses of Bipolar Disorder and Post Traumatic Stress Disorder. Resident #25 A record review of Resident #25's "Care Plan" revealed a problem related to behavioral symptoms, including placing himself on the floor and banging his head on the floor. Interventions included monitoring behaviors twice daily and educating the resident regarding safety if he continued to lie on the floor. If the resident's behavior escalated to hitting his head on the floor or wall, staff were directed to offer the protective helmet, re-educate the resident regarding the risk of self-harm, and encourage him to wear the helmet. If the resident refused the helmet and continued self-injurious behavior, the charge nurse was directed to offer a PRN (as needed) medication "if ordered." On 08/11/2026 at 11:45 AM, during an observation and interview, Resident #25 was observed getting out of bed. A soft protective helmet was observed on the television stand. Resident #25 stated he did not wear the helmet. A small scab was observed on the bridge of the resident's nose and left eyebrow. On 08/11/2026 at 11:55 AM, during an interview, Registered Nurse (RN) #2 stated Resident #25 had a known behavior of placing himself on the floor and had sustained a nasal fracture following a fall over the weekend. RN #2 stated the resident was receiving frequent safety checks and routinely refused to wear the physician-ordered protective helmet. On 08/12/2026 at 12:20 PM, during an observation,	F0657					

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F0657 SS = D	Continued from page 6 Resident #25 was seated in his wheelchair and was not wearing the physician-ordered protective helmet. On 08/12/2026 at 12:30 PM, during an interview, CNA #2 stated Resident #25 refused to wear the helmet and had a known behavior of placing himself on the floor. CNA #2 stated that when the resident was first admitted to the facility, he banged his head on the floor when he did not get his way. CNA #2 stated the resident no longer banged his head on the floor but continued to place himself on the floor as a behavior. On 08/12/2026 at 1:45 PM, during an interview, LPN #2 stated she was working when Resident #25 was found on the floor on 08/08/2026. LPN #2 stated the resident had a laceration to the left eyebrow and bridge of the nose and redness to the left knee. LPN #2 confirmed Resident #25 was not wearing his protective helmet at the time of the incident and stated the resident "never" wore the helmet because he refused it. LPN #2 stated the helmet had originally been implemented because of the resident's behavior of hitting his head on the floor or wall. On 08/12/2026 at 2:00 PM, during an observation, Resident #25 was observed in his wheelchair approaching the nurses' station and was not wearing the physician-ordered protective helmet. On 08/12/2026 at 2:30 PM, during an interview and review of Resident #25's care plan, the Director of Nursing (DON) stated she had not observed Resident #25 wear the helmet because he refused to wear it. The DON confirmed the resident's care plan addressed placing himself on the floor and banging his head on the floor. The DON stated the care-plan intervention directing staff to offer a PRN medication if the resident refused the helmet and continued self-injurious behavior did not identify a specific medication. The DON stated the resident's care plan should contain specific care approaches, including medications and other interventions. On 08/12/2026 at 3:10 PM, during an interview and review of Resident #25's care plan, the Administrator stated the resident had a history of banging his head on the floor and a helmet had been ordered to prevent injury. The Administrator confirmed the care-plan intervention regarding use of a PRN medication was not specific and stated he expected the resident's care plan to be resident-centered and interventions to be specific. On 08/12/2026 at 3:20 PM, during an interview and	F0657					

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F0657 SS = D	Continued from page 7 review of Residents #2's and #25's care plans, RN #1 stated residents' care plans were expected to be updated as changes occurred and were used to direct staff in providing individualized care. RN #1 confirmed Resident #2's care plan did not reflect the resident's identified PTSD triggers and Resident #25's care plan did not reflect the resident's continued refusal to wear the physician-ordered protective helmet or include revised interventions addressing the resident's fall risk. A record review of Resident #25's "Face Sheet" revealed the facility admitted the resident on 08/07/2024 with diagnoses including Epilepsy and Bipolar Disorder. A record review of Resident #25's "Physician Order Report" for August 2026 revealed an active physician order for the resident to wear a helmet at all times when out of bed for safety due to hitting his head on floors and walls. A record review of Resident #25's Comprehensive MDS, with an ARD of 07/14/2026, revealed a BIMS summary score of 5, which indicated severe cognitive impairment. Section I identified diagnoses including Seizure Disorder or Epilepsy and Bipolar Disorder.	F0657					
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to implement effective, individualized interventions to reduce the risk of accidents and injury for a resident with known behaviors of placing himself on the floor and routinely refusing a physician-ordered protective helmet, resulting in an unwitnessed fall with facial lacerations and an open nasal fracture, for one (1) of two (2) residents reviewed for accidents. (Resident	F0689					

