STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/03/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT HILLS COMMUNITY LIVING CENTER	**1600 RAYMOND RD , JACKSON, Mississippi, 39204**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
M0000	Initial Comments The State Agency (SA) conducted an Annual Recertification survey along with five (5) Compliant Investigations (CI MS #3185590, CI MS #3055871, CI MS #3049319, CI MS #3048639, and CI MS #3176412) at the facility from 8/31/26 through 9/3/26. CI MS #3048639 was investigated for quality of care, dignity and respect and accidents. CI MS #3049319 was investigated for resident safety, CI MS #3055871 was investigated for environment, CI MS #3185590 was investigated for neglect and quality of care. There were no citations related to these CIs. CI MS #3176412 was investigated for falls and M640 was cited. During the annual recertification survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500 and M0610.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical	M0500		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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M0500	Continued from page 1 record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours	M0500		

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M0500	Continued from page 2 of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and	M0500		

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M0500	Continued from page 3 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure residents were free from physical and verbal abuse, intimidation, and fear of retaliation from facility staff for four (4) of (19) sampled Residents. Resident #4, #29, #57 and #82. Findings include: Record review of the facility policy, “Abuse and Neglect Policy and Procedure,” undated, revealed, “Purpose: Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff…Policy: To provide a safe environment for all residents free of abuse…” Record review of the facility investigation received post annual survey dated 9/8/26 revealed additional residents and staff who also witnessed the alleged abuse were identified during the annual survey by the State Agency (SA). Resident #29 During an interview on August 31, 2026, at 11:46 AM, Resident #29 stated she has asthma, is currently on oxygen, and receives breathing treatments every six hours as needed. She reported that on weekends, Registered Nurse (RN) #1 refuses to provide her breathing treatments when requested. Resident #29 stated RN #1 makes statements such as, “I will give you the medication when I feel like it, I do not care about every six hours.” Resident #29 reported it is sometimes eight (8) to ten (10) hours before RN #1 administers the treatment after she asks. She stated she continues to wheeze, experiences chest tightness, and remains congested until RN #1 decides to bring the treatment. Resident #29 stated she is not comfortable with (RN #1) due her becoming irate when asked about medications or questioned. Resident #29 reported she has not informed the Administrator due to fear of retaliation, noting that no administrative staff are present on weekends and she is concerned about how RN#1 will treat her when Administration is not in the	M0500		

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M0500	Continued from page 4 building. In a follow-up interview with Resident #29 on September 2, 2026, at 9:48 AM (Administrator Present), she re-stated that she is not comfortable with RN #1. She informed the Administrator she experiences RN #1 as abrasive, abusive, and intimidating. Resident #29 stated she fears what RN#1 could potentially do to her and worries that RN#1 may one day refuse to give her medication out of spite. A record review of the "Admission Record" revealed the facility admitted Resident#29 on 8/5/26 with diagnoses including Chronic Obstructive Pulmonary Disease, Unspecified and Shortness of Breath. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/11/26 revealed a Brief Interview for Mental Status of (14) indicating Resident #29 is cognitively intact. Resident #4 During an interview on September 1, 2026, at 11:36 AM Resident #4 stated (RN #1) passes his medications in the evenings and on weekends. He reported that many interactions with her are difficult because she is rude and yells at him. Resident #4 stated he reported this to the Administrator about a month ago, and she told him she would look into it, but he never received follow-up. He stated RN #1 continues to come into his room, and he feels nothing will be done to address his concerns. A record review of the "Admission Record" revealed the facility admitted Resident #4 on 8/25/23 with diagnoses including Anxiety Disorder, Unspecified A record review of the quarterly MDS with an ARD of 7/7/26 revealed a BIMS score of (15) indicating Resident #4 is cognitively intact. Resident #82 During an interview on September 1, 2026, at 11:41 AM Resident #82 stated that during multiple interactions, RN #1 has rudely told her to “shut up” and she has observed RN #1 saying this to other residents while staff were present. Resident #82 stated the Administrator has also witnessed this behavior, and nothing was done. A record review of the "Admission Record" revealed the facility admitted the Resident#82 on 8/6/26 with diagnoses including Depression Unspecified.	M0500		

