

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255266		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/27/2026	
NAME OF PROVIDER OR SUPPLIER BRANDON COURT				STREET ADDRESS, CITY, STATE, ZIP CODE 100 BURNHAM ROAD , BRANDON, Mississippi, 39042			
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F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 08/24/2026 through 08/27/2026. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F677, F688, F690 and F761. The facility had a census of 73 and was licensed for 100 beds.			F0000			
F0656 SS = E	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			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 = E	Continued from page 1 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, 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, interviews, record reviews and facility policy review the facility failed to develop comprehensive care plans related to baths, oral care, nail care and Foley catheter care for four (4) of (16) comprehensive care plans reviewed. Resident #30, #40, #53 and #73. Findings include: Record review of the facility's "Care Plan Process," revised 03/26, revealed the care plan was driven by identified resident issues and conditions, as well as each resident's unique characteristics, strengths, and needs. The policy directed the facility to develop and implement an interdisciplinary care plan based on assessment information gathered throughout the Resident Assessment Instrument process, with necessary monitoring and follow-up. Resident #30 On 08/24/2026 at 12:51 PM, during an interview, Resident #30 stated he received a whirlpool bath once a week. He stated his last bath occurred one week earlier and that missed baths happened frequently. On 08/25/2026 at 3:20 PM, during an interview and record review, the Director of Nursing (DON) stated Resident #30 should receive a whirlpool bath on each scheduled bath day. The DON reviewed Resident #30's bath documentation and confirmed the resident received only three of 11 scheduled			F0656			

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F0656 SS = E	Continued from page 2 whirlpool baths during the previous 30 days. The Director of Nursing stated Resident #30's scheduled bath days were Tuesday, Thursday, and Saturday. On 08/25/2026 at 3:30 PM, during an interview, Resident #30 stated he received a whirlpool bath that day. He stated he would not receive another whirlpool bath until the following week, although his scheduled bath days were Tuesday, Thursday, and Saturday. Record review of Resident #30's "Face Sheet" revealed the facility admitted the resident on 07/12/2017 with diagnoses that included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting an unspecified side and morbid obesity due to excess calories. Record review of Resident #30's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/01/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section GG revealed Resident #30 required partial or moderate assistance with showering or bathing. Record review of Resident #30's "Care Plan Report" revealed no goals or interventions addressing the resident's need for assistance with bathing, preference for whirlpool baths, or scheduled bath days. Resident #40 On 08/24/2026 at 11:53 AM, during an interview, Resident #40 stated she received bed baths weekly. She stated she wanted a complete bed bath rather than perineal care only and had not received a complete bed bath in several weeks. On 08/25/2026 at 2:03 PM, during an interview, Resident #40 stated she received a complete bed bath that day. She stated she was pleased but wanted to receive a complete bed bath on each scheduled bath day. On 08/26/2026 at 3:30 PM, during an interview, the DON stated Resident #40 should receive a complete bath on each scheduled bath day. The DON stated failure to provide a complete bath could affect the resident's skin, contribute to skin breakdown, and be mentally draining for the resident. The DON stated it was important for residents to receive complete baths on their assigned bath days. Record review of Resident #40's "Face Sheet"			F0656			

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F0656 SS = E	Continued from page 3 revealed the facility admitted the resident on 03/12/2025 with diagnoses that included unspecified osteoarthritis and urinary tract infection, site not specified. Record review of Resident #40's MDS with an ARD of 08/03/2026, revealed a BIMS score of 13, which indicated the resident was cognitively intact. Record review of Resident #40's "Care Plan Report" revealed no goals or interventions addressing the resident's need for complete bed baths, bathing preference, or scheduled bath days. Resident #53 On 08/24/2026 at 3:42 PM, during an observation and interview, Resident #53 was seated near the nurses' station. The resident's teeth had plaque buildup, yellowish-brown staining, and brown plaque between the teeth. The resident's fingernails were jagged and had a brown substance underneath them. Resident #53 was oriented to person only. On 08/25/2026 at 10:28 AM, during a telephone interview, Resident #53's Resident Representative (RR) stated her concerns involved the resident's teeth and nail care. The RR stated she visited the resident regularly and observed that his teeth were stained and had buildup. She stated Resident #53 had previously taken pride in his appearance and hygiene. On 08/25/2026 at 10:57 AM, an observation of Resident #53 revealed his fingernails remained jagged and dirty. His teeth continued to have plaque buildup, yellowish-brown staining, and brown plaque between the teeth. On 08/26/2026 at 1:47 PM, during an observation and interview, Certified Nursing Assistant (CNA)#1 confirmed Resident #53's fingernails were jagged and dirty and required cleaning and trimming. CNA #1 stated she began brushing the resident's teeth that morning. On 08/26/2026 at 3:40 PM, during an interview, the DON stated that CNAs were expected to provide oral care three times daily and nurses were responsible for ensuring the care was completed. The DON stated oral care should be provided after each meal and as needed. She stated nail care should be provided weekly and could be completed by CNAs or nurses. The DON stated Resident #53 sometimes refused care and staff should document each refusal.			F0656			

