

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255247		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/20/2026	
NAME OF PROVIDER OR SUPPLIER REST HAVEN HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 103 CUNNINGHAM DRIVE , RIPLEY, Mississippi, 38663			
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F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI) MS #3109952 at the facility from 08/17/26 through 08/20/26. CI MS #3109952 was investigated for sufficient staffing and there were no citations related to this complaint. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited deficiencies F578, F628, F641, F645, F656, F677, F689, F698, F812, F880 and F908. The facility had a census of 47 and was licensed for 60 beds.			F0000			
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still			F0578			

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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F0578 SS = D	Continued from page 1 legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff and resident interviews, and facility policy review, the facility failed to ensure changes to a resident's advance directive/code status was documented accurately and consistently in the resident's chart for one (1) of 15 resident reviewed. Resident #38 Findings Include: Review of the facility policy titled "Advance Directives," with a revision date of August 2017, revealed "Standard: The facility would respect each resident's right to participate in and/or make his/her treatment decisions...Procedure...11. Changes or revocations of a directive, which could be written or oral, must be noted in the resident's clinical records. The facility must notify the attending physician and surrogate decision-maker of the change or revocation. The care plan team will be informed of changes and/or revocations so that the appropriate changes could be made in the resident assessment and care plan..." Record review of Resident #38's physical clinical record revealed a Physician Orders for Sustaining Treatment (POST) form dated 2/7/24, which indicated Resident #38 elected Do Not Attempt Resuscitation (DNR) and Comfort Measures Only. Record review of Resident #38's electronic "Order Summary Report" revealed an order for Cardiopulmonary Resuscitation (CPR) dated 7/16/25. The electronic clinical record identified Resident #38's code status as CPR; however, the resident's physical clinical record contained the POST form indicating DNR and Comfort Measures Only. On 8/19/2026 at 2:05 PM, during an interview with Licensed Practical Nurse (LPN) #1 and LPN #2 regarding Resident #38's code status, LPN #1 stated she would review the electronic clinical record to determine the resident's code status. LPN #1 stated the electronic record			F0578			

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F0578 SS = D	Continued from page 2 indicated that Resident #38 was a CPR and she would initiate chest compressions if Resident #38 was found unresponsive without a pulse. LPN #2 stated she would review the resident's physical chart, which indicated Resident #38 was Comfort Measures Only, and she would not initiate CPR if Resident #38 was found unresponsive without a pulse. During an interview on 8/19/2026 at 2:30 PM with Resident #38, she stated she had been DNR for a long time. Resident #38 stated Social Services had previously discussed her code status with her, and she changed her status to CPR. On 8/19/26 at 2:35 PM, during an interview with Medical Records, she reviewed Resident #38's electronic clinical record and confirmed the resident was coded as CPR on the electronic profile. Medical Records reviewed the document section in the computer and identified her scanned POST form dated 2/7/24, which indicated DNR and Comfort Measure Only. During an interview on 8/19/2026 at 3:00 PM, with Social Services, she stated Resident #38 had been DNR for a long time and the resident had subsequently changed her code status to CPR. Social Services stated the updated form reflecting the change to CPR never made it into the resident's chart. Social Services confirmed the updated documentation should have been placed in the clinical record and not documented solely as an order in the electronic record. Social Services further confirmed the conflicting documentation could cause confusion during an emergency, and the records should be consistent. On 8/20/2026 at 4:00 PM, during an interview with Director of Nursing (DON), she stated she thought Resident #38's code status had been changed but did not see the corresponding documentation when she reviewed the record. The DON confirmed the resident's physical and electronic clinical records should be consistent to prevent an error regarding the resident's end-of-life wishes. Record review of the Admission Record revealed Resident #38 was admitted to the facility on 2/12/2018 with medical diagnoses that included Type 2 Diabetes Mellitus and Chronic Obstructive Pulmonary Disease. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/06/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #38 was cognitively intact.			F0578			
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation.			F0628			

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F0628 SS = D	Continued from page 3 When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F0628					

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F0628 SS = D	Continued from page 4 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the	F0628					

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F0628 SS = D	Continued from page 5 Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of	F0628					

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F0628 SS = D	Continued from page 6 this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to send written notice of transfer/bed hold to the resident representative (RR) (Resident #4, and #50) and failed to notify the State Long-Term Care Ombudsman of the hospital transfer (Resident #50) for two (2) of four (4) residents reviewed for transfer/discharge notice. Findings Include: Review of the facility policy titled "Transfer and Discharges" dated 08/2019 revealed the following: "Process: ... g. Provide a notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated. h. Social Services Director, or designee, shall provide notice of emergency transfer to a representative of the State Long-Term Care Ombudsman but they may be sent when practicable, such as in a list of residents on a monthly basis." Resident #4			F0628			

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F0628 SS = D	Continued from page 7 Record review of Resident #4's "Progress Notes" dated 5/19/26 revealed, "Resident noted change in condition this morning during med pass. Blood glucose obtained with reading of 49. Blood pressure obtained with reading of 97/46. Resident cold to touch, minimally responsive, and noted gurgling respirations/noises. Glucagon administered per protocol with no effective response noted. EMS (emergency management services) notified and arrived to assess resident. Resident transferred to 'Proper name of hospital.'" Record review of Resident #4's "Notice of Transfer/Bed Hold Agreement" revealed the resident was transferred to the hospital on 5/19/26 with abnormal vital signs. The resident's daughter was notified by phone of the bed hold on 5/20/26. There was no indication that the written notice of transfer/bed hold agreement was mailed to the RR. An interview with Social Services (SS) on 8/18/26 at 2:10 PM revealed she was responsible for completing the written hospital transfer notification and bed-hold notice after a resident was transferred to the hospital. She stated nursing staff made the initial notification to the family at the time of transfer, and she called the RR to explain and offer the bed hold. SS confirmed she did not mail the letter to the RR and stated she was not aware this was a federal regulation. Record review of the "Admission Record" revealed the facility readmitted Resident #4 on 5/22/26 with medical diagnoses that included Type 1 Diabetes Mellitus with Diabetic Chronic Kidney Disease and Dependence on Renal Dialysis. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/8/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 12 under Section C, indicating Resident #4 was moderately cognitively impaired. Resident #50 Record review of Resident #50's "Progress Notes" dated 6/22/26 revealed, "Resident has complained of abdominal pain, last bowel movement (BM) on 6/20/26, has blood-tinged urine in catheter bag this morning. Temperature of 100.5 and skin is hot to touch. States he is just not feeling well. Blood Pressure (BP) 119/55, Pulse (P) 85, Blood Sugar (BS) 211, Respirations (R) 18, Oxygen saturation (O2 sat) 94% room air. Refused to take any medication this	F0628					