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M0500	Continued from page 5 A record review of the admission MDS with an ARD of 8/12/26 revealed a BIMS score of (15) indicating Resident #82 is cognitively intact. Resident #57 Resident #57 stated in an interview on 9/1/26 at 12:19 PM, that she was happy to be moved to the other side of the building to ensure RN #1 would no longer be her medication nurse. She reported RN #1 was rude during many interactions. Resident #57 stated interactions with RN #1 increased her anxiety and made her nervous day-to-day because she did not like the way RN#1 spoke to her. A speaker phone interview was conducted with RN#1 on 9/2/26 at 8:43 AM, with several State Agency members (SA) present. RN #1 acknowledged she was rehired at the facility in April 2026 to work as a medication nurse. She recalled being terminated in April 2024 when the regional staff informed her, she was being let go due to resident reports that she was “hollering” and mean. RN #1 stated she is naturally loud and accepted the termination without rebuttal. When informed of current complaints, RN #1 stated she is “not going to say she does not have her days,” and admitted she sometimes comes to work “in a mood,” acknowledging she can understand why residents would say she is rude. She stated it is not right for her to behave that way, and she should be respectful, calm, and treat residents with dignity. She stated she is “still working on that.” During an interview on 09/02/26 at 10:10 AM, Resident #57 stated that in late March or April 2026, Licensed Practical Nurse (LPN) #1 entered her room to administer pain medication. Resident #57 stated she asked LPN #1 questions about the medication, including when it was due and the prescribed dosage. She stated LPN #1 placed the medication cup and a cup of water on the bedside table. Resident #57 picked up both cups and continued asking questions about the medication. Resident #57 stated LPN #1 told her, “I will take those pills from you if you don’t take them.” Resident #57 stated LPN #1 reached for the medication cup while it was in her hand. She stated she held the medication cup tightly, but LPN #1 pried her hand open and removed the cup. Resident #57 stated LPN #1 then exited the room.Resident #57 stated Certified Nursing Assistant (CNA) #2 was present and witnessed the incident. Resident #57 stated the incident made her feel sad and angry, but she was not afraid of LPN #1. She stated she called the	M0500		

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M0500	Continued from page 6 Nursing Home Administrator (NHA) and left a message requesting that the NHA speak with her on Monday morning regarding the incident. Resident #57 stated the NHA did not return her telephone call. She stated she spoke with the NHA that Monday and reported what had occurred. Resident #57 stated the NHA asked whether she had a witness and told her that she would investigate the incident and follow up with her. Resident #57 stated the NHA never informed her of the results of an investigation. During an interview on 09/02/26 at 10:37 AM, the NHA initially denied knowledge of the incident. The NHA then recanted her statement and acknowledged that she remembered the incident. The NHA stated she spoke with Resident #57 and LPN #1. She stated Resident #57 reported that she was asking questions about her medication, but the NHA could not recall all the information Resident #57 provided. The NHA stated LPN #1 denied prying Resident #57's hand open or taking the medication from her hand. She stated LPN #1 reported that Resident #57 refused to take the medication. The NHA acknowledged that she did not conduct an investigation or report the allegation to the State Agency. She stated, in hindsight, she should have reported the allegation. The NHA stated she spoke with both parties, but the incident did not register with her as possible abuse. She confirmed Resident #57 reported that LPN #1 placed her hands on her. The NHA stated LPN #1 worked long shifts and sometimes came to work irritated or upset, which carried over into the care provided to residents. The NHA stated she had written statements from CNA #2 and LPN #1 but would have to locate them. A record review of the "Admission Record" revealed the facility admitted Resident #57 on 8/16/22 with diagnoses including Anxiety Disorder Unspecified. A record review of the quarterly MDS with an ARD of 7/14/26 revealed a BIMS score of (13) indicating Resident #57 is cognitively intact. On 9/1/26 at 12:49 PM, the Administrator stated she did not learn about the prior complaints until after rehiring RN #1. She stated no concerns had been brought to her recently regarding RN#1, so she assumed everything was fine. The Administrator acknowledged RN #1 was terminated in April 2024 due to the way she spoke to and treated residents. She stated RN #1 was recently rehired because she was not on the "Do Not Rehire" list, so she assumed it was acceptable. During an interview on 9/3/26 at 8:15 AM, the	M0500		

