

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255262		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2026	
NAME OF PROVIDER OR SUPPLIER LAURELWOOD COMMUNITY LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1036 WEST DRIVE , LAUREL, Mississippi, 39440			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 8/31/26 through 9/3/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F880, F561, F628, F641, F656, F657, F685, F692, F695, F700, and F836. The facility had a census of 52 and was licensed for 60 beds.			F0000			
F0880 SS = F	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			F0880			

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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F0880 SS = F	Continued from page 1 infections before they can spread to other persons in the facility; (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 observations, interviews, record review, and facility policy review, the facility failed to maintain infection prevention and control practices in accordance with facility policy and established infection prevention and control practices by failing to: 1) follow established infection-control practices for a resident on contact precautions for Resident	F0880					

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F0880 SS = F	Continued from page 2 #55; 2) prevent contamination of clean laundry during transport and delivery; and 3) perform hand hygiene after contact with a potentially contaminated environmental surface and before handling residents' meal trays, napkins, straws, and utensils, during one (1) of four (4) survey days. Findings include: A review of the facility's policy titled "Infection Control Policy and Procedure" revealed "...To 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..." A record review of the "Infection Control/MDRO/Isolation/PPE In-Service" dated 07/31/2026 revealed staff received education related to infection control, multidrug-resistant organisms (MDROs), isolation, and personal protective equipment (PPE). Resident #55 On 09/01/2026 at 12:01 PM, the State Agency (SA) observed Resident #55's lunch meal delivered to the resident's room by Certified Nursing Assistant (CNA #1) on a regular plate with a reusable domed lid. Resident #55 was on contact precautions. The SA asked CNA #1 whether the resident should have been served the meal using disposable Styrofoam dinnerware and plastic utensils. CNA #1 stated she had informed the Dietary Department of the resident's isolation status; however, "they don't listen." On 09/01/2026 at 12:19 PM, an interview with Dietary Manager (DD #2) revealed communication between the Nursing and Dietary Departments was not always effective. DD #2 stated he was unaware of the type of transmission-based precautions Resident #55 required at the time of the interview. DD #2 further stated Dietary staff received monthly in-service education and additional education was provided when issues or concerns were identified. On 09/03/2026 at 11:23 AM, an interview with Registered Nurse (RN #1), Infection Preventionist in Training, revealed information regarding residents on contact precautions was communicated through the facility's electronic medical record, PointClickCare (PCC), visually identified by signage posted on residents' doors, and discussed during daily morning stand-up meetings to ensure staff were	F0880					

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F0880 SS = F	Continued from page 3 aware of residents requiring transmission-based precautions. RN #1 further stated that, according to facility practice, residents on contact precautions were to be served meals on disposable Styrofoam plates with disposable plastic utensils so the items could be discarded after use. On 09/03/2026 at 1:05 PM, an interview with the Director of Nursing (DON) revealed staff had access to residents' physician orders and comprehensive care plans through the electronic health record, as well as the Medication Administration Record (MAR) and Treatment Administration Record (TAR), which identified required precautions. The DON stated resident precautions were also discussed during daily morning meetings. The DON further stated residents on contact precautions were to be served meals using disposable Styrofoam products so the items could be discarded after use. On 09/03/2026 at 2:15 PM, an interview with the Administrator revealed she expected staff to be observant of signage posted on residents' doors regarding required PPE. The Administrator stated residents' infection-control needs were discussed during daily stand-up meetings and communicated to staff through the electronic health record and comprehensive care plans. A record review of Resident #55's "Admission Record" revealed the facility admitted the resident on 08/21/2026 with diagnoses including Enterocolitis due to Clostridium Difficile, not specified as recurrent. A record review of Resident #55's "Order Summary Report" revealed an active physician's order, dated 08/21/2026, for contact precautions related to C-diff (Clostridium difficile). A record review of Resident #55's 5-Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/27/2026, revealed a Brief Interview for Mental Status (BIMS) summary score of 8, which indicated the resident was moderately cognitively impaired. Laundry Delivery: On 09/01/2026 at 1:26 PM, during an observation of clean laundry delivery, the SA observed a laundry staff member allow residents' clean clothing to contact the floor during two (2) deliveries. The staff member repeatedly removed the cloth covering the clean-laundry cart and tucked the cloth into a handrail affixed to the wall, leaving the clean laundry			F0880			

