

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255091		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/17/2026	
NAME OF PROVIDER OR SUPPLIER LEXINGTON MANOR SENIOR CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 56 ROCKPORT ROAD , LEXINGTON, Mississippi, 39095			
(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			F0000			
	The State Agency (SA) conducted an annual recertification survey at the facility from 09/14/2026 through 09/17/2026. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F812, F656, F692, F761 and F836. The facility had a census of 55 and was licensed for 60 beds.						
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to store and maintain food under sanitary conditions by failing to: 1) properly package, date, and label an opened			F0812			

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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F0812 SS = E	Continued from page 1 frozen food product; and 2) identify and remove spoiled produce from refrigerated storage for one (1) of (4) days of survey. Findings include: A review of the facility's policy titled "Food Storage Labeling Policy," revised 10/2023, revealed "...the facility will ensure the safety and quality of food by following good storage and labeling procedures..." A record review of the "In-Service," dated 07/01/2026, revealed education included staff job duties and responsibilities related to the freezer and cooler. On 09/14/2026 at 11:03 AM, during an observation of the Dietary Department and interview with Dietary Manager (DD) #1, the State Agency (SA) observed an opened box of frozen black-eyed peas stored in the freezer. The black-eyed peas were exposed and had not been repackaged, dated, or labeled after opening. The original shipping box containing the black-eyed peas was torn, tattered, and misshaped. The SA observed fresh broccoli stored in a clear plastic bag in the refrigerator. A brown, slimy substance was visible inside the bag surrounding the broccoli. DD #1 observed the broccoli and stated it appeared spoiled despite having been received the previous week. DD #1 removed the broccoli from the refrigerator. DD #1 stated the Head Cook was responsible for ensuring opened food items were repackaged, dated, and labeled after opening. DD #1 stated she was ultimately responsible for checking produce, ensuring it was properly rotated, and removing spoiled produce from storage. On 09/16/2026 at 12:33 PM, during an interview, DD #1 stated dietary staff received an in-service on 07/01/2026 that addressed job duties and freezer responsibilities. DD #1 stated the education included cook aides and their responsibilities related to the freezer. On 09/17/2026 at 10:55 AM, during an interview, the Director of Nursing (DON) stated her expectation was for the Dietary Department to establish a schedule for monitoring the refrigerators and freezers to ensure food items were properly packaged, dated, and labeled and were discarded when indicated. The DON stated dietary staff were responsible for following established food-storage and monitoring procedures. On 09/17/2026 at 10:59 AM, during an interview, the Administrator stated her expectation was for the Dietary Department to have a weekly monitoring	F0812					

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F0812 SS = E	Continued from page 2 system in place, with check sheets maintained for the refrigerators and freezers. The Administrator stated dietary staff were expected to use the check sheets to verify food products were properly packaged and labeled and expired food products were identified and removed.	F0812					
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 3 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to develop and implement comprehensive person-centered care plans that addressed identified and individualized care needs by failing to: 1) implement identified safety interventions and ensure the care plan reflected the safety intervention being used for a resident with impaired safety awareness; and 2) develop a care plan that identified the amount and scheduled times of prescribed enteral feedings and addressed a scheduled enteral feeding when the resident attended dialysis three (3) days each week for two (2) of (17) sampled residents reviewed for comprehensive care plans. Residents #28 and #8. Findings include: A record review of the facility's policy titled "Comprehensive Care Plans," revised 02/2017, revealed "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment...Policy Explanation and Compliance Guidelines...4. The comprehensive care plan will describe...a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being..." Resident #28 A record review of Resident #28's "Admission Record" revealed the facility admitted the resident on 11/18/2025 with a diagnosis including personal history of traumatic brain injury and attention and concentration deficit. A record review of Resident #28's "Quarterly Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 08/05/2026, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact.	F0656					

