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	255336	A. BUILDING _____ B. WING _____	03/20/2025

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification Survey along with two (2) Complaint Investigations (CI MS #27722 and CI MS #27860) at the facility from 3/17/25 through 3/20/25. CI MS #27722 was investigated regarding facility staffing, falls, and resident safety. CI MS# 27860 was investigated regarding neglect, quality of care and accidents. There were no citations related to the CIs. 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 F561, F623, F637, F646, F656, and F740. The facility held a license for 122 beds, with a census of 111.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		4/16/25

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

Electronically Signed | 04/09/2025

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F 561	Continued From page 1 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews, and facility policy review, the facility failed to honor resident food dislikes by placing food items on meal trays that were identified as dislikes for one (1) of four (4) days of observation. Resident #58. Findings included: A review of the facility's "Resident Rights Policy," revised 12/4/2016, revealed, "... Responsibilities...The facility must support the resident in the exercise of his or her rights... Procedure... 6. Resident Rights. The resident has the right to a dignified existence, self-determination..." A review of the facility's booklet titled "A Matter of Rights: A Guide to Your Rights and Responsibilities as a Resident" with a copyright date of 2017 revealed, "... Freedom of Choice - You are entitled to make decisions, whenever possible, for yourself based on your interests and preferences..." On 03/17/2025 at 12:27 PM, during an interview	F 561	F561 (1) On 3/17/25 the tray for Resident #58 was removed and replaced with a tray that honored her food preferences. (2) The facility has determined that all residents have the potential to be affected by failure to honor food preferences. (3) In-services began on 3/17/25 by the Registered Dietitian (RD) with kitchen staff regarding the need to honor food dislikes, providing a substitution, and ensuring all add ons were on trays. In-services to be completed by 4/10/2025. On 3/26/25, the Quality Assurance and Assessment (QAA) Committee met and reviewed the Resident Rights Policy and approved with no changes. Kitchen employee numbers one (1) and seven (7) will plate the food and be responsible for reading the meal ticket and providing a substitution for all dislikes listed on the ticket. Kitchen employee numbers four (4) and nine (9) will place the trays on the carts for delivery and be responsible for checking the tray for accuracy to make sure substitutions for dislikes and add on	

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F 561	Continued From page 2 and observation, Resident #58 was observed eating lunch independently. The lunch tray included lasagna and mashed potatoes with gravy. Resident #58 stated that she has told kitchen staff repeatedly not to serve certain items, yet they continue to send her food she requested not to receive. She explained the staff ask her multiple times what she wants but still brings her the wrong meal. An observation of the resident's tray card revealed lasagna was listed as a dislike. Resident #58 stated she now relies on her own food because she is tired of telling staff to bring something else. On 03/17/2025 at 12:40 PM, during an interview, Certified Nurse Aide (CNA) #1 confirmed that lasagna was listed as a dislike on Resident #58's meal ticket, yet she received it for lunch. On 03/19/2025 at 8:25 AM, during an interview, the Dietary Manager (DM) stated she could not recall whether she completed Resident #58's likes and dislikes documentation. She explained that likes and dislikes documentation should be completed for all new admissions and updated as needed. She stated that CNAs or nurses should notify the kitchen when residents are not eating or when changes to the meal ticket are required. She confirmed the Cook is responsible for reading meal tray tickets and honoring preferences during tray line setup. The DM was not aware Resident #58 received lasagna on 03/17/2025 and stated that this was an error by the cook. She confirmed her expectation that all residents' likes and dislikes are honored. On 03/20/2025 at 1:00 PM, during an interview, the Administrator stated that all staff are expected to honor residents' rights and choices at all times	F 561	food items were provided. (4) Beginning 3/24/2025, the RD or Dietary Manager (DM) will conduct tray audits weekly, for three (3) months, on twelve (12) residents to verify that the tray matches the diet order, was prepared correctly, and that preferences were observed. Corrective action will be taken at the time if issues are identified. Audit reports will be reviewed by QAA monthly beginning 4/16/25, for 3 months. The committee will make any changes if needed to ensure compliance.	