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F0656 SS = E	Continued from page 4 Record review of Resident #53's "Face Sheet" revealed the facility admitted the resident on 10/22/2021 with diagnoses that included need for assistance with personal care, cerebral infarction due to thrombosis of the left middle cerebral artery, and personal history of transient ischemic attack and cerebral infarction without residual deficits. Record review of Resident #53's MDS with an ARD of 07/08/2026, revealed a BIMS score of six, which indicated the resident was severely cognitively impaired. Record review of Resident #53's "Personal Hygiene Task" from 7/27/26 through 8/25/26 revealed oral care was documented on (14) of 30 days, and nail care was documented on (19) of 30 days. Record review of Resident #53's "Care Plan Report" revealed no goals or interventions addressing oral hygiene, nail care, the frequency of care, the resident's history of taking pride in his personal appearance, or approaches for addressing and documenting refusals of care. Resident #73 On 08/24/2026 at 2:21 PM, an observation revealed Resident #73's Foley catheter was draining yellow urine. Resident #73 declined an interview with the State Agency. On 08/26/2026 at 2:42 PM, during an interview, the DON stated CNAs provided Foley care. She stated Resident #73 changed his own catheter because he was independent and had performed the task at home before entering the facility. She stated staff assisted the resident with catheter care. She stated Resident #73 wore gloves while performing catheter care but did not wear a gown. The DON confirmed the resident's Foley catheter care and participation in self-care should be addressed in the comprehensive care plan. Record review of Resident #73's "Face Sheet" revealed the facility admitted the resident on 08/27/2020 with diagnoses that included paraplegia, unspecified benign prostatic hyperplasia with lower urinary tract symptoms, and neuromuscular dysfunction of the bladder. Record review of Resident #73's "Order Summary Report" revealed an order to change the Foley catheter using a 16 French catheter with a 10 cubic centimeter balloon and to change the drainage bag	F0656		

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F0656 SS = E	Continued from page 5 as needed for leakage or dislodgement. The order directed staff to use only a silicone catheter. Record review of Resident #73's "Care Plan Report" revealed no goals or interventions addressing Foley catheter care, Foley site care, infection prevention measures, staff assistance, monitoring, or the resident's participation in changing his catheter and drainage bag. On 08/26/2026 at 3:40 PM, during an interview and record review, the DON reviewed the comprehensive care plans for Residents #30, #40, #53, and #73 and confirmed the identified care needs were not included. She stated all activities of daily living care should be included in the care plan so certified nursing assistants would know how to provide each resident's care. She stated the Kardex was developed from the care plan and used by certified nursing assistants to provide care. She stated the care plan should be accurate, individualized, and include information such as the type of bath and the resident's bath schedule. She stated care plans should be reviewed and updated at least quarterly.		F0656				
F0677 SS = E	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, interviews, record reviews and facility policy review the facility failed to provide and consistently complete baths, whirlpool baths, nail care and oral care for three (3) of (18) residents reviewed for Activities of Daily Living care. Resident #30, #40 and #53. Findings Include: Record review of the facility's policy, "Activities of Daily Living," revised 09/25, revealed"...ADLs shall include, but are not limited to personal hygiene, bathing, voiding, toileting, repositioning and offering meals..." Resident #30 During an interview on 08/24/2026 at 12:51 PM, Resident #30 stated he received a whirlpool bath once a week. He stated his last bath was one week		F0677				

