STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255318	A. BUILDING _____ B. WING _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J G ALEXANDER NURSING CENTER	25112 HIGHWAY 15 UNION, MS 39365

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey and Complaint Investigation (CI MS #26987), at the facility from 01/27/25 through 01/30/25. The SA investigated CI MS #26987 for resident abuse, quality of treatment, and restraints related to a fracture of unknown origin. There were no citations related to the complaint investigation. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F580,F692, F700, F732,F740, F758, F812, F865. The facility had a census of 55 and licensed for 60.	F 000		
F 550 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. §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	F 550		2/22/25

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

Electronically Signed | 02/17/2025

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F 550	Continued From page 1 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 observations, interviews, record reviews, and the facility policy review, the facility failed to honor residents' rights and dignity by not honoring requests for a second bed rail as an enabler and by posting signs at the head of the bed related to resident care for three (3) of 16 sampled residents: Resident #5, Resident #39, and Resident #54. Findings include: A review of the facility's "Resident Rights Policy" revised in 09/2022 revealed, "... Facility will ensure the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside	F 550	1) a. On 01/29/2025, facility Ward Clerk removed all signage related-to resident care for Resident #5, Resident #39, and Resident #54. (Exhibit 550A) b. On 01/28/2025, facility Physical Plant Manager installed bed rails for Resident #5, Resident #39, and Resident #54. (Exhibit 550B) 2) All facility residents have potential to be affected by the same deficient practice. 3) a. On 2/3/2025, Quality Assurance (QA) revised policy/procedure(s) related to	

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F 550	Continued From page 2 and outside the facility. Facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance and enhancement of their quality of life, recognizing each resident's individuality. The facility will protect and promote the rights of each resident ..." Resident #5 On 01/28/25 at 10:51 AM, Resident #5 requested to speak with the State Agency (SA). During the interview and observation, the resident explained that she had only one bed rail on the right side but had requested another on the left. She was told that the state removed bed rails. Resident #5 stated she needed both rails to assist with turning and to feel safer at night following an elective hip replacement. The SA observed one half-bed rail on the right side of the bed. The resident explained that she used a recliner on the left side to assist with turning, which was unsafe, and she feared rolling out of bed. On 01/28/25 at 01:25 PM, during an interview, Certified Nurse Aide (CNA) #2 stated that Resident #5 had repeatedly requested an additional bed rail, as had other residents. The management was notified, but residents and staff were informed that only one bed rail was allowed. CNA #2 confirmed that Resident #5 used the existing bed rail for turning and getting out of bed. After her hip surgery, Resident #5 required a stand-up lift and had difficulty moving in bed with only one bed rail. On 01/28/25 at 03:40 PM, Licensed Practical Nurse (LPN) #1 confirmed that Resident #5 had only one bed rail, similar to most residents.	F 550	ensuring improper signage remains unposted from resident rooms and ensuring all residents who prefer bed rails have access to the same. (See Exhibit 550C) b. On 1/31/25, facility Staff Development Coordinator conducted an all-staff quarterly in-service related-to ensuring improper signage remains unposted in resident rooms and ensuring all residents who prefer bed rails have access to the same. (See Exhibit 550D) 4) a. On 01/30/2025, facility Resident Services Coordinator began completing Resident Bed Rail Preferences Form for all residents, to be conducted on admission and quarterly thereafter in order to ensure that all residents who prefer bed rails receive the same. (See Exhibit 550E) b. On 1/30/2025, Director of Nurses (DON) began completing monthly Resident Room Audits to ensure that zero improper signage related-to resident care is posted in resident rooms. (See Exhibit 550F) c. Beginning no later than 2/21/2025 Quality Assurance (QA) will meet and receive the data related to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-services based upon findings and results achieved.	

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F 550	Continued From page 3	F 550		

According to LPN #1, upper management instructed staff that no resident could have two bed rails due to SA regulations. Resident #5 struggled to get out of bed post-hip replacement and continued to request two bed rails but was denied.

On 01/29/25 at 04:10 PM, during an observation of Resident #5's transfer from a wheelchair to bed with the Therapy Director and CNA #3, staff used a stand-up lift. The resident demonstrated upper body strength while using the lift. Positioned on the left side of the bed, Resident #5 stated that an additional bed rail would assist with transfers. The Therapy Director confirmed that Resident #5 had requested another bed rail but was denied.

A review of Resident #5's "Admission Record" indicated admission on 12/05/22 with diagnoses including Other Chronic Pain and Presence of Neurostimulator.

A review of Resident #5's "Annual Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 11/15/24 indicated a Brief Interview for Mental Status (BIMS) score of 12, signifying intact cognition. Section GG showed no upper extremity impairment, and the resident required supervision or touch assistance with transfers.

A review of Resident #5's "Bedrails Consent" signed by her daughter on 08/01/24 did not specify the use of only one bedrail. The consent form had "Yes" checked under the question, "Do you choose to use bedrails on your bed while in the facility?"

Resident #54

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On 01/27/25 at 01:41 PM, during an observation and interview, the SA observed Resident #54 in bed with one bed rail up. The resident asked why he did not have four bed rails like he had in the hospital.

On 01/28/25 at 02:50 PM, Registered Nurse (RN) #5 explained that the facility only allowed one bed rail unless deemed necessary. Resident #54 had only had one side rail since admission, and no residents were allowed four bed rails.

On 01/28/25 at 03:00 PM, during an interview, Resident #54 stated he had been at the facility for nearly a year and had requested another bed rail to assist with turning. He was informed that only one was allowed. The resident denied upper arm weakness and continued to request a second bed rail for assistance.

On 01/29/25 at 03:30 PM, during an interview, the Director of Nursing (DON) stated that the facility limited bed rails to one per resident for safety reasons but lacked documentation supporting this decision. She was unaware of requests from Resident #5 or Resident #54 and confirmed that alternative positioning aids had not been considered.

A review of Resident #54's "Admission Record" indicated admission on 02/21/24 with diagnoses including Osteomyelitis of the Vertebra and Rheumatoid Arthritis.