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F0689 SS = D	Continued from page 8 #25). Findings include: A record review of the facility's policy titled, "Fall Prevention/Reduction Program," revised September 2020, revealed, "... It is the policy of (Proper Name) ... to decrease falls and the potential for falls of individuals receiving services residents through assessment, re-assessment, post-fall assessment and interventions to prevent a fall or the recurrence of a fall. Establish processes to ensure a safe therapeutic environment by assessing all ... residents to identify and address personal and/or environmental risk factors that might predispose them to falls and to take appropriate measures to mitigate those factors ... Prevention of falls is the responsibility of every employee ... Ensure that the residents treatment/care plan guide reflect the interventions that ... employees should be aware of so as to aid in preventing falls..." A record review of Resident #25's "Accident/Incident Report Form" dated 08/08/2026 revealed the resident was found lying on the floor and sustained a small laceration to the bridge of the nose, a small laceration below the left eyebrow, and an abrasion to the left knee. Interventions documented following the incident included 15-minute safety checks. A record review of Resident #25's "Allegation Hand Off Form" dated 08/10/2026 revealed the facility identified the 08/08/2026 incident as an unwitnessed fall. The resident was transported to the hospital on 08/10/2026, and the hospital after-visit summary identified a diagnosis of an open fracture of the nasal bone. A record review of Resident #25's "After Visit Summary" dated 08/10/2026 revealed the resident was evaluated for a fall and facial injury and diagnosed with an open fracture of the nasal bone. On 08/11/2026 at 11:45 AM, during an observation and interview, Resident #25 was observed getting out of bed. A soft protective helmet was observed on the television stand. Resident #25 stated he did not wear the helmet. A small scab was observed on the bridge of the resident's nose and left eyebrow. On 08/12/2026 at 12:20 PM, during an observation, Resident #25 was seated in his wheelchair and was not wearing the physician-ordered protective helmet. On 08/12/2026 at 12:30 PM, during an interview,	F0689					

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F0689 SS = D	Continued from page 9 Certified Nursing Aide (CNA) #2 stated Resident #25 refused to wear the helmet and had a known behavior of placing himself on the floor. CNA #2 stated that when the resident was first admitted to the facility, he banged his head on the floor when he did not get his way. CNA #2 stated the resident no longer banged his head on the floor but continued to place himself on the floor as a behavior. On 08/12/2026 at 1:45 PM, during an interview, Licensed Practical Nurse (LPN) #2 stated she was working when Resident #25 was found on the floor on 08/08/2026. LPN #2 stated the resident had a laceration to the left eyebrow and bridge of the nose and redness to the left knee. LPN #2 confirmed Resident #25 was not wearing his protective helmet at the time of the incident and stated the resident "never" wore the helmet because he refused it. LPN #2 stated the helmet had originally been implemented because of the resident's behavior of hitting his head on the floor or wall. On 08/12/2026 at 2:00 PM, during an observation, Resident #25 was observed in his wheelchair approaching the nurses' station and was not wearing the physician-ordered protective helmet. On 08/12/2026 at 2:30 PM, during an interview and review of Resident #25's care plan, the Director of Nursing (DON) stated she had not observed Resident #25 wear the helmet because he refused to wear it. The DON confirmed the resident's care plan addressed placing himself on the floor and banging his head on the floor. The DON stated the care-plan intervention directing staff to offer a PRN medication if the resident refused the helmet and continued self-injurious behavior did not identify a specific medication. The DON stated the resident's care plan should contain specific care approaches, including medications and other interventions. On 08/12/2026 at 3:10 PM, during an interview and review of Resident #25's care plan, the Administrator stated the resident had a history of banging his head on the floor and a helmet had been ordered to prevent injury. The Administrator confirmed the care-plan intervention regarding use of a PRN medication was not specific and stated he expected the resident's care plan to be resident-centered and interventions to be specific. On 08/13/2026 at 1:30 PM, during an observation, Resident #25 was observed in his wheelchair near the nurses' station wearing a ball cap and not wearing the physician-ordered protective helmet.	F0689					