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F0677 SS = E	Continued from page 6 earlier. During an interview, on 08/25/2026 at 3:30 PM, during an interview, Resident #30 stated he received a whirlpool bath that day. He stated he would not receive another bath until the following week because he only received one bath each week. During an interview on 08/25/2026 at 3:20 PM, the Director of Nursing (DON) stated Resident #30 should receive a whirlpool bath on each of his scheduled bath days. The DON reviewed Resident #30's bath documentation and confirmed he received only three of the 11 whirlpool baths scheduled during the 30-day review period. The DON confirmed Resident #30's scheduled bath days were Tuesday, Thursday, and Saturday. Record review of Resident #30's "Face Sheet" revealed the facility admitted him on 07/12/2017 with diagnoses that included hemiplegia and hemiparesis following unspecified cerebrovascular disease and morbid obesity due to excess calories. Record review of Resident #30's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/01/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact. Section GG revealed Resident #30 required partial or moderate assistance with showering or bathing. Record review of Resident #30's "Personal Hygiene" bath documentation from 7/28/26 through 8/25/26 revealed he received three (3) of the (11) whirlpool baths scheduled for Tuesdays, Thursdays, and Saturdays. Resident #40 During an interview on 08/24/2026 at 11:53 AM, Resident #40 stated she received bed baths weekly. She stated she wanted a complete bed bath instead of perineal care only and had not received a complete bath in several weeks. During an interview on 08/25/2026 at 2:03 PM, Resident #40 stated she received a complete bed bath that day. She stated she was pleased but wanted to receive a complete bed bath on each of her scheduled bath days. During an interview on 08/26/2026 at 3:30 PM, the DON stated Resident #40 should receive a complete bath on each scheduled bath day. The DON stated failure to provide complete baths could negatively			F0677			

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F0677 SS = E	Continued from page 7 affect the resident's skin, contribute to skin breakdown, and cause emotional distress. The DON stated it was important for residents to receive complete baths on their assigned bath days. Record review of Resident #40's "Face Sheet" revealed the facility admitted her on 03/12/2025 with diagnoses that included unspecified osteoarthritis and urinary tract infection. Record review of Resident #40's MDS, with an ARD of 08/03/2026, revealed a BIMS score of 13, indicating she was cognitively intact. Record review of Resident #40's "Personal Hygiene" bath task documentation from 7/28/26 through 8/25/26 revealed she received five (5) complete baths during the 30-day review period. The remaining documented care consisted of partial baths. During an interview on 08/26/2026 at 1:47 PM, Certified Nursing Assistant (CNA) #1 stated Residents #30, #40, and #53 had scheduled bath days on Tuesday, Thursday, and Saturday. CNA #1 stated she did not know whether Residents #30 and #40 received their scheduled baths. Resident #53 During an observation and interview on 08/24/2026 at 3:42 PM, Resident #53 was seated near the nurses' station. Observation revealed plaque buildup and brownish staining between his teeth. His fingernails were jagged and had a brown substance underneath them. Resident #53 was oriented to person only. During a telephone interview on 08/25/2026 at 10:28 AM, Resident #53's Resident Representative (RR) stated her concerns involved the resident's oral and nail care. She stated she visited him regularly and observed that his teeth were stained and had buildup. She stated Resident #53 had always taken pride in his appearance and personal hygiene. During an observation on 08/25/2026 at 10:57 AM, revealed Resident #53's fingernails remained jagged and dirty. His teeth continued to have yellowish and brown staining with visible plaque buildup between them. During and observation and interview on 08/26/2026 at 1:47 PM, CNA #1 initially stated the Activities Department provided nail care. CNA #1 then stated CNAs could provide nail care to residents who did			F0677			

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F0677 SS = E	Continued from page 8 not have diabetes. CNA #1 confirmed Resident #53's fingernails were jagged and dirty and required cutting and cleaning. CNA #1 stated she began brushing Resident #53's teeth that morning. Observation revealed his fingernails remained jagged and dirty, and his teeth continued to have visible plaque and staining. During an interview on 08/26/2026 at 3:40 PM, the DON stated the facility did not have a dentist who provided services in the facility. The DON stated the facility was working to arrange dental services. The DON stated residents were referred to an outside dentist for concerns such as tooth pain or broken teeth, but residents were not referred for routine dental cleanings. The DON stated CNAs were responsible for providing oral care three times a day and nurses were responsible for ensuring the care was completed. The DON stated she was also responsible for following up. The DON stated oral care should be provided after each meal and as needed. She stated nail care should be provided once a week and could be performed by a CNA or nurse. The DON stated Resident #53 sometimes refused care and staff should document each refusal. Record review of Resident #53's "Face Sheet" revealed the facility admitted him on 10/22/2021 with diagnoses that included need for assistance with personal care, cerebral infarction due to thrombosis of the left middle cerebral artery, and a history of transient ischemic attack and cerebral infarction. Record review of Resident #53's MDS, with an ARD of 07/08/2026, revealed a BIMS score of 6, indicating severe cognitive impairment. Record review of Resident #53's "Personal Hygiene" task documentation from 7/27/26 through 8/25/26 revealed oral care was documented as completed on 14 days. Nail care was documented as completed on 19 days. The record did not include documented refusals or evidence that staff followed up when the care was not completed.	F0677			
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition	F0688			