A review of Resident #54's Quarterly MDS with an ARD of 11/28/24 revealed a BIMS score of 14, indicating intact cognition. Section GG indicated no extremity impairments and the resident required supervision or touch assistance with

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F 550	Continued From page 5 transfers. A review of Resident #54's "Bedrails Consent" dated 02/21/24 did not specify the use of only one bedrail. The form had "Yes" checked under the question, "Do you choose to use bedrails on your bed while in the facility?" Resident #39 On 01/27/25 at 11:30 AM, the SA observed Resident #39 in bed with signage posted at the head of the bed, including: "Enhanced barrier," "Oral care," "Turning schedule - keep heels floated," and "Keep head of bed up at all times." A proper name was included on the signs. On 01/28/25 at 03:00 PM, CNA #5 confirmed that the signage had been in place for an extended period and contained resident care instructions. On 01/29/25 at 02:20 PM, the Administrator and DON confirmed that signage related to personal care should not be displayed on walls, as it violated Resident #39's dignity. The DON stated she was unaware of the postings and confirmed the signs would be removed. Both the Administrator and DON stated they expected all staff to honor residents' rights and avoid posting personal care instructions publicly. On 01/29/25 at 03:20 PM, RN #2 confirmed that one of the names on the signage belonged to a former staff member and acknowledged that resident care instructions should not be posted on the wall. She identified the postings as a dignity issue.	F 550		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.)	F 580		2/22/25

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F 580	Continued From page 6 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

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F 580	Continued From page 7 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to notify the physician of a significant change in condition, as evidenced by the facility did not notify the physician of a resident's 33-pound weight loss of 17 percent (%) of total body weight, persistent drowsiness affecting oral intake, and the failure to implement dietary recommendations which delayed necessary medical interventions and contributed to continued weight loss for one (1) of sixteen (16) sampled residents (Resident #45) Cross Reference F692 and F758 Findings included: On 01/27/2025 at 1:01 PM, during an observation and interview with Resident #45's family member, the resident was in his room for lunch. He was drowsy and did not wake up for the Certified Nursing Assistant (CNA) who was attempting to feed him. He eventually woke up to eat two (2) small bites of food when encouraged by the family member. The family member expressed concern that the resident had lost approximately 20 pounds since being discharged from a	F 580	1) On 1/29/2025, Director of Nurses (DON) notified physician of significant changes related-to the weight loss, persistent drowsiness, and dietary recommendations for Resident #45, received new orders, and updated resident care plan accordingly. (See Exhibit 580A) 2) All residents have potential to be affected by the same deficient practice. 3) a. On 1/31/2025, Quality Assurance(QA) revised Policy and Procedure related-to identification of significant changes and implementation of dietary needs for positive outcomes in order to ensure that significant changes for chronic illness and dietary needs for residents with chronic illness are properly treated. (See Exhibit 580B) b. On 2/3/25 facility Administrator completed contracting update with facility Contract Nurse Practitioner in order to implement facility-wide Nurse Practitioner	

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F 580	Continued From page 8 behavioral health hospital in March 2024. During an observation an interview on 01/28/2025 at 12:10 PM, in the dining hall, Resident #45 was observed sleeping throughout the lunch period. CNA #1 attempted to wake him multiple times, but the resident did not respond and did not eat. CNA #1 stated that the resident frequently fell asleep during meals or slept entirely through mealtime. During an interview on 01/29/2025 at 12:01 PM, the Resident Representative (RR) expressed concern about Resident #45's recent psychiatric status, as he had been consistently sleeping through meals and was difficult to wake up. He reported requesting a psychiatric consultation on 01/24/2025. A record review of Resident #45's weight summary revealed that the resident weighed 191 pounds on 03/04/2024 and 158 pounds on 01/17/2025, reflecting a total weight loss of 33 pounds in ten (10) months. A record review of Resident #45's meal intake percentages from 01/01/2025 through 01/28/2025 revealed his documented meal intake was between 0-25 percent of meals on (13) of (28) days. A record review of the "Progress Notes" revealed Resident #45 had a "Nutrition/Dietary Note", 9/11/2024, authored by the Registered Dietitian (RD), that indicated, " ...WT (Weight) Change: -3.7% x (times) 1 mo (month), -6.6% WL (Weight Loss) x 3 mo, -18.8% SWL (Significant Weight Loss) x 6 mo ...Comments ...Intake does not meet nutritional needs. Resident has	F 580	continuing monitoring of chronic care including, but not limited to, implementation of dietary recommendations and proper identification of significant changes for physician notification. (See Exhibit 580C) c. On 2/14/2025, facility Contract Nurse Practitioner initiated quarterly in-service training for all licensed nursing staff related-to proper identification of significant changes for physician notification and proper implementation of dietary recommendations. (See Exhibit 580D) 4) a. On 2/4/25, the Director of Nurses (DON) implemented monthly Chronic Care Audit(s) for three months in order to ensure proper identification of significant changes with physician notification and implementation of dietary recommendations. (Exhibit 580E) b. Beginning no later than 2/21/2025 Quality Assurance (QA) will meet and receive the data related to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-services based upon findings and results achieved.	

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experienced a continued WL with a SWL for 6 mo. Resident observed asleep in bed this morning. Resident has been receiving a SF (Sugar Free) house supplement TID (three times daily) but this was DC'd (Discontinued) on 9/10/25. Oral intake of meals has declined over the last month ...Interventions: 1. House Supplement 8 oz (ounces) TID at medpass - document intake on eMAR (electronic Medication Administration Record) ..."

A record review of the "Progress Notes" revealed Resident #45 had a "Nutrition/Dietary Note", 11/13/2024, authored by the Registered Dietitian (RD), that indicated, " ...Resident has experienced SWL x 6 mo. RD recommended a house supplement 8 oz BID at medpass at last visit in October. It does not appear the supplement was implemented ...WT Change ...-13% SWL x 6 mo ...Comments ...Intake does not meet nutritional needs ...RD recommended a supplement at the last 2 visits. Recommendation was not implemented ...Interventions: 1. House Supplement 8 oz BID at medpass - document intake on eMAR ..."

A record review of the "Order Summary Report" with active orders as of 1/29/25 revealed Resident #45 had a physician's order dated 3/4/24 for a low concentrated sweets diet with regular texture related to Type 2 Diabetes Mellitus with Hyperglycemia, an order dated 4/2/24 for Trileptal 150 milligrams (mg) to be given twice daily for Dementia with Agitation and Depression and an order dated 4/2/24 for Rexulti 1 mg to be given daily for Dementia with Agitation. There were no current orders for the house supplement of MedPass as recommended by the RD.

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A record review of the eMAR for Resident #45 for October 2024, November 2024, December 2024, and January 2025 revealed there was no documentation that MedPass was administered as recommended by the RD.