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F0628 SS = D	Continued from page 8 morning. Refused breakfast. Notified Nurse Practitioner (proper name), new order to send to Emergency Room (ER) for evaluation (eval) and Computed Tomography (CT) of abdomen/pelvis. (Proper Name) Hospital Emergency Medical Technician (EMT) arrived at 8:45 AM to transport resident via stretcher to ER." Record review of Resident #50's "Notice of Transfer/Bed Hold Agreement" revealed the form documented that the resident was transferred to the hospital on 6/21/26 because of blood in the urine. The form documented that the resident's son, who was identified as the resident's emergency contact, was notified by telephone and declined the bed hold on 6/21/26. Record review revealed Resident #50 was his own responsible party, and the son was not identified as the resident's representative or otherwise authorized to make decisions on the resident's behalf. There was no evidence that Resident #50 was provided with written notice of the emergency transfer or the facility's bed-hold policy. Record review of facility's "Emergency Transfer Log for the Office of the State Long-Term Care Ombudsman" for June 2026, revealed Resident #50 was not listed on the list of emergency transfers for June 2026. An interview with Social Services (SS) on 8/18/26 at 2:10 PM stated she did not mail the letter to the RR because she was not aware this was a federal regulation. She further stated that she did not list Resident #50 on the notice to ombudsman form for June because he was not returning to the facility and it was an emergency transfer/discharge. She stated she was not aware that he should have been included in the notice to ombudsman. During an interview on 8/20/26 at 11:43 AM, Social Services stated she was responsible for completing the written hospital transfer and bed-hold notices and the facility's notification to the Office of the State Long-Term Care Ombudsman. She confirmed that Resident #50 was transferred to the emergency room on 6/22/26 and that she had incorrectly dated the transfer form 6/21/26. She confirmed that Resident #50 was his own responsible party and that the resident's son was listed only as the emergency contact. She stated the written transfer and bed-hold notices were not provided to Resident #50. She further confirmed that she did not include Resident #50 on the June 2026 emergency-transfer log submitted to the Office of the State Long-Term Care Ombudsman because the transfer was an emergency and the resident was not returning to the facility.			F0628			

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F0628 SS = D	Continued from page 9 She stated she was unaware that the emergency transfer was required to be reported to the Office of the State Long-Term Care Ombudsman. Record review of the "Admission Record" revealed the facility admitted Resident #50 on 6/16/26 with medical diagnoses that included Chronic Kidney Disease, Stage 4 (Severe) and Malignant Neoplasm of Prostate. Record review of the MDS, with an ARD of 6/22/26, revealed a BIMS summary score of 13 under Section C, indicating Resident #50 was cognitively intact.	F0628					
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F0641					

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F0641 SS = D	Continued from page 10 This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to accurately complete residents' Minimum Data Set (MDS) assessments, specifically Section N (Medications) for Resident #3, Resident #20 and Resident #26, and Section J (Pain) for Resident #1, for four (4) of 15 MDS assessments reviewed. Findings Include: Record review of the facility policy titled "MDS/RAI (Resident Assessment Instrument) Standard" revealed under, "Standard: This facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences using the resident assessment instrument (RAI) specified by CMS (Centers for Medicare & Medicaid Services)." Resident #1 Record review of Resident #1's MDS with an Assessment Reference Date (ARD) of 7/15/26 revealed under section J, item J0410 revealed the resident experienced pain almost constantly and item J0100A was coded as not receiving a scheduled pain medication regimen during the 5-day look-back period. Record review of Resident #1's July 2026 Medication Administration Record (MAR) revealed an order dated 11/25/25, "Lyrica oral capsule 100 mg (milligrams) give 100 mg (milligrams) by mouth three times a day for pain." The MAR documented Resident #1 received Lyrica during the 5-day look-back period. An interview with the MDS Nurse on 8/19/26 at 9:28 AM confirmed Resident #1 received scheduled Lyrica for pain. She explained that she had never coded Lyrica as a pain medication on the MDS because she thought the item referred only to opioids. She stated she used the RAI for guidance and acknowledged she inaccurately coded the MDS under the pain medication regimen item. Record review of the "Admission Record" revealed the facility admitted Resident #1 on 7/01/25 with medical diagnoses that included Other Muscle Spasm and Primary Osteoarthritis, Left Shoulder. Record review of Resident #1's MDS with an Assessment Reference Date (ARD) of 7/15/26			F0641			

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F0641 SS = D	Continued from page 11 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #1 was cognitively intact Resident #3 Record review of Resident #3's MDS with an ARD of 5/20/26 revealed under section N, item N0415E1 the resident was coded as receiving an anticoagulant medication during the 7-day look-back period. Record review of Resident #3's May 2026 MAR revealed the resident did not receive an anticoagulant medication during the 7-day look-back period. Record review of the "Admission Record" revealed the facility admitted Resident #3 on 2/10/26 with a medical diagnosis that included Osteoarthritis of Knee, Unspecified. Record review of Resident #3's MDS with an ARD of 5/20/26 revealed under section C, a BIMS summary score of 3, indicating Resident #3 was severely cognitively impaired. Resident #20 Record review of Resident #20's MDS with an ARD of 5/13/26 revealed under section N, the resident was coded as receiving insulin injections for 7 days during the 7-day look-back period. Record review of Resident #20's May 2026 MAR revealed the resident did not receive insulin during the 7-day look-back period. Record review of the "Admission Record" revealed the facility admitted Resident #20 on 12/27/24 with a medical diagnosis that included Type 2 Diabetes Mellitus without Complications. Record review of Resident #20's MDS with an ARD of 5/13/26 revealed under section C, a BIMS summary score of 15, indicating Resident #20 was cognitively intact. Resident #26 Record review of Resident #26's MDS assessment, with an ARD of 07/29/2026, revealed Section N0415, High-Risk Drug Classes: Use and Indication, was coded "1—Yes" for anticoagulant use and "0—No" for antiplatelet use. Record review of Resident #26's July 2026			F0641			

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F0641 SS = D	Continued from page 12 Medication Administration Record (MAR) revealed the Resident #26 did not receive an anticoagulant medication during the 7-day look-back period. Record review of Resident #26's July 2026 MAR revealed an order dated 4/25/26, "Plavix oral tablet 75 mg (milligrams) give one tablet by mouth one time a day for hemiplegia and hemiparesis following cerebral infarction affecting right dominant side." The MAR documented Resident #26 received Plavix during the 7-day look-back period. Record review of the "Admission Record" revealed the facility admitted Resident #26 on 4/24/26 with a medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side. Record review of Resident #26's MDS with an ARD of 7/29/26 revealed under section C, a BIMS summary score of 15, indicating Resident #26 was cognitively intact. An interview with the Director of Nursing (DON) on 8/18/26 at 11:26 AM revealed the MDS Nurse started in October 2025. The DON stated she had already identified accuracy issues with the MDS assessments and had been reviewing and modifying some assessments. An interview with the MDS Nurse on 8/18/26 at 1:22 PM confirmed she coded the MDS assessments for Residents #1 and Resident #3, Resident #20 and Resident #26 in error. She stated Resident #20 received Mounjaro, and she thought it was insulin. The MDS Nurse stated she was not sure what happened with Resident #3's assessment and confirmed the MAR did not reflect that Resident #3 received an anticoagulant. She confirmed that she thought Plavix was an anticoagulant and wasn't aware that it was an antiplatelet for Resident #26. She stated the assessments should be completed accurately to identify the medications residents received and to develop their plans of care.			F0641			
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:			F0645			

