

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255302		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/24/2026	
NAME OF PROVIDER OR SUPPLIER SENATOBIA HEALTHCARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 402 GETWELL DR , SENATOBIA, Mississippi, 38668			
(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 Re-certification survey along with a Complaint Investigation (CI MS#3692885) at the facility from 9/22/26 through 9/24/26. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F550, F578, F558, F628, F656, F,657, F684, F688, F698, F806, F808 and F812. The SA investigated CI#3692885 and no deficiencies were cited. The census at the time of the survey was 100 and the facility is licensed for 106 beds.			F0000			
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:			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 Based on observation, interview, and facility policy review, the facility failed to ensure food was stored and dishware was sanitized in accordance with established food safety requirements. This failure was evidenced by the facility's low-temperature dishwasher operating below the required 120°F wash temperature, with temperatures of 106°F and 110°F observed after multiple cycles, and by multiple ready-to-eat and time/temperature control for safety foods stored in the kitchen refrigerator without required date marking. These failures affected one (1) of two (2) kitchen tours and had the potential to result in inadequate sanitization of dishware and utensils and the service of food of unknown storage duration, increasing the risk for foodborne illness to residents. Findings Include: Review of the facility policy titled "Food Safety Requirements" revealed under, "Policy: Food will be stored, prepared, distributed and served in accordance with professional standards for food service safety..." Review of the facility policy titled "Dishwasher Temperature" revealed under, "Policy: It is the policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwasher temperatures.... 4. For low temperature dishwashers (chemical sanitization): a. The wash temperature shall be 120 F (Fahrenheit). b. The sanitizing solution shall be 50ppm (parts per million) hypochlorite (chlorine) on dish surface in final rinse..." Review of the facility policy titled "Date Marking for Food Safety" revealed under, "Policy: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food.... 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared..." Observation during the initial kitchen tour on 9/22/26 at 10:06 AM revealed Dietary Staff #2 running dirty dishes through the low temperature dishwasher. During an interview, Dietary Staff #2 said she did not know whether the dishwasher was a low or high temperature machine. When asked what wash temperature was required, she stated, "I don't know." She said she did not know where the temperature gauge was located, that she was supposed to check it, or that she was supposed to check the sanitizing solution. She said she had worked in the kitchen for only a few months and had	F0812			

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F0812 SS = E	Continued from page 2 not been trained to run the dishwasher. Dietary Staff #3 stated her position was for the tray line, but that staff had been asked to help with the dishes. After several cycles, the dishwasher wash temperature was 106 degrees Fahrenheit. Observation and interview with the Dietary Manager (DM) on 9/22/26 at 10:28 AM revealed he was in his second day of employment at the facility. He confirmed the dishwasher was a low temperature machine and that the wash temperature should reach 120 degrees Fahrenheit. After several more cycles, the gauge rose only to 110 degrees Fahrenheit. The DM stated he did not know how long the machine had operated below the required temperature. During an interview on 9/22/26 at 10:33 AM, Dietary Staff #3 revealed he normally ran the dishwasher when he worked and that the wash temperature must reach 70 degrees. When asked how to check the chlorine concentration of the sanitizing solution, he could not demonstrate the process. The DM then instructed him how to check the concentration. The test result was 100 parts per million (PPM). Observation of the kitchen refrigerator with the DM on 9/22/26 at 10:40 AM revealed the following items without dates: eight ham and turkey sandwiches in a rectangular metal container; one gallon of vegetable soup in a clear plastic container; half of a sliced tomato; chicken noodle soup in a square metal pan; an open package of crackers; and one slice of luncheon meat in a clear sandwich bag. A five-pound plastic container of mustard potato salad had a use-by date of 8/23/26. The DM confirmed the items were not dated and said he could not determine how long they had been in the refrigerator. He said the items would have to be discarded because their storage time could not be verified. He confirmed the items could cause foodborne illness if served to residents. He said the crackers and luncheon meat appeared to belong to a staff member and should not have been stored in the kitchen refrigerator.	F0812					
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F0550					

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F0550 SS = D	Continued from page 3 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, facility policy review, and staff and resident interviews, the facility failed to promote and maintain resident's dignity and right to self-determination for four (4) of 100 residents reviewed for residents' rights. Residents #10, #47, #69, #80 Findings Include: Review of the facility policy titled "Resident Rights" revealed, "The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility." Also revealed under, "5. Self-determination: The resident had the right to and the facility must promote and facilitate resident			F0550			

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F0550 SS = D	Continued from page 4 self-determination through support of resident choice, including but not limited to: ... b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident..." Review of the facility's undated policy titled "Promoting/Maintaining Resident Dignity" with no revision date revealed, "It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity..." Resident #10 During an observation and interview on 9/23/26 at 12:12 PM, Resident #10 was in bed with a wander bracelet on her right ankle. She said she entered the facility for therapy after a hospital stay and had previously lived with her son. She said she made her own decisions, and no one held power of attorney or conservatorship for her. According to the resident, her son told her the previous month that she could not return to his home. She told staff she did not want to remain at the facility and would walk out. She said she became upset and was sent to the hospital after staff reported that she had made a suicidal statement, although she did not recall making that statement. She said paramedics gave her an injection and took her to the hospital against her wishes. Upon her return, staff placed the bracelet on her ankle. The resident stated, "I didn't even know what it was; I had to ask them and was told, If I tried leaving here or tried to go out the door, they would bring me back and would call the police on me. They will not let me leave until I have somewhere safe to go; I can't even get out the doors." She also stated, "I go to the front door and sit but If I get to close it alarms and I have to be moved back." Resident #10 said she did not consent to the bracelet and wanted it removed. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/03/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #10 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #10 on 10/27/25 with medical diagnoses that included Malignant Neoplasm of Unspecified Site of Unspecified Female Breast and Chronic Obstructive Pulmonary Disease. Record review of Resident #10's "Progress Notes" revealed notes dated 8/22/26, "Resident sitting at nurses' station demanding to be let leave the			F0550			