During an interview on 01/29/2025 at 3:00 PM, the Director of Nursing (DON) reviewed the RD's note dated 11/13/2024, which recommended starting house supplements based on prior dietary recommendations from 09/11/2024, which were never implemented. The DON stated that the recommendation was likely not received due to turnover among facility dietitians. She further explained that dietary recommendations were typically given to the physician via a communication folder, and the physician signed off for approval. She confirmed that the supplements were not started as they should have been, and stated she would initiate them immediately.

During an interview on 01/30/2025 at 11:45 AM, the Medical Director stated he was unaware of the resident's weight loss and had not been notified by nursing staff. He stated that the resident was prescribed multiple psychotropic medications, including Rexulti, which could cause lethargy, and Trileptal, which could affect appetite. He explained that he should have been informed of the weight loss through dietitian reports in Quality Assurance meetings but had not been made aware. He acknowledged that the weight loss should have been addressed sooner.

A record review of the "Admission Record" revealed the facility admitted Resident #45 on 03/04/2024 with diagnoses that included Alzheimer's Disease, onset date of 04/04/2024.

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F 580	Continued From page 11 A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2024 revealed Resident #45 had lost five (5) % or more of his weight in the last month or 10 % in the last six months, and that he had current diagnoses of Alzheimer's Disease and Dementia. The MDS also revealed he had a Brief Interview for Mental Status (BIMS) score of (5), which indicated the resident's cognition was severely impaired.	F 580		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record	F 692	1) On 1/29/2025, Director of Nurses	2/22/25

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F 692	Continued From page 12 review, the facility failed to ensure that a resident did not experience a significant weight loss of over 10% in six months, as evidenced by Resident #45 was observed to be lethargic and was unable to intake appropriate nutrition to sustain weight. Resident #45 did not have Registered Dietitian (RD) interventions implemented when ordered and did not have medications reviewed for one (1) of sixteen (16) sampled residents (Resident #45) Cross Reference F580 and F758 Findings included: During an observation and interview on 01/27/2025 at 1:01 PM, with Resident #45's family member, the resident was in his room for lunch. He was drowsy and did not wake up for the CNA who was attempting to feed him. He eventually woke up to eat two (2) small bites of food when encouraged by the family member. The family member expressed concern that the resident had lost approximately 20 pounds since being discharged from a behavioral health hospital in March 2024. During an observation on 01/28/2025 at 12:10 PM, Resident #45 was in the dining hall but remained asleep throughout the entire lunch period and did not wake up despite multiple attempts by CNA #1. During an interview on 01/29/2025 at 11:23 AM, Registered Nurse (RN)#2 stated that psychiatric services were being ordered for Resident #45 because his son requested a psychiatric consultation on 01/24/2025. RN #2 confirmed that the resident had not received a psychiatric	F 692	(DON) notified physician of the weight loss, lethargy, Dietician□s interventions, and medication review for Resident #45, Consultant Pharmacist completed consult for medication review, and Director of Nurses (DON) received new physician□s orders, and updated resident care plan accordingly. (See Exhibit 692A) 2) All residents have potential to be affected by the same deficient practice. 3) a. On 1/31/25, Quality Assurance (QA) revised Policy and Procedure related-to identification of chronic care issues related-to weight loss, lethargy, and proper implementation of Dietician□s recommendations and Consultant Pharmacist□s medication reviews in order to ensure that chronic illness and dietary recommendations for residents with chronic illness are properly treated. (See Exhibit 692B) b. On 2/3/25, facility Administrator completed contracting update with facility contract Nurse Practitioner in order to implement facility-wide Nurse Practitioner continuing monitoring of chronic care including, but not limited to, implementation of Dietician□s recommendations and proper identification of and treatment for weight loss, lethargy, and Consultant Pharmacist□s and Psychological Services Provider□s medication review consultations. (See Exhibit 692C) c. On 1/31/25, facility Administrator completed new contract with facility	

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F 692	Continued From page 13 follow-up since returning from the behavioral health hospital ten (10) months ago. During an observation on 01/29/2025 at 1:59 PM, Resident #45 was asleep in his wheelchair in the common area near the nurses' station. During an interview on 01/29/2025 at 3:12 PM, the Director of Nursing (DON) confirmed that a psychiatric consultation for medication management had not been in progress until the resident's son requested the consultation on 01/24/2025. The DON stated that it was standard practice for the facility's Medical Doctor of Behavioral Health (MDB) to follow up with residents discharged from behavioral health units but acknowledged that this did not occur in this case. During an observation on 01/30/2025 at 9:35 AM, Resident #45 was asleep in his wheelchair in his room. On 01/30/2025 at 11:45 AM, during an interview the Medical Director stated he was unaware of the resident's weight loss and had not been notified by nursing staff. He stated that the resident was prescribed multiple psychotropic medications, including Rexulti, which could cause lethargy, and Trileptal, which could affect appetite. He explained that he should have been informed of the weight loss through dietitian reports in Quality Assurance meetings but had not been made aware. He acknowledged that the weight loss should have been addressed sooner. During an interview on 01/30/2025 at 1:41 PM, RN #3 stated that Resident #45 had exhibited altered sleep patterns prior to his psychiatric	F 692	psychiatric care provider in order to implement facility-wide psychological continuing monitoring of care including, but not limited to, proper implementation of medication reviews. (See Exhibit 692D) d. On 2/14/2025, facility contract Nurse Practitioner initiated quarterly in-service training for all licensed nursing staff related-to proper implementation of Dietician□s recommendations and chronic care monitoring including, but not limited to, identification of weight loss, lethargy, and residents in need of medication reviews. (See Exhibit 692E) 4) a. On 2/4/25, the Director of Nurses (DON) implemented monthly Chronic Care Audit in order to ensure proper implementation of Dietician□s recommendations and proper identification of lethargy, weight loss, and residents in need of medication reviews. (Exhibit 692F) b. Beginning no later than 2/21/2025 Quality Assurance (QA) will meet and receive the data related to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-services based upon findings and results achieved.	

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hospitalization but that his drowsiness had worsened in the past few months, causing him to miss meals.