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F0656 SS = D	Continued from page 4 A record review of Resident #28's "Care Plan Report" revealed the resident was identified as impulsive with impaired safety awareness and poor judgment related to an old head injury. The care plan identified that the resident operated the bed remote, raised the bed up and down, and had a history of falling out of bed while operating the remote. The care plan identified a goal for the resident to remain free from falls out of bed related to impaired safety awareness. Interventions directed staff to attach the bed remote to the wall at the head of the bed with Velcro, maintain the bed in the low position, maintain the call light within easy reach, and encourage the resident to call for assistance with the bed. The comprehensive care plan did not identify locking the resident's bed controls as a safety intervention. On 09/14/2026 at 1:23 PM, during an observation and interview, the State Agency (SA) observed Resident #28 lying in bed. The resident stated a nurse had turned off the power to his bed and that nurses did this frequently. The SA asked the resident to call for a nurse, and the resident activated the call light. The Director of Nursing (DON) responded and confirmed the resident was unable to independently elevate the head of the bed because the controls located at the foot of the bed were locked, restricting operation of the bed. The DON unlocked the controls, and Resident #28 was then able to independently elevate and lower the head of the bed. On 09/15/2026 at 3:27 PM, during a follow-up interview and record review of Resident #28's comprehensive care plan, the DON confirmed the resident's bed remote was attached to the side rail despite the comprehensive care plan directing staff to secure the remote to the head of the bed with Velcro as a safety intervention. The DON acknowledged the comprehensive care plan did not identify locking the bed controls as a safety intervention. The DON stated the facility expected staff to assess each resident's ability to safely use the bed remote and ensure the comprehensive care plan accurately reflected individualized safety interventions. On 09/17/2026 at 9:32 AM, during an interview, Certified Nursing Assistant (CNA) #3 stated Resident #28 frequently operated the bed remote and elevated the bed to a high position or raised the head of the bed to a position CNA #3 considered unsafe. On 09/17/2026 at 10:13 AM, during an interview and record review, Registered Nurse (RN) #2, Care Plan			F0656			

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F0656 SS = D	Continued from page 5 Nurse for 13 years, stated the comprehensive care plan was used to communicate residents' care needs and interventions to staff, including interventions addressing identified behaviors. RN #2 stated care plans were reviewed and updated quarterly, annually, with significant changes, new or changed orders, and as needed. RN #2 reviewed Resident #28's comprehensive care plan and confirmed locking the resident's bed controls was not identified as a safety intervention. RN #2 stated the intervention directing staff to secure the bed remote to the head of the bed with Velcro originated from the resident's previous care plan and had been carried forward to the current care plan, although the resident currently had a different bed. RN #2 confirmed the current comprehensive care plan did not include locking the bed controls as an intervention to address the resident's identified safety needs. On 09/17/2026 at 10:42 AM, during an interview, the Administrator stated her expectation was for the interdisciplinary team (IDT) and appropriate departments to participate in care plan meetings, identify and communicate changes in residents' conditions, orders, and care needs, and ensure identified changes and interventions were documented and implemented in residents' comprehensive care plans. Resident #8 A record review of Resident #8's "Admission Record" revealed the facility admitted the resident on 08/19/2025 with diagnoses including End Stage Renal Disease, Dependence on Renal Dialysis, Gastrostomy Status, and Type 2 Diabetes Mellitus (DM) with Hypoglycemia without Coma. A record review of Resident #8's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/04/2026, revealed the Brief Interview for Mental Status (BIMS) was not conducted. Sections C0700 and C0800 indicated the resident had short- and long-term memory impairment. Section K indicated the resident received nutrition through a feeding tube, and Section O indicated the resident received dialysis. A record review of Resident #8's "DM Nutrition Screen/Evaluation & MDS Documentation," dated 08/04/2026, revealed the resident received Nepro enteral formula with a total volume of 948 milliliters (mL) per day. A record review of Resident #8's "Order Summary			F0656			