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F 561	Continued From page 3 to ensure high-quality care. A record review of Resident #58's Admission Record revealed the facility admitted the resident on 01/13/2025 with diagnoses including Limb-Girdle Muscular Dystrophy. A record review of Resident #58's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/21/2025 revealed she had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. A record review of Resident #58's meal tickets dated 03/17/2025 and 03/18/2025 revealed lasagna listed as a dislike.	F 561		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623		4/16/25

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F 623	Continued From page 4	F 623		

(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State

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F 623	Continued From page 5 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide a reason for a resident transfer	F 623	F623 (1) Resident #5 is currently in the facility	

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F 623	Continued From page 6 for one (1) of 23 residents sampled. Resident #5 Findings Include: A review of the facility's "Notice of Transfer or Discharge" dated 09/02/24 revealed there was no explanation for the resident's discharge to the hospital. A review of the facility's "Notice of Transfer or Discharge" dated 12/14/24 revealed there was no explanation for the resident's discharge to the hospital. A record review of the facility's "Admission Record" revealed the facility admitted the resident on 5/20/16 with diagnoses including Heart Failure. On 3/20/25 at 8:05 AM, an interview with the Social Services Director revealed the Charge Nurse is responsible for filling in the "Notice of Resident Transfer or Discharge" form and the Business Office Coordinator mails the form to the Resident Representative (RR). On 03/20/25 at 9:50 AM, an interview with Registered Nurse (RN) #1 Charge Nurse revealed she has never filled in the "Notice of Resident Transfer or Discharge" at the time a resident is sent to the hospital. RN #1 stated she fills out the "Functional Abilities and Goals: Discharge" form on the computer. RN #1 stated there is no place on the form for a reason for the hospitalization. RN #1 stated she notates the reason for the hospitalization in the progress note. On 03/20/25 at 10:13 AM, an interview with RN	F 623	and the Resident Representative (RR) was provided written notice explaining the reason for transfer for the 9/2/24 and 12/14/24 transfers. (2) The facility has determined that all residents who are transferred or discharged have the potential to be affected by the failure to provide the reason for transfer. (3) On 3/26/25, Quality Assurance and Assessment (QAA) Committee met and reviewed the Resident Transfer and Discharge Policy and approved with no changes. The electronic Notice of Resident Transfer or Discharge form was reviewed and changes were recommended. The question The reason for the transfer/discharge is for the following reason(s): on the electronic Notice of Resident Transfer or Discharge form was updated to a required field. In-services began on 3/26/25, by the Director of Nursing (DON) with all Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) to review the Resident Transfer and Discharge Policy, changes to the form, and the circumstances regarding required notices and documentation for residents upon transfer and discharge from the facility. In-services will be completed by 4/15/25. New staff hired to these positions will be in-serviced upon hire. (4) Beginning 3/24/25 for a period of three (3) months the Business Office Coordinator (BOC) or the Administrator will conduct a record audit of all residents who have been transferred or discharged from the facility to ensure the record	

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F 623	Continued From page 7 #2 Charge Nurse revealed she does not fill in the "Notice of Resident Transfer or Discharge" at the time of a resident being sent from the facility to the hospital. RN #2 stated she fills out the "Functional Abilities and Goals: Discharge" form on the computer. RN#2 stated she will then write a progress not regarding the hospitalization. On 03/20/25 at 10:30 AM, an interview with the Business Office Coordinator (BOC), acknowledged that it is her responsibility to mail the "Notification of Resident Transfer or Discharge" to the Resident Representative. The BOC stated she receives a notification from the Electronic Medical Record that lets her know that the "Notification of Resident Transfer or Discharge" has been saved to the system. The BOC stated she will print the form and mail it to the Resident Representative. On 03/20/25 at 11:12 AM, an interview with the Assistant Director of Nursing (ADON) revealed it is the responsibility of the Charge Nurse to fill in the "Notification of Resident Transfer or Discharge" at the time a resident is being sent to the hospital. The ADON acknowledged that "Notification of Resident Transfer or Discharge" forms dated 9/2/24 and 12/14/2024 did not list information detailing the reason for the hospitalization. The ADON stated going forward she expects the facility's staff to adequately inform the resident and the RR in writing of the reason for hospitalization. On 03/20/25 at 11:20 AM, during an interview the Director of Nursing (DON) acknowledged the "Notification of Resident Transfer or Discharge" forms dated 9/2/24 and 12/14/24 did not list information detailing the reason for the	F 623	includes a completed notice. Corrective action will be taken at the time if issues are identified. Audit reports will be reviewed by QAA monthly beginning 4/16/25, for 3 months. The committee will make any changes if needed to ensure compliance.	