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F0689 SS = D	Continued from page 10 On 08/13/2026 at 2:20 PM, during an interview, Registered Nurse (RN) #3 stated Resident #25 "never" wore his protective helmet because he always refused it. RN #3 stated that when the resident refused the helmet, staff redirected and educated him. On 08/13/2026 at 2:30 PM, during an interview, CNA #3 stated she found Resident #25 lying on the hallway floor on 08/08/2026 with his hands and arms under his forehead, his broken glasses beside him, and his wheelchair behind him. CNA #3 stated the resident had not been wearing his helmet because he refused to wear it and "never" wore it. On 08/13/2026 at 3:00 PM, during a telephone interview, RN #4 stated she was the charge nurse when Resident #25 was found on the hallway floor on 08/08/2026. RN #4 stated the resident had lacerations to the left eyebrow and bridge of the nose and redness or a superficial abrasion to the left knee. RN #4 stated Resident #25 had a history of placing himself on the floor multiple times per day for various reasons. A record review of Resident #25's "Face Sheet" revealed the facility admitted the resident on 08/07/2024 with diagnoses including Epilepsy and Bipolar Disorder. A record review of Resident #25's "Physician Order Report" for August 2026 revealed an active physician order for the resident to wear a helmet at all times when out of bed for safety due to hitting his head on floors and walls. A record review of Resident #25's Comprehensive Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/14/2026, revealed a Brief Interview for Mental Status (BIMS) summary score of 5, which indicated severe cognitive impairment. Section I identified diagnoses including Seizure Disorder or Epilepsy and Bipolar Disorder.	F0689					
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F0698					

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NAME OF PROVIDER OR SUPPLIER REGINALD P WHITE NURSING FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1451 NORTH LAKE LAND DRIVE , MERIDIAN, Mississippi, 39307			
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F0698 SS = D	Continued from page 11 This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to ensure dialysis services were provided and coordinated in accordance with the resident's assessed needs by failing to ensure post-dialysis weight information was obtained from the dialysis provider or otherwise obtained and documented following five dialysis treatments, for one (1) of (1) resident reviewed for dialysis services. (Resident #31). Findings include: A record review of Resident #31's "Face Sheet" revealed the facility admitted the resident on 02/11/2025 with a diagnosis of End Stage Renal Disease. A record review of Resident #31's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/31/2026, revealed Section C documented a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was unable to complete the interview. A record review of Resident #31's "Physician Order Report" revealed an active physician order for dialysis every Monday, Wednesday, and Friday at 6:30 AM at (Proper Name Dialysis). A record review of Resident #31's "Dialysis Transfer Assessments" revealed no post-dialysis weights were documented following dialysis treatments on 06/05/2026, 06/10/2026, 06/26/2026, 07/13/2026, and 07/22/2026. On 08/12/2026 at 8:47 AM, during an interview, the Director of Nursing (DON) stated the dialysis center obtained Resident #31's post-dialysis weight following dialysis treatment and the documented weight accompanied the resident upon return to the facility. The DON stated facility staff did not obtain a separate post-dialysis weight upon the resident's return and relied on the weight documented by the dialysis center. On 08/13/2026 at 11:18 AM, during an interview and review of Resident #31's dialysis documentation, the DON stated the resident's post-dialysis weight was expected to be documented on the form accompanying the resident upon return to the facility. The DON stated that when a post-dialysis weight was not documented, facility staff could contact the dialysis center to obtain the missing weight or reweigh the resident at the facility. The			F0698			

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F0698 SS = D	Continued from page 12 DON reviewed the Dialysis Transfer Assessments dated 06/05/2026, 06/10/2026, 06/26/2026, 07/13/2026, and 07/22/2026 and confirmed the post-dialysis weights were not documented. On 08/13/2026 at 11:38 AM, during an interview, Licensed Practical Nurse (LPN) #1 stated the medication cart nurse or charge nurse reviewed the dialysis form when Resident #31 returned from dialysis and was responsible for ensuring the post-dialysis weight was documented. LPN #1 stated that when a post-dialysis weight was not documented, nursing staff could contact the dialysis clinic to obtain the missing weight. LPN #1 confirmed she had not previously contacted the dialysis clinic to obtain a missing post-dialysis weight. On 08/13/2026 at 2:16 PM, during an interview, the Administrator stated nursing staff were expected to review dialysis documentation when the resident returned to the facility and ensure post-dialysis weights were documented. The Administrator stated that when a post-dialysis weight was missing, staff were expected to contact the dialysis clinic to obtain the weight or weigh the resident at the facility.			F0698			
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to provide trauma-informed care that accounted for a resident's history of trauma and identified and addressed triggers that could cause re-traumatization, including developing resident-specific interventions to minimize or mitigate identified triggers, for one (1) of (16) sampled residents. (Resident #2). Findings include: During an interview on 08/11/2026 at 10:11 AM, Resident #2 stated he had experienced multiple			F0699			

