STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255306	A. BUILDING _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH AND REHAB OF HOUSTON	1000 EAST MADISON STREET HOUSTON, MS 38851

(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
F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification Survey and a Complaint Investigation (CI) MS #28305 at the facility from 3/30/25 through 4/2/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited regulatory deficiencies at F576, F640, F641, F656, F677, F679, and F880. The SA found the facility not to be in compliance with CI MS #28305 regarding residents' choices and cited F561. The facility had a census of 45 at the time of survey and was licensed for 60 beds.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages	F 576		5/15/25

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

Electronically Signed | 04/21/2025

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 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.

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F 576	Continued From page 1 and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review and facility policy review, the facility failed to deliver resident mail on Saturdays for five (5) of 31 sampled residents. This has the potential to affect all residents in the facility. Resident #4, Resident #20, Resident #22, Resident #35, and Resident #38. Findings Include: Record review of the facility policy "Mail Delivery Policy" dated 2/2009 revealed, "The mail will be delivered to the resident Monday thru Friday by the Activity Director. If the resident receives mail on Saturday, it will be delivered to the resident by the week-end RN (Registered Nurse) Unit Manager." During a Resident Council Meeting on 03/31/25 at	F 576	F576 • On 04-01-25 the Business Office Manager (BOM) checked the Business Office to ensure that any mail that had been delivered to the facility had also been delivered to the residents. On 04-02 -25 the BOM met with Residents #4, # 45, 22, 35 and #38 and informed them that they do not currently have any mail to be delivered. On 04-02-25 the Administrator notified the United States Postal Service of the requirement to have mail delivered to the facility on Saturdays. • All residents that receive mail have the potential to be affected by the deficient practice. • On 04-03-25 the Administrator in-serviced the weekend nursing supervisor of mail being delivered by the	

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F 576	Continued From page 2 2:00 PM five of the thirteen residents in attendance revealed that they did not have mail delivered on Saturdays. Resident #38, Resident Council President, revealed that there was no one in the front office on the weekend to pass the mail out to them. Resident #4, Resident #20, Resident #22, and Resident #35 confirmed that the staff handed their mail out during the week and that they did not get mail on Saturdays. An interview on 03/31/25 at 3:40 PM with Registered Nurse (RN) #1, revealed that she worked on the weekends and that she hadn't ever accepted mail on Saturdays. She revealed that the front office was closed on the weekends. RN #1 revealed that if mail was delivered to the facility on Saturdays, she could pass it out to the residents. An interview on 04/01/25 at 9:10 AM with the Director of Nursing (DON), revealed that the mail carrier did not deliver mail to the facility on Saturdays because there was no one in the front office to give it to. She revealed that if the facility had any mail on Saturdays, the mail carrier delivered it the following Monday when they had someone to distribute it to. DON agreed that residents should receive their mail on Saturdays if they had any, and they should not have to wait until the following Monday to get it. On 04/01/25 at 10:00 AM, an interview with the Administrator (ADM) revealed that there had been some inconsistencies with the mail but she was not aware that mail was not delivered on Saturdays. ADM confirmed that it was important for the residents to receive their mail and that it should be passed out on the days the mail ran.	F 576	postal service on Saturdays and the responsibility of the weekend supervisor to take the mail to the resident's room. • The BOM will check mail on Monday for four (4) weeks to ensure that the mail is not left from the weekend beginning 04-16-25. The Administrator will meet with the weekend supervisor weekly for 4 weeks to follow up on mail being delivered from the postal service and to ensure that it was delivered to the resident on the date of delivery beginning 04-16-25. The Activity Director will follow up monthly in the Resident Council meeting for three (3) months regarding receiving mail on Saturdays beginning 04-16-25. The Administrator/Activity Director/Business Office Manager will bring audits to the monthly QA meeting for three months for recommendations or changes needed to ensure consistent substantial compliance beginning 05-14-25.	

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F 576	Continued From page 3	F 576		

Record review of Resident #4's "Admission Record" revealed an admission date of 04/17/08.

Record review of Resident #4's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/27/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that she had no cognitive deficits.

Record review of Resident #20's "Admission Record" revealed an initial admission date of 12/13/18.