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F0656 SS = D	Continued from page 6 Report" revealed active physician orders for NPO (nothing by mouth) status dated 4/2/26 and Nepro 237 cubic centimeters (cc) via percutaneous endoscopic gastrostomy (PEG) tube four (4) times daily at 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM. The order indicated the prescribed enteral nutrition provided 1,706 kilocalories (kcal), 77 grams (g) of protein, 689 mL of water from formula, 929 mL total fluid, and 100% of the Recommended Dietary Intake (RDI) dated 4/23/26. The report further revealed an active physician's order for dialysis at DaVita every Monday, Wednesday, and Friday dated 8/19/25. A record review of Resident #8's September 2026 "Medication Administration Record (MAR)" revealed an active physician's order for Nepro 237 cc via PEG tube four (4) times daily at 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM. The 2:00 PM feeding was documented with code "13" on 09/02/2026, 09/04/2026, 09/07/2026, 09/09/2026, 09/11/2026, and 09/14/2026. A record review of Resident #8's "Care Plan Report" revealed a focus for dialysis on Monday, Wednesday, and Friday and a separate focus for tube feeding. The tube-feeding intervention indicated the resident received Nepro but did not identify the prescribed amount or scheduled feeding times. The care plan contained no intervention addressing the resident's scheduled 2:00 PM enteral feeding when the resident was away from the facility for dialysis. During an interview on 09/15/2026 at 1:50 PM, Licensed Practical Nurse (LPN) #1 stated Resident #8 received dialysis every Monday, Wednesday, and Friday and received Nepro through the PEG tube four (4) times daily. LPN #1 stated the 2:00 PM feeding was documented with code "13" when Resident #8 was at dialysis and confirmed code "13" indicated the resident was out of the facility at dialysis. LPN #1 confirmed the resident's care plan identified Nepro four (4) times daily but did not identify the scheduled feeding times or an intervention addressing the 2:00 PM feeding when the resident attended dialysis. On 09/15/2026 at 2:15 PM, during an interview, the MDS Nurse confirmed Resident #8's comprehensive care plan contained no intervention addressing the resident's scheduled 2:00 PM enteral feeding when the resident attended dialysis. During an interview on 09/15/2026 at 2:40 PM, the Registered Nurse (RN) #1 Charge Nurse stated she was not aware of any intervention addressing Resident #8's scheduled 2:00 PM enteral feeding			F0656			

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F0656 SS = D	Continued from page 7 while the resident attended dialysis. During an interview on 09/15/2026 at 2:50 PM, Certified Nurse Aide (CNA) #1 stated Resident #8 was NPO, received nutrition through the PEG tube, and attended dialysis every Monday, Wednesday, and Friday. CNA #1 confirmed no nutritional items were sent with Resident #8 to dialysis. During an interview on 09/15/2026 at 3:00 PM, the Director of Nursing (DON) stated Resident #8 attended dialysis every Monday, Wednesday, and Friday and confirmed the resident's scheduled 2:00 PM enteral feeding was not provided while the resident was at dialysis. The DON confirmed there were no interventions addressing the missed 2:00 PM feeding on dialysis days and confirmed code "13" documented on the MAR indicated the resident was at dialysis. The DON stated physician orders were expected to be reflected in the comprehensive care plan and that the MDS Nurse was responsible for updating the care plan with physician orders. During a telephone interview on 09/15/2026 at 3:40 PM, the Dietitian stated she was unaware Resident #8 had not been receiving the scheduled 2:00 PM enteral feeding on dialysis days. The Dietitian stated she had written the enteral feeding order for four (4) feedings daily and had expected the facility to schedule the feedings around the resident's dialysis schedule. The Dietitian confirmed Resident #8 should have received four (4) enteral feedings daily.			F0656			
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;			F0692			

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F0692 SS = D	Continued from page 8 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, facility policy review and record review, the facility failed to provide prescribed enteral nutrition to a resident who was NPO (nothing by mouth) by failing to administer the scheduled 2:00 PM enteral feeding on dialysis days and failing to ensure an alternative intervention was implemented to provide the prescribed nutrition for one (1) of (17) sampled residents reviewed for nutrition. Resident #8. Findings include: A record review of the facility policy titled "Transcribing Physician Orders Policy" with no date, revealed "...It is the policy of this facility to...follow the attending physician's orders as written...Procedure...Orders will be followed...according to the prescribed physician's instructions..." A record review of Resident #8's "Admission Record" revealed the facility admitted the resident on 08/19/2025 with diagnoses including End Stage Renal Disease, Dependence on Renal Dialysis, Gastrostomy Status, and Type 2 Diabetes Mellitus (DM) with Hypoglycemia without Coma. A record review of Resident #8's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/04/2026, revealed the Brief Interview for Mental Status (BIMS) was not conducted. Sections C0700 and C0800 indicated the resident had short- and long-term memory impairment. Section K indicated the resident received nutrition through a feeding tube, and Section O indicated the resident received dialysis. A record review of Resident #8's "DM Nutrition Screen/Evaluation & MDS Documentation," dated 08/04/2026, revealed the resident's enteral feeding formula was Nepro with a total prescribed volume of 948 milliliters (mL) per day. A record review of Resident #8's "Order Summary Report" revealed active physician orders as of 09/15/2026, for NPO (nothing by mouth) status dated 4/2/26 and Nepro 237 cubic centimeters (cc) via percutaneous endoscopic gastrostomy (PEG) tube four (4) times daily at 10:00 AM, 2:00 PM, 6:00 PM,	F0692					