A record review of the "Progress Notes" revealed Resident #45 had a "Nutrition/Dietary Note", 9/11/2024, authored by the Registered Dietitian (RD), that indicated, " ...WT (Weight) Change: -3.7% x (times) 1 mo (month), -6.6% WL (Weight Loss) x 3 mo, -18.8% SWL (Significant Weight Loss) x 6 mo ...Comments ...Intake does not meet nutritional needs. Resident has experienced a continued WL with a SWL for 6 mo. Resident observed asleep in bed this morning. Resident has been receiving a SF (Sugar Free) house supplement TID (three times daily) but this was DC'd (Discontinued) on 9/10/25. Oral intake of meals has declined over the last month ...Interventions: 1. House Supplement 8 oz (ounces) TID at medpass - document intake on eMAR (electronic Medication Administration Record) ..."

A record review of the "Progress Notes" revealed Resident #45 had a "Nutrition/Dietary Note", 11/13/2024, authored by the Registered Dietitian (RD), that indicated, " ...Resident has experienced SWL x 6 mo. RD recommended a house supplement 8 oz BID at medpass at last visit in October. It does not appear the supplement was implemented ...WT Change ...-13% SWL x 6 mo ...Comments ...Intake does not meet nutritional needs ...RD recommended a supplement at the last 2 visits. Recommendation was not implemented ...Interventions: 1. House Supplement 8 oz BID at medpass - document intake on eMAR ..."

A record review of Resident #45's weight

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summary revealed that the resident weighed 191 pounds on 03/04/2024 and 158 pounds on 01/17/2025, reflecting a total weight loss of 33 pounds in ten (10) months.

A record review of Resident #45's meal intake percentages from 01/01/2025 through 01/28/2025 revealed his documented meal intake was between 0-25 percent of meals on thirteen (13) of twenty-eight (28) days.

A record review of the eMAR for Resident #45 for October 2024, November 2024, December 2024, and January 2025 revealed there was no documentation that MedPass was administered as recommended by the RD.

A record review of Resident #45's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2024 revealed in Section N that the resident received antipsychotics on a routine basis. Section K revealed the resident had lost five (5) % percent or more of his weight in the last month or ten (10) % in the last six months. Section I indicated that the resident had current diagnoses of Alzheimer's Disease and Dementia. Section C revealed a Brief Interview for Mental Status (BIMS) score of (5), which indicated the resident's cognition was severely impaired.

A record review of the "Order Summary Report" with active orders as of 1/29/25 revealed Resident #45 had a physician's order dated 3/4/24 for a Low concentrated sweets diet with regular texture related to Type 2 Diabetes Mellitus with hyperglycemia, an order dated 4/2/24 for Trileptal 150 milligrams (mg) to be given twice daily for Dementia with Agitation and Depression and an order dated 4/2/24 for Rexulti 1 mg to be

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F 692	Continued From page 16 given daily for Dementia with Agitation. There were no current orders for the House Supplement of MedPass as recommended by the RD. A record review of Resident #45's "Admission Record" revealed the facility admitted the resident on 03/04/2024 with a diagnosis of Alzheimer's Disease, with an onset date of 04/04/2024.	F 692		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and facility policy review the facility failed to maintain a record log of bed rail maintenance for	F 700	1) On 2/3/25, facility Physical Plant Manager initiated bedrail maintenance log entry showing properly functioning	2/22/25

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F 700	Continued From page 17 two (2) of 16 sampled residents (Resident #5 and Resident #54). Findings Include: A record review of the facility's policy, "Side Rail Policy," dated 06/25/18, revealed, "It is the policy of this facility to attempt to use appropriate alternatives prior to installing a side or bed rail. If a side or bed rail is used, the facility will ensure correct installation, use, and maintenance of bed rails ... Follow the manufacturer's recommendations and specifications for installing and maintaining rails..." A record review of the "Zenith Series" manual revealed "... Recommended Maintenance ... Regular maintenance of the Long Term Bed is necessary to ensure continuing proper and safe operations ... Inspect all fasteners for wear or looseness every six (6) months ..." On 01/28/25 at 10:51 AM, during an interview and observation, Resident #5 requested to see the State Agency (SA). The resident explained she only had one bed rail on the right side but had asked for another on the left. She was told the state removed the bed rails. She stated she had at least six (6) falls from rolling out of bed and expressed a desire for another bed rail to assist with turning and to feel safer at night. She recently elected to undergo a hip replacement and stated she needed both rails to assist with turning in bed. The SA observed a half-bed rail on the right side of the bed. The resident explained that she had a recliner on the left side, which she used to assist with turning if she could reach it. However, she stated that this method was unsafe and that she was afraid of rolling out of bed. She	F 700	bedrail(s) for Resident #5 and Resident #54. (See Exhibit 700A) 2) All residents have the potential to be affected by the same deficient practice. 3) a. On 2/3/25, Quality Assurance (QA) reviewed and revised policy and procedure related-to proper monitoring and logging of bedrail maintenance. (See Exhibit 700B) b. On 2/3/25, facility Administrator-in-Training conducted in-service training for all facility maintenance staff related-to proper inspection and documentation of bedrail maintenance. (See Exhibit 700C) 4) a. On 2/3/25, Physical Plant Manager initiated quarterly auditing for three quarters on all resident beds with bed rails to ensure proper bed rail maintenance. (See exhibit 700D) b. Beginning no later than 2/21/2025 Quality Assurance (QA) will meet and receive the data related to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-services based upon findings and results achieved.	

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also reported shaking the bed rail daily to ensure it was not too loose. The bed rail was observed to be loose but intact.

On 01/28/25 at 3:00 PM, during an interview and observation, Resident #54 explained that he had been at the facility for almost a year. He stated that, while on therapy load, he asked why he could not have another bedrail on the left side of his bed to assist with turning and repositioning. The resident denied any upper arm weakness and stated he had asked staff for another bed rail but was told he could only have one. He clarified that he did not want or need four (4) bed rails but would like a second to assist with turning.

On 01/29/25 at 2:20 PM, during an interview, Maintenance #1 explained that upon admission, if a resident needed a bed rail, the therapy director or nursing department notified him to install one. He stated that this was usually done upon admission and that he did not perform any maintenance on the bed rail or bed afterward unless staff submitted a complaint in the maintenance logbook at the nurse's station. He stated he had never checked bed rails for security or looseness unless staff reported an issue and submitted a maintenance request work order. He further stated that he did not maintain a log for bed rail maintenance.

On 01/27/25 at 1:41 PM, during an observation, Resident #54 was observed upright in bed with one (1) bed rail up. The resident questioned why he did not have all four (4) rails up as he did in the hospital. He stated that he had requested another bed rail to help with positioning but was told he could only have one.