Record review of Resident #20's Quarterly MDS with ARD 12/4/24 under Section C revealed a BIMS Score of 15 which indicated that she had no cognitive deficits.

Record review of Resident #22's "Admission Record" revealed an admission date of 11/04/24.

Record review of Resident #22's Quarterly MDS with ARD of 02/06/25 under Section C revealed a BIMS Score of 15 which indicated that she had no cognitive deficits.

Record review of Resident #35's "Admission Record" revealed an admission date of 03/25/22.

Record review of Resident #35's Quarterly MDS with ARD of 11/19/25 under Section C revealed a BIMS Score of 15 which indicated that she had no cognitive deficits.

Record review of Resident #38's "Admission Record" revealed an initial admission date of 07/22/22.

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F 576	Continued From page 4 Record review of Resident #38's Quarterly MDS with ARD of 12/09/24 under Section C revealed a BIMS Score of 15 which indicated that she had no cognitive deficits.	F 576		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment.	F 640		5/15/25

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F 640	Continued From page 5 (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to transmit Minimum Data Set (MDS) Assessments timely for six (6) of 31 residents' MDS assessments reviewed. Residents #15, #16, #19, #30, #34, and #35. Findings include: A review of a typed statement on facility letterhead, and signed by the Administrator on 4/2/25 revealed, "It is the policy of (Proper Name of the facility) to follow the RAI (Resident Assessment Instrument) manual, chapter 2, Timeliness of MDS." A record review of the facilities MDS 3.0 Final Validation Report revealed that the following MDS Assessments were submitted late on 3/28/25: Resident #15 last completed and submitted MDS with an Assessment Reference Date of 11/20/24.	F 640	F 640 • As of 04-02-25 the Minimum Data Set (MDS) Coordinator completed and submitted the late assessments for Resident #15, # 16, #19, #30,# 34, and #35 and they are all accepted as of 04-02-25. • All residents have the potential to be affected by the deficient practice. • On 04-03-25 the Director of Nursing (DON) in-serviced the MDS Coordinator on timely submission of MDS's. On 04-03-25 the MDS Coordinator ran a list to identify residents that currently have late submissions and correct them. • The MDS nurse will run a weekly submission list for 4 weeks and then monthly to identify any late MDS submissions beginning 04-16-25. The DON will review the weekly submission list with the MDS Coordinator for 4 weeks	

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F 640	Continued From page 6 Resident #16 last completed and submitted MDS with an Assessment Reference Date of 11/25/24. Resident #19 last completed and submitted MDS with an Assessment Reference Date of 11/20/24. Resident #30 last completed and submitted MDS with an Assessment Reference Date of 11/21/24. Resident #34 last completed and submitted MDS with an Assessment Reference Date of 2/12/25. Resident #35 last completed and submitted MDS with an Assessment Reference Date of 2/17/25. In an interview on 4/01/25 at 1:10 PM, the Registered Nurse MDS Coordinator revealed she has only been with the facility for a week and found out when she came into the position that there were a lot of MDS Assessments that were not completed and therefore were very late. Now she is working to get things caught up and completed. In an interview on 4/01/25 at 4:49 PM, the Administrator (ADM) confirmed that she was aware the facility had MDS assessments that were late being submitted. She stated, "We knew they were late, our MDS nurse quit, and we knew we were continually getting behind." She revealed the current MDS coordinator has been here for about a week and is working to get things caught up and back on track. She revealed MDS Assessments are very important because they determine the care needed for the residents and ensure payment.	F 640	and then monthly. The DON and MDS Coordinator will bring the findings of audits to monthly QA meeting for three months for recommendations or changes needed to ensure consistent substantial compliance beginning 05-14-25.	
F 641 SS=E	Accuracy of Assessments	F 641		5/15/25