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F0645 SS = D	Continued from page 13 (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before	F0645					

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F0645 SS = D	Continued from page 14 admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, and facility policy review, the facility failed to ensure an accurate Preadmission Screening and Resident Review (PASARR) Level I screening was completed and updated to reflect a resident's mental health diagnosis and psychotropic medications for one (1) of two (2) residents for reviewed for PASARR. Resident #5 Findings Include: Record review of the facility policy titled "Resident Assessment-Coordination with PASARR Program" revealed under "Standard,; This facility coordinates assessments with the Preadmission Screening and Resident Review (PASARR) program to ensure individuals with a mental disorder, intellectual disability, or related condition receives care and services in the most integrated setting appropriate to their needs..." Record review of the Admission Record revealed Resident #5 was admitted to the facility on 4/27/2026 with medical diagnoses that included Metabolic Encephalopathy and Schizophrenia. Record review of Resident #5's PASARR Level I screening dated 4/29/26 revealed metabolic encephalopathy was identified as the resident's diagnosis. Further review revealed schizophrenia was not identified and no medications were listed on the screening. Record review of Resident #5's "Order Summary Report" revealed an order dated 5/5/26 for Olanzapine Oral Tablet 5 milligrams (mg), give 1 tablet by mouth at bedtime for Schizophrenia, Unspecified. Further review revealed no correction, or status change was submitted to update Resident #5's PASARR information to reflect the resident's mental health diagnosis and psychotropic medications. During an interview on 8/18/2026 at 10:56 AM a Maximus			F0645			

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F0645 SS = D	Continued from page 15 representative stated the PASARR Level I screening and algorithm was driven by the diagnoses and medications entered into the screening. The representative stated Resident #5's submitted information did not trigger a Level II evaluation. During an interview on 8/19/2026 at 10:20 AM with Social Services stated she completed Resident#5's PASARR Level I screening. She stated she did not add Schizophrenia to the screening and no change form was submitted, and psychotropic medications were not added. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/29/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #4 was cognitively intact.	F0645					
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)- (A) The resident's goals for admission and desired outcomes.	F0656					

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F0656 SS = D	Continued from page 16 (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 observation, record review, interview and facility policy review, the facility failed to develop comprehensive, individualized, person-centered care plans that included measurable objectives and interventions addressing identified medical and nursing needs for five (5) of 15 residents reviewed for comprehensive care plans. Resident #2, Resident #4, Resident #7, Resident #8, and #26 Findings include: Review of the facility policy titled "RAI (Resident Assessment Instrument)/Care Planning Management" revised 4/19, revealed under, "The Care Plan: The comprehensive care plan is completed within seven (7) days after the MDS (Minimum Data Set) is completed, and reviewed quarterly thereafter. If Modifications, deletions, additions are necessary, changes should be made at the time of occurrence." Resident #2 Review of Resident #2's Care Plan Detail revealed a focus area for Functional Abilities (Self Care and Mobility) Deficit. The care plan identified the resident required partial/moderate assistance with personal hygiene and supervision or touching assistance with showering/bathing. On 8/17/26 at 10:55 AM an observation and interview revealed Resident #2's fingernails were approximately one-half (1/2) inch in length with a brown substance underneath the nails. Resident #2 stated staff shaved him and cut his nails, but he would like his fingernails trimmed because they were "really long."	F0656					

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F0656 SS = D	Continued from page 17 An interview on 8/18/2026 at 9:00 AM, with Licensed Practical Nurse (LPN) #2 stated Resident #2 received nail care on his shower days. On 8/20/2026 at 9:05 AM during an interview Certified Nursing Assistant (CNA) #5 stated she helps with showers and that Resident #2 received nail care during his showers on Monday, Wednesday, and Friday. She stated she thought she trimmed them on the previous Friday, and she didn't realize they were as long as they were. On 8/19/2026 at 11:27 AM, during an interview with the Minimum Data Set (MDS) Nurse, she stated the purpose of the care plan was to provide care to the residents based on their individual needs. Record review of the Admission Record revealed Resident #2 was admitted to the facility on 3/05/2026 with medical diagnoses that included Parkinson's Disease. Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/10/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 03, indicating Resident #2 was severely cognitively impaired. Resident #4 Record review of Resident #4's August 2026 Medication Administration Record (MAR) revealed an order dated 4/21/26 for a fluid restriction of 32 ounces (946 milliliters [mL]) every 24 hours. Record review of Resident #4's "Care Plan Detail" revealed a focus identifying that the resident received hemodialysis. However, the care plan was not developed to include the physician-ordered fluid restriction or individualized interventions directing staff to measure, record, and monitor all sources of fluid provided during each 24-hour period. An interview with the MDS nurse on 8/21/26 at 10:30 AM confirmed Resident #4's care plan did not address the physician-ordered fluid restriction. She stated the purpose of the care plan was for staff to know how to care for the resident and exactly how much fluid to provide. Record review of Resident #4's "Admission Record" revealed the facility readmitted Resident #4 on 5/22/26 with diagnoses that included Type 1 Diabetes Mellitus with Diabetic Chronic Kidney Disease and Dependence on Renal Dialysis.			F0656			

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F0656 SS = D	Continued from page 18 Record review of the MDS, with an ARD of 7/08/26, revealed a BIMS summary score of 12 under Section C, which indicated Resident #4 was moderately cognitively impaired. Resident #7 During initial rounds on 8/17/2026 at 10:53 AM, Resident #7 was observed with bruising around her right eye and stated she had fallen out of bed the previous week. During an interview on 08/18/2026 at 9:37 AM, Resident #7 stated she had rolled out of bed and landed face down on the floor. Review of Resident #7's Progress Notes: ALERT SBAR-Fall Note dated 8/11/2026 at 3:11 PM revealed Resident #7 was found lying on the floor on the right side between her bed and bedside table. Resident #7's head was located at the bottom of bedside table. The resident stated she fell out of bed and hit her face/neck. Resident #7 sustained a facial laceration during the fall and was transferred to the emergency department for evaluation. Review of Resident #7's Progress Notes: Plan of Care Note dated 8/11/2026 at 6:22 PM revealed Dermabond was applied to her facial laceration, and computed tomography scans revealed no facial or cranial fractures. The resident subsequently returned to the facility. Review of Resident #7's Progress Notes: ALERT SBAR-Fall Note dated 6/17/2026 at 11:24 PM revealed Resident #7 was found lying on the floor on the right side of her bed. The resident stated, "I fell out of the bed." The note documented that Resident #7 was educated regarding the importance of using her call light and keeping her bed in its lowest position. Review of Resident #7's Order Summary Report revealed an order dated 06/17/2026 for a one-quarter side rail on the left side of Resident #7's bed for positioning and mobility. However, the low-bed intervention and the use of the one-quarter positioning rail were not incorporated into Resident #7's comprehensive care plan following the 06/17/2026 fall. On 08/18/2026 at 11:49 AM, during an interview, the Nurse Educator confirmed Resident #7 rolled out of bed on 06/17/2026 while repositioning herself. The Nurse Educator stated Resident #7's bed was	F0656					