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F 623	Continued From page 8 hospitalization. The DON stated it is the responsibility of the Charge Nurse to fill in the form. The DON acknowledged that the RR would benefit from having clear written communication regarding the residents' hospitalizations. The DON stated that going forward they will make the forms instructions clearer to provide more information.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment after a resident experienced two (2) or more declines in activities of daily living and an increase in behavioral symptoms for one (1) of twenty-three (23) sampled residents. Resident #10. Findings included: A review of the facility's "MDS (Minimum Data	F 637	F637 (1) On 3/19/25 Minimum Data Set (MDS) Coordinator updated care plan for Resident #10 to reflect significant weight loss due to cognitive/behavioral disorder and refusal of medications/meals/care. On 4/9/25, MDS Coordinator completed significant change assessment for Assessment Reference Date (ARD) of 4/8/25. Resident #10 is to be seen by psychiatric Nurse Practitioner (NP) on 4/11/2025.	4/16/25

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F 637	Continued From page 9 Set), CAA (Care Area Assessments), and Care Plan Documentation Policy, revised 11/14/2023, ... It is the purpose of this facility to provide documentation in the medical record for MDS, CAA, and care plan purposes ... Discussion: 1. The staff completing each portion of the MDS is responsible for ensuring that documentation is found in the medical record to support the coding they perform ..." A review of the "Long Term Care Resident Assessment Instrument (RAI) User's Manual" Version 1.19.1 dated October 2024 revealed, "... A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'self-limiting'; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan ..." A record review of Resident #10's Admission Record revealed the facility admitted the resident on 10/01/2021 with diagnoses including Bipolar Disorder, Unspecified, Psychotic Disorder with Hallucinations Due to Known Physiological Conditions, Psychotic Disorder with Delusions, and Other Symptoms and Sign Involving Cognitive Function and Awareness. A record review of Resident #10's MDS Care Profile revealed no Significant Change MDS had been completed since admission. The most recent Quarterly MDS was completed on 01/09/2025. A record review of the "Order Summary Report"	F 637	(2) The facility has determined that all residents have the potential to be affected by the failure to complete a Significant Change in Status Minimum Data Set (MDS) assessment. (3) An in-service was held on 3/24/25 by the Director of Nursing (DON), to review the Resident Assessment Instrument (RAI) Manual Chapter 2 specific to significant change assessment guidelines and the MDS, Care Area Assessment (CAA), and Care Plan Documentation Policy with Interdisciplinary Team (IDT), including MDS Coordinators. Beginning on 03/24/25, during the daily stand up meetings, the Activities of Daily Living (ADL) Significant Change and Alert Listing Reports from within the Electronic Medical Record (EMR) system were used to identify residents who may need a significant change assessment. These reports will be reviewed during the daily stand up meeting Monday through Friday. (4) Beginning 3/24/25 for a period of four (4) weeks MDS Coordinators will monitor the completion of significant change assessments using an MDS Significant Change Checklist for ten (10) residents weekly. Then for five (5) residents weekly for 4 weeks. Then weekly for one (1) resident ongoing for a period of no less than three (3) months. Corrective action will be taken at the time if issues are identified. Audit reports will be reviewed by Quality Assurance and Assessment (QAA) Committee monthly beginning 4/16/25, for 3 months. The committee will make any changes if needed to ensure compliance.	