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F0692 SS = D	Continued from page 9 and 10:00 PM. The order indicated the prescribed enteral nutrition provided 1,706 kilocalories (kcal), 77 grams (g) of protein, 689 mL of water from formula, 929 mL total fluid, and 100% of the Recommended Dietary Intake (RDI) dated 4/23/26. The report further revealed an active order for dialysis at (Proper Name) every Monday, Wednesday, and Friday dated 8/19/25. A record review of Resident #8's September 2026 "Medication Administration Record (MAR)" revealed the active order for Nepro 237 cc via PEG tube four (4) times daily at 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM. The 2:00 PM feeding was documented with code "13" which indicated dialysis on 09/02/2026, 09/04/2026, 09/07/2026, 09/09/2026, 09/11/2026, and 09/14/2026. On 09/15/2026 at 1:50 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated Resident #8 received dialysis every Monday, Wednesday, and Friday and received Nepro through the PEG tube four (4) times daily. LPN #1 stated the 2:00 PM feeding was documented with code "13" when the resident was at dialysis and confirmed code "13" indicated the resident was at dialysis. On 09/15/2026 at 2:40 PM, during an interview, the Registered Nurse (RN) #1 Charge Nurse stated she was not aware of any intervention addressing Resident #8's scheduled 2:00 PM enteral feeding while the resident attended dialysis. On 09/15/2026 at 2:50 PM, during an interview, Certified Nurse Aide (CNA) #1 stated Resident #8 was NPO, received nutrition through the PEG tube, and attended dialysis every Monday, Wednesday, and Friday. CNA #1 confirmed no nutritional items were sent with Resident #8 to dialysis. On 09/15/2026 at 3:00 PM, during an interview, the Director of Nursing (DON) stated Resident #8 attended dialysis every Monday, Wednesday, and Friday and confirmed the resident's scheduled 2:00 PM enteral feeding was not provided while the resident was at dialysis. The DON confirmed there were no interventions addressing the missed 2:00 PM feeding on dialysis days and confirmed code "13" documented on the MAR indicated the resident was at dialysis. On 09/15/2026 at 3:40 PM, during a telephone interview, the Dietitian stated she was unaware Resident #8 had not been receiving the scheduled 2:00 PM enteral feeding on dialysis days. The Dietitian stated she had written the enteral feeding			F0692			

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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	
F0692 SS = D	Continued from page 10 order for four (4) feedings daily and had expected the facility to schedule the feedings around the resident's dialysis schedule. The Dietitian confirmed Resident #8 should have received four (4) enteral feedings daily.	F0692					
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to ensure Schedule II controlled substances were stored in a permanently affixed compartment when a medication cart contained a removable narcotic storage box containing Schedule II controlled substances for one (1) of two (2) medication carts observed. Findings include: A review of the facility's policy titled "Medication Storage in the Facility," undated, revealed, "...Procedures...Schedule [II-V] medications...are stored in a permanently affixed, [double-locked] compartment separate from all other medications..."	F0761					