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F0656 SS = D	Continued from page 19 positioned higher than it should have been because the resident preferred to be at eye level with her bedside table. The Nurse Educator stated she educated Resident #7 about the importance of leaving the bed in its lowest position and that the resident verbalized understanding. Record review of Resident #7's fall care plan revealed the following: "6.17.26 – no injury." "8.11.26 – no injury." Resident was educated to call for assistance before attempting to get out of bed. 6.17.26 Bed was to remain in the lowest position when staff were not providing direct care. 8.11.26 Non-skid socks were to be in place. 6.20.26 The resident's call light was to remain within reach. 6.20.26 The resident's room was to remain free of clutter. 6.20.26 The resident was to be referred to physical, speech, and/or occupational therapy as needed. 6.20.26 The Fall care plan inaccurately identified the 08/11/2026 fall as resulting in no injury despite documentation that Resident #7 sustained a facial laceration requiring emergency department evaluation. The record revealed that both falls occurred when Resident #7 rolled or fell from bed. The care plan interventions related to non-skid socks, room clutter, and calling for assistance before attempting to get out of bed did not specifically address the identified mechanism of the resident's falls. The one-quarter positioning rail ordered and installed on 06/17/2026 was not identified on the care plan. The only revision made following the second fall on 08/11/2026 was the addition of the instruction to maintain the bed in its lowest position when staff were not providing direct care. This	F0656					

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F0656 SS = D	Continued from page 20 intervention had previously been identified following the 06/17/2026 fall but had not been incorporated into the care plan at that time. Record review of Resident #7's Progress Notes dated 4/28/26, revealed Resident #7 returned to the facility from the hospital on 04/28/2026. The readmission nursing assessment identified a 7.5-centimeter (cm) by 4-cm deep tissue pressure injury to the resident's right outer hip, including two darkened areas measuring 3 cm by 2 cm and 4.5 cm by 2 cm. The Nurse Practitioner was notified. Record review of physician orders dated 04/28/2026 directed staff to apply a large foam dressing to the right hip daily; reposition the resident every two hours and as needed, alternating between the resident's back and left side; and administer 30 milliliters of liquid protein twice daily for wound healing. Record review of Resident #7's comprehensive care plan revealed it did not contain a problem, measurable goal, or interventions addressing the right hip pressure injury, wound treatment, repositioning, pressure relief, or nutritional support from 04/28/2026 through 06/15/2026. The first care-plan interventions addressing the pressure injury were initiated on 06/16/2026 and 06/17/2026, approximately seven weeks after the pressure injury and corresponding care needs were identified. During an interview on 08/20/2026 at 8:30 AM, the MDS Nurse confirmed that a care plan addressing Resident #7's pressure injury should have been developed when the resident returned from the hospital on 04/28/2026. During an interview on 08/20/2026 at 8:35 AM, the Director of Nursing (DON) confirmed that Resident #7's comprehensive care plan did not address the right hip pressure injury when the resident returned from the hospital on 04/28/2026. The DON confirmed that a care plan addressing the pressure injury and corresponding care needs should have been developed at that time. Record review of the "Admission Record" revealed the facility admitted Resident #7 on 3/6/26 with a medical diagnosis that included Relapsing-Remitting Multiple Sclerosis. Record review of Resident #7's MDS with an ARD of 6/10/26 revealed under section C, a BIMS summary score of 10, indicating moderate cognitive impairment.			F0656			

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F0656 SS = D	Continued from page 21 Resident #8 Record review of Resident #8's "Care Plan Detail" revealed under, "Focus: The resident is at risk for falls with hx (history) of falls r/t (related to) gait/balance problems, psychoactive drug use." Further review of the "Fall Reports" revealed the following falls: On 11/08/25 at 7:30 PM, during medication pass, staff heard a noise and found the resident standing beside the bed. The resident fell onto his buttocks and then onto his back. On 11/09/25 at 6:00 PM, the resident was found on the floor in his room, lying on his left side. He reported that his head was spinning. On 12/14/25 at 8:45 PM, while attempting to get up to use the bathroom, the resident stumbled, struck his head on the wall, and fell onto his left side. Post-incident documentation identified an abrasion and a left trochanteric (hip) fracture. On 01/14/26 at 12:55 AM, the resident was found on the floor in his room after attempting to get up to go to the bathroom. On 02/05/26 at 9:38 PM, while transferring from the bed to his wheelchair, the resident slipped from the wheelchair and sat on the floor. On 02/09/26 at 9:20 AM, the resident was found on the floor in front of the bathroom door after attempting to go to the bathroom and falling onto his knees. On 02/11/26 at 1:00 AM, the resident was found on the floor after attempting to use the urinal. On 02/11/26 at 3:30 PM, while at the nurses' station, the resident fell onto his left elbow while attempting to get tools to fix his truck. On 02/12/26 at 5:35 PM, the resident was observed on the floor with his head near the bathroom. On 02/13/26 at 11:00 AM, the resident got out of his wheelchair and fell in his room while "Attempting to go home." On 02/18/26 at 6:00 AM, the resident was found on the floor in his room.			F0656			

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F0656 SS = D	Continued from page 22 On 03/08/26 at 1:10 PM, the resident entered another resident's room and fell at the bathroom door. On 03/14/26 at 11:15 PM, the resident's roommate found him beside the bed after a fall. On 04/14/26 at 7:00 PM, a nurse observed the resident standing before he fell near the end of his bed. On 04/15/26 at 2:00 PM, housekeeping notified nursing that the resident had fallen in the shower room. On 04/25/26 at 7:15 AM, the resident was found on the floor at the nurses' station. On 04/27/26 at 2:40 PM, the resident was observed in the hallway near his wheelchair after another staff member reported seeing him fall. On 05/01/26 at 10:00 AM, the resident was observed sitting on the floor in the lounge/yellow room while holding onto a recliner. On 05/19/26 at 5:00 PM, the resident was observed on the day-room floor between his wheelchair and a sofa chair. On 05/20/26 at 7:15 PM, the resident was observed on the floor in the yellow room/day room. On 05/23/26 at 1:30 PM, the resident leaned forward in his wheelchair and slid onto the floor. On 07/19/26 at 10:00 AM, the resident was observed lying on his right side on the floor in the yellow room. Further review of the "Care Plan Detail" revealed general interventions that included keeping the bed low and locked, keeping the call light within reach, using a concave mattress, providing a custom high-back/tilt wheelchair, and monitoring for recurrence. However, the care plan did not include individualized interventions addressing the circumstances and contributing factors associated with Resident #8's recurring falls. The care plan did not identify the assistance, supervision, or monitoring required when the resident attempted to rise or transfer without assistance; specify the frequency or locations for increased monitoring; address repeated attempts to use the bathroom or urinal; or direct staff regarding interventions for falls occurring in the day room, hallway, nurses' station,	F0656					