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F 641	Continued From page 7 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to accurately complete Section N of an Annual Minimum Data Set (MDS) Assessment for one (1) of 31 resident MDS assessments reviewed. Resident #24. Findings Include: Record review of the facility policy "MDS (Minimum Data Set) Assessment revealed, "It is the policy of this facility to follow the RAI (Resident Assessment Instrument) process as set forth by CMS (Centers for Medicare and Medicaid Services) protocol." Record review of Resident #24's Annual MDS with an Assessment Reference Date (ARD) of 01/13/25 revealed under Section N - Medications, revealed that a hypnotic medication was coded as "Yes", the resident is receiving. Record review of Resident #24's "Order Summary Report" of active orders as of 01/13/25 revealed the resident did not have an order for a medication with a drug classification of hypnotic. Record review of Resident #24's "Medication Administration Record" revealed that she did not receive a hypnotic during the seven day look back period from 01/07/25 through 01/13/25. An interview on 04/02/25 at 9:15 AM with	F 641	F 641 " On 04-15-25 the Minimum Data Set (MDS) Coordinator completed a modification on Resident #9 and resubmitted. " All residents are at risk of being affected by the deficient practice. " The Director of Nursing (DON) in-serviced the MDS Coordinator on importance of correct coding in Section N of the MDS on 04-02-25. The Director of Nursing will review Section N of the MDS's weekly for accurate coding beginning week of 04-16-25 for three months. " The MDS Coordinator will review Section N for proper coding with each MDS completed over the next 90 days beginning 04-16-25. The MDS Coordinator will bring the findings to the monthly QA meeting for three months for recommendations or changes needed to ensure consistent substantial compliance beginning 05-14-25.	

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F 641	Continued From page 8 Registered Nurse (RN) MDS Coordinator revealed that she was new to the facility and that she was not working there during the time of the last completed MDS Assessment for Resident #24. She confirmed that Resident #24 was not taking a hypnotic and that Section N of Resident #24's Annual MDS with ARD of 01/13/25 was coded inaccurately. RN MDS Coordinator revealed that there was no documentation to reflect that Resident #24 was taking a hypnotic and stated, "It's black and white to me, it's either there or it's not." Record review of Resident #24's "Admission Record" revealed the facility admitted the resident on 09/02/22 with medical diagnoses that included Parkinson's Disease and Major Depressive Disorder. Record review of Resident #24's Annual MDS with ARD of 01/13/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 08 which indicated that she had moderate cognitive deficits.	F 641		
F 656 SS=E	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 -	F 656		5/15/25

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F 656	Continued From page 9 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record reviews, and facility policy reviews, the facility failed to implement a care plan for a resident's Activities of Daily Living (ADL) care for one (1) of	F 656	F656 • On 04-02-25 the Director of Nursing updated the care plan and Kardex to reflect on the need for oral care every two	

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F 656	Continued From page 10 31 resident care plans reviewed. Resident #9. Findings include: Record review of facility policy titled "Following the Care Plan Policy" dated 1/2011, revealed, "It is the policy of this facility to follow a written and approved care plan for each resident. All employees will be trained upon hire and be required to follow the care plan." Record review of the care plan, date initiated 7/16/24, revealed Resident #9 has an ADL self-care performance deficit related to hemiplegia, limited mobility, musculoskeletal impairment, stroke and has contractures to all extremities with associated spasticity. Interventions include oral care every shift. On 3/30/25 at 4:25 PM, an observation revealed Resident #9 with a thick white substance covering his upper and lower lip and sides of his mouth. On 3/30/25 at 6:25 PM, an observation and interview with Resident #9's Representative (RR) revealed she has to clean his mouth every time she visits, which is often. She admitted that she had talked to the staff about it, but it has not improved. On 4/01/25 at 8:30 AM, during an interview, Licensed Practical Nurse (LPN) #1 admitted that she had seen white stuff on Resident # 9's mouth occasionally and had to clean it off. She revealed that it was both the CNAs and the nurse's responsibility to provide oral care to the residents. In an interview on 4/1/25 at 1:35 PM, the	F 656	hours for resident #9. Other residents who require oral care were assessed by the Director of Nursing (DON) to assure oral care was being provided. • Residents that require assistance with oral care are at risk of being affected by the deficient practice. • On 04-14-25 The DON in-serviced the nursing staff on providing oral care to residents that require it. On 04-14-25 The Director of Nursing in serviced staff on importance of following the Kardex and care plan. • The DON or Registered Nurse Supervisor will check residents three times a week for four weeks and then once a month for two months who require assistance with oral care to ensure that oral care is being provided every two hours beginning 04-16-25. The DON will bring findings from the audits to the monthly Quality Assurance (QA) meeting for three months for recommendations or changes needed to ensure consistent substantial compliance beginning 05-14-25.	