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F0550 SS = D	Continued from page 5 facility. She states she is her own RP (Responsible Party) and she wants to leave. Resident states she will sleep outside until she finds a place. Attempts made to redirect resident unsuccessful. ... Pt (patient) son visited and told pt she could not live on her own due to safety concerns. Pt became very upset and began telling nursing staff she was leaving the facility and would "walk around until she had the money for a place of her own." Nursing staff notified RP, Admin (Administrator), DON (Director of Nursing), and supervisor as well as called facility psychiatrist when pt stated, "I just don't want to live anymore." Facility psychiatrist as well as on call NP (Nurse Practitioner) gave orders for pt to have psychiatric evaluation done due to suicidal thoughts, Pt was transported via EMS (Emergency Management Services) to 'Proper name of Hospital' after becoming aggressive with EMS and refusing RP, son (Proper name) agreed for pt to be seen for psych evaluation." Also revealed under, "Behavior Note: Resident verbalized to staff "I don't want to live anymore." Resident noted to be in emotional distress and attempting to leave the facility AMA (against medical advice)..." Record review of Resident #10's "Hospital Discharge Summary" dated 8/27/26 revealed, "Presents to the ED (emergency department) with aggressive and agitation with concerns of suicidal statements. Patient resides in a nursing home; this morning, she was aggressive to the nursing home staff and was reported that she had suicidal statements for which she required chemical and physical restraints in the nursing home. Upon interview, patient denies reporting suicidal statements. In the ED, vital signs concerning for tachycardia with labs remarkable for AKI (Acute Kidney Injury), Hypercalcemia (high calcium) and UA (urinalysis) concerning for bacteriuria. She received IV (intravenous) abx (antibiotics) and was admitted to medicine for further management. Pt was evaluated by psychiatry and started on Zoloft and Seroquel. Her UTI (Urinary Tract Infection) was treated with merrem (antibiotic). She was deemed stable for d/c (discharge) back to SNF (skilled nursing facility) on 8/27/26." Record review of Resident #10's "Order Details" showed an order dated 8/27/26: "Wander Guard to right ankle to alert staff to exit seeking. Check placement and function q (every) shift." Record review of Resident #10's "Elopement Evaluation," dated 8/27/26, identified the resident as a wanderer because she expressed a desire to go home or stayed near an exit door. The evaluation			F0550			

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F0550 SS = D	Continued from page 6 showed no history of elopement or attempts to leave without notifying staff. During an interview on 9/23/26 at 12:30 PM, the DON revealed she had worked at the facility for about three weeks. She said staff applied the wander bracelet because Resident #10 threatened to walk across the parking lot and go home. The DON confirmed that the resident did not have dementia, was cognitively intact, and did not have a power of attorney for decision-making. During an interview on 9/23/26 at 4:37 PM, Social Services (SS) revealed Resident #10 demanded to leave after her son told her she could not return to his home. SS stated nursing staff then applied the wander bracelet. During an interview on 9/24/26 at 9:20 AM, the Administrator (ADM) revealed the bracelet was applied for safety. He referred to an incident several years earlier in which he stated another cognitively intact resident left the facility and police were called. He said residents were no longer allowed on the front porch and the facility used wander bracelets for residents who might leave. He said he told Resident #10 she could not leave because she had nowhere to stay and was at high risk for self-harm. He confirmed she had not attempted to go out the door but had threatened to leave and said she would sleep in a ditch. He revealed he told her he would call the police and Adult Protective Services (APS) if she left. The ADM acknowledged that Resident #10 was cognitively intact and should be able to make decisions about her care, but stated, "I can't allow her to leave." When asked whether she had consented to the bracelet, he stated, "I was told she did." After being informed that the resident wanted it removed, he stated, "We can't take it off because she has not been back from the hospital 30 days yet," and described this as facility protocol. During an interview on 9/24/26 at 10:05 AM, Certified Nurse Aide (CNA) #1 revealed Resident #10 had never tried to leave through the doors. The CNA stated staff applied the wander bracelet after the resident said she wanted to leave the facility. During a telephone interview on 9/24/26 at 11:10 AM, Registered Nurse (RN) #1 revealed she was instructed to apply the wander bracelet when Resident #10 returned from the hospital because the resident had expressed a desire to go home. Resident #47			F0550			

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F0550 SS = D	Continued from page 7 Resident #69 Resident #80 During an observation of residents in the dayroom of the 200 Hall on 9/22/2026 at 10:26 AM, Resident #47, Resident #69, and Resident #80 were observed sitting in the dayroom with seven (7) other residents. A sign was taped to the back of the residents' wheelchairs that stated, "I'M READY FOR BED!" On 9/22/2026 at 10:30 AM, Licensed Practical Nurse (LPN) #1, assigned to the 200 Hall stated, "Today was the first time I have witnessed signs on the wheelchairs. I'm not sure who put them on the wheelchairs or why." During an interview with the DON on 9/22/2026 at 11:00 AM, she stated she was unaware of signs on the wheelchairs and would not have agreed to the use of signage on the back of a resident's wheelchair. During an interview on 9/22/2026 at 11:05 AM with the Administrator, he stated a staff member had placed the signs on the wheelchairs to remind CNAs which residents needed to be assisted to bed. The Administrator stated residents' rights and signage had previously been addressed with staff, and he was not in agreement with signage being placed on the back of the residents' wheelchairs. Record review of a copy of the signage provided to the surveyor read, "IM READY FOR BED!" On 9/23/2026 at 3:36 PM, RN #1, stated she had typed the note to inform CNAs which residents needed assistance getting to bed. She stated she had not intended the signs to be harmful or malicious. She confirmed that residents have a right to dignity and respect and signs on the back of residents' wheelchairs should not have been used. Record review of the "Admission Record" revealed the facility admitted Resident #47 on 11/23/2023 with medical diagnoses that included Unspecified Dementia.	F0550					

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F0550 SS = D	Continued from page 8 Record review of the MDS with an ARD of 8/28/26 revealed under section C, a BIMS of 4, which indicated Resident #47 had severe cognitive impairment. Record review of the "Admission Record" revealed the facility admitted Resident #69 on 5/15/2026 with medical diagnoses that included Dementia. Record review of the MDS with an ARD of 8/18/2026 revealed under section C, a BIMS of 3, which indicated Resident #69 had severe cognitive impairment. Record review of the "Admission Record" revealed the facility admitted Resident #80 on 10/11/2023 with medical diagnoses that included Vascular Dementia. Record review of the MDS with an ARD of 8/14/2026 revealed under section C, a BIMS of 3, which indicated Resident #80 had severe cognitive impairment.			F0550			
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident who required supervision during meals was offered and provided breakfast when the resident declined to eat in the dining room for one (1) of nine (9) residents reviewed for dining. Resident #14 Findings include: Review of the facility policy titled "Meal Supervision and Assistance" revealed under, "Policy: The resident will be prepared for a well-balanced meal in a calm environment, location of his/her preference and with adequate supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event..." An observation of Resident #14 on 9/23/26 at 10:25			F0558			