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F0880 SS = F	Continued from page 4 uncovered. The staff member then returned the cloth that had contacted the handrail to the clean laundry. On 09/01/2026 at 2:05 PM, during an interview, the Housekeeping Supervisor (HS) identified herself as the staff member observed delivering the clean laundry. The HS stated she recalled that some clothing was long enough to contact the floor and that she removed the cloth covering the cart and tucked it into the handrail during multiple stops. The HS confirmed the floor was contaminated and that anything contacting the floor would therefore be contaminated. The HS further stated the handrail was touched by people throughout the day and acknowledged that placing the cart cover on the handrail was unsanitary and left the clean laundry uncovered. On 09/03/2026 at 1:19 PM, during an interview, the Administrator stated she expected clean clothing to remain covered during transport and to be put away in a sanitary manner. Dining Room: On 08/31/2026 at 11:27 AM, during an observation of the main dining room, the SA observed Licensed Practical Nurse (LPN) #1 pick up a wet-floor sign from the floor and, without performing hand hygiene, proceed to set up residents' meal trays and handle residents' napkins, straws, and utensils while setting up their place settings. During an interview at that time, LPN #1 confirmed she picked up the wet-floor sign and then proceeded to handle residents' meal trays, napkins, straws, and utensils without performing hand hygiene. LPN #1 stated maintaining sanitary conditions during dining service was important for infection control. On 09/03/2026 at 12:40 PM, during an interview, the Director of Nursing (DON) stated LPN #1 had informed her of the failure to perform hand hygiene in the dining room. The DON confirmed that LPN #1 should have performed hand hygiene after picking up the wet-floor sign and before continuing meal service. The DON stated maintaining sanitary conditions during dining service was important to decrease the risk of infection and that she expected nursing staff to maintain proper hand hygiene.	F0880					
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination.	F0561					

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F0561 SS = D	Continued from page 5 The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to honor a resident's right to make choices about significant aspects of her life by failing to honor documented meal preferences and serving foods identified as dislikes for one (1) of (16) sampled residents reviewed for resident choices. Resident #2. Findings include: A record review of the facility's policy titled "Residents Rights and Quality of Life Policy and Procedure," with no date, revealed "... All residents have the right to a dignified existence, self-determination, and communication with and access to people and services inside and outside the facility ..." On 08/31/2026 at 12:47 PM, during an observation and interview, Resident #2 stated her biggest complaint was about the food. Resident #2 stated the food was not the best and that an alternate meal was available. Resident #2 stated she had been			F0561			

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F0561 SS = D	Continued from page 6 served foods she disliked on multiple occasions. On 09/01/2026 at 11:33 AM, during an interview, Licensed Practical Nurse (LPN) #1 stated Resident #2 had complained several times to her and other staff about the food and stated the food did not taste good. LPN #1 stated the resident was offered alternate meal choices. LPN #1 stated she would check with the resident to determine whether she wanted the alternate meal and inform her of the available alternative. LPN #1 stated she had not had the opportunity to ask Resident #2 about the alternate meal that day. On 09/01/2026 at 11:50 AM, the State Agency (SA) observed Resident #2 in bed with her lunch tray on the bedside table. The meal tray contained a bowl of red beans and rice, fried okra, cornbread, cake, and a bowl of chicken and dumplings. Resident #2 stated she did not like red beans and rice or okra and had repeatedly informed staff of these dislikes. Resident #2 stated she had asked staff to obtain the alternate meal and had eaten approximately half of the chicken and dumplings. Resident #2 stated staff continued to place foods on her tray that were identified as dislikes. On 09/01/2026 at 2:10 PM, during an interview, Dietary Department (DD) Staff #2 stated Resident #2 had previously complained that her food preferences were not being honored and that her likes and dislikes had been updated frequently in response to her complaints. DD #2 stated he was unaware Resident #2 had been served red beans and rice with fried okra that day. DD #2 stated alternate and always-available menu items were available and staff communicated residents' choices to the kitchen. On 09/02/2026 at 9:40 AM, during an interview, Certified Nurse Aide (CNA) #2 stated Resident #2 ate well on some days and poorly on others. CNA #2 stated that when Resident #2 ate in the dining room, the resident would request an alternate meal. CNA #2 stated Resident #2 had complained about the food and about receiving foods from the kitchen that she did not like. On 09/02/2026 at 11:40 AM, during an observation in the dining room, the SA observed Resident #2's lunch tray contained rice and gravy. Resident #2 stated rice and gravy were listed as her dislikes, but she continued to receive them on her meal trays. Resident #2 stated she did not like the facility's gravy and had informed staff of the preference. CNA #2 confirmed Resident #2's meal ticket identified gravy and rice as dislikes.			F0561			