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F 656	Continued From page 11 Minimum Data Set (MDS) Coordinator revealed the care plans are developed so the staff will know how to take care of each resident's needs. She confirmed that Resident #9's ADL care plan regarding his oral care was not being followed and that the care plan lacked further development for Resident #9's individual needs. During an interview on 4/01/25 at 1:45 PM, the Interim Director of Nurses (DON) revealed Resident #9's oral care should be done more than just each shift since he has a feeding tube and is probably a mouth breather. She revealed the resident's plan of care was not being followed in regard to his oral care, and it should have been. Record review of Resident #9's "Admission Record" revealed he was admitted to the facility on 1/24/13 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction and Gastrostomy status.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident representative interviews, record review, and facility policy review, the facility failed to ensure a dependent resident received appropriate oral care for one (1) of 45 residents residing in the facility. Resident #9. The scope and severity for this citation was	F 677	F 677 " On 04-02-25 the Licensed Practical Nurse (LPN) #1 assigned to Resident #9 performed oral care on resident to ensure that his mouth was clean and moist. Resident #9 is receiving oral care as needed. On 04-02-25 The Director of	5/15/25

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F 677	Continued From page 12 increased to "E" for a repeated citation from the previous annual recertification survey. Findings include: Record review of the facility policy titled "ADL (Activities of Daily Living) Care Policy" dated 8/23 revealed, "It is the policy of this facility to provide appropriate treatment and services in relation to ADL care to residents to ensure all ADL needs are met on a daily basis while attaining or maintaining the residence of highest, practicable, physical, mental, and social well-being." An observation on 3/30/25 at 4:25 PM revealed Resident #9 with a thick white substance inside the corners of his mouth and covering his upper and lower lip. An interview on 3/30/25 at 6:25 PM with Resident #9's Resident Representative (RR) sitting at the bedside, she stated that she visits frequently and usually has to wash his lips and mouth off when she arrives. She revealed she has told the staff about his mouth not getting cleaned. She understands that the staff can't be with him 24 hours a day but thinks they could do better by ensuring he is cleaned up. She revealed she has visited before and found him with white dried secretions on his lips, and that tells her that his sputum stayed on his lips long enough to dry up. During an interview on 4/01/25 at 8:30 AM, Licensed Practical Nurse (LPN) #1 revealed that occasionally at the beginning of shift, the resident will have an white sputum on his mouth and lips. She stated, "It doesn't happen all of the time but does occasionally." She revealed that the Certified Nursing Assistants (CNA) are	F 677	Nursing assessed other residents to assure oral care was being provided. " Residents that require assistance with oral care are at risk of being affected by the deficient practice. " On 04-14-25 the Director of Nursing (DON) in-serviced the nursing staff on identifing residents that need assistance with oral care and providing oral care to residents when needed. On 04-14-25 the Director of Nursing in-serviced nurses on checking residents to ensure oral care is being provided at the time they are passing medications. " The DON or Registered Nurse Supervisor will check residents three times a week for four weeks and then once a month for two months who require assistance with oral care to ensure that oral care is being provided every two hours beginning 04-16-25. The DON will bring findings from the audits to the monthly Quality Assurance (QA) meeting for three months for recommendations or changes needed to ensure consistent substantial compliance beginning 05-14-25.	

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F 677	Continued From page 13 responsible for his ADL care, which includes his mouth care, and that the nurses are also responsible for oral care each shift. In an interview on 4/1/25 at 12:45 PM, with CNA #2, she stated that they clean Resident #9's mouth when they do his ADL care. She admitted that if the staff would clean his mouth each time they checked on him, then that stuff wouldn't dry on his mouth. During an interview on 4/01/25 at 1:45 PM, the Interim Director of Nurses (DON) revealed Resident #9's oral care should be done each shift and more often since he is fed by a feeding tube and probably a mouth breather. She revealed that it is her expectation that each resident is adequately groomed and presentable in appearance. Record review of Resident #9's "Admission Record" revealed he was admitted to the facility on 1/24/13 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction, Gastrostomy status, and Adult Failure to Thrive.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of	F 679		5/15/25