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with active orders as of 03/19/2025, revealed Resident #10 had a physician's order, dated 11/26/2024, Do Not Resuscitate (DNR), Do Not Transfer, Comfort Measures Only, dated 11/26/2024, with no diagnosis or clinical rational for comfort measures indicated.

A record review of the "Physician's Order Sheet" revealed Resident #10 had a Physician's Order, dated 08/29/2024 to send the resident to an emergency room for evaluation of increased behaviors, and another Physician's Order, dated 11/14/2024, to send the resident to a Behavioral Health Unit (BHU) for further evaluation.

A record review of the Social Services Quarterly Note dated 01/09/25 revealed Resident #10 has had a "Change in status" in her cognitive status, social interaction, mood status, behavioral status, and rejection of care/resident choices.

On 03/19/2025 at 2:25 PM, during an interview, the Director of Nursing (DON) confirmed Resident #10 had been sent to a BHU twice. Resident #10 was sent out once on 08/2024 and again on 11/14/2024. The resident had demonstrated increased behaviors, ceased taking oral medications, and was eating very little. Following the last BHU visit (11/14/24), the resident's family elected to place her on comfort measures only. The DON acknowledged that Resident #10 continued to refuse medications and food.

On 03/19/2025 at 3:20 PM, during an interview, Licensed Practical Nurse (LPN) #2/MDS Nurse, she explained that a Significant Change MDS should be completed when a resident experiences two (2) or more significant changes

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F 637	Continued From page 11 in health status. LPN #2 confirmed that Resident #10 had not had a Significant Change MDS in the past year despite having been to the BHU twice, refusing oral medications, eating inconsistently, experiencing significant weight loss, and being placed on comfort measures. She stated that a Significant Change Assessment should have been completed. On 03/20/2025 at 12:45 PM, during an interview, Registered Nurse (RN) #3, who serves as the Reimbursement Coordinator and completes Pre-Admission Screening and Resident Review (PASRR), stated that she was aware of Resident #10's recent health status changes. She confirmed the resident had been to a BHU twice, placed on comfort measures, refused oral medications, and lost significant weight-all of which met criteria for a Significant Change in Status Assessment. She acknowledged that the assessment had not been completed and stated, "It was just missed." On 03/20/2025 at 1:00 PM, during an interview, the Administrator stated that she was aware of the decline in Resident #10's condition and expects all staff to perform their job duties correctly, including ensuring assessments are completed accurately and on time.	F 637		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.	F 646		4/16/25

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F 646	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to notify the state mental health authority following a significant change in status for one (1) of two (2) residents reviewed for Preadmission Screening and Resident Review (PASRR) Level II. Resident #10 Findings included: A review of the facility's policy titled "PASRR Screening" with a review date of 11/19/2023 revealed, " ... This facility coordinates assessments with the preadmission screening and resident review (PASRR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs ... Policy Explanation and Compliance Guidelines: ... 7. Any Level II resident who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional review. 8. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: ... c. A resident transferred, admitted, or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment ..." A record review of Resident #10's Admission Record revealed the facility admitted the resident on 10/01/2021 with diagnoses including Bipolar Disorder, Unspecified, Psychotic Disorder with Hallucinations Due to Known Physiological	F 646	F646 (1) On 4/4/25, Registered Nurse (RN) #3 submitted a preadmission screening and resident review (PASARR) change in status form for review for Resident #10. On 4/8/25, the facility received notification that no PASARR Level II was required at this time. (2) The facility has determined that all residents who have a significant change in mental or physical condition who has a mental illness or intellectual disability diagnosis have the potential to be affected by the failure to notify the state mental health authority following a significant change in status. (3) An in-service was held on 3/24/25 by the Director of Nursing (DON), to review the Resident Assessment Instrument (RAI) Manual – Chapter 2 specific to significant change assessment guidelines and the MDS, Care Area Assessment (CAA), and Care Plan Documentation Policy with Interdisciplinary Team (IDT), including MDS Coordinators. Beginning on 03/24/25, during the daily stand up meetings, the Activities of Daily Living (ADL) Significant Change and Alert Listing Reports from within the Electronic Medical Record (EMR) system were used to identify residents who may need a significant change assessment. These reports will be reviewed during the daily stand up meeting Monday through Friday. (4) Beginning 3/24/25 for a period of four (4) weeks MDS Coordinators will monitor the completion of significant change	