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F0561 SS = D	Continued from page 7 On 09/03/2026 at 2:10 PM, during an interview, DD #2 stated he expected kitchen staff to honor residents' documented likes and dislikes when preparing meal trays. On 09/03/2026 at 3:45 PM, during an interview, the Administrator stated she expected staff to honor residents' rights at all times. A record review of Resident #2's meal ticket dated 09/01/2026 revealed the menu included red beans and rice with sausage and fried okra. The meal ticket identified "No Red Beans and Rice" and listed fried okra and okra as resident dislikes. A record review of Resident #2's meal ticket dated 09/02/2026 revealed the menu included savory roasted chicken over rice. The meal ticket identified gravy and rice as resident dislikes. A record review of Resident #2's "Admission Record" revealed the facility admitted the resident on 02/25/2026 with diagnoses including Collapsed Vertebra, Not Elsewhere Classified, Lumbar Region, Subsequent Encounter for Fracture with Routine Healing. A record review of Resident #2's "Order Summary Report" revealed an active physician's order dated 02/26/2026, for CCHO (Controlled Carbohydrate) diet, Regular texture, Regular consistency. A record review of Resident #2's "Quarterly Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 07/29/2026, revealed a Brief Interview for Mental Status (BIMS) Summary Score of 15, which indicated the resident was cognitively intact. Section K revealed the resident was on a therapeutic diet.	F0561			
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. 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	F0628			

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F0628 SS = D	Continued from page 8 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 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;	F0628					

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F0628 SS = D	Continued from page 9 (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 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	F0628					

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F0628 SS = D	Continued from page 10 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 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.	F0628					

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F0628 SS = D	Continued from page 11 §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 and interview, the facility failed to use language understandable to the resident and/or Resident Representative (RR) on the facility's transfer/discharge notice for two (2) of (2) residents reviewed for the discharge process. Residents #6 and Resident #52. Findings include: Resident #6 A record review of Resident #6's "Admission Record" revealed the facility admitted the resident on 04/08/2026 with diagnoses including Aftercare following Joint Replacement Surgery. A record review of Resident #6's Discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/15/2026, revealed the resident was discharged from the facility with return anticipated to a short-term general hospital. A record review of Resident #6's Quarterly MDS, with an ARD of 07/08/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. A record review of the facility's "Order Audit Report" dated 09/01/2026 for Resident #6 revealed an order for "Send to ER (Emergency Room) for evaluation" with order date 04/15/2026.			F0628			

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F0628 SS = D	Continued from page 12 A record review of Resident #6's "Transfer/Discharge Notice Form," dated 04/15/2026, revealed the "Reason for transfer/discharge" was documented as "Functional decline." Resident #52 A record review of Resident #52's "Admission Record" revealed the facility admitted the resident on 06/29/2026 with diagnoses including Encounter for Orthopedic Aftercare following Surgical Amputation. A record review of the Discharge MDS with an ARD of 07/14/2026 revealed Resident #52 was discharged from the facility with return anticipated to a short-term general hospital. A record review of the Admission MDS, with an ARD of 07/05/2026, revealed Resident #52 had a BIMS score of 5, which indicated the resident was severely cognitively impaired. A record review of the facility's "Order Audit Report," dated 09/01/2026, for Resident #52 revealed an order, dated 07/14/2026, to "send to ER for evaluation change in LOC (level of consciousness)." A record review of Resident #52's "Transfer/Discharge Notice Form," dated 07/14/2026, revealed the "Reason for transfer/discharge" was documented as "Altered LOC." On 09/03/2026 at 8:49 AM, during an interview, the Director of Nursing (DON) stated the nurse was responsible for completing the transfer/discharge notice. The DON stated it was important for the Resident Representative (RR) to clearly understand what was going on with the residents and that she expected nursing staff to complete the notice using words that the resident and family could understand.	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	F0641			

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F0641 SS = D	Continued from page 13 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. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interviews, and the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, the facility failed to ensure the accuracy of a Minimum Data Set (MDS) assessment by incorrectly coding a resident as having a significant weight loss when the resident did not meet the criteria for significant weight loss, for one (1) of (16) sampled residents reviewed for MDS accuracy. Resident #1. Findings include: A review of the "Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual" effective date October 1, 2025 revealed, "...K0300: Weight Loss...Coding Instructions Mathematically round weights as described in Section K0200 before completing the weight loss calculation...Code 2, yes...if the resident has experienced a weight loss of 5% or more in 30 days or 10% or more in 180 days..." A record review of Resident #1's "Admission	F0641					