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F0656 SS = D	Continued from page 23 shower room, or other locations identified in the fall documentation. An interview with the Director of Nursing on 8/20/26 at 11:40 AM revealed the facility moved Resident #8 closer to the nurses' station and conducted hourly visual monitoring. She stated the resident's falls decreased after placement of a suprapubic catheter. She confirmed the care plan did not include individualized interventions addressing the circumstances and contributing factors associated with Resident #8's falls. The relocation near the nurses' station and hourly visual monitoring identified during the interview were not included in the written care plan. Record review of Resident #8's "Admission Record" revealed the facility admitted Resident #8 on 11/05/25 with diagnoses that included Alzheimer's Disease, History of Falling, and Displaced Fracture of Base of Neck of Left Femur. Record review of the MDS, with an ARD of 7/01/26, revealed a BIMS summary score of 3 under Section C, which indicated Resident #8 was severely cognitively impaired. Resident #26 Review of Resident #26's physician orders revealed an active order for Plavix Oral Tablet 75 milligrams (mg) (clopidogrel bisulfate), one tablet by mouth daily. An additional active order, dated 04/30/2026, directed staff to monitor Resident #26 every shift for signs and symptoms of bleeding associated with clopidogrel therapy. Review of Resident #26's comprehensive care plan revealed the care plan did not identify the resident's antiplatelet therapy or associated risk for bleeding. The care plan did not include a measurable objective or interventions addressing the physician-ordered every-shift monitoring for signs and symptoms of bleeding. During an interview on 08/18/2026 at 1:56 PM, the MDS Nurse confirmed that Resident #26 received Plavix (clopidogrel), an antiplatelet medication and that the risk for bleeding care plan should have been developed. During an interview on 08/18/2026 at 2:18 PM, the DON confirmed Resident #26's comprehensive care plan did not address the resident's antiplatelet			F0656			

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F0656 SS = D	Continued from page 24 therapy, risk for bleeding, or the physician-ordered every-shift monitoring for signs and symptoms of bleeding. The DON stated the purpose of the comprehensive care plan was to inform staff of the individualized care and services required for each resident. Record review of the "Admission Record" revealed the facility admitted Resident #26 on 4/24/26 with a medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side. Record review of Resident #26's MDS with an ARD of 7/29/26 revealed under section C, a BIMS summary score of 15, indicating Resident #26 was cognitively intact.	F0656			
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 interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care related to fingernail hygiene for one (1) of forty-seven (47) residents reviewed for ADL care. Resident #2. Findings Include: Review of the facility policy titled "Resident Hygiene", Bath and Shower Standard" with a revision date of June 2022 revealed under "Standard It is the practice of the facility to assist residents with bathing/showering to maintain proper hygiene and help prevent skin infections. Bathing includes washing the entire body and residents' fingernails and toenails would be trimmed when needed..." During an observation and interview on 8/17/26 at 10:55 AM revealed Resident #2's fingernails were approximately one-half (1/2) inch in length with a brown substance underneath the nails. Resident #2 stated staff shaved him and cut his nails, and he would like his fingernails trimmed because they were "really long." During an observation on 8/18/2026 at 8:56 AM,	F0677			

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F0677 SS = D	Continued from page 25 Resident #2's fingernails remained approximately one-half (1/2) inch in length with a brown substance underneath the nails. On 8/18/2026 at 9:00 AM, Licensed Practical Nurse (LPN) #2 stated Resident #2 received nail care on his shower days. During an interview on 8/20/2026 at 9:05 AM, Certified Nursing Assistant (CNA) #5 stated she helps with showers and that Resident #2 received nail care during his showers on Monday, Wednesday, and Friday. CNA #5 stated she washed the resident's nails and trimmed them when the resident told her he wanted them trimmed, they do not have a specific day of the week or time of the month to check if they need their nails trimmed. She stated he had not informed her he wanted his fingernails trimmed. She stated she thought she trimmed them on the previous Friday, and she didn't realize they were as long as they were. On 8/20/2026 at 9:30 AM, during an interview with the Director of Nursing (DON), she stated she observed Resident #2's fingernails, and they were dirty and long. The DON stated the resident could cut himself with his fingernails and cause an infection. She stated it was her expectation that residents' fingernails be kept clean and trimmed. Record review of the Admission Record revealed Resident #2 was admitted to the facility on 3/05/2026 with medical diagnoses that included Parkinson's Disease. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/10/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 03, indicating Resident #2 was severely cognitively impaired.	F0677					
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.	F0689					

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F0689 SS = D	Continued from page 26 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide adequate supervision and implement effective, individualized interventions to prevent repeated falls for one (1) of two (2) resident reviewed for accidents and supervision. Resident #8 Findings include: Review of the facility policy titled "Fall Standard" with a revision date of 05/26 revealed under "Standards of Practice: The facility strives to reduce the risk for falls and injuries by promoting the implementation of the Risk Reduction: Falls and Injuries Program. Residents are assessed for the fall risk factors. The interdisciplinary team works with the residents and family to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence..." An observation of Resident #8 on 08/17/26 at 1:30 PM revealed the resident was in the dayroom, standing up from his wheelchair taking three steps, while his legs were unsteady and beginning to buckle. No staff were present or close enough to assist the resident. The Survey Agency (SA) notified staff, and the resident was assisted back into his wheelchair, toileted and taken back into the day room/yellow room where staff tilted his wheelchair back approximately 45 degrees and elevated his legs and there were no staff present. Record review of the "Fall Reports" revealed the following falls from 11/2025 through 7/2026: On 11/08/25 at 19:30 (7:30 PM): During medication pass, staff heard a noise and found the resident standing beside the bed. The resident fell onto his buttocks and then onto his back. He stated he was trying to get into his chair. Staff assessed the resident, noted no injury, assisted him back to bed, and obtained vital signs. Staff instructed him to use the call light, placed the bed in the low position, and placed the call light within reach. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 11/09/25 at 18:00 (6:00 PM): The resident was found on the floor in his room, lying on his left side. He reported that his head was spinning. Staff assessed the resident, noted no skin issues,			F0689			