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F0558 SS = D	Continued from page 9 AM revealed he was sitting in his wheelchair in the hallway. He stated, "I did not have anything to eat this morning; I didn't get my breakfast and I'm hungry." On 9/23/26 at 10:40 AM, an interview with Licensed Practical Nurse (LPN) #3 confirmed Resident #14 had not eaten that day. LPN #3 stated Resident #14 was at risk for aspiration and choking and required supervision while eating. LPN #3 stated he had to eat in the dining area for staff to supervise him, but he refused to go to the dining room for breakfast. An interview on 9/23/26 at 10:43 AM, Certified Nurse Aide (CNA) #3 stated she was assigned to Resident #14 that day but had been pulled to another hall shortly after breakfast. CNA #3 stated she knew Resident #14 had not eaten breakfast because she saw his tray on the cart and his meal ticket was marked as refused. An interview on 9/23/26 at 10:47 AM, CNA #2 stated she knew Resident #14 had refused to go to the dining area for breakfast. CNA #2 confirmed staff had not offered him the tray to eat in his room and had marked the meal as refused. A follow-up interview on 9/23/26 at 10:49 AM, LPN #3 stated she was unaware Resident #14 could choose to eat in his room. LPN #3 acknowledged that staff should honor his preference and provide assistance and supervision where he chose to eat. An interview on 9/23/26 at 10:52 AM, the Director of Nursing (DON) confirmed staff should supervise a resident's meal in the resident's room if that was the resident's choice. The DON stated the facility had an extra aide on the floor to help because many residents required assistance with meals. Record review of the "Admission Record" revealed the facility admitted Resident #14 on 8/31/26 with medical diagnosis that included Cerebral Infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/7/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 9, which indicated Resident #14 was moderately cognitively impaired.			F0558			
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or			F0578			

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F0578 SS = D	Continued from page 10 discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to accurately document, implement, and communicate a resident's current choice regarding cardiopulmonary resuscitation (CPR) by failing to update the electronic medical record (EMR) from Do Not Resuscitate/No CPR after a subsequent Physician Orders for Sustaining Treatment (POST) form directed staff to "Attempt Resuscitation/CPR," And the facility failed to ensure advance directive/code	F0578					

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F0578 SS = D	Continued from page 11 status was established for a resident by failing to complete a POST form following admission for two (2) of 23 residents reviewed for advance directives and code status, Resident #8 and Resident #83. Findings include: Review of facility policy titled, "Communication of Code Status" undated, revealed, "It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information..." Resident #8 Record review of Resident #8's Order Summary Report revealed an order for Do Not Resuscitate (DNR)/No Cardiopulmonary Resuscitation (CPR), dated 05/31/2024. Record review of Resident #8's Mississippi Physician Orders for Sustaining Treatment (POST) form, dated 06/17/2026, revealed "Attempt Resuscitation/CPR" was selected, indicating the resident was to receive cardiopulmonary resuscitation if she had no pulse and was not breathing. During an interview on 09/23/2026 at 2:20 PM, the Director of Nursing (DON) confirmed Resident #8's code status was documented as Do Not Resuscitate (DNR) in the electronic medical record (EMR) and stated nursing staff would rely on the EMR to determine the resident's code status during an emergency. After reviewing Resident #8's updated POST form dated 06/17/2026, which identified the resident as Full Code, the DON confirmed the EMR had not been updated to reflect the resident's current choice. The DON stated, "This is a problem," and acknowledged that the end of life wishes that the resident had chosen on 06/17/26 did not match the previous order dated 05/31/24. Record review of Resident #8's Admission Record revealed the resident was admitted to the facility on 5/31/24 with medical diagnoses that included Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/7/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 15 under Section C, which indicated Resident #8 was cognitively intact.			F0578			

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F0578 SS = D	Continued from page 12 Resident #83 Record review of Resident #83's "Mississippi Physician Orders for Sustaining Treatment (POST)" form revealed no selection for cardiopulmonary resuscitation (CPR) and no signatures. Record review of a letter dated 9/23/2026 and authored by the Administrator, revealed, "With the responsible party failing to sign the paperwork and the Resident's current cognitive status, the facility has not established a new code status or completed a new POST for [Resident #83]." During an interview on 9/23/2026 at 11:45 AM, Resident #83 was unable to understand or appropriately respond to questions asked during the interview. During an interview on 9/23/2026 at 3:50 PM, the Administrator confirmed that the POST form was not completed upon Resident #83's admission. He stated Resident #83's responsible party refused to sign the paperwork and confirmed no attempts had been made to contact the other individuals listed as contacts for Resident #83. The Administrator further confirmed there was no conservatorship in place for Resident #83 and that the process to establish conservatorship had not been initiated. He confirmed Resident #83 was cognitively impaired and unable to understand or make decisions regarding code status. Record review of "Admission Record" revealed Resident #83 admitted to facility on 7/30/2026 with a diagnosis of Displaced Spiral Fracture of Shaft of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing. Record review of MDS with ARD of 8/7/2026 revealed under Section C, a BIMS summary score of three (3), indicating Resident #83 was severely cognitively impaired.	F0578					
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. 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	F0628					

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F0628 SS = D	Continued from page 13 documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or 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	F0628					

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F0628 SS = D	Continued from page 14 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the 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	F0628					

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F0628 SS = D	Continued from page 15 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or			F0628			

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F0628 SS = D	Continued from page 16 therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to complete transfer notifications and provide bed hold notifications for two (2) of three (3) residents reviewed for transfer and discharge. Resident #11 and Resident#104 Findings include: Review of the facility policy titled, "Bed Hold Notice" dated 3/19/25, revealed, "Policy: It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave..." Review of the facility policy titled, "Transfer and Discharge" undated, revealed, "...The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. The specific reason and basis for transfer or discharge. b. The effective date of transfer or discharge. c. The specific location...to which the resident is to be transferred or discharged...4. Generally, the notice must be			F0628			