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F0641 SS = D	Continued from page 14 Record" revealed the facility originally admitted the resident on 03/24/2021 with diagnoses including End Stage Renal Disease. A record review of Resident #1's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/12/2026, revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Section K0300, Weight Loss, was coded to indicate the resident had experienced a weight loss of 5% (percent) or more in the last month or loss of 10% or more in last six (6) months. A record review of Resident #1's "Nutritional Assessment," dated 06/10/2026, revealed the Registered Dietitian (RD) documented, "Wt (weight) has been stable over last 6 months..." On 09/02/2026 at 12:27 PM, during an interview, the RD stated Resident #1 should not have been coded on the MDS as having significant weight loss. The RD stated the resident's weight had increased and remained stable following the addition of dietary supplements. On 09/02/2026 at 12:35 PM, during an interview, the Dietary Manager (DM) stated Resident #1's weight information was calculated incorrectly when he coded the MDS. The DM stated accurate information was important to determine how to assist residents and that he would thoroughly review the information before submitting it in the future. On 09/02/2026 at 12:47 PM, during an interview, Licensed Practical Nurse (LPN) #2/MDS Nurse stated she was responsible for confirming the accuracy of information on the MDS prior to submission. After being informed of the incorrect coding of Resident #1's weight loss, LPN #2 acknowledged the importance of ensuring the MDS contained accurate information. On 09/02/2026 at 1:20 PM, during an interview, the Director of Nursing (DON) stated the DM used weights from an incorrect look-back period when completing the nutrition section of Resident #1's MDS with an ARD of 06/12/2026, which resulted in Resident #1's weight loss being coded incorrectly. The DON stated the MDS Nurse was responsible for confirming the accuracy of information on the MDS prior to submission and that she expected the MDS to be coded accurately. On 09/03/2026 at 1:03 PM, during an interview, the Administrator stated she was aware Resident #1's			F0641			

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F0641 SS = D	Continued from page 15 MDS contained incorrect weight-loss information. The Administrator stated the MDS Nurse was responsible for confirming the accuracy of all data before submission and that accurate MDS coding was necessary to provide an accurate assessment of the resident.	F0641					
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. (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.	F0656					

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F0656 SS = D	Continued from page 16 §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 observations, interviews, record review, and facility policy review, the facility failed to develop and implement comprehensive person-centered care plans that addressed residents' identified needs by failing to: 1) develop a care plan addressing a resident's use of bedrails for mobility and positioning; 2) administer oxygen at the rate identified in a resident's care plan and 3) provide assistance with a resident's hearing aid as identified in the resident's care plan, for three (3) of (16) residents reviewed for comprehensive care plans. Residents #27, #45, and #55. Findings include: A record review of the facility's policy titled "Care Plan Policy and Procedure," with no date, revealed "Purpose: To provide a comprehensive person-centered plan of care addressing resident's needs, strengths, goals, and approaches ... Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals, and approaches ..." Resident #45 A record review of Resident #45's "Comprehensive Care Plan" revealed no care plan for bedrails. On 08/31/2026 at 1:05 PM, during an observation and interview with Resident #45, the State Agency (SA) observed the resident lying/sitting sideways toward the end of the bed with both half-length bedrails up. Resident #45 stated he uses the bedrails to help get up and down in the bed and to turn and reposition. On 09/01/2026 at 11:37 AM, during an observation and interview with Resident #45, the SA observed Resident #45 walking out of his room with his rollator. He stated he likes to keep the bedrails up so that he can use them to get up and out of bed and help with turning and repositioning. The SA observed half-length bedrails up. On 09/01/2026 at 11:45 AM, during an interview, Licensed Practical Nurse (LPN) #1 stated Resident	F0656					

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F0656 SS = D	Continued from page 17 #45 was alert and oriented to person, place, and time. She confirmed the resident had half-length bedrails on his bed in the raised position. LPN #1 stated Resident #45 uses the bedrails to assist with getting in and out of bed and positioning in the bed. On 09/03/2026 at 1:20 PM, during an interview, LPN #2 stated Resident #45's Comprehensive Care Plan did not address the resident's use of bedrails. LPN #2 stated she was unaware the resident's half-length bedrails were being maintained in the raised position and confirmed a care plan had not been developed addressing the resident's use of the bedrails for mobility and positioning. On 09/03/2026 at 3:50 PM, during an interview, the Administrator stated she expected staff to develop resident-centered care plans and to follow the residents' care plans. A record review of Resident #45's "Admission Record" revealed the facility admitted the resident on 02/03/2026 with diagnoses including Type 2 Diabetes Mellitus with Diabetic Mononeuropathy. A record review of Resident #45's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/29/2026, revealed a Brief Interview for Mental Status (BIMS) Summary Score of 15, which indicated the resident was cognitively intact. A record review of Resident #45's "Quarterly Evaluation Bundle," dated 05/06/2026, revealed a Bed Rail Evaluation indicating the resident did not desire bedrails to be raised. The evaluation was completed by LPN #2. Resident #55 A record review of Resident #55's "Care Plan Report" revealed an intervention for oxygen BNC (by nasal cannula) at two (2) Liters per Minute (LPM) and as needed (PRN). On 08/31/2026 at 1:21 PM, the SA observed Resident #55 in bed receiving oxygen at three (3) LPM via nasal cannula. On 09/03/2026 at 1:10 PM, during an interview, Registered Nurse (RN) #1, Care Plan Nurse, stated the purpose of the comprehensive care plan was to provide a complete picture of each resident's needs and serve as a tool to guide nursing staff in providing individualized care. RN #1 stated staff were expected to follow each resident's comprehensive			F0656			