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F 646	Continued From page 13 Conditions, Psychotic Disorder with Delusions, and Other Symptoms and Sign Involving Cognitive Function and Awareness. A record review of Resident #10's Preadmission Screening and Resident Review (PASRR) dated 08/24/2020 revealed no diagnosis of Alzheimer's Disease but noted that the resident had a recent history of mental illness and takes or has a history of taking psychotropic medications. A record review of Resident #10's PASRR Level II dated 09/08/2020 revealed the resident was exempt from PASRR at that time. The documentation also stated, "If there is a change in symptoms, behaviors, or a new diagnosis, the nursing facility should submit a status change." A record review of the "Physician's Order Sheet" revealed Resident #10 had a Physician's Order, dated 08/29/2024 to send the resident to an emergency room for evaluation of increased behaviors, and another physician's order, dated 11/14/2024, to send the resident to a Behavioral Health Unit (BHU) for further evaluation. On 03/18/2025 at 1:00 PM, during an interview with the Director of Nursing (DON), he explained that the facility does offer psychiatric services, but once a resident is on palliative or comfort care, those services are discontinued. The DON stated that Resident #10 had previously received psych services, but since being placed on comfort measures only, she is no longer followed. The DON acknowledged that Resident #10 continues to experience good and bad days with behaviors, hallucinations, and delusions. The resident had been sent to the hospital and subsequently admitted to a Behavioral Health Unit (BHU) twice.	F 646	assessments using an MDS Significant Change Checklist for ten (10) residents weekly. Then for five (5) residents weekly for 4 weeks. Then weekly for one (1) resident ongoing for a period of no less than three (3) months. Corrective action will be taken at the time if issues are identified. Audit reports will be reviewed by Quality Assurance and Assessment (QAA) Committee monthly beginning 4/16/25, for 3 months. The committee will make any changes if needed to ensure compliance.	

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F 646	Continued From page 14 The family later elected comfort measures only. The DON confirmed that the facility did not submit a change in status referral for a PASRR Level II after either BHU admission. He stated that the PAS (Pre-admission Screening) and PASRR on file were the only screenings completed and acknowledged he was not aware that being sent to a BHU or an increase in behaviors required a new referral. On 03/20/2025 at 12:45 PM, during an interview with Registered Nurse (RN) #3, she explained that she is the Reimbursement Coordinator and Minimum Data Set (MDS) Coordinator and completes the PASRR process. She confirmed that she was aware Resident #10 had been to the BHU twice recently. She stated she was not aware that a resident with a Level II, or a resident transferred and admitted to an inpatient psychiatric stay, required a status change referral to the state mental health authority. On 03/20/2025 at 1:00 PM, during an interview with the Administrator, she explained that she was aware of the decline in Resident #10's health status, increased behaviors, and that the resident had been admitted to an inpatient BHU twice. She stated that she expects all staff to perform their duties correctly and for assessments to be completed accurately and on time. The Administrator acknowledged she was not aware that an inpatient psychiatric stay triggered a requirement for a PASRR status change referral. She believed that if the resident's behaviors were ongoing, a new referral was not required.	F 646		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		4/16/25

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§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the