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F0628 SS = D	Continued from page 17 provided at least 30 days prior to a transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because...c. An immediate transfer or discharge is required by the resident's urgent medical needs...e. In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and Long-Term Care (LTC) Ombudsman as soon as practicable before the transfer or discharge. The facility will maintain evidence that the notice was sent to the Ombudsman...10. Emergency Transfers to Acute Care...g. Provide a notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated. h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices..." Resident #11 Review of Resident #11's Health Status Note dated 7/13/26 revealed, "Notified Resident of Emergency Room (ER) transfer order. Resident was accepting and willing to go to ER. Called (proper name) for transportation. Paperwork and bed hold printed for transferring to ER gave to floor Nurse." During an interview with Social Services on 9/23/26 at 4:49 PM, when questioned about bed-hold notification following hospital admission, she stated, "Usually Admissions goes over that during admission." She stated that the former skilled care coordinator did that until she left in June. She further stated that she was not instructed to do notification to Ombudsman until the Director of Nursing (DON) told her about it today. During an interview on 9/23/26 at 4:55 PM with Admissions Coordinator, he confirmed that he does review the bed hold policy upon admission with the resident and their Resident Representative (RR). When questioned about the hospital discharge process, he stated Social Services would call and ask the RR if they wanted to pay bed-hold for the bed. Social services tell them the price of the bed hold. He stated, "To my knowledge...I'm not sure. I just know the social worker handles that." During an interview on 9/23/26 at 5:01 PM, the Administrator, when asked about the process of bed-hold notification with hospital discharges, he stated, "Notice of bed hold would go with the patient to the hospital. The nurse doing the discharge prints			F0628			

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F0628 SS = D	Continued from page 18 the bed hold templet and sends it with the patient." When asked about the notification to the Ombudsman, he stated, "The DON had that responsibility until she left in July...so we are behind." During an interview with Licensed Practical Nurse (LPN) #4 on 9/23/26 at 5:11 PM regarding hospital discharge process, she stated, "I send a face sheet, orders list, bed hold, transfer/discharge, any labs or x-ray with the resident." She stated the bed hold form was kept in a folder at the nurse's station. During an interview on 09/24/2026 at 10:16 AM with the DON she confirmed Resident #11's bed hold for 7/13/2026 was not done. She stated she checked with medical records to ensure that it wasn't in her office, but it wasn't. She also confirmed the ombudsman was not notified of any discharges for July. She stated she found the Ombudsman Notification Logs for January 2026 – June 2026, but no other months were available. Record review of Resident #11's Admission Record revealed the resident was admitted to the facility on 4/17/2026 with medical diagnoses that included End Stage Renal Disease and Dependence on Renal Dialysis. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/27/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 15 under Section C, which indicated Resident #11 was cognitively intact. Resident #104 Review of Resident #104's "Progress Note" dated 8/24/2026 at 8:38 PM revealed the resident was transferred to the hospital on 8/24/2026 for abdominal pain. Review of Resident #104's record did not contain documentation that written bed-hold information was provided to the resident or resident representative at the time of transfer. The record also did not contain documentation that notice of the transfer was sent to the Office of the State Long-Term Care Ombudsman. During an interview on 9/24/2026 at 11:12 AM, Social Services stated the transfer bed-hold			F0628			

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F0628 SS = D	Continued from page 19 information had not been sent to the family, and there was no notification sent to the Ombudsman regarding transfer. She stated she had not been informed that she was supposed to complete them. She stated the staff member who previously completed the documents left in June 2026. On 9/24/2026 at 11:35 AM, the DON stated she was unaware that the transfer bed-hold information had not been sent to the family, and that notification had not been sent to the Ombudsman. Record review of the "Admission Record" revealed the facility admitted Resident #104 on 5/11/2024 with medical diagnoses that included Chronic Obstructive Pulmonary Disease. Record review of the MDS with an ARD of 6/29/2026 revealed under section C, a BIMS of 4, which indicated Resident #104 had severe cognitive impairment.	F0628					
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	F0656					

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F0656 SS = D	Continued from page 20 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. §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 accurate, individualized, comprehensive care plans for three (3) of 23 residents reviewed for care planning (Residents #8, #11, and #16). Specifically, the facility failed to ensure that Resident #8's care plan accurately reflected her current code status; Resident #11's care plan identified the need for hemodialysis but did not address his fluid restriction and related monitoring/interventions; and Resident #16's care plan included interventions for management of bilateral hand contractures that were not implemented as ordered. Findings include: Review of the facility policy titled "Comprehensive Care Plans," undated, revealed, "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident..." Resident #8 Record review of Resident #8's Advance Directive care plan revealed, "I have the following in place for advance directives: Code Status - Do Not Resuscitate (DNR)."	F0656					

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F0656 SS = D	Continued from page 21 Record review of Resident #8's Mississippi Physician Orders for Sustaining Treatment (POST) form, dated 06/17/2026, revealed "Attempt Resuscitation/ cardiopulmonary resuscitation (CPR)" was selected for when the resident had no pulse and was not breathing. During an interview on 09/24/2026 at 9:13 AM, the Minimum Data Set (MDS) Coordinator stated Resident #8's code status care plan should match her most recent POST form. She stated staff use residents' care plans to determine how to provide their care. Record review of Resident #8's Admission Record revealed the resident was admitted to the facility on 05/31/2024 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side. Review of Resident #8's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/07/2026, revealed a Brief Interview for Mental Status (BIMS) summary score of 15 which indicated Resident #8 was cognitively intact. Resident #11 Record review of Resident #11's comprehensive care plan revealed "I need hemodialysis r/t (related to) renal failure ". No identification of a fluid restriction and no interventions for monitoring or managing the resident's fluid intake were included on the care plan. On 09/23/2026 at 12:20 PM during an observation and interview, following Resident #11's dialysis treatment, the resident's bedside table held a water pitcher, an unopened 16-ounce bottle of carbonated beverage, and an unopened eight-ounce bottle of another carbonated beverage. Resident #11 stated, "They just filled up my water pitcher." When asked about fluid restrictions, he stated, "I'm not supposed to have over 32 ounces a day." During an interview on 09/24/2026 at 9:27 AM, the MDS Coordinator confirmed that a fluid-restriction care plan had not been developed because the facility had no fluid-restriction orders for the resident. She stated, "If I see an order, I put a care plan in place for it." Record review of Resident #11's Admission Record revealed the resident was admitted to the facility on 04/17/2026 with diagnoses that included end-stage	F0656					