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F 679	Continued From page 14 each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record reviews, and facility policy reviews, the facility failed to provide an ongoing activity program designed to meet the needs of each resident for four (4) of 14 residents interviewed during the Resident Council meeting as evidenced by a lack of group activities on weekends. Residents #20, #22, #38 and #39. Findings include: A record review of facility policy titled, "Activity Program", dated 1/21/22, revealed, "An ongoing program of activities is designed to meet the needs of each resident. ... Individualized and group activities are provided that: a. Reflect the schedules, choices, and rights of the residents; b. Are offered at hours convenient to the residents, including evenings, holidays, and weekends." Record review of the March 2025 Activity Calendar revealed each Saturday in March "INDIVIDUAL PURSUIT" was listed as the activity. Church services were listed each Sunday morning with "CHECKERS/MOVIES" as the 2:00 PM activity each Sunday. Resident #20 During an interview 03/30/25 at 4:50 PM, Resident #20 stated she loved attending group activities, but the facility did not have activities on Saturday's. She admitted that she gets bored on Saturdays and would like there to be activities.	F 679	F 679 " On 04-03-25 The Activity Director held a Resident Council Meeting to inform the residents that if no outside activity was planned for Saturdays that a Nurse Aide would be assigned to Activities and would be present for the entire activity. Residents #20, #22, #38, and #39 were in attendance at the meeting. " Residents that attend activities are at risk of being affected by the deficient practice. " On 04-04-25 the Administrator in serviced the Activity Director regarding program activities designed to meet the needs of each resident and that activities are offered at hours convenient to the residents. On 04-04-25 the Administrator inserviced the Activity Director on assigning the weekend activities to a nurse aide and to review the activity plan with that nurse aide on each Thursday prior to the weekend assignment. On 04-16-25 the Administrator in-serviced the two Nurse Supervisors that work on weekends regarding the responsibility of the nurse aide assigned to weekend activity to conduct the entire activity and to be present for the entire activity. " The Activity Director will attend one weekend activity a month for three months to ensure that it meets the needs of the residents beginning 04-16-25. The Activity Director will review weekend activities with Resident Council each	

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F 679	Continued From page 15 An interview with the Administrator on 4/1/25 at 4:00 PM revealed the facility was required to provide daily group activities and other activities that interest the residents even on the weekend. She confirmed the facility failed to provide the residents with activities on Saturday for those residents that choose to attend. During an interview on 4/2/25 at 9:50 AM, the Activity Director confirmed the residents need activities that meet their interests daily and the facility had failed to provide these on Saturdays for "a while now". She stated the facility had a family council group that was extremely active and had activities for the residents every Saturday, but the president of that group had a family illness, so she was less involved. Since that time, the family group had "fizzled out". She admitted that during the winter months, residents were more confined inside and this could cause them to feel "a little stir crazy and bored". Then she added that she provided games and puzzles for the residents to do on their own on the weekend, but there were no scheduled group activities. Record review of Resident #20's Annual Minimum Data Set (MDS) Section F with Assessment Reference Date (ARD) of 9/17/24, revealed the resident's response of "very important" to the question, "How important is it to you to do things with groups of people?" To the question, "How important is it to you to do your favorite activities", the resident's response was, "very important". Record review of Resident #20's "Admission Record", revealed the resident was admitted to the facility on 12/13/18.	F 679	month for three months beginning 04-16-25. The Administrator will interview three residents a week for four weeks regarding the activities program and weekend activities beginning 04-16-25. The Activity Director and the Administrator will bring the findings from the audits to monthly Quality Assurance meeting for three months for recommendations or changes needed to ensure consistent substantial compliance beginning 05-14-25.	

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Record review of Resident #20's Quarterly MDS Section C with an ARD of 12/4/24, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident was cognitively intact.

Resident #22

During an interview on 3/30/25 at 3:30 PM, Resident #22 revealed weekends are pretty boring here. They got us some games to play, but many folks don't know how to play them, and they just sit and stare at each other. She revealed that on Sundays, someone comes in and does a church service, but we are on our own after that.