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M0500	Continued from page 7 Administrator stated Resident #4 had complained to her about how RN #1 spoke to him. Regarding Resident #82, the Administrator acknowledged she also had an incident involving RN #1 but believed she had resolved it and did not know concerns were ongoing. The Administrator stated she expects staff to show compassion, patience, courtesy, and to be mindful of their tone. She stated residents have the right to feel safe, to choose how they receive medications, and to report grievances without fear of retaliation. During an interview on 9/3/26 at 4:37 PM, the Director of Nursing (DON) denied any knowledge of RN #1's behavior but acknowledged RN #1 should not speak rudely or harshly to residents because such behavior is threatening, can cause depression, and may make residents uncomfortable communicating their needs. A record review of the facility "Employment Record" for RN#1 revealed she was terminated effective 4/5/24. A record review of the facility "Employment Record" for RN#1 revealed she was rehired on 4/7/26 and had currently been employed at the facility for 4 months. A record review of the "Employee Timecard" revealed RN#1 most recently worked on 8/28/26, 8/29/26 and 8/30/26.	M0500		
M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review,	M0610		

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M0610	Continued from page 8 the facility failed to provide necessary activities of daily living (ADL) care, specifically fingernail and hand hygiene care for two (2) of (19) sampled residents reviewed for nail care and contracture management. Residents #13 and #20. Findings include: Record review of the facility policy “ADL Care of a Resident Policy and Procedure” revealed activities of daily living care would be provided according to each resident’s individualized needs. The policy directed staff to provide care specific to the resident’s needs to achieve the most desirable results. Resident #13 During an observation on 8/31/2026 at 11:51 AM, Resident #13 was observed with both hands contracted and drawn upward. The fingernails on both hands extended approximately ¼ inch beyond the fingertips and had ragged edges. The fingernails were digging into the palms of the resident’s contracted hands. The palms were moist, and an odor was present. During an observation on 9/1/2026 at 12:14 PM, Resident #13’s fingernails remained long and ragged and continued to dig into the palms of the contracted hands. During an interview on 9/1/2026 at 12:25 PM, Licensed Practical Nurse (LPN) #3 initially stated that all nursing staff were responsible for cutting and filing residents’ fingernails. After consulting another nurse, LPN #3 stated that a body-audit schedule was posted at the nurses’ stations and that nurses were responsible for trimming and filing residents’ fingernails according to the schedule. Review of the schedule revealed Resident #13’s fingernails were scheduled to be trimmed and filed on Saturdays during the 7:00 AM shift. During an observation and interview on 9/1/2026 at 3:00 PM, the Director of Nursing (DON) accompanied the State Agency (SA) surveyor to Resident #13’s room. The DON observed Resident #13’s contracted hands and the long fingernails digging into the palm area. The DON stated, “Oh, those are long. I see where they are digging into her palm there.” The DON also confirmed that a slight odor was present in the palm area. The DON stated that nurses were responsible for trimming and filing residents’ fingernails during the scheduled body audits.	M0610		