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F0656 SS = D	Continued from page 22 renal disease and dependence on dialysis. Review of Resident #11's MDS, with an ARD of 07/27/2026, revealed a BIMS summary score of 15 which indicated Resident #11 was cognitively intact . Resident #16 Record review of Resident #16's "Care Plan Report" revealed that she had limited physical mobility related to Parkinson's Disease, contractures of bilateral hands/ Upper Extremity and Lower Extremity, and Weakness. Interventions included in the care plan documented, "5/26/26-Place carrot in both hands every morning x (times) 6 (six) hrs (hours)/day-nurse to remove every 2 (two) hours and as needed for skin and circulation checks." On 09/22/26 at 11:00 AM an observation revealed Resident #16 lying in bed and she had bilateral hand contractures. Her right hand was closed tightly in a fist with her fingernails touching the palm of her hand and her left hand was closed and she had the ability to flex and extend her left index finger. There were no hand devices in use. During an interview on 09/24/2026 at 9:30 AM, the MDS Coordinator confirmed that Resident #16's care plan was not being implemented if the staff was not utilizing the carrots in her hands for contractures as the physician had ordered. Record review of Resident #16's "Admission Record" revealed an admission date of 02/18/10 with diagnoses that included Unspecified Dementia and Need for Assistance with Personal Care. Record review of Resident #16's Physician order dated 05/28/26 revealed order to place carrot in both hands every morning for six hours per day and for nurse to remove every 2 hours and as needed for skin and circulation checks. Record review of Resident #16's MDS with ARD of 08/13/26 under Section C revealed a BIMS Score of 99 which indicated that she had severe cognitive deficits. Section GG revealed that she had upper extremity impairment on both sides.			F0656			

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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-- (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 record review, family and staff interview and facility policy review, the facility failed to invite the resident representative (RR) to participate in care plan meetings and failed to conduct care plan meetings quarterly for one (1) of 23 sampled residents, Resident #69 Findings Include: Record review of facility policy titled, "Comprehensive Care Plans," stated, "The comprehensive care plan will be developed by an interdisciplinary team (IDT), that includes, but is not limited to.....The resident and the resident's representative..... The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly	F0657			

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F0657 SS = D	Continued from page 24 Minimum Data Set (MDS) assessment." Record review of Resident #69's "Plan of Care Note" dated 6/2/2026, revealed, "IDT meeting held on this date." The note did not identify the IDT members who participated, nor did it document participation by the resident or resident representative (RR). During a telephone interview on 9/22/2026 at 3:22 PM, Resident #69's RR stated that since Resident #69's admission on 05/15/26, she had not received any telephone calls or letters regarding care plan meetings. She stated that had she been notified of a care plan meeting, she and her sister would have attended. During an interview on 9/24/2026 at 10:30 AM, the Social Worker confirmed the only care plan meeting documented for Resident #69 was held on 6/2/2026. She confirmed the "Plan of Care Note" did not identify who attended the meeting. She stated the "Plan of Care Note" entered into the electronic medical record was the facility's documentation of care plan meetings and that sign-in sheets were not used. The Social Worker stated RRs were invited to care plan meetings by telephone and invitations were not mailed. She stated she did not document telephone calls made to invite RRs and confirmed there was no documentation to show that Resident #69's RR was contacted or invited to the 6/2/2026 care plan meeting. The Social Worker stated care plan meetings were held quarterly according to the Minimum Data Set (MDS) schedule. She confirmed Resident #69 was past due for another care plan meeting and that another care plan meeting had not been held or scheduled. She further confirmed she had not contacted Resident #69's RR to schedule a care plan meeting for the previous quarterly MDS dated 08/18/26. During an interview on 9/24/2026 at 11:35 AM, the Director of Nursing (DON) confirmed that care plan meetings should be held quarterly and that Resident #69's RR should have been invited to participate in the care plan meetings. The DON also confirmed that the previous care plan meeting should have been held around 08/18/26 for the last Assessment Reference Date (ARD) for the last quarter and confirmed that it was not. Record review of "Admission Record" revealed Resident #69 was admitted to facility on 5/15/2026 with a diagnosis of Chronic Kidney Disease, Stage 4 (Severe).			F0657			

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F0657 SS = D	Continued from page 25 Record review of the MDS with an ARD of 08/18/26 revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating that the resident was severely cognitively impaired.	F0657					
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview and facility policy review, the facility failed to provide a physician ordered treatment necessary to address a resident's bilateral lower-extremity edema and maintain the resident's highest practicable physical well-being. Specifically, the facility failed to apply compression stockings as ordered every morning and remove them at bedtime for one (1) of 23 sampled residents (Resident #67). Findings Include: Record review of facility policy titled "Physician/Practitioner Orders For Non Medications" revealed, "In long term care (LTC) facilities, physician orders for non-medication care are legally binding and must be followed exactly as written..." Record review of the "Order Summary Report" revealed an active order dated 5/20/2025 for, "Apply compression stockings to bilateral lower extremities (BLE)s every (q) AM, remove at hour of sleep (HS). Ensure proper size with appropriate measurements." During an observation on 9/22/2026 at 11:59 AM, Resident #67 was seated in her wheelchair in the dining room. Gross edema was observed to both lower extremities. Resident #67 was wearing gripper socks; no compression stockings were observed. During an observation and interview on 9/23/2026 at 10:41 AM, Licensed Practical Nurse (LPN) #6 confirmed Resident #67 had gross pitting edema to	F0684					

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F0684 SS = D	Continued from page 26 both lower extremities, with indentations from the gripper socks she was wearing. LPN #6 initially stated, "There is no order for compression stockings." She stated Resident #67 was typically assisted out of bed during the 11:00 PM to 7:00 AM shift and returned to bed at the end of the day shift or during the 3:00 PM to 11:00 PM shift. LPN #6 reviewed Resident #67's orders and confirmed there was an active order to apply compression stockings. Review of the order with LPN #6 revealed there was no schedule associated with the order and "no documentation required" was selected. LPN #6 stated, "That's why I didn't know that it was an order." She stated the Nurse Practitioner (NP) entered the order, and a facility nurse confirmed it and the nurse who confirmed the order should have ensured a schedule was entered and that the order populated to the Medication Administration Record/Treatment Administration Record (MAR/TAR). LPN #6 confirmed she had not been applying Resident #67's compression stockings and that no task had been entered for Certified Nursing Assistants (CNAs) to apply them. During an interview on 9/23/2026 at 11:35 AM, CNA #5 stated she was aware Resident #67 was supposed to wear compression stockings. CNA #5 reviewed Resident #67's tasks on the kiosk and confirmed there was no task listed for applying or removing the compression stockings. She also reviewed the Kardex and confirmed it did not include instructions to apply or remove the compression stockings. When asked how she knew Resident #67 was supposed to wear the compression stockings, CNA #5 was unable to recall. CNA #5 confirmed Resident #67 was wearing gripper socks and did not have compression stockings on. She stated Resident #67 was assisted out of bed by the 11:00 PM to 7:00 AM shift and acknowledged that when she observed the resident was not wearing the compression stockings, she should have applied them. During an interview on 9/23/2026 at 3:30 PM, LPN #4 revealed she had confirmed the order for Resident #67's compression stockings. She stated she did not routinely work with Resident #67 and was assisting the nurses with confirming orders. LPN #4 acknowledged that when confirming the order, she failed to ensure a schedule was entered so the order would populate to the MAR/TAR. During an interview on 9/24/2026 at 12:00 PM, the Director of Nursing (DON) stated it was her expectation that all physician orders be followed. She stated that when Resident #67's compression stocking order was confirmed, a schedule should			F0684			