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F0699 SS = D	Continued from page 13 traumatic events and identified loud noises as something he did not like. During an interview on 08/12/2026 at 10:17 AM, Resident #2 discussed his history of trauma and identified being yelled at or cursed at as distressing to him. During an interview on 08/12/2026 at 11:26 AM, Certified Nursing Assistant (CNA) #1 stated Resident #2 had discussed his PTSD and history of sexual trauma with staff. CNA #1 stated she was unaware of identified PTSD triggers or individualized care interventions addressing the resident's trauma history. During an interview on 08/12/2026 at 1:34 PM, Licensed Practical Nurse (LPN) #3 stated Resident #2 had discussed his PTSD experiences and had become nervous and upset when his former roommate used inappropriate language toward him. LPN #3 stated the resident was subsequently moved to a private room but she was unaware of identified PTSD triggers or individualized interventions addressing the resident's trauma history. During an interview on 08/13/2026 at 10:10 AM, Resident #2 stated his former roommate had yelled and cursed at him, attempted to hit him, and made a sexually threatening statement that caused him to feel scared and unsafe because of his history of sexual trauma. Resident #2 stated he felt unable to defend himself because he used a wheelchair. The resident stated he felt safe and was doing better since being moved to a private room and reported no further incidents with the former roommate or other residents. During an interview on 08/13/2026 at 11:00 AM, Social Services #1 stated she was aware of Resident #2's PTSD and had spoken with the resident following the incident with his former roommate. Social Services #1 stated Resident #2 was moved to a private room and safety checks were initiated following the incident. She stated she did not complete PTSD assessments or screenings to identify residents' trauma-related triggers. During an interview and review of Resident #2's care plan, on 08/13/2026 at 11:30 AM, the Director of Nursing (DON) stated she was aware of the resident's PTSD and history of sexual trauma. The DON confirmed Resident #2's care plan identified PTSD but did not identify the resident's trauma-related triggers or include individualized interventions addressing those triggers. The DON	F0699					

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F0699 SS = D	Continued from page 14 stated identifying and care planning the resident's triggers would assist staff in providing care and preventing situations that could cause the resident to feel unsafe or experience re-traumatization. During an interview on 08/13/2026 at 12:56 PM, Registered Nurse (RN) #1 confirmed Resident #2's care plan did not identify triggers associated with his PTSD and stated she was unaware of an assessment completed to identify the resident's trauma-related triggers. During an interview on 08/13/2026 at 2:45 PM, the Administrator confirmed Resident #2's trauma-related triggers should have been identified and addressed in the resident's care plan to minimize the potential for re-traumatization. A record review of Resident #2's "Face Sheet" revealed the facility admitted the resident on 05/12/2026 with diagnoses including Personal History of Traumatic Brain Injury, Bipolar Disorder, current episode depressed, severe, without psychotic features, and Post-Traumatic Stress Disorder (PTSD). A record review of Resident #2's "Physician Order Report" revealed active physician orders for safety checks every 15 minutes and behavior monitoring twice daily. A record review of Resident #2's Comprehensive Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/18/2026, revealed a Brief Interview for Mental Status (BIMS) summary score of 5, indicating severe cognitive impairment. Section I identified diagnoses of Bipolar Disorder and Post-Traumatic Stress Disorder (PTSD). A record review of Resident #2's medical record revealed no documented assessment identifying the resident's trauma-related triggers and no individualized interventions to minimize or mitigate the potential for re-traumatization associated with the resident's PTSD. A record review of Resident #2's "Psychology Progress Notes" dated 07/13/2026 revealed the resident reported his roommate threatened him, used vulgar language, attempted to hit him, and made a sexually threatening statement. The resident reported the incident caused him to feel scared due to his history of sexual assault. A record review of Resident #2's "Clinical Progress Notes" dated 07/13/2026 revealed Resident #2 reported he was scared of his roommate, did not			F0699			

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F0699 SS = D	Continued from page 15 feel safe, and did not want to return to the room with the roommate.			F0699			