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On 01/29/25 at 2:45 PM, during an interview, the Administrator stated that he was not aware of any log for bed or bed rail maintenance. He confirmed that the facility had a maintenance book at the nurse's station and that staff were expected to document maintenance needs in the book.

On 01/30/25 at 11:00 AM, during an interview, the Maintenance Director stated that he could not find any maintenance guidelines related to bed rails. He explained that he installed the bed rails by sliding the pins into the slots and did not check them again unless a maintenance request was submitted.

On 01/30/25 at 2:30 PM, during an interview, the Administrator reported that he was not aware that maintaining a log of bed rail maintenance was a requirement but stated that the facility would make changes to comply with regulations.

A record review of Resident #5's "Admission Record" revealed the facility admitted her initially on 12/05/22 with diagnoses of Other Chronic Pain and Presence of Neurostimulator.

A record review of Resident #5's "Bedrails Consent" revealed that her daughter signed the consent on 08/01/24. The consent did not specify the use of only one bed rail. The question "Do you choose to use bedrails on your bed while in the facility?" was checked "Yes."

A record review of Resident #54's "Admission Record" revealed the facility admitted him on 02/21/24 with diagnoses of Osteomyelitis of the Vertebra, Sacral, and Sacrococcygeal Region and Rheumatoid Arthritis, Unspecified.

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F 700	Continued From page 20 A record review of Resident #54's "Bedrails Consent" dated 02/21/24 revealed an "X" in place of a signature. The consent did not specify the use of only one bed rail. The question "Do you choose to use bedrails on your bed while in the facility?" was checked "Yes".	F 700		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to	F 732		2/22/25

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F 732	Continued From page 21 exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review the facility failed to post daily nursing staffing information in a clean and readable format in a prominent place readily accessible to residents and visitors. The postings also failed to include the facility name, date, census, and the total number and actual hours worked per shift for two (2) of four (4) survey days. Findings include: A record review of the facility's policy, "Posted Nurse Staffing Information," revised in September 2022, revealed: "... The facility posts the following information on a daily basis: 1. Facility Name 2. Current date 3. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: ... 4. Resident census. The facility must post the nurse staffing data mentioned above on a daily basis at the beginning of each shift. The data must be posted in a clear and readable format and in a prominent place readily accessible to residents and visitors ..." On 01/27/25 at 3:00 PM, during a walk-through of the facility, the State Agency (SA) observed no staffing posting.	F 732	1) On 1/30/25, facility Administrator removed daily posted staffing data from behind the facility Nurse□s Desk and identified the glass and aluminum enclosed corkboard posting area across-from the facility Nurses□ Desk as a prominent location and posted daily staffing information there in a clean and readable format, readily accessible to visitors and residents, containing the facility name, date, census, and the total number and actual hours worked per shift. (See Exhibit 732A) 2) All residents have the potential to be affected by the same deficient practice. 3) a. On 2/3/25, Quality Assurance (QA) revised facility policy and procedure to include small corkboard behind facility Nurse□s Desk as a possible additional location and include glass and aluminum enclosed corkboard posting area across from facility Nurses□ Desk as a mandatory prominent location. (See Exhibit 732B) b. On 1/31/25, Director of Nurses (DON) initiated quarterly in-service training for licensed nursing staff related-to proper	

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F 732	Continued From page 22 On 01/28/25 at 9:25 AM, during a walk-through of the facility, no staffing posting was observed. On 01/28/25 at 10:25 AM, during an interview, the Director of Nursing (DON) explained that staffing is usually posted around the nurse's station and that there is also a binder containing staffing information. On 01/28/25 at 3:25 PM, during a walk-through of the facility, no staffing posting was noted. On 01/29/25 at 1:50 PM, during an interview, Registered Nurse (RN) #1 stated that staffing had never been posted since she had been at the facility. She explained that she fills out the staffing information daily and that it is kept in a binder. She also reported that she completed the total number of hours most days at the end of her shift. On 01/29/25 at 2:00 PM, during an interview, the DON and Administrator both stated that they were not aware staffing had to be visibly posted daily. They understood that staffing information had to be available for access if someone requested to view it, but not that it needed to be visibly displayed. They stated that this issue would be addressed, and that staffing would be posted daily.	F 732	identification of current staffing posting at the glass and aluminum enclosed corkboard posting area across-from the facility Nurses Desk. (See Exhibit 732C) 4) a. On 1/31/25, Charge Nurse initiated daily auditing for three months related to ensuring proper posting of staffing information in the proper location. (See Exhibit 732D) b. Beginning no later than 2/21/2025 Quality Assurance (QA) will meet and receive the data related to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-services based upon findings and results achieved.	
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest	F 740		2/22/25

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F 740	Continued From page 23 practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. 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 received necessary behavioral health services to address psychiatric needs and psychotropic medication management. Specifically, the resident was prescribed Rexulti and Trileptal for behavioral health needs in April 2024 but had not been reassessed by a psychiatric provider for ten (10) months which resulted in Resident #45 exhibiting excessive drowsiness, missing multiple meals, and experiencing a significant weight loss of over (10) percent (%) in six months for one (1) of (16) sampled residents. (Resident #45) Findings included: During an observation and interview on 01/27/2025 at 1:01 PM, Resident #45 was in the dining room being assisted by Certified Nursing Assistant (CNA) #1 with eating. The resident's family member was also present. The resident mostly slept throughout the meal, awakening briefly when the family member prompted him to eat. The family member stated that she was concerned because the resident had lost approximately 20 pounds since being discharged from a behavioral health hospital in March 2024. She explained the resident had been increasingly	F 740	1) On 02/07/2025, facility psychiatric provider reassessed Resident #45 related-to exhibiting excessive drowsiness, missing meals, and experiencing weight loss, and consult was received and reported to physician by Director of Nurses (DON) with new physician□s orders received and care plan was revised and physician□s orders and plan of care were implemented. (See Exhibit 740A) 2) All residents have the potential to be affected by the same deficient practice 3) a. On 01/31/2025, new contract with new psychiatric care provider was initiated by facility administrator, and revised contract options with Nurse Practitioner provider implemented on 02/3/2025 related-to provision of chronic care management, to include oversight for all residents of symptoms exhibited by Resident #45. (See Exhibit 740B) b. On 01/31/2025, Quality Assurance (QA) revised policy and procedure related-to provision of services by psychiatric care provider to include routine notification of symptoms exhibited by	