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F0689 SS = D	Continued from page 27 assisted him back to his wheelchair, obtained vital signs, and initiated neurological checks. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 12/14/25 at 20:45 (8:45 PM): While trying to get up to use the bathroom, the resident stumbled, struck his head on the wall, and fell onto his left side. He reported severe left hip pain and stated, "My hip is broken." His pain was documented as 10/10. The resident was sent to the emergency room. Post-incident documentation identified an abrasion and a left trochanteric (hip) fracture. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 01/14/26 at 00:55 (12:55 AM): The resident was found on the floor in his room after attempting to get up to go to the bathroom. He reported falling and striking his side on the bottom rail of the bed. He reported side and hip pain. The resident was sent to the emergency room for an X-ray evaluation. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/05/26 at 21:38 (9:38 PM): While transferring from the bed to his wheelchair, the resident slipped from the wheelchair and sat on the floor. He stated, "I slipped out of my wheelchair." Staff assisted him back to the wheelchair and then to bed. The assessment documented no injury or pain. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/09/26 at 09:20 (9:20 AM): The resident was found on the floor in front of the bathroom door after attempting to go to the bathroom and falling onto his knees. He reported buttock pain, and an abrasion was noted on his right knee. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/11/26 at 01:00 (1:00 AM): The resident was found on the floor after attempting to use the urinal. He landed on his right side and sustained a small abrasion to his right elbow. Staff assessed the resident, provided first aid, returned him to bed, and encouraged him to call for assistance. The bed was in the low position, and the call light was within reach. Review of the post-fall investigation and clinical record did not identify a new or revised			F0689			

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F0689 SS = D	Continued from page 28 individualized fall-prevention intervention. On 02/11/26 at 15:30 (3:30 PM): While at the nurses' station, the resident fell onto his left elbow while attempting to get tools to fix his truck. Staff transferred him back to his wheelchair with two-person assistance and obtained vital signs. Redness was noted, and no pain was documented. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/12/26 at 17:35 (5:35 PM): The resident was observed on the floor with his head near the bathroom. He stated he was trying to use the bathroom. Staff returned him to his wheelchair with two-person assistance. A skin tear was documented on his right elbow. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/13/26 at 11:00 (11:00 AM): The resident got out of his wheelchair and fell in his room while "Attempting to go home." A head-to-toe assessment identified a skin tear and bruising to his left elbow and bruising to his left rib area. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 02/18/26 at 06:00 (6:00 AM): After reporting chest pain earlier that morning, the resident was found on the floor in his room and stated, "I just fell in the floor." A skin tear was noted on his right upper forearm. Two certified nursing assistants (CNAs) returned him to bed using a Hoyer lift. The report stated he was sent to the emergency room based on nursing judgment. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 03/08/26 at 13:10 (1:10 PM): The resident entered another resident's room and fell at the bathroom door. Resident was found on his right side. Staff assessed him for redness, skin issues, and pain; none were documented. He was assisted back to his wheelchair. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 03/14/26 at 23:15 (11:15 PM): The resident's roommate found him beside the bed after a fall. The resident stated he was going to see his brother. An			F0689			

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F0689 SS = D	Continued from page 29 abrasion to his right elbow was documented and treated. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 04/14/26 at 19:00 (7:00 PM): A nurse observed the resident standing before he fell near the end of his bed. When asked what he was trying to do, the resident stated, "I was trying to get to my car." Staff completed an assessment and obtained vital signs. No pain or injury was documented. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 04/15/26 at 14:00 (2:00 PM): Housekeeping notified nursing that the resident had fallen in the shower room. He was found sitting on his left side, with his legs behind him, leaning against a wheelchair and positioned between two wheelchairs. He was unable to describe the fall. Staff assessed him and obtained vital signs. The resident denied pain, and no new skin issue was documented. Two staff members assisted him into his wheelchair, and neurological checks were initiated. The record did not indicate that staff were present in the shower room or explain how the resident accessed the locked shower room. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 04/25/26 at 07:15 (7:15 AM): The resident was found on the floor at the nurses' station. The report stated he had wanted to use the bathroom much of the night and morning despite having a catheter. The resident stated he was trying to go to the bathroom. Staff returned him to his wheelchair. An abrasion to his right upper arm was cleaned and dressed. A pain score of 8 and stomach pain were documented. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 04/27/26 at 14:40 (2:40 PM): The resident was observed in the hallway near his wheelchair after another staff member reported seeing him fall. The report stated he landed on his right side and struck his head. Staff obtained vital signs and assessed his level of consciousness. An order was obtained to send him to the emergency room because he struck his head. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 05/01/26 at 10:00 (10:00 AM): The resident was	F0689					

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F0689 SS = D	Continued from page 30 observed sitting on the floor in the lounge/yellow room while holding onto a recliner and positioned between his wheelchair and the recliner. He stated, "I was trying to sit down." Two staff members returned him to his wheelchair. No injury, pain, or new skin issues were documented. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 05/19/26 at 17:00 (5:00 PM): The resident was observed on the day-room floor between his wheelchair and a sofa chair after attempting to transfer himself from the wheelchair to the chair. Two CNAs assisted him back to his wheelchair. No skin issue, loss of consciousness, or change in range of motion was documented. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 05/20/26 at 19:15 (7:15 PM): The resident was observed on the floor in the yellow room/day room with a quarter-sized area documented on the left back side of his head. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 05/23/26 at 13:30 (1:30 PM): At the nurses' station, the resident leaned forward in his wheelchair and slid onto the floor. He was unable to provide details of the event. A head-to-toe assessment was completed, and no apparent injury was documented. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. On 07/19/26 at 10:00 (10:00 AM): The resident was observed lying on his right side on the floor in the yellow room. He experienced right hip and lower back pain and was transferred to the hospital for evaluation. Review of the post-fall investigation and clinical record did not identify a new or revised individualized fall-prevention intervention. An interview with Certified Nurse Aide (CNA) #3 on 08/19/26 at 10:10 AM revealed she knew Resident #8 was at risk for falls but stated he had not fallen during her shift. She stated he liked to sit up in his wheelchair and watch westerns, so he usually stayed in the dayroom. CNA #3 stated staff rounded on the resident every two hours and kept his bed in the lowest position when he was in bed. She confirmed he was unable to use the call light because of his impaired memory. She stated a camera was in the			F0689			