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F0684 SS = D	Continued from page 27 have been entered and the nurse confirming the order should have placed the order on the 24-hour report or communication board. The DON further stated Medical Records staff were responsible for auditing new orders the following day to ensure the order schedule was correct.	F0684					
F0688 SS = D	Record review of "Admission Record" revealed Resident #67 was admitted to the facility on 7/23/2018 with diagnoses of Essential (Primary) Hypertension and Edema, Unspecified. Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to provide the physician ordered services to prevent the likelihood of worsening contractures for 1 (one) of 2 (two) residents reviewed for range of motion (ROM) and contractures, Resident #16. Findings Include: Review of the facility policy "Prevention of Decline in Range of Motion" revealed under "Policy Explanation Compliance Guidelines: 1. The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systemic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventative care..."	F0688					

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F0688 SS = D	Continued from page 28 An observation on 09/22/26 at 11:00 AM revealed Resident #16 lying in bed and she had bilateral hand contractures. Her right hand was closed tightly in a fist with her fingernails touching the palm of her hand and her left hand was closed and she had the ability to flex and extend her left index finger and there were no hand devices in use. Follow-up observations on 09/23/26 at 8:35 AM and at 11:10 AM and on 09/24/26 at 8:13 AM revealed Resident #16 lying in her bed with bilateral hand contracture and no devices were in place inside of her hands. There were three carrot hand devices on top of her nightstand next to her bed. Resident #16 had severe cognitive deficits and was dependent on staff to meet her needs. An interview on 09/23/26 at 2:30 PM with Certified Nursing Assistant (CNA) #4, revealed that Resident #16 did not have hand devices to be placed in her hands, and she confirmed that she had never observed anything placed in her hands. CNA #4 entered Resident #16's room and confirmed the three soft carrot hand devices located on her nightstand next to her bed and not in use in resident's hands. CNA #4 revealed that the application of hand devices was not listed on her Kardex/task list, so she didn't know to do it. An interview on 09/24/26 at 8:35 AM with Licensed Practical Nurse (LPN) #5 revealed that Resident #16 was assigned to her and she took care of her often. She revealed that Resident #16 was bedbound and dependent on staff to care for her. LPN #5 revealed that Resident #16 had bilateral hand contractures and confirmed that she had observed the carrots in her hands a few times before but not every day and further confirmed that if hand splints or devices were placed in her hands, the resident would not be able to remove them. LPN #5 confirmed the three soft hand carrots on her nightstand and confirmed she was not wearing them today. At that time LPN #5 reviewed Resident #16's physician orders on the computer, confirmed the order for the carrots to be placed for six hours a day and stated, "I didn't know about the order" and confirmed that she had not been making sure they were in place. She further revealed that the use of hand splints was often put in place to help keep the hands open to prevent fingernails from cutting into the skin causing possible breakdown and infection. An interview on 09/24/26 at 8:45 AM with the Director of Nursing (DON) revealed that there were no excuses for the carrot devices not to be in place in Resident #16's contracted hands as ordered. She	F0688					

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F0688 SS = D	Continued from page 29 revealed that the carrot devices should be placed in resident's hands every day for six hours to help prevent her fingernails from touching her hands which could cause skin breakdown and worsening of contractures. She revealed that her expectation was for all nurses and CNAs to follow the orders located on the Task list and on her care plan. She revealed that she had recently printed all the resident tasks off and reviewed with staff of the importance of following the care assigned to each resident. The DON confirmed the order for the hand splints to be applied daily for 6 hours and stated she would have to make adjustments to ensure this was completed. Record review of Resident #16's "Admission Record" revealed an admission date of 02/18/10 with diagnoses that included Unspecified Dementia and Need for Assistance with Personal Care. Record review of Resident #16's Physician order dated 05/28/26 revealed order to place carrot in both hands every morning for six (6) hours per day and for nurse to remove every 2 hours and as needed for skin and circulation checks. Record review of Resident #16's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/13/26 under Section GG revealed that she had upper extremity impairment on both sides. Record review of Resident #16's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/13/26 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 99 which indicated that she had severe cognitive deficits.			F0688			
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to coordinate dialysis-related fluid management with the dialysis provider and attending practitioner to ensure that daily fluid restrictions were being adhered to and monitored for two (2) of 23 sampled residents. Resident #11 and Resident #12 Findings include:			F0698			

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F0698 SS = D	Continued from page 30 Review of the facility policy titled "Hemodialysis," undated, revealed, "...The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include...Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services...3. The facility will coordinate and collaborate with the dialysis facility to assure that: a. The resident's needs related to dialysis treatments are met...d. There is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff..." Record review of facility policy titled "Fluid Restriction" revealed, "It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders..." Resident #11 During an observation and interview on 09/23/2026 at 12:20 PM, following Resident #11's dialysis treatment, the resident's bedside table held a water pitcher, an unopened 16-ounce bottle of carbonated beverage, and an unopened eight-ounce bottle of a carbonated beverage. Resident #11 stated, "They just filled up my water pitcher." When questioned about fluid restrictions, Resident #11 stated, "I'm not supposed to have over 32 ounces a day." Review of Resident #11's Order Summary Report for 04/01/2026 through 09/23/2026 revealed no active or discontinued order for a fluid restriction. The Order Summary Report included an active order dated 07/20/2026 that directed staff to "Offer eight (8) ounces (oz) water with medications to promote urinary health every shift; may offer water flavor/enhancers if no allergy to red dye." During an observation on 09/23/2026 at 1:02 PM, Resident #11's lunch tray included an (8) eight-ounce glass of tea. During an interview on 09/23/2026 at 2:26 PM, the Director of Nursing (DON) stated, "I have only been here three weeks, and I have yet to meet the Registered Dietitian." When questioned regarding Resident #11's fluid restriction, the DON reviewed the resident's orders and confirmed there was no order for a fluid restriction and no documentation that nursing staff monitored the resident's fluid intake. The DON stated she had been told the Registered Dietitian visited the facility weekly. The			F0698			