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F0656 SS = D	Continued from page 18 care plan. A record review of Resident #55's "Admission Record" revealed the facility admitted the resident on 08/21/2026 with diagnoses including Enterocolitis due to Clostridium Difficile, not specified as recurrent and Chronic Respiratory Failure, unspecified whether with Hypoxia or Hypercapnia. A record review of Resident #55's "Order Summary Report" revealed an active physician's order, dated 08/21/2026, for O2 (oxygen) BNC at two (2) LPM and PRN (as needed) every shift. A record review of Resident #55's 5-Day MDS with an ARD of 08/27/2026, revealed a BIMS summary score of 8, which indicated the resident was moderately cognitively impaired. Section O revealed the resident received oxygen therapy. Resident #27 A record review of Resident #27's "Care Plan Report" revealed interventions directing staff to assist with the insertion, removal, and cleaning of hearing aids and to store the hearing aids on the medication cart. On 08/31/2026 at 1:37 PM, the SA observed Resident #27 was not wearing a hearing aid. During an interview at that time, Resident #27 stated he had lost one of his hearing aids while residing at the facility. On 09/01/2026 at 1:50 PM, during an interview, the Director of Nursing (DON) stated Resident #27 had one remaining hearing aid that was stored on the medication cart. On 09/02/2026 at 12:57 PM, during an interview, Licensed Practical Nurse (LPN #3), Medication Cart Nurse, stated Resident #27 had one hearing aid stored in the medication cart. The SA observed the resident's hearing aid stored in a locked drawer of the medication cart. On 09/02/2026 at 1:20 PM, during a follow-up interview, Resident #27's spouse and Resident Representative (RR) stated she was unaware the resident still had one hearing aid and had previously been informed that both hearing aids had been destroyed. The RR stated the resident could keep and use the remaining hearing aid as long as he did not destroy it. The RR further stated she had not given the facility permission to withhold the			F0656			

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F0656 SS = D	Continued from page 19 remaining hearing aid or prevent the resident from wearing it. On 09/02/2026 at 1:44 PM, during an interview, the DON stated Resident #27 had one remaining hearing aid and that the hearing aid should have been in place unless the resident refused to wear it. The DON stated a refusal should have been documented in the resident's medical record. On 09/02/2026 at 2:00 PM, the SA observed LPN #3 place Resident #27's remaining hearing aid into the resident's ear during medication administration. On 09/02/2026 at 3:15 PM, the DON informed the SA there was no documentation in Resident #27's medical record indicating the resident had refused to wear the remaining hearing aid. On 09/03/2026 at 2:00 PM, during an interview, the Administrator stated she expected Resident #27's refusals to wear the hearing aid to be documented on the Medication Administration Record (MAR). A record review of Resident #27's "Admission Record" revealed the facility admitted the resident on 03/20/2024 with diagnoses including Type 2 Diabetes Mellitus without complications. A record review of Resident #27's "Order Details," dated 06/23/2026, revealed a physician's order to "Take both hearing aids at bedtime and place in case in Nurse Cart and put hearing aids in ears in AM." A record review of Resident #27's Quarterly MDS with an ARD of 07/08/2026, revealed a BIMS score of 3, which indicated the resident was severely cognitively impaired. Section B0300 indicated the resident used a hearing aid or other hearing appliance.	F0656			
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F0657			

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F0657 SS = D	Continued from page 20 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to revise a comprehensive person-centered care plan to reflect a resident's significant weight loss for one (1) of (16) sampled residents. Resident #31. Findings include: A record review of the facility's policy titled "Care Plan Policy and Procedure," with no date, revealed "Purpose: To provide a comprehensive person-centered plan of care addressing resident's needs, strengths, goals, and approaches ... Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals, and approaches ...3. The Resident's care plan will be updated as needed ..." A record review of Resident #31's "Care Plan Report" revealed the comprehensive care plan had not been revised to identify the resident's significant weight loss. A record review of Resident #31's "Nutritional Assessment," dated 08/05/2026, revealed the resident had experienced weight loss over the previous three (3) months. A record review of Resident #31's "Weight Summary" revealed the resident weighed 116.1			F0657			