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M0610	Continued from page 9 Record review of Resident #13's "Admission Record" revealed Resident #13 was admitted to the facility on 1/18/17 with diagnoses that included type 2 diabetes and dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/26 revealed staff assessed the resident and determined the resident had severe cognitive impairment. Section GG indicated the resident was dependent of staff for all ADLs. Resident #20 During an observation on 8/31/2026 at 12:01 PM, Resident #20 was observed with contracted hands and deformed fingers. The fingernails on both hands were long and ragged. No hand rolls were in use. During an observation on 9/1/2026 at 12:03 PM, Resident #20’s hands remained clenched. The fingernails remained long and ragged, and several fingernails were digging into the palms of both hands. During an interview on 9/1/2026 at 2:35 PM, Resident #20’s Resident Representative (RR) stated that the resident had previously been able to hold finger foods and feed herself but could no longer do so. The RR stated that Resident #20 had previously used hand rolls to help manage the contractures and prevent the fingernails from digging into her skin. The RR stated that she had not seen staff use the hand rolls for several months. The RR further stated that she had repeatedly informed staff that Resident #20’s fingernails needed to be trimmed and filed. According to the RR staff stated that they would address the concern but failed to do so. When the RR lifted Resident #20’s hand, the fingernails remained long and jagged, and an odor was present. During an observation and interview on 9/1/2026 at 3:00 PM, the DON observed Resident #20’s contracted hands and the long fingernails digging into the palm areas. The DON stated, “Oh my,” and informed the RR that staff would trim and file the resident’s fingernails. The DON stated that nursing staff were expected to provide care according to each resident’s needs, orders, and care-plan interventions. The DON stated that nurses were expected to follow the body-audit schedule for fingernail trimming and filing. The DON also stated that she had conducted several trainings and in-services regarding the issue. Record review of Resident #20's "Admission	M0610		

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M0610	Continued from page 10 Record" revealed the resident was admitted to the facility on 10/4/23 with diagnoses that included cerebral palsy and bilateral hand contractures and depended on staff for all activities of daily living care. Record review of the MDS with an ARD of 5/26/26 revealed a BIMS score of three (3) indicating the resident had severe cognitive impairment.	M0610		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident with known behaviors was provided adequate supervision during transportation to prevent accidents, as evidenced by Resident #17 falling in the facility transportation van on two (2) occasions after repeatedly releasing the wheelchair safety belt. This deficient practice affected one (1) of (19) sampled residents reviewed for accidents and supervision and resulted in Resident #17 sustaining a head injury requiring emergency medical evaluation. Findings Include: Record review of the facility policy “Accident/Incidents,” undated, revealed the purpose of the policy was to ensure that persons involved in an incident or accident were evaluated, received treatment as indicated, and were monitored for disposition of the incident or accident. Record review of the facility policy "Transportation Vehicle Policy and Procedure,” undated, revealed the purpose was to provide transportation in a safe manner according to state laws and guidelines and that only trained transportation staff would utilize the van/bus lift for transports. Record review of the Center for Medicare and Medicaid Services (CMS) Form 2567 dated 2/23/26 revealed the facility had previously been cited for failing to properly secure a wheelchair security device and prevent an accident involving a resident	M0640		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
M0640	Continued from page 11 who depended on the facility van and staff for transportation to medical appointments. A record review of the hospital "History and Physical" dated 8/24/26 revealed Resident #17 was admitted to the hospital following a fall in the facility van. The record indicated Resident #17 sustained a laceration to the back of the head, right-sided weakness, complained of blindness in the right eye, and experienced a temporary loss of consciousness. On 9/1/26 at 9:00 AM, Resident #17 stated he had experienced two (2) falls while being transported from dialysis in the facility van. Resident #17 stated the Certified Nursing Assistants (CNAs) failed to secure him in his wheelchair to prevent him from falling. On 9/1/26 at 9:15 AM, Resident #17's son stated Resident #17 had experienced (2) falls while being transported from dialysis. He stated Resident #17 had told him that the CNAs were not securing his wheelchair. The son also stated the facility had told the family that Resident #17 continued to release the self-releasing seat belt while in the van. On 9/1/26 at 11:00 AM, Resident #6 (who was on the van when the incident occurred) stated Resident #17 was attempting to release his seat belt during transportation from dialysis on 8/24/26. Resident #6 stated she repeatedly told the transportation CNAs that Resident #17 would not leave his wheelchair alone and that he was always releasing his seat belt. On 9/1/26 at 1:00 PM, during observation of Resident #17 being transported in the facility van, CNA #5 pushed the resident's wheelchair onto the ramp and initially failed to secure the wheelchair to the van. CNA #5 subsequently secured the wheelchair and safety belt. The observation further revealed Resident #17 was able to release the self-releasing seat belt used to secure him in the wheelchair. On 9/1/26 at 1:20 PM, CNA #4 stated Resident #17 repeatedly attempted to release the wheelchair straps and self-releasing seat belt during transportation. CNA #4 stated that following a previous fall, the Administrator instructed the transportation CNAs that one CNA was to always sit in the back of the van with the residents. CNA #4 stated she was driving and CNA #5 was responsible for sitting in the back; however, CNA #5 remained in the passenger seat. CNA #4 stated that if someone had been sitting in the back with the residents, Resident #17 "probably would not have fallen."	M0640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/03/2026**