In an interview on 4/01/25 at 9:37 AM, the Activities Director confirmed that Resident #22 had voiced concerns that she would like to do weekend activities. She revealed she is trying to build the activities department back up and confirmed that there were no organized group activities for the month of March. She revealed it has been quite some time since there have been weekend activities

During an interview on 4/01/25 at 10:10 AM, the Administrator confirmed that the family council members used to be very involved in weekend activities, but they haven't been there in a while.

Record review of Resident #22's Admission MDS Section F with an ARD of 11/11/24 revealed the resident's response to the question, "How important is it to you to do your favorite activities?" was, "Very important".

Record review of Resident #22's "Admission Record" revealed the resident was admitted to

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the facility on 11/04/24.

Record review of Resident #22's MDS Section C with an ARD of 11/11/24, revealed a BIMS of 15 which indicated the resident was cognitively intact.

Resident #38

On 03/31/25 at 1:30 PM, an interview with Resident #38, Resident Council President, revealed that they attended monthly Resident Council Meetings and had several residents who attended regularly. She revealed that some of the residents had brought up in the past that there weren't enough activities planned during the week and no activities on the weekends. She revealed that they had preaching on Sunday and that's it.

Record review of Resident #38's "Admission Record" revealed an initial admission date of 07/22/22.

Record review of Resident #38's Quarterly MDS with ARD of 12/09/24 under Section C revealed a BIMS Score of 15 which indicated that she had no cognitive deficits.

Resident #39

An interview on 3/30/25 at 3:45 PM, Resident #39 revealed he would love to have something to do on the weekend. He stated that they don't have anything to do on Saturdays, and have a preacher who comes in early Sunday, but after that, we don't have anything to do. Resident #39 stated, "I mainly just stay in bed and watch TV or sleep on the weekends."

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F 679	Continued From page 18 Record review of Resident #39's Annual MDS Section F with ARD of 7/30/24 revealed the resident's response of "Very important" to the question, "How important is it to you to do things with groups of people?" To the question, "How important is it to you to do your favorite activities?" the resident's response was, "Very important." Record review of Resident #39's "Admission Record" revealed the resident was admitted to the facility on 8/1/23. Record review of Resident #39's MDS Section C with ARD of 7/30/24 revealed a BIMS score of 8 which indicated the resident had moderate cognitive impairment.	F 679		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		5/15/25

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staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 20 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure implementation of infection prevention and control practices to prevent the potential transmission of communicable diseases and infections for two (2) of three (3) resident care areas observed (Resident #1 and Resident #9). Specifically, the facility failed to: 1. Post appropriate transmission-based precautions signage for a resident on contact isolation for Methicillin Resistant Staphylococcus Aureus (MRSA) (Resident #1); and 2. Ensure staff followed Enhanced Barrier Precautions (EBP), including wearing a gown, during the administration of medication via a Percutaneous Endoscopic Gastrostomy (PEG) tube (Resident #9). These failures had the potential to contribute to the transmission of infectious organisms to other residents, staff, and visitors within the facility. The scope/severity for this deficiency was increased to "E" - pattern. F880 was also cited during the last annual recertification survey. Findings include:	F 880	F 880 On 04-01-2025 The Director of Nursing placed a contact isolation sign on Resident #1s door. On 04-02-25 the Director of Nursing observed other residents rooms to ensure that if they were on isolation that the proper signage was located on the outside of that residents' room door. On 04-02-025 the Director of Nursing in serviced Licensed Practical Nurse #1 regarding proper PPE while caring for a resident on enhanced barrier precautions. " Residents on isolation precautions are at risk of being affected by the deficient practice. " On 04-14-25 the Director of Nursing serviced the nursing staff on placing notification on a residents room door to identify that the resident is in isolation and requires PPE when caring for that resident. On 04-14-25 the Director of Nursing in serviced the nursing staff on proper identification on the outside of a residents door to identify that the resident is in isolationand requires PPE when entering room or caring for a resident. On 04-14-25 the Director of Nursing in serviced staff on proper PPE for isolation	