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F 740	Continued From page 24 drowsy and sleeping throughout the day. During an observation on 01/28/2025 at 12:10 PM, Resident #45 was in the dining hall but remained asleep throughout the entire lunch period and did not wake up despite multiple attempts by CNA #1. During an interview on 01/29/2025 at 11:23 AM, Registered Nurse (RN) #2 stated that psychiatric services were being ordered for Resident #45 because his son requested a psychiatric consultation on 01/24/2025. RN #2 confirmed that the resident had not received a psychiatric follow-up since returning from the behavioral health hospital ten (10) months ago. During an observation on 01/29/2025 at 1:59 PM, Resident #45 was asleep in his wheelchair in the common area near the nurses' station. During an interview on 01/29/2025 at 3:12 PM, the Director of Nursing (DON) confirmed that a psychiatric consultation for medication management had not been in progress until the resident's son requested the consultation on 01/24/2025. The DON stated that it was standard practice for the facility's Medical Doctor of Behavioral Health to follow up with residents discharged from behavioral health units but acknowledged that this did not occur in this case. During an observation on 01/30/2025 at 9:35 AM, Resident #45 was asleep in his wheelchair in his room. On 01/30/2025 at 11:45 AM, during an interview, the Medical Director stated that typically, the facility's psychiatric Nurse Practitioner evaluates	F 740	residents in need of psychiatric provider reassessment. (See Exhibit 740C) c. On 02/14/2025, Nurse Practitioner provided outside-contractor in-service training for all licensed nurses related-to ensuring psychiatric provider reassessments are rendered for all residents in a timely manner. (See Exhibit 740D) 4) a. The Director of Nurses (DON) will begin on 02/04/2025 to audit for all residents, two times a week on six residents for three months related-to proper and timely provision of resident reassessments by psychiatric care provider. (See Exhibit 740E) b. Beginning no later than 2/21/2025 Quality Assurance (QA) will meet and receive the data related to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-services based upon findings and results achieved.	

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F 740	Continued From page 25	F 740		

residents returning from psychiatric hospitalizations. He confirmed that Resident #45 should not have gone (10) months without a psychiatric follow-up and stated that a psychiatric consultation should have been completed within 90 days of admission to a behavioral health unit.

On 01/30/2025 at 1:41 PM, during an interview, RN #3 stated that Resident #45 had exhibited altered sleep patterns prior to his psychiatric hospitalization but that his drowsiness had worsened in the past few months, causing him to miss meals.

A record review of Resident #45's "Admission Record" revealed the facility admitted the resident on 03/04/2024 with a diagnosis of Alzheimer's Disease, with an onset date of 04/04/2024.

A record review of Resident #45's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2024 revealed that the resident was currently prescribed an antipsychotic medication. The MDS also revealed the resident had lost five (5) percent or more of his weight in the last month or ten (10) % in the last six months. Section I indicated the resident had current diagnoses of Alzheimer's Disease and Dementia. Section C revealed a Brief Interview for Mental Status (BIMS) score of (5), which indicated the resident's cognition was severely impaired.

A record review of the "Order Summary Report" with active orders as of 1/29/25 revealed Resident #45 had a physician's order dated 3/4/24 for a Low concentrated sweets diet with regular texture related to Type 2 Diabetes Mellitus with hyperglycemia, an order dated 4/2/24 for

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F 740	Continued From page 26 Trileptal 150 milligrams (mg) to be given twice daily for Dementia with Agitation and Depression and an order dated 4/2/24 for Rexulti 1 mg to be given daily for Dementia with Agitation. A record review of the facility's psychiatric consultation/referral criteria revealed that symptoms warranting a psychiatric consultation/referral included being prescribed an antipsychotic medication and experiencing changes in mood, withdrawing,or apathy (marked indifference to environment).	F 740		
F 758 SS=G	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 758		2/22/25

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F 758	Continued From page 27 contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure that a resident received a Gradual Dose Reduction (GDR) as required for psychotropic medications. Specifically, the resident was prescribed Rexulti and Trileptal for behavioral health needs in April 2024 but had not undergone a GDR for over ten (10) months. Resident #45 exhibited excessive drowsiness, missing multiple meals, and significant weight loss exceeding 10 percent (%) over six (6) months for one (1) of sixteen (16) sampled residents (Resident #45) Cross Reference F580 and F692	F 758	1) On 01/29/2025, Resident #45 was reviewed-for and received a pharmacy consult for a Gradual Dose Reduction (GDR), with new physician orders received, and care plan updated accordingly by Directof or Nurses (DON) with implementation of Gradual Dose Reduction(GDR). (See Exhibit 758A) 2) All residents have potential to be affected by the same deficient practice. 3) a. On 01/31/2025, all residents with	

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F 758	Continued From page 28 Findings included: A review of the facility's policy titled "Free From Unnecessary Psychotropic Concerns," revised September 2022, revealed, "The facility will ensure based on the comprehensive assessment of the resident that ...b. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs...i. Dose reductions will occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence. Compliance with the requirement to perform a GDR may be met, for example, within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, a facility attempts a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated ..." At 1:01 PM on 01/27/2025, during an observation and interview with Resident #45's family member, the resident was in his room for lunch. He was drowsy and did not wake up for the CNA who was attempting to feed him. He eventually woke up to eat two (2) small bites of food when encouraged by the family member. The family member expressed concern that the resident had lost approximately 20 pounds since being discharged from a behavioral health hospital in March 2024. On 01/28/2025 at 12:10 PM, during an observation, Resident #45 was in the dining room, but slept throughout the entire lunch period and did not wake up despite multiple attempts by	F 758	potential need of Gradual Dose Reduction (GDR) received pharmacy consult related-to the same, and physician reviewed the same on 02/10/2025, rendered orders where relevant, and orders were received by Director of Nurses (DON) and care plans were updated where relevant and implemented on 02/11/2025. (See Exhibit 758B). b. On 01/31/2025, Quality Assurance (QA) revised policy and procedure related-to Gradual Dose Reduction (GDR). (See Exhibit 758C) c. On 02/14/2025, Nurse Practitioner conducted outside-contractor in-service training for all licensed nursing staff related-to proper application of Gradual Dose Reduction (GDR) in a timely manner. (See Exhibit 758D) 4) a. On 2/4/25 Director of Nurses (DON) will begin audit as provided by Nurse Practitioner to be conducted by Director of Nurses (DON) on a monthly basis for three months in order to ensure proper implementation of timely Gradual Dose Reductions (GDR□s). (See exhibit 758E) b. Beginning no later than 2/21/2025 Quality Assurance (QA) will meet and receive the data related to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-services based upon results findings achieved.	