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F0689 SS = D	Continued from page 31 dayroom so that staff could watch the residents when they were at the desk charting. She confirmed staff were not always present at the desk to visualize the camera and revealed it probably would be best to have him located in an area where staff could visualize him closely. An interview with Registered Nurse (RN) #1 on 08/19/26 at 10:15 AM revealed Resident #8 had a lot of falls. She stated the resident was falling a lot because he had urinary frequency. RN #1 stated his falls had reduced since he had a recent suprapubic catheter inserted, and confirmed he frequently attempted to get up without assistance because of urinary frequency. She confirmed a scheduled toileting program had not been initiated by the facility. An interview with the Director of Nursing (DON) on 08/20/26 at 11:40 AM revealed Resident #8's falls were reviewed in the morning meetings. She explained that most of his falls were due to him wanting to go to the bathroom. She stated staff would take him, but he would not do anything, and after getting back in his wheelchair, he would want to go again. The DON stated his falls were due to his "disease process". She stated they had provided him with activity boards, done one-on-one activities, moved him closer to the nurse's station and therapy referrals. She confirmed she did not have documentation showing the facility had completed a root-cause analysis of the resident's falls or any documentation the falls were reviewed in high-risk meetings. When asked specifically about the 04/15/26 fall, when housekeeping notified nursing that Resident #8 was on the shower-room floor and the record did not indicate that staff were present, the DON stated, "I don't know what happened." She confirmed she did not investigate the incident to try and determine if staff were present or how the resident accessed the locked shower room or came to be on the floor. She stated, "I am doing so many other jobs; I don't have time." She confirmed she did not consistently follow through on the residents' falls. The DON confirmed that the facility had failed to provide adequate supervision to prevent numerous falls with Resident #8. Record review of the "Admission Record" revealed the facility admitted Resident #8 on 11/05/25 with medical diagnoses that included Alzheimer's Disease, History of Falling, Benign Prostatic Hyperplasia with lower urinary tract symptoms, and Displaced Fracture of Base of Neck of Left Femur.			F0689			

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F0689 SS = D	Continued from page 32 Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/01/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 3, which indicated Resident #8 was severely cognitively impaired.	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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to allocate and monitor all sources of fluid to ensure one (1) of three (3) residents reviewed for dialysis remained within the physician-ordered fluid restriction. Resident #4 Findings include: Record review of the facility policy titled "Renal Dialysis Management," revised 8/21, revealed under "Procedure: The facility assures that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice..." Record review of Resident #4's "Order Details" revealed an order dated 8/12/25, "Dialysis in "Proper name of city" every (M/W/F) (Monday, Wednesday, and Friday)" with a chair time of 12:30 PM. Record review of Resident #4's August 2026 Medication Administration Record (MAR) revealed an order dated 4/21/26 for a fluid restriction of 32 ounces (946 milliliters [mL]) every 24 hours. The MAR also revealed an order dated 2/16/26 for "Nepro with lunch and supper three times a day," scheduled at 8:00 AM, 12:00 PM, and 5:00 PM. The three scheduled 240-mL Nepro supplements totaled 720 mL (approximately 24 ounces), leaving approximately 226 mL (8 ounces) for all other fluids during the 24-hour period. An observation of Resident #4's breakfast meal on	F0698					

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F0698 SS = D	Continued from page 33 8/18/26 at 8:38 AM revealed staff offered the resident 240 mL of Nepro, 240 mL of milk, 240 mL of coffee, and 120 mL of apple juice, for a total of 840 mL (approximately 28 ounces). The resident was also scheduled to receive two additional 240-mL Nepro supplements later that day, in addition to fluids offered with lunch and dinner. An observation of Resident #4's breakfast meal on 8/20/26 at 8:10 AM revealed staff offered the resident 240 mL of Nepro, 240 mL of milk, 120 mL of cranberry juice, and 120 mL of orange juice, for a total of 720 mL (approximately 24 ounces). The resident was also scheduled to receive two additional 240-mL Nepro supplements later that day, in addition to fluids offered with lunch and dinner. During an observation and interview on 8/20/26 at 8:21 AM, Registered Nurse (RN) #1 confirmed Resident #4 was receiving a large amount of fluid with breakfast and was on a 32-ounce fluid restriction. RN #1 stated, "We need to get his fluid restriction clarified." RN #1 confirmed the fluids offered with meals and the Nepro ordered three times daily could easily exceed the resident's fluid restriction and cause fluid accumulation. A telephone interview with the Registered Dietitian (RD) on 8/20/26 at 8:42 AM revealed she spoke with the dialysis RD monthly and reviewed Resident #4's dialysis laboratory results. The RD stated the resident's albumin was low, so she increased the Nepro from twice daily to three times daily. When asked about the three daily Nepro supplements leaving approximately eight (8) ounces for all other fluids during the 24-hour period, the RD stated, "I see what you're saying." The RD confirmed she had not completed a fluid allocation for dietary and nursing staff. She further confirmed the fluid restriction should be strictly monitored to prevent excess fluid intake and related complications. Record review of Resident #4's meal ticket revealed "CCHO Renal, (Consistent carbohydrate diabetic diet with renal restrictions) FR, (Fluid restriction) Reg (Regular texture), DBL PT (Double protein portions)," with Nepro listed under preferences. The meal ticket did not identify the amount of fluid dietary staff could provide with each meal or account for the 720 mL of Nepro scheduled each day. Record review of Resident #4's August 2026 MAR revealed an order dated 7/11/25 to "Record intake and output every shift." The documentation did not contain a complete, combined 24-hour total of fluids received from meals, Nepro supplements, medication			F0698			

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F0698 SS = D	Continued from page 34 administration, and other sources to show that the resident remained within the ordered 32-ounce daily fluid restriction. An interview with Certified Nurse Aide (CNA) #3 on 8/20/26 at 9:10 AM revealed Resident #4 usually received 240 mL of milk, 120 mL of juice, and 240 mL of coffee with breakfast, and 240 mL of tea with lunch and dinner. An interview with the Director of Nursing (DON) on 8/21/26 at 10:48 AM confirmed Resident #4's fluid intake was not tracked to include fluids received with meals, medications, supplements, and other sources. She stated the failure to track all fluid sources could result in excess fluid accumulation. Record review of Resident #4's "Admission Record" revealed the facility readmitted Resident #4 on 5/22/26 with diagnoses that included Type 1 Diabetes Mellitus with Diabetic Chronic Kidney Disease and Dependence on Renal Dialysis. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/8/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 12 under Section C, indicating Resident #4 was moderately cognitively impaired.	F0698			
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve	F0812			

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F0812 SS = D	Continued from page 35 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure dietary staff were trained and knowledgeable regarding the operation of the high-temperature dish machine, including monitoring the required wash and final-rinse temperatures to ensure proper sanitization of dishware. This deficient practice was identified during one (1) of three (3) kitchen observations. Findings Include: Review of the facility policy Sanitation and Infection Control – Machine Warewashing dated 11/2019 revealed, "Standard: All dishes and utensils will be washed and sanitized after each use..." Review of the dish washer Installation and Operation Manual issued 7/10/2006 revealed "Section 1: Specification Information...Temperatures Wash—Fahrenheit (F) (Minimum) 150, Rinse F (minimum) 180..." During an observation of the kitchen on 8/19/26 at 8:15 AM, Dietary Cook #2 sprayed soiled dishes in the sink while the high-temperature dish machine operated with dishes inside. When asked the minimum temperatures required to ensure the dish machine properly sanitized the dishes, Dietary Cook #2 stated, "I don't know." She was unable to locate the dish machine's temperature gauge and stated she had never been trained to operate the machine. Dietary Cook #2 requested assistance from Dietary Staff #3. Dietary Staff #3 obtained the temperature log from the wall and stated the wash temperature must reach 150 degrees Fahrenheit (F), and the final-rinse temperature must reach 180 degrees F. Dietary Cook #2 confirmed she did not know the required temperatures or that the temperatures had to be monitored. During an additional interview, Dietary Cook #4 also stated she also did not know the required dish machine temperatures. An interview with the Dietary Manager (DM) on 8/19/26 at 11:06 AM revealed Dietary Cook #2 did not usually operate the dish machine but confirmed that she had been trained to operate the dish machine. The DM confirmed that they did not have a policy related to checking temperatures, but the staff	F0812					