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F 880	Continued From page 21 A record review of the facility policy titled "Enhanced Barrier Precautions," dated 10/23, revealed, "It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms...Enhanced barrier precautions" refer to the use of gown and gloves for use during high-contact resident care activities ...(residents with wounds or indwelling medical devices)... c. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves..." Record review of facility policy titled, "Infection Prevention and Control Program", undated, revealed, "It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections". Resident #1 During an interview on 3/30/25 at 5:25 PM, Resident #1 stated he had wounds on his lower legs. A hanging isolation organizer was noted on his door. There was no signage on his door that indicated what type of isolation the resident was in or what type of Personal Protective Equipment (PPE) was needed. During an interview on 3/31/25 at 10:30 AM, the	F 880	and enhanced barrier precaution resident when entering the residents room and providing care for isolation residents. " The Director of Nursing will observe isolation precaution residents two times weekly for three weeks then monthly for two months for proper signage on resident room door beginning 04-16-25. The Director of nursing will observe nursing staff caring for residents that require PPE when receiving care two times weekly for three weeks and then monthly for two months beginning 04-14-25 to ensure staff is wearing proper PPE when entering an isolation room and when caring for an isolation resident. The Director of Nursing will bring the findings from the audits to monthly Quality Assurance meeting for three months for recommendations or changes needed to ensure consistent substantial compliance beginning 05-14-25.	

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Infection Preventionist/Treatment Nurse stated that Resident #1 had Methicillin Resistant Staphylococcus Aureus (MRSA) in his leg wounds and was on contact isolation for this infection. She stated he was receiving antibiotics and after completing those, a repeat culture would be done. She stated the proper use of PPE helped prevent the spread of an infection. She acknowledged the resident did not have signage on his door to indicate what type of isolation the resident was on or what type of protective equipment needed to be used.

An interview with the Administrator on 3/31/25 at 11:40 AM confirmed that Resident #1 was in contact isolation due to MRSA in a wound and signage on or near the resident's door was required. She stated when a resident was placed in contact isolation, the type of precaution and the PPE to be used was required to be placed in a visible area outside of the resident's room. She stated signage was necessary to inform staff and visitors what PPE was needed to help prevent the spread of infection. She confirmed the facility failed to place proper infection control signage on or near a resident's door to identify the type precautions and the appropriate PPE to use.

Record review of Resident #1's "Order Summary Report" revealed an order dated 3/25/25 to "Maintain contact precautions due to MRSA infection in lower leg every shift related to bacterial infection".

Record review of Resident #1's "Admission Record" revealed the resident was admitted to the facility on 11/12/18. Diagnoses included Bacterial Infection, Non-pressure Chronic Ulcer of left and right lower legs, and Venous

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23	F 880		

Insufficiency.

Record review of Resident #1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/13/25, revealed a Brief Interview for Mental Status (BIMS) of 10 which indicated the resident had moderate cognitive impairment.

Resident #9

An observation on 4/01/25 at 8:25 AM revealed Licensed Practical Nurse (LPN) #1 administered Resident #9's medications through a PEG tube without wearing a gown for EBP. She confirmed she failed to wear a protective gown and revealed she knows that she should have. She revealed that EBP is supposed to be utilized when providing care to the resident since he has a PEG tube. She revealed we even discussed wearing the gown when I gave him his medications this morning, but I got nervous and forgot to do it.

During an interview on 4/01/25 at 2:24 PM, the Interim Director of Nurses (DON) confirmed that the nurse should have worn the PPE when administering his medications through the PEG. She revealed that EBP is implemented to protect the residents and the staff from spreading germs.

During an interview on 4/02/25 at 12:06 PM, the Infection Control Nurse revealed that for any residents under EBP, the facility's requirements and expectations are that the staff wear the proper PPE to reduce the possible spread of infections.

Record review of Resident #9's "Order Summary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255306	A. BUILDING _____ B. WING _____	04/02/2025

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F 880	Continued From page 24 Report" with active orders as of 4/1/25 revealed an order for EBP related to PEG every shift. Record review of Resident #9's "Admission Record" revealed he was admitted to the facility on 1/24/13 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction and Gastrostomy status.	F 880		