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F0761 SS = D	Continued from page 11 On 09/16/2026 at 9:24 AM, during an observation and interview, the State Agency (SA) observed medication cart #2 contained a narcotic storage box containing Schedule II controlled substances. The narcotic storage box was not permanently affixed within the medication cart and could be removed from the cart. Licensed Practical Nurse (LPN) #2 confirmed the narcotic storage box was not permanently affixed within the medication cart and could be removed. On 09/16/2026 at 9:54 AM, during an observation and interview with the Director of Nursing (DON), the SA observed one (1) of two (2) medication carts contained a narcotic storage box that was not permanently affixed within the medication cart and could be removed. The DON confirmed the narcotic storage box was not permanently affixed and stated the narcotic storage box was supposed to be permanently affixed within the medication cart. On 09/16/2026 at 10:30 AM, during an interview, the facility's Consultant Pharmacist stated she completed monthly pharmacy visits, provided recommendations, and performed random controlled-substance reconciliations. She stated she had not reviewed the medication cart narcotic storage during her monthly pharmacy visits and was unaware the narcotic storage box was not permanently affixed within the medication cart. On 09/17/2026 at 9:28 PM, during an interview, the Administrator stated that she was unaware the narcotic storage box was not permanently affixed within the medication carts.			F0761			
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.			F0836			

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F0836 SS = D	Continued from page 12 §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 interviews, record review, and facility policy review, the facility failed to comply with state nursing facility staffing requirements by failing to designate a licensed nurse to serve as the Charge Nurse responsible for supervision of the total nursing activities in the facility, separate from the medication/treatment nurse assignment, from 7:00 AM to 8:00 AM and from 4:30 PM to 11:00 PM, for one (1) of three (3) shifts reviewed for charge nurse supervision. Findings include: A review of the facility's policy titled "Nursing Services and Sufficient Staff" dated 2025, revealed "...Policy Explanation and Compliance Guidelines...2. The facility must designate a licensed nurse to serve as a charge nurse on each tour of duty..." A record review of the facility's "Daily Staffing Pattern" revealed no designated charge nurse for more than eight (8) hours a day. On 09/16/2026 at 10:35 AM, during an interview, Licensed Practical Nurse (LPN) #3, Staff Development Nurse, stated the facility had a Registered Nurse (RN) designated as the Charge Nurse from 8:00 AM until 4:30 PM. LPN #3 stated RN #3, Wound Care Nurse, assumed the Charge Nurse role until 5:30 PM. LPN #3 confirmed that between the hours of 5:30 PM and 11:00 PM, one of the cart nurses served as the Charge Nurse. LPN #3 stated there was no written assignment identifying which cart	F0836					

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F0836 SS = D	Continued from page 13 nurse was responsible for serving as the Charge Nurse; however, the nurses understood who would assume the role each night. On 09/16/2026 at 2:55 PM, during an interview, RN #1, Charge Nurse, stated her shift was from 8:00 AM until 4:30 PM. RN #1 stated that when her shift ended at 4:30 PM, the most seasoned cart nurse assumed the Charge Nurse role for the remainder of the evening. RN #1 stated that sometimes RN #3, Wound Care Nurse, assumed the Charge Nurse role until the end of her shift at 5:30 PM. On 09/16/2026 at 3:04 PM, during an interview, RN #3, Wound Care Nurse, stated her shift was from 8:30 AM until 5:30 PM. RN #3 stated that when RN #1's shift ended at 4:30 PM, she assumed the Charge Nurse role from 4:30 PM until 5:30 PM while continuing to perform her assigned Wound Care Nurse duties. RN #3 stated she continued to perform wound care and complete wound-care documentation during this time. On 09/16/2026 at 3:10 PM, during an interview, Certified Nursing Assistant (CNA) #2 stated her shift was from 6:30 AM through 7:00 PM. CNA #2 stated that from 7:00 AM through 8:00 AM and from 4:30 PM until the end of her shift at 7:00 PM, she depended on the cart nurse when she required supervisory assistance. On 09/16/2026 at 3:14 PM, during an interview, the Director of Nursing (DON) stated she was aware of the facility's need for a designated Charge Nurse from 7:00 AM through 8:00 AM and from 4:30 PM through 11:00 PM. The DON stated the importance of having a designated Charge Nurse was to provide coverage in the event of an immediate resident-care situation and to prevent the cart nurse from being pulled away from assigned duties. The DON stated the facility would have to hire someone to provide Charge Nurse coverage during the identified times. On 09/16/2026 at 3:19 PM, during an interview, the Administrator stated there had never been a problem that warranted hiring a Charge Nurse until 11:00 PM because the facility did not admit residents at night or on weekends. The Administrator stated she would confer with the facility's corporate office regarding hiring someone to serve as a Charge Nurse until 11:00 PM.			F0836			