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F0698 SS = D	Continued from page 31 DON reviewed Resident #11's admission history and physical and confirmed someone had written "fluid restriction?" on the front page; however, she found no documentation that the question had been clarified or addressed. The DON reviewed the facility Registered Dietitian's notes dated 04/23/2026, 05/14/2026, 06/26/2026, and 07/27/2026 and confirmed the dietitian had documented that Resident #11 was not on a fluid restriction. During a telephone interview on 09/23/2026 at 2:40 PM, a Registered Nurse (RN) at (proper name) Dialysis center, confirmed Resident #11 was on a 32-ounce-per-24-hour fluid restriction. The RN stated, "I'm sure he goes above that; he comes in above his dry weight." The RN confirmed Resident #11 had not required additional dialysis treatment days to remove excess fluid since admission to the nursing facility. During a telephone interview on 09/23/2026 at 2:50 PM, the facility's Registered Dietitian stated Resident #11 was not on a fluid restriction. She stated that, based on her communication with the Registered Dietitian at the dialysis center, she understood that Resident #11 was not on a fluid restriction. The facility Registered Dietitian stated, "If she makes any changes, she will notify me, and she has not notified me." During a telephone interview on 09/23/2026 at 2:55 PM, the Registered Dietitian at the dialysis center confirmed Resident #11 was on a fluid restriction and stated, "I keep him on 32 ounces." Record review of Resident #11's documented Fluid Intake with Meals was 1,200 milliliters on 09/15/2026 and 1,560 milliliters on 09/17/2026. Both amounts were greater than 32 ounces, approximately 946 milliliters. The record did not establish the total fluid consumed during either 24-hour period because fluids at medication pass, between meals, and in the resident's, room were not documented. Record review of Resident #11's Admission Record revealed the resident was admitted to the facility on 4/17/2026 with medical diagnoses that included End Stage Renal Disease and Dependence on Renal Dialysis. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/27/26, revealed a Brief Interview for Mental Status (BIMS) summary score of 15 under Section C, which indicated Resident #11 was cognitively intact.			F0698			

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NAME OF PROVIDER OR SUPPLIER SENATOBIA HEALTHCARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 402 GETWELL DR , SENATOBIA, Mississippi, 38668			
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F0698 SS = D	Continued from page 32 Resident #12 Record review of Resident #12's Medication Administration Record (MAR) revealed an order for a "1,000 milliliter (mL) fluid restriction, Breakfast 4 oz (ounces) (120 cc (cubic centimeters)) juice, 6 oz. (180 cc) coffee, 8 oz. (240 cc) milk, Lunch 4 oz (120 cc) tea or water, Supper 4 oz. (120 cc) tea or water TOTAL 26 oz. (780 cc) fluids, Nursing Service should deliver the remaining 8 oz (240 cc)". Further review of the resident's allotted fluids for meals and medication administration revealed the amounts totaled 1,020 mL over a 24-hour period, exceeding the ordered fluid restriction by 20 ml. Record review of Resident #12's fluid intake documentation and medication administration documentation revealed fluid intake was documented separately for meals and medication administration; however, there was no documentation of a cumulative 24-hour fluid intake to demonstrate Resident #12's total fluid consumption was monitored in accordance with the 1,000 ml fluid restrictions. An observation on 9/22/2026 at 12:26 PM revealed Resident #12 had eight (8) ounces of unsweet tea on her lunch tray. During an interview on 9/22/2026 at 12:30 PM, Certified Nursing Assistant (CNA) #4 confirmed Resident #12 had 240 ml of unsweet tea on her meal tray. CNA #4 stated she had set up Resident #12's meal tray and did not check the meal ticket. CNA #4 reviewed the meal ticket and confirmed it indicated Resident #12 was on a 1,000 mL fluid restriction and should have received four (4) ounces of unsweet tea with the meal. CNA #4 stated she did not know how many ounces equals 240 mL and asked, "It's not four?" During an interview on 9/24/2026 at 10:17 AM, Licensed Practical Nurse (LPN) #6 confirmed Resident #12 was on a 1,000 ml fluid restriction. LPN #6 stated she did not track the amount of fluids Resident #12 consumed throughout the day or the resident's total fluid intake over a 24-hour period. She stated she provided Resident #12 with 240 mL of fluid each day during medication administration.			F0698			

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F0698 SS = D	Continued from page 33 During an interview on 9/24/2026 at 12:20 PM, the DON confirmed Resident #12 was on a 1,000 ml fluid restriction and that the resident's total fluid intake over 24 hours was not monitored or documented. The DON stated it was her expectation that the resident's fluid restriction be followed. She stated the error with the amount of fluid provided on the meal tray originated in the kitchen; however, she acknowledged the Certified Nursing Assistant (CNA) serving the meal tray should have identified the error and should have known that 240 mL was more than four (4) ounces indicated on the meal ticket. The DON also confirmed that the 240 mL of fluid documented during medication administration exceeded the amount ordered. Record review of "Admission Record" revealed Resident #12 was admitted to the facility on 5/18/2026 with diagnoses of End Stage Renal Disease and Dependence on Renal Dialysis.	F0698					
F0806 SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to prevent a resident from receiving food containing a documented allergen for one (1) of nine (9) residents reviewed for dining. Resident #58 Findings Include: Review of the facility policy titled "Food Preparation Guidelines" revealed under, "Policy: It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status....5. Staff shall accommodate	F0806					