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M0640	Continued from page 12 On 9/1/26 at 1:30 PM, CNA #5 stated Resident #17 repeatedly attempted to release the safety belt and required repeated redirection. CNA #5 acknowledged she sat in the front passenger seat during transportation and was aware Resident #17 had previously attempted and successfully released the safety belt. On 9/2/26 at 9:00 AM, CNA #3 stated the Administrator had instructed the transportation aides after the previous February incident that someone was to always sit in the back seat with residents. CNA #3 stated CNA #5 was unable to get up in time to prevent Resident #17 from falling from the wheelchair. On 9/2/26 at 10:00 AM, the Administrator confirmed Resident #17 fell backwards in the transportation van on 8/24/26 after attempting to manipulate the wheelchair locking mechanism. The Administrator stated she had previously instructed the transportation CNAs in February that one CNA should sit in the back of the van with residents to prevent further falls. The Administrator acknowledged she did not provide a written in-service regarding the instruction. She stated the CNAs failed to follow her instructions and that following the instruction could have prevented Resident #17 from falling on 6/16/26 and 8/24/26. On 9/3/26 at 3:13 PM, the Director of Nursing (DON) confirmed the Administrator had instructed the transportation CNAs in February that one CNA should ride in the back with residents to prevent further falls. The DON confirmed the transportation CNAs failed to follow the Administrator's instruction and stated that following the instruction could possibly have prevented the resident from falling. A record review of the Employee Corrective Coaching Form dated 8/24/26 revealed CNA #5 was suspended for five (5) days following the safety incident. A record review of the Employee Corrective Coaching Form dated 8/24/26 revealed CNA #4 was reprimanded for not following the appropriate transportation van safety procedure. A record review of the facility "Admission Record" revealed Resident #17 was admitted on 3/16/26 with diagnoses that included Stage 5 kidney disease and Left Below Knee Amputation. A record review of residents'17's Quarterly	M0640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/03/2026**

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M0640	Continued from page 13 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/24/26 revealed a staff assessment was completed with no Brief Interview for Mental Status (BIMS) score documented. Staff assessed Resident #17 for cognitive skills for daily decision making and coded a two (2) which indicated the resident had moderate cognitive impairment and made poor decisions; cues/supervision were required. Section G indicated the resident needed a wheelchair for transportation. Resident #6 A record review of the facility "Admission Record" revealed the resident was admitted on 3/31/26 with diagnoses that included End stage renal disease, and renal dialysis A record review of resident's Quarterly MDS with an ARD of 6/26/26 revealed a BIMS score of 10 which indicated the resident had moderate cognitive impairment.	M0640		