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F0657 SS = D	Continued from page 21 pounds (lbs.) on 02/05/2026 and 101.1 lbs. on 08/06/2026, a decrease of 15 pounds over approximately six months. On 08/31/2026 at 12:09 PM, during a Resident Representative (RR) interview for Resident #31, she stated the Resident had lost quite a bit of weight gradually and was on an appetite stimulant. On 09/01/2026 at 12:10 PM, during an interview, Dietary Department (DD) Staff #2 stated Resident #31 had experienced weight loss but that the resident's weights had become stable. DD #2 stated that double protein had been added to the resident's meal ticket, Ensure supplements had been provided for two (2) months, and an appetite stimulant had been ordered. On 09/01/2026 at 2:10 PM, during an interview, Certified Nurse Aide (CNA)#3 stated Resident #31 sometimes ate her meals and sometimes did not. CNA #3 stated the resident's family brought snacks, which the resident sometimes ate instead of her meals. CNA #3 stated alternate meal items were offered, but the resident sometimes continued to decline the meal. CNA #3 confirmed the resident had experienced weight loss. On 09/03/2026 at 1:27 PM, during an interview, Licensed Practical Nurse (LPN) #2 stated Resident #31 had weight loss identified on the resident's most recent Minimum Data Set (MDS) assessment and confirmed the comprehensive care plan had not been revised to reflect the weight loss. On 09/03/2026 at 1:35 PM, during an interview, Registered Nurse (RN) #1 stated the purpose of the care plan was to provide resident-specific information regarding how to care for the resident and to ensure staff were aware of the resident's care needs and interventions. RN #1 stated she expected staff to follow the care plan and interventions to provide quality care. On 09/03/2026 at 3:53 PM, during an interview, the Administrator stated she expected resident-centered care plans to reflect residents' current assessments. The Administrator confirmed she was aware that care plans had not been revised and developed as expected and stated the facility had identified the concern and implemented a corrective action plan. A record review of Resident #31's "Admission Record" revealed the facility admitted the resident initially on 01/30/2019 and re-entry on 12/24/2023 with diagnoses including Other Persistent Atrial	F0657					

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F0657 SS = D	Continued from page 22 Fibrillation and Other Specified Peripheral Vascular Diseases.	F0657					
F0685 SS = D	A record review of Resident #31's Annual MDS with an Assessment Reference Date (ARD) of 08/05/2026, revealed a Brief Interview for Mental Status (BIMS) Summary Score of 7, which indicated the resident was severely cognitively impaired. Section K0300 indicated the resident had a weight loss of 5% or more in the last month or 10% or more in the last six (6) months. Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review, the facility failed to provide assistance with a resident's hearing aid in accordance with the physician's order when the resident's hearing aid was stored on the medication cart and was not provided for use, with no documented evidence the resident refused to wear the hearing aid for one (1) of (1) resident reviewed for hearing assistance. Resident #27. Findings include: During an observation on 08/31/2026 at 1:37 PM, the State Agency (SA) observed Resident #27 was not wearing a hearing aid. During an interview at that time, Resident #27 stated he had lost one of his hearing aids while residing at the facility. On 09/01/2026 at 11:23 AM, during an interview, Resident #27's spouse and Resident Representative (RR) stated the resident had removed his hearing	F0685					

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F0685 SS = D	Continued from page 23 aids and destroyed them approximately one month earlier. During an interview on 09/01/2026 at 1:50 PM, the Director of Nursing (DON) stated Resident #27 had one remaining hearing aid that was stored on the medication cart. During an interview on 09/01/2026 at 2:17 PM, the Administrator stated Resident #27 had broken one of his hearing aids and had one remaining hearing aid stored in the medication cart. The SA informed the Administrator that the RP reported the resident had destroyed both hearing aids. The Administrator stated she recalled the hearing aids being broken but could not recall exactly when the incident occurred. During an interview on 09/02/2026 at 12:57 PM, Licensed Practical Nurse (LPN #3), Medication Cart Nurse, stated Resident #27 had one hearing aid stored in the medication cart. The SA observed the resident's hearing aid stored in a locked drawer of the medication cart. During a follow-up interview on 09/02/2026 at 1:20 PM, Resident #27's spouse and RR stated she was unaware the resident still had one hearing aid and had previously been informed that both hearing aids had been destroyed. The RR stated the resident could keep and use the remaining hearing aid as long as he did not destroy it. The RR further stated she had not given the facility permission to withhold the remaining hearing aid or prevent the resident from wearing it. During an interview on 09/02/2026 at 1:44 PM, the DON stated Resident #27 had one remaining hearing aid, and the hearing aid should have been in place unless the resident refused to wear it. The DON stated a refusal to wear the hearing aid should have been documented in the resident's medical record. The SA informed the DON that Resident #27 was not wearing the remaining hearing aid, and the RR was unaware the resident still had a hearing aid available. The DON stated a refusal would be documented on the Medication Administration Record (MAR). The SA requested documentation reflecting application of, or refusal to wear, the resident's hearing aid. During an observation on 09/02/2026 at 2:00 PM, the SA observed LPN #3 place Resident #27's remaining hearing aid into the resident's ear during medication administration.	F0685					