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F0806 SS = D	Continued from page 34 resident allergies, intolerances, and preferences, providing appropriate alternatives when needed..." An observation of Resident #58 on 9/23/26 at 12:40 PM revealed she was eating lunch in her room. Her tray contained chopped hamburger steak and gravy, turnip greens, mashed potatoes, cornbread, apple pie, and tea. The meal ticket listed "Allergies: Cinnamon/peanuts." Resident #58 stated the apple pie had cinnamon on it and that she was allergic to cinnamon. She stated that if she had eaten the pie, she would have had to go to the hospital. An interview with Certified Nurse Aides (CNAs) #2 and CNA #3 on 9/23/26 at 12:48 PM confirmed the apple pie had cinnamon topping. CNA #3 confirmed the cinnamon allergy was listed on the meal ticket and stated dietary staff needed to be more careful because the resident could have an allergic reaction to the dessert. An interview with Dietary Staff #1 on 9/23/26 at 12:57 PM revealed she assembled the lunch trays and provided the apple pie to Resident #58. She confirmed the pie contained cinnamon and stated she overlooked the allergy on the meal ticket because she was "Just in hurry". She confirmed this placed the resident at risk for an allergic reaction. Record review of the "Admission Record" revealed the facility admitted Resident #58 on 7/29/26 with medical diagnosis that included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/05/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident #58 was moderately cognitively impaired.	F0806			
F0808 SS = D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.	F0808			

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F0808 SS = D	Continued from page 35 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review the facility failed to ensure a resident received her prescribed therapeutic diet to include nectar thick fluids for 1 (one) of 10 (ten) residents observed for dining. Resident #19 Findings Include: Review of the facility policy "Thickened Liquids" revealed that "The facility provides commercially prepared thickened liquids, as prescribed, to residents who require them..." An observation and interview conducted on 09/23/26 at 12:30 PM revealed Resident #19 sitting upright in bed while being fed by her Resident Representative (RR). RR reported that Resident #19 was dependent on staff for feeding and required assistance with meals and stated, "I just want my mother to be taken care of." RR further reported that while visiting Resident #19, she received her lunch meal tray, which included a cup of regular, thin-consistency tea. She stated that Resident #19 had an order for thickened liquids due to increased coughing episodes during meals. She reported that Resident #19 had begun coughing during meals prior to admission to the facility and had been evaluated by Speech-Language Pathology (SLP), with the primary concern being the risk of aspiration and potential development of pneumonia. An observation of Resident #19's meal tray confirmed the presence of a four-ounce cup of regular, thin-consistency brown liquid. Review of Resident #19's lunch meal ticket dated Wednesday, 09/23/26 documented, "Diet ... Thick Fluids - Nectar." During an observation and interview on 09/23/26 at 12:40 PM, Licensed Practical Nurse (LPN) #5 confirmed that Resident #19 had received regular-consistency tea on her meal tray and that the meal ticket indicated an order for nectar-thickened fluids. LPN #5 stated that providing regular, thin-consistency fluids to a resident with an order for thickened liquids could result in choking or aspiration and potentially lead to pneumonia. LPN #5 stated that she would address the issue immediately. An interview with the Director of Nursing (DON) on 09/23/26 at 12:50 PM revealed that Resident #19 had an order for thickened liquids for a specific clinical reason and that the incorrect beverage should have been identified before the tray was delivered to the resident. DON identified multiple opportunities for the error to have been recognized			F0808			

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F0808 SS = D	Continued from page 36 and corrected, including by the three kitchen staff members working on the tray line and the Certified Nursing Assistant (CNA) who delivered the tray to Resident #19. The DON stated that the situation was concerning and that residents were expected to receive their prescribed diets and fluid consistencies to prevent potential complications. An interview with Dietary Aide #4 on 09/23/26 at 1:00 PM revealed that she was the last staff member on the meal line and was responsible for placing beverages on the meal trays. Dietary Aide #4 stated that she was required to compare the beverages with the meal ticket to ensure that residents received the prescribed consistency. She acknowledged that she was "going so fast" while placing beverages on the trays and failed to identify the incorrect beverage on Resident #19's tray. She confirmed that it was important for residents to receive the prescribed diet and fluid consistency to prevent potential complications. An interview with the Dietary Manager (DM) on 09/23/26 at 1:08 PM revealed that it was important for residents to receive their prescribed therapeutic diets. DM stated that his expectation was for kitchen staff to follow the diet and fluid consistency documented on each meal ticket. An interview with Speech-Language Pathologist on 09/24/26 at 10:45 AM revealed that Resident #19 had recently been discharged from the SLP caseload following treatment for swallowing difficulty. The SLP confirmed that Resident #19 had a dietary order for nectar-thickened liquids and stated that the order should be followed to ensure the resident's safety. The SLP explained that providing regular, thin-consistency fluids to Resident #19 could result in coughing and increase her risk for aspiration. The SLP further explained that thickened liquids for a resident with dysphagia slow the swallowing process and may help reduce the risk of complications. Record review of Resident #19's "Order Summary Report" revealed an order effective 08/30/26 for No Added Salt (NAS) diet Regular texture, Nectar consistency. Record review of Resident #19's "Admission Record" revealed an admission date of 07/08/26 and that she had a diagnosis of Dysphagia, Record review of Resident #19's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/15/26 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 02 which indicated	F0808			

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F0808 SS = D	Continued from page 37 that she had severe cognitive deficits.	F0808					
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 review of the Payroll-Based Journal (PBJ) Staffing Data Report, staffing records, interview, and facility policy review, the facility failed comply with state nursing facility staffing requirements of a minimum of 2.80 hours of direct nursing care per resident per 24-hour period on two (2) of 26 weekend days reviewed during Quarter 3 of 2026. The facility reported 2.60 hours per resident on 04/26/2026 and 2.75 hours per resident on 05/03/2026. Review of the facility policy titled "Nursing Services	F0836					

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F0836 SS = D	Continued from page 38 and Sufficient Staff," undated, revealed, "Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychological well-being of each resident..." Review of the PBJ Staffing Data Report for Quarter 3 of 2026, April 1 through June 30, revealed the facility triggered for excessively low weekend staffing. Record review of the Staffing Grid for the 26 Saturdays and Sundays in Quarter 3 of 2026 revealed the facility reported 2.60 hours of direct nursing care per resident on 04/26/2026 and 2.75 hours on 05/03/2026. Both were below the state minimum of 2.80 hours per resident per 24-hour period. During an interview on 09/24/2026 at 1:40 PM, the Workforce Manager reviewed the staffing for 04/26/2026 and 05/03/2026. She stated both dates had staff call-ins and agency staff did not fill the open shifts and confirmed that they were below the state minimum for staffing. She stated she or other staff sometimes cover shifts, but staff do not always come in for a last-minute call-in.			F0836			