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F0812 SS = D	Continued from page 36 had competency check offs that were completed. The DM confirmed all kitchen staff should know the minimum dish machine temperatures to ensure proper sanitization. Record review of the "Employee Competency Standard" for Dietary Cook #2 revealed she was checked off as competent in flatware washing and sanitization, mechanical dishwashing, and manual dishwashing on 7/21/26. An interview with the Administrator on 8/20/26 at 9:48 AM revealed he expected all dietary staff to know how to operate the kitchen equipment and understand the equipment requirements. He stated the Dietary Manager was responsible for ensuring dietary staff have this knowledge.	F0812					
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F0880					

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F0880 SS = D	Continued from page 37 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement infection prevention and control practices for one (1) of four (4) care areas observed, specifically related to maintaining the urinary drainage system off the floor and following Enhanced Barrier Precautions during catheter care for Resident #7. Findings include:	F0880					

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F0880 SS = D	Continued from page 38 Record review of the facility policy titled "Incontinence Management - Indwelling Catheters" revised 01/2020, revealed, "...Indwelling Catheter Care...To promote hygiene, comfort, and reduce migration of infectious organisms to the bladder...Procedure...2. The urinary drainage bag will be maintained off the floor at all times...4. The drainage bag will not be placed directly on the floor, including during resident care, transfers, repositioning, transportation, toileting, bathing, or environmental services...At no time should a urinary drainage bag be intentionally placed or allowed to remain on the floor..." Record review of the facility policy titled "Enhanced Barrier Precautions" dated 05/2024, revealed, "...Enhanced barrier precautions (EBP) should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk...Resident Status...Has a wound or indwelling medical device, without secretions or excretions that are able to be covered or contained...Use EBP...Yes..." Record review of Resident #7's Order Summary Report revealed an active order dated 05/29/2026 for Foley Catheter 14 French 10 cubic centimeters (cc) bulb Diagnosis: Neuromuscular Dysfunction of Bladder, unspecified. During the initial tour on 08/17/2026 at 10:45 AM, Resident #7's urinary catheter drainage bag was observed lying on the floor. During an interview on 08/17/2026 at 10:56 AM, Certified Nursing Assistant (CNA) #2 confirmed that Resident #7's catheter drainage bag was lying on the floor. CNA #2 stated the drainage bag should not touch the floor because of infection-control concerns. During an interview on 08/18/2026 at 8:51 AM, the Director of Nursing (DON) confirmed that Resident #7's catheter drainage bag should not have been on the floor because the practice increased the risk for infection. On 08/19/2026 at 9:58 AM, CNA #1 was observed providing catheter care to Resident #7 without wearing a gown as required under Enhanced Barrier Precautions and as noted by EBP signage posted on the door entering the room. During catheter care, CNA #1 touched the resident's bed remote with the same gloves used to provide catheter care without removing the gloves and performing hand hygiene.			F0880			

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F0880 SS = D	Continued from page 39 CNA #1 confirmed that she should have worn a gown and should not have touched environmental surfaces with the gloves that were used during catheter care. During an interview on 08/19/2026 at 10:21 AM, the DON confirmed that CNA #1 should have worn a gown and gloves under Enhanced Barrier Precautions during catheter care. The DON further confirmed that CNA #1 should have removed the soiled gloves and performed hand hygiene before touching other items in the resident's room. Record review of the "Admission Record" revealed the facility admitted Resident #7 on 7/1/26 with a medical diagnosis that included Relapsing-Remitting Multiple Sclerosis and Neuromuscular Dysfunction of Bladder. Record review of Resident #7's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/10/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, indicating Resident #7 had moderate cognitive impairment.	F0880					
F0908 SS = D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to ensure the three-compartment sink was operational and available to sanitize dishes that could not be accommodated in the dishwasher for one (1) of three (3) kitchen tours. Findings Include: Review of the facility policy titled "Work Order Standard" revealed under, "Standard: It shall be the standard of this facility to process work orders timely in order to provide a safe and functional environment...Procedure: 1. When there is something identified as in need of repair, a concern noted with a piece of equipment or a malfunction in a piece of equipment, the person identifying the concern must report it to their supervisor. 2. The supervisor will then enter the work order into the work order log..."	F0908					

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F0908 SS = D	Continued from page 40 Review of the facility policy titled "Manual Warewashing," revised 11/19, revealed under, "Standard: Dining service pots and pans that cannot fit in a dish machine are clean and sanitized in a three-compartment sink..." During an observation of an attempted demonstration of the three-compartment sink with Dietary Staff #3 on 8/19/26 at 8:32 AM, she revealed the sink did not work and had been out of service for almost a year. She stated the wash and rinse compartments would not hold water. When the water was turned on, it immediately drained through the floor drain. Dietary Staff #3 revealed maintenance was aware of the problem and had been notified but had not repaired the sink. An interview with the Administrator on 8/19/26 at 8:48 AM revealed he had not been notified that the three-compartment sink was not working. An interview with the Dietary Manager (DM) on 8/19/26 at 11:06 AM confirmed the three-compartment sink was not operational and stated, "It hasn't been out that long." She stated she had told maintenance every day since the sink stopped working but could not recall whether she entered a work order. The DM stated she had also notified the Administrator. When asked what kitchen staff would do to sanitize dishes if the dishwasher malfunctioned or if something was too large to place in the dish machine, she stated, "I don't know." An interview with Maintenance on 8/19/26 at 11:16 AM revealed this was the first time he had heard that the three-compartment sink was not working. He confirmed he had not been notified and confirmed that the facility used TELS (electronic work order system) for repairs and confirmed he had not received any repair requests for the kitchen. Record review of the June through August 2026 "Work Orders" revealed no evidence that a work order was submitted for the three-compartment sink. An interview with the Administrator on 8/20/26 at 9:48 AM confirmed it was the Dietary Manager's responsibility to ensure malfunctioning kitchen equipment was reported to maintenance for timely repair. He confirmed the three-compartment sink was essential for properly sanitizing larger dishes that could not fit in the dishwasher.			F0908			