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F0688 SS = D	Continued from page 9 demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review the facility failed to assess a resident with a significant bilateral hand contracture and provide appropriate treatment, services, equipment, or positioning interventions to maintain or prevent further decline in range of motion for one (1) of (18) sampled Residents. Resident #62. Findings include: A record review of the facility policy, "Therapy Screenings," revised 10/19, reveals, "Purpose: To identify patients in need of therapy evaluation...Residents are screened according to the following priorities: Newly admitted patients...The Therapy Department should coordinate the therapy screening procedure to ensure completion within 48 hours..." On 8/24/26 at 12:13 p.m., during an interview, Resident #62 stated he had been admitted to the facility approximately 30 days earlier after being diagnosed with Parkinson's disease. He reported that staff had not provided range-of-motion exercises since his admission. During the interview the State Agency (SA) observed Resident #62 had significant contractures of both hands. On 8/26/26 at 1:34 PM, during an interview, the Therapy Director stated it was the facility's standard practice to screen every newly admitted resident within the first week of admission. She explained that members of the therapy staff shared responsibility for completing the screenings and that no specific staff member was assigned to ensure	F0688					

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F0688 SS = D	Continued from page 10 completion. The Therapy Director acknowledged that staff had not completed an initial therapy screening for Resident #62 and could not explain why it had not been completed. She stated the screening would have guided staff in caring for the resident's contracted hands. She explained that the initial screening would have identified possible comfort and positioning measures, including therapy carrots or similar hand-positioning devices. She confirmed that staff had not implemented any interventions or received guidance for managing Resident #62's hand contractures. On 8/26/26 at 2:00 PM, during an interview the Occupational Therapist stated an initial screening would have included an assessment of Resident #62's functional hand use and the condition of his contracted palms. She stated the assessment would determine whether equipment such as palm protectors was needed to keep the resident's palms dry, protect the skin from nail-related injury, and reduce the risk of maceration. She confirmed that such initial screenings are done when the facility admit new Residents. On 8/26/26 at 2:32 PM, during an interview, the Director of Nursing (DON) stated therapy screenings and recommendations help residents maintain or improve their quality of life. She acknowledged that part of the Therapy Departments role, is to complete an initial screening for every newly admitted resident. On 8/27/26 at 11:27 AM, in an interview with the Administrator, she acknowledged that the therapy team is expected to screen new admits within the first week of admission. She indicated this is done to help keep with the resident current quality of life or see what can be done to improve it as it is their policy to do so. A review of the "Face Sheet" revealed the facility admitted Resident #62 on 7/27/26 with diagnoses that included Parkinson's disease with dyskinesia, without mention of fluctuations, and unspecified nutritional deficiency. A review of the Minimum Data Set assessment (MDS) with an Assessment Reference Date (ARD) of 8/3/26 revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of (15), indicating intact	F0688					

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F0688 SS = D	Continued from page 11 cognition.	F0688					
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record reviews and facility policy review the facility failed to do an assessment on Resident #73 for self-Foley care failed to obtain a physician order for self-care and failed to document that the resident was doing self-care of a foley for one (1) of two (2) residents with catheters. Resident #73. Findings Include:	F0690					