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Certified Nursing Assistant (CNA) #1.

On 01/29/2025 at 1:59 PM, during an observation, Resident #45 was asleep in his wheelchair in the common area near the nurses' station.

On 01/30/2025 at 9:35 AM, during an observation, Resident #45 was asleep in his wheelchair in his room.

A record review of Resident #45's "Admission Record" revealed the facility admitted the resident on 03/04/2024 with a diagnosis of Alzheimer's Disease, with an onset date of 04/04/2024.

A record review of Resident #45's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2024 revealed in Section N that the resident received antipsychotics on a routine basis. Section K revealed the resident had lost five (5) % or more of his weight in the last month or ten (10) % in the last six months. Section I indicated that the resident had current diagnoses of Alzheimer's Disease and Dementia. Section C revealed a Brief Interview for Mental Status (BIMS) score of (5), which indicated the resident's cognition was severely impaired.

A record review of the "Order Summary Report" with active orders as of 1/29/25 revealed Resident #45 had a physician's order dated 4/2/24 for Trileptal 150 milligrams (mg) to be given twice daily for Dementia with Agitation and Depression and an order dated 4/2/24 for Rexulti 1 mg to be given daily for Dementia with Agitation.

A record review of Resident #45's "Weight

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Summary" revealed the resident weighed 191 pounds on 03/04/2024 and 158 pounds on 01/17/2025, reflecting a total weight loss of 33 pounds in (10) months.

A record review of Resident #45's meal intake percentages from 01/01/2025 through 01/28/2025 revealed his documented meal intake was between 0-25 percent of meals on (13) of (28) days.

A record review of the medical record for Resident #45 revealed there was no documentation that a GDR had been attempted for Trileptal or Rexulti.

On 01/29/2025 at 11:23 AM, during an interview, Registered Nurse (RN) #2 confirmed that Resident #45 had not received a GDR for psychotropic medications since returning from the behavioral health hospital (10) months ago.

On 01/29/2025 at 3:12 PM, an interview with the Director of Nursing (DON) confirmed that a GDR had not been completed and should have been attempted within six (6) months of the resident being placed on psychotropic medications, including Trileptal and Rexulti.

On 01/30/2025 at 11:45 AM, during an interview, the Medical Director stated that typically, the facility's psychiatric Nurse Practitioner (NP) evaluates residents returning from psychiatric hospitalizations. He agreed that a GDR should have been attempted and noted that a GDR for Rexulti was initiated on 01/29/2025.

On 01/30/2025 at 1:41 PM, during an interview, RN #3 stated that Resident #45 had exhibited

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F 758	Continued From page 31 altered sleep patterns prior to his psychiatric hospitalization but that his drowsiness had worsened in the past few months, causing him to miss meals.	F 758		
F 812 SS=F	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 observations, interviews, and facility policy review, the facility failed to label and date food stored in the refrigerator and freezer and failed to dispose of expired food for one (1) of four (4) days of kitchen observations. Findings include: A review of the facility ' s "Food Storage Labeling" policy, revised on 10/23, revealed: "...8.a.i.	F 812	1) On 1/27/25, Dietary Manager disposed-of the package of sliced ham, bag of bacon bits, the package of sliced roast beef, the unopened packages of sliced roast beef, the bag of shredded cheddar cheese, the fire-braised pork loin, the bag of frozen biscuits, the bag of frozen chicken patties, the package of hamburger patties, the pecan pie, the lemon juice, and properly mopped and	2/22/25

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F 812	Continued From page 32 Identify the food item's use-by date or expiration date ... iv. Food in storage units will be surveyed routinely to identify and discard foods that have passed their manufacturer use-by or expiration date ... 2. Refrigerator storage weekly ...." On 01/27/25 at 11:14 AM, during an initial tour with the Dietary Manager (DM), the following observations were made: In Refrigerator #1, one (1) package of sliced ham was opened and unlabeled, and a spill of orange juice was observed on the bottom of the refrigerator. In Refrigerator #3, one (1) bag of bacon bits was opened and unlabeled, and (1) package of sliced roast beef with a use-by date of 09/12/24, received on 10/06/24, was opened. Additionally, three (3) unopened packs of sliced roast beef had a use-by or freeze-by date of 11/10/24. A five (5)-lb bag of shredded cheddar cheese was opened and unlabeled. Also, a thawed, unopened fire-braised pork loin with a use-by or freeze-by date of 08/23/24, received on 12/12/24, was observed. The DM confirmed these items were expired and collected them for disposal. In Freezer #1, one (1) bag of frozen biscuits was open and unlabeled. In Freezer #2, one (1) bag of frozen chicken patties and (1) package of hamburger patties was open and unlabeled. A 10-inch pecan pie with an expiration date of 01/24/25 was also observed. In the dry storage room, (1) 48-oz container of Real Lemon Juice was observed opened on 01/05/24 but not stored in the refrigerator, despite manufacturer instructions to refrigerate after opening. On 01/27/25 at 11:20 AM, the DM confirmed the presence of expired and improperly stored food items and collected them for disposal.	F 812	cleaned the spilled orange juice. (See Exhibit 812A) 2) All residents have the potential to be affected by the same deficient practice. 3) a. On 1/27/25, the Contracted Certified Dietary Manager made observation of all food items in the dry food storage area, and ensured that all of it was properly labeled, dated, and disposed-of, where appropriate. (See Exhibit 812B) b. On 2/3/25, the contracted Certified Dietary Manager conducted monthly in-service training for all dietary staff related-to proper labeling, dating, and disposal of all food items in the dry food storage area. (See Exhibit 812C) 4) a. The Contracted Certified Dietary Manger assigned to the Dietary Manager a weekly audit for three months related-to proper foodservice Label, Date, Dispose, and Cleaning in order to ensure that zero food items are stored in the dry food storage area unless they are properly labeled, dated, and/or disposed-of, and that the floors remain clean. (See Exhibit 812D). b. Beginning no later than 2/21/2025 Quality Assurance (QA) will meet and receive the data related to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of	

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F 812	Continued From page 33 On 01/30/25 at 11:10 AM, during an interview, the Certified Dietary Manager (CDM) and Registered Dietitian (RD) stated that their expectations for kitchen staff include completing education and training for their positions, following federal guidelines, and adhering to food labeling and handling policies to prevent foodborne illness among residents. On 01/30/25 at 02:00 PM, during an interview, the Administrator revealed that he was aware that some items had been out of date but had since been discarded. He explained that the facility added a kitchen in April 2024 because the previous contract with the local hospital's kitchen to service residents ended in May 2024. The Administrator stated there is now a completely different kitchen staff and that he believes the staff is competent. He also noted that the facility changed food providers in November 2024, which may have contributed to expired foods being delivered to the facility.	F 812	relevant audit(s) and in-services based upon findings and results achieved.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to	F 865		2/22/25

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systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and

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facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information.