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F0685 SS = D	Continued from page 24 During an interview on 09/02/2026 at 3:15 PM, the DON informed the SA there was no documentation in Resident #27's medical record indicating the resident had refused to wear the remaining hearing aid. During an interview on 09/03/2026 at 2:00 PM, the Administrator stated she expected Resident #27's refusals to wear the hearing aid to be documented on the MAR. A record review of Resident #27's "Admission Record" revealed the facility admitted the resident on 03/20/2024 with diagnoses including Type 2 Diabetes Mellitus without complications. A record review of Resident #27's "Order Details," dated 06/23/2026, revealed a physician's order to "Take both hearing aids at bedtime and place in case in Nurse Cart and put hearing aids in ears in AM." A record review of Resident #27's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/08/2026, revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident was severely cognitively impaired. Section B0300 indicated the resident used a hearing aid or other hearing appliance.			F0685			
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there			F0692			

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F0692 SS = D	Continued from page 25 is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a physician-ordered dietary intervention was provided as ordered for a resident when orange juice ordered with the lunch meal for hypokalemia was not provided during two (2) of (2) dining observations. Resident #1. Findings include: A record review of Resident #1's "Admission Record" revealed the facility admitted the resident on 03/24/2021 with diagnoses including End Stage Renal Disease. A record review of Resident #1's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/12/2026, revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. A record review of the "Order Audit Report" dated 09/01/2026 for Resident #1 revealed an active physician order dated 03/31/2021 for "Serve orange juice with lunch meal (hypokalemia)." A record review of Resident #1's meal ticket dated 09/02/2026 revealed "orange juice for lunch every day" was noted on the ticket. On 09/01/2026 at 12:45 PM, during a dining observation, Resident #1 ate approximately 95 percent of the lunch meal. The resident's lunch tray did not contain the physician-ordered orange juice. On 09/02/2026 at 12:35 PM, during a dining observation, Resident #1 was not served the physician-ordered orange juice with his lunch meal. On 09/02/2026 at 12:40 PM, during an interview, the Dietary Manager (DM) stated he was unaware that Resident #1 had an order for orange juice with lunch. The DM stated it was an oversight by his department that the orange juice was not added to the resident's lunch tray. The DM stated physician orders must be followed for the health of residents and confirmed the kitchen would begin serving Resident #1's meals as ordered. 09/03/2026 1:05 PM, during an interview, the Administrator stated she had been made aware that Resident #1's order for orange juice with lunch had			F0692			

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F0692 SS = D	Continued from page 26 not been followed. The Administrator stated the facility was there to follow orders and believed the failure was an oversight because the kitchen staff were good at following medical orders. The Administrator stated she expected orders to be followed and meals to be served correctly.	F0692					
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure oxygen therapy was administered in accordance with a physician's order when a resident ordered to receive oxygen at two (2) liters per minute (LPM) via nasal cannula and as needed (PRN) was observed receiving oxygen at three (3) LPM on (3) consecutive survey days, for one (1) of (1) residents reviewed for respiratory care. Resident #55. Findings include: A review of the facility's policy titled "Oxygen Administration Policy and Procedure," dated 02/25/2026, revealed "...administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissue. Procedure 1. Check physician's order for liter flow and method of oxygen administration..." A record review of Resident #55's "Admission Record" revealed the facility admitted the resident on 08/21/2026 with diagnoses including Enterocolitis due to Clostridium Difficile, not specified as recurrent and Chronic Respiratory Failure, unspecified whether with Hypoxia or Hypercapnia. A record review of Resident #55's "Order Summary Report" revealed an active physician's order, dated 08/21/2026, for O2 (oxygen) BNC (by nasal cannula) at two (2) LPM and PRN (as needed) every shift.	F0695					