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F0690 SS = D	Continued from page 12 Record review of the facility's "Urinary Catheter "with a revision date of 01/24 revealed, "Procedure 1. Obtain a physician order... 12. Perform hand hygiene...15. Put on sterile gloves..." On 08/25/2026 at 1:19 PM, during an interview and observation, Resident #73 declined to allow the State Agency to observe his urinary catheter care. The urinary catheter was draining yellow urine. On 08/26/2026 at 2:42 PM, during an interview, the Director of Nursing (DON) stated Resident #73 changed his urinary catheter himself with staff assistance. She stated the resident had performed his own catheter changes at home and was independent with the procedure. She stated the resident wore clean gloves when inserting the catheter. The DON acknowledged the facility had not assessed the resident's ability to perform catheter insertion safely, did not have a physician's order authorizing the resident to perform the procedure, and did not document the resident's performance of the procedure in the medical record. She stated the Treatment Nurse observed the resident change the urinary catheter monthly. She confirmed the facility should complete an assessment of the resident's ability to perform the procedure. On 08/27/2026 at 10:58 AM, during an interview, Registered Nurse (RN) #2, who served as the Treatment Nurse, stated she brought the catheter insertion kit to Resident #73's room and set up the supplies on a table. She stated Resident #73 applied clean gloves, cleaned his penis with iodine, and inserted the urinary catheter. RN #2 stated she wore sterile gloves and inflated the catheter balloon after the resident inserted the catheter. She stated she believed the resident used hand sanitizer before applying the clean gloves but did not verify that he performed hand hygiene. She acknowledged that she did not document the resident's catheter insertion or her supervision of the procedure in the progress notes. RN #2 confirmed urinary catheter insertion required sterile technique. She acknowledged that Resident #73 inserted the catheter while wearing clean gloves instead of sterile gloves, which placed him at risk for infection. She stated the resident had performed his own catheter insertions in this manner since she began working at the facility in 2020. On 08/27/2026 at 12:13 PM, during a follow-up interview, the DON confirmed Resident #73 was at risk for infection when he inserted the urinary catheter using clean gloves instead of sterile gloves. She stated the resident should have used sterile gloves. She also confirmed the facility did not have			F0690			

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F0690 SS = D	Continued from page 13 a physician's order authorizing the resident to perform his own catheter insertion and should have obtained one. Record review of Resident #73's "Face Sheet" revealed an admission date of 08/27/2020 and diagnoses that included paraplegia, benign prostatic hyperplasia with lower urinary tract symptoms, and neuromuscular dysfunction of the bladder. Record review of Resident #73's "Order Summary Report" revealed an order dated 11/19/24 to change the Foley catheter using a 16 French catheter with a 10 cc (cubic centimeter) balloon and to change the catheter and drainage bag as needed for leakage or dislodgement. The order directed staff to use only a silicone catheter. The physician orders did not include an order authorizing Resident #73 to insert or change his own urinary catheter. Record review of Resident #73's Minimum Data Set assessment, with an Assessment Reference Date of 06/17/2026, revealed a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. Record review of Resident #73's Electronic Treatment Administration Record for June 2026, July 2026 and August 2026 revealed the urinary catheter was documented as changed on 06/15/2026, 07/15/2026, and 08/15/2026. A nurse initialed each entry. Record review of Resident #73's "Progress Notes *NEW*" from June 2026 through August 2026 revealed no documentation that the resident inserted or changed his own urinary catheter, that nursing staff supervised the procedure, or that staff assessed his ability to perform the procedure using sterile technique.	F0690					
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761					

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F0761 SS = D	Continued from page 14 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and facility policy review the facility failed to ensure expired medications were removed from active medication stock for one (1) of two (2) medication carts observed. The 100 Hall medication cart. Findings Include: Record review of the facility policy "Medication Storage", dated 04/06, latest revision 11/17 revealed, "There shall be storage areas provided... including a separate and secure area shall be provided for the storage of medications that are discontinued, expired, or otherwise unusable..." Record review of the facility policy "Destruction of Unused, Expired or Discontinued Medications", dated 01/13, latest revision 10/19, revealed, "All outdated, discontinued and/or recalled drugs... will be given to the Director of Nursing (DON) for proper disposition. These will be removed during monthly inspections or at any other time as such are found, and will be disposed of..." On 08/25/2026 at 11:30 AM, an inspection of the 100 Hall medication cart was conducted with Licensed Practical Nurse (LPN) #1. The inspection revealed the following: One bottle of Cetirizine HCl 10-milligram tablets remained in active medication stock after the manufacturer's expiration date of 07/2026. During an interview on 08/25/2026 at 11:40 AM, LPN # 1 confirmed the opened, undated medications and the expired medication stored on the 100 Hall medication cart. She stated staff should not use undated medications because they could not			F0761			

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F0761 SS = D	Continued from page 15 determine whether the medications had expired. She stated expired medications could be less effective and could cause a resident to become ill. During an interview on 08/25/2026 at 12:08 PM, the DON was informed of the expired medication identified on the 100 Hall medication cart. She stated expired medications could be less effective, could interact with other medications, and could cause residents to become ill. The DON stated she expected staff to discard expired medications. She acknowledged responsibility for ensuring staff followed these medication-storage practices.			F0761			