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F 865	Continued From page 36 A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to sustain corrective actions to prevent recurrence of a previously cited deficiency. Specifically, the facility was cited for failing to label and date food stored in the refrigerator and freezer during an annual recertification survey on 8/3/23 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of nine (9) deficiencies cited. F812 Findings Include: Record Review of the facility's policy "Quality Assessment and Performance Improvement (QAPI) Program" revised September 2022, revealed, " ...The facility will ...5. To establish that the facility's Quality Assurance and Assessment (QAA) committee has made a good faith attempt to correct an identified quality deficiency, a facility will do more than just subjectively assert it has made a good faith attempt; rather, the facility's actions, taken as a whole, will evidence a good	F 865	1) By or before 1/27/25, Facility terminated the contract with the local hospital's kitchen and replaced all dietary staff, all dietary equipment, all foodservice licensure, all dietary food suppliers, dietician consultant providers, and all physical plant kitchen related items, including walls and floors that were all indirectly monitored by the facility during the 8/3/2023 survey process, and began a new system of direct monitoring of the new staff, physical plant, foodstuffs, and area; by 1/27/25, facility dietary began utilizing a new direct-monitoring system via the Label, Date, and Dispose Audit (See Exhibit 865A) in order to ensure all food items located in the facility□s new directly-monitored dry food storage area is properly and timely labeled, dated, and disposed-of, and floors are clean, where appropriate. 2) All residents have the potential to be affected by the same deficient practice. 3) a. New Kitchen Direct-Monitoring	

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F 865	Continued From page 37 faith attempt to identify and correct quality deficiencies ... The Governing Body and/or executive leadership (or organized group of an individual who assumes full legal authority and responsibility for operation of the facility), must ensure the QAPI Program: is defined, implemented, and ongoing;... is sustained through transitions in leadership and staffing..." Record review of the "Provider History Profile" on the Certification and Survey Provider Enhanced Reporting (CASPER) report revealed the facility received a citation for F812 - Food Procurement, Store/Prepare/Serve Sanitary on the previous annual survey conducted 8/3/2023. Record review of the Centers for Medicare and Medicaid Services (CMS-2567) (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 8/3/2023, revealed the facility received a citation for F812, " ...Based on observation, staff interviews, and facility policy review, the facility failed to ensure items in the kitchen refrigerator/freezer were dated and labeled and food items were discarded by the expiration date ..." During the current annual recertification survey, the facility failed to label and date food stored and dispose of expired foods in the refrigerator and freezer in one (1) of four (4) days in kitchen observations. On 01/30/2025 at 12:20 PM, during an interview, Registered Nurse (RN) # 3 who was previously responsible for QAPI stated that she was still overseeing QAPI despite the facility hiring	F 865	System Policy was implemented by the Quality Assurance/Quality Assurance Performance Improvement (QAA/QAPI) Committee on 2/3/25 to include access to monitor the kitchen by all facility department managers. (See Exhibit 865B). b. On 2/3/25, facility Administrator-in-Training conducted in-service training for all department managers in order to ensure all department managers were capable of directly monitoring the facility kitchen and properly completing the Label, Date, and Dispose Audit. (See Exhibit 865C) c. Beginning on 2/3/25, facility Administrator-in-Training will complete a Management Coaching Schedule (See Exhibit 865D) for all department managers to assist the Dietary Manger in completion of the Label, Date, and Dispose Audit on a rotating basis, such that each department manager will provide said assistance on at least a weekly basis, in order to ensure proper support for Dietary Manager related-to implementation of Quality Assurance Performance Improvement (QAPI) goals. 4) a. The facility Administrator will receive results of Management Coaching Schedule on a weekly basis for three months from Administrator-in-Training in order to ensure that facility Dietary Manager is properly coached on implementation of Quality Assurance Performance Improvement (QAPI) goals. (Exhibit 865E).	

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F 865	Continued From page 38 someone else for the role. She explained that the new hire had not yet taken over the responsibilities, and the facility had scheduled a meeting to address the transition. RN #3 stated she was unaware that food storage issues were still occurring in the kitchen. She explained that at the time of the last survey, the facility's kitchen was associated with the hospital, but since April 2024, the facility had transitioned to its own independent kitchen. Since that transition, the kitchen staff has undergone several turnovers, and the facility was now on its third kitchen director. RN #3 reported that after the last survey on 8/3/2023, concerns related to food storage were discussed in QAPI meetings every month for the first four (4) months. She stated that audits were completed and submitted to the Director of Nursing (DON) until December 2023. However, she acknowledged that no further kitchen audits had been conducted since then, nor had kitchen issues been discussed, as the facility believed the concerns had been addressed with the new kitchen. She confirmed that although the facility had implemented the initial plan of correction, it failed to sustain those corrective actions following kitchen staff turnover and operational changes. RN #3 stated she would present these concerns to the QAPI committee again to develop new action plans and resume audits of the kitchen. On 01/30/2025 at 2:30 PM, during an interview, the Administrator and the DON confirmed that the facility had completed the plan of correction for the previous kitchen-related deficiency from 8/3/2023. The Administrator stated that the kitchen had been in operation since April 2024 and had undergone multiple staff turnovers. He further stated that he had spoken with the new kitchen manager, who was currently in training,	F 865	b. Beginning no later than 2/21/2025 Quality Assurance (QA) will meet and receive the data related to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-service based upon findings and results achieved.	

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F 865	Continued From page 39 and that they planned to continue addressing the kitchen-related concerns.	F 865		