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F0695 SS = D	Continued from page 27 A record review of Resident #55's "Medication Administration Record (MAR)" for September 2026 revealed an active physician's order for O2 BNC at two (2) LPM and PRN related to Chronic Respiratory Failure. The MAR revealed staff documented the physician-ordered oxygen at two (2) LPM as administered on 09/01/2026, 09/02/2026, and 09/03/2026. A record review of Resident #55's 5-Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/27/2026, revealed a Brief Interview for Mental Status (BIMS) summary score of 8, which indicated the resident was moderately cognitively impaired. Section O revealed the resident received oxygen therapy. At 1:21 PM, on 08/31/2026 the State Agency (SA) observed Resident #55 in bed receiving oxygen at (3) LPM via nasal cannula. At 12:03 PM, on 09/01/2026 the SA observed Resident #55 in bed receiving oxygen at three (3) LPM via nasal cannula. The oxygen tubing was dated 09/01/2026. At 9:35 AM, on 09/02/2026 at 9:35 AM, the SA and Licensed Practical Nurse (LPN) #1 observed Resident #55 receiving oxygen at (3) LPM via nasal cannula. During an interview at that time, LPN #1 stated she was responsible for checking, dating, and labeling Resident #55's oxygen tubing and that the resident's oxygen was ordered at two (2) LPM via nasal cannula. LPN #1 further stated she typically checked the resident's oxygen each time she administered medications. LPN #1 reviewed the resident's physician order in PointClickCare (PCC) and confirmed the oxygen was ordered at two (2) LPM via nasal cannula and as needed (PRN). At 3:42 PM, on 09/02/2026 during an interview, the Director of Nursing (DON) revealed she expected nursing staff to check residents' oxygen concentrators during rounds and medication administration. The DON further stated nursing staff were expected to follow physician orders and residents' comprehensive care plans. At 2:00PM, on 09/03/2026 during an interview, the Administrator revealed she expected nursing staff to ensure residents' oxygen was set and administered in accordance with physician orders.			F0695			

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F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure the safe use of bedrails by failing to: 1) obtain informed consent for the use of bedrails; and 2) complete an ongoing bedrail safety assessment for one (1) of three (3) residents reviewed for bedrail use. Resident #45 Findings include: A record review of the facility's policy "Bed Safety and Bed Rails," with reviewed date of 8/2023, revealed "... Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent ..." On 08/31/2026 at 1:05 PM, during an observation and interview with Resident #45, the State Agency (SA) observed the resident lying/sitting sideways toward the end of the bed with both half-length bedrails up. Resident #45 stated he uses the bedrails to help get up and down in the bed and to turn and reposition.	F0700					

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F0700 SS = D	Continued from page 29 On 09/01/2026 at 11:37 AM, during an observation and interview with Resident #45, the SA observed Resident #45 walking out of his room with his rollator. He stated he likes to keep the bedrails up so that he can use them to get up and out of bed and help with turning and repositioning. The SA observed half-length bedrails up. On 09/01/2026 at 11:45 AM, during an interview, Licensed Practical Nurse (LPN) #1 stated Resident #45 was alert and oriented to person, place, and time. She confirmed the resident had half-length bedrails on his bed in the raised position. LPN #1 stated Resident #45 uses the bedrails to assist with getting in and out of bed and positioning in the bed. On 09/03/2026 at 1:20 PM, during an interview, LPN #2 stated she was unaware the resident's half-length bedrails were being maintained in the raised position. On 09/03/2026 at 3:50 PM, during an interview, the Administrator stated she expected staff to follow regulations and guidelines related to bedrail use. A record review of Resident #45's "Admission Record" revealed the facility admitted the resident on 02/03/2026 with diagnoses including Type 2 Diabetes Mellitus with Diabetic Mononeuropathy. A record review of Resident #45's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/29/2026, revealed a Brief Interview for Mental Status (BIMS) Summary Score of 15, which indicated the resident was cognitively intact. A record review of Resident #45's "Quarterly Evaluation Bundle," dated 05/06/2026, revealed a Bed Rail Evaluation indicating the resident did not desire bedrails to be raised. The evaluation was completed by LPN #2. A record review revealed the last documented Bed Rail Evaluation was completed on 05/06/2026, with no subsequent quarterly Bed Rail Evaluation documented through 09/03/2026. A record review of Resident #45's medical record revealed no documented informed consent for the resident's use of bedrails.			F0700			

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F0836 SS = D	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a licensed nurse designated as the charge nurse was separate from the medication/treatment nurse by assigning the medication/treatment nurse to also serve as the charge nurse from 7:00 PM to 11:00 PM during the 3:00 PM to 11:00 PM shift for one (1) of four (4) days of survey. Findings include: A record review of the facility's staffing grid dated 08/18/2026 through 08/31/2026 revealed there was no separate licensed nurse designated to serve as the charge nurse from 7:00 PM until 11:00 PM.	F0836					

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F0836 SS = D	Continued from page 31 A record review of the time sheets for the 14 days prior to the survey revealed no additional licensed nurse was scheduled to serve as the charge nurse from 7:00 PM until 11:00 PM separate from the medication/treatment nurse. On 09/01/2026 at 8:15 AM, during an interview, the Director of Nursing (DON) stated the facility's Registered Nurses (RNs) worked 12-hour shifts from 7:00 AM until 7:00 PM and the RN served as the charge nurse during those hours. The DON stated that from 7:00 PM until 11:00 PM, she verbally assigned the medication/treatment nurse working the medication cart to also serve as the charge nurse. The DON confirmed that having a separate licensed nurse designated as the charge nurse from 7:00 PM until 11:00 PM would free the medication/treatment nurse to maintain focus on the residents in the event of an emergency.		F0836				