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F 656	Continued From page 16 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 interview, record review, and facility policy review the facility failed to develop and implement a comprehensive, person-centered care plan and individualized interventions, as evidenced by not addressing ongoing behavioral symptoms and providing individualized comfort care interventions, despite a known history of psychotic and aggressive behaviors, which resulted in Resident #10 having frequent behavioral episodes, refusal of medications and food, and frequent combative interactions with staff.for one (1) of twenty-three (23) residents reviewed for care planning. Resident #10 Findings include: A review of the facility's policy titled, "MDS (Minimum Data Set), CAA (Care Area Assessments), and Care Plan Documentation Policy," with a reviewed date of 01/24/24, revealed, "... It is the purpose of this facility to provide documentation in the medical record for MDS, CAA, and care plan purposes ... Discussion: ... 6. The care plan will be updated on an ongoing basis with significant changes in interventions..." A record review of Resident #10's "Comprehensive Care Plan" revealed Resident #10 had a "MOOD" care plan with interventions in place. The interventions, however were not all	F 656	F656 (1) On 3/19/25 care plans for Resident #10 were reviewed by the Minimum Data Set (MDS) Coordinator and updated to align the Behavioral Health and Intervention task documentation and with the comprehensive care plan interventions. (2) The facility has determined that all residents have the potential to be affected by the failure to develop and implement a comprehensive, person-centered care plan and individualized interventions. (3) On 3/26/25, the Quality Assurance and Assessment (QAA) Committee met and reviewed the Comprehensive Person-Centered Care Plan Policy and approved with no changes. An in-service was held with the MDS Coordinators on 4/7/25 by the Director of Nursing (DON), to review the Comprehensive Person-Centered Care Plan Policy. (4) Beginning 3/24/25, care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinators. All care plans will be updated as indicated. Beginning 3/24/25, the DON will complete weekly audits of care plans for three (3) months. Audits will be completed to ensure that comprehensive care plans are developed	

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F 656	Continued From page 17 inclusive and aligned with all the Certified Nursing Assistant (CNA) documentation interventions indicated in the "Behavior Monitoring Interventions" for Resident #10. A record review of Resident #10's "Admission Record" revealed the facility admitted the resident on 10/01/21 with diagnoses that included Bipolar Disorder, Psychotic Disorder with Hallucinations Due to Known Physiological Conditions, Psychotic Disorder with Delusions, and other cognitive disorders. A record review of the "Behavior Monitoring and Interventions" documentation for March 2025 revealed Resident #10 exhibited frequent and escalating behavioral symptoms, including physical aggression, verbal outbursts, and refusal of care. Behavioral episodes were documented on multiple dates across all shifts, including but not limited to 03/11, 03/13, 03/14, 03/15, 03/16, 03/17, 03/21, and 03/22, often involving grabbing, hitting, pushing, scratching, screaming, cursing, and threatening staff. The most frequently used interventions included redirecting the resident, providing food/drink, re-approach, and offering comfort measures such as massage or repositioning. However, the documented outcomes were consistently noted as either "same" (unchanged) or "worsened." In addition, the intervention choices for the CNA documentation were not specific to Resident #10 and did not align with comprehensive care plan interventions. During an interview, on 03/17/25 at 1:25 PM, CNA #3 stated that Resident #10 is always confused and has daily behaviors. She explained that the resident is noncompliant with care and becomes	F 656	for residents. Corrective action will be taken at the time if issues are identified. Audit reports will be reviewed by QAA monthly beginning 4/16/25 for 3 months. The committee will make any changes if needed to ensure compliance.	

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aggressive during care. She confirmed the behaviors have been ongoing for many months.

During an interview with the Director of Nursing (DON) on 03/18/25 at 1:00 PM, he explained that the facility provides psychiatric services. However, once a resident is placed on palliative or comfort care, psychiatric services are no longer offered.

During an interview on 03/18/25 at 3:00 PM, Licensed Practical Nurse (LPN) #3 explained that Resident #10 had been in a prolonged state of psychosis since her Depakote was discontinued. The family requested the resident be kept on comfort measures only. She stated the only behavioral intervention in place is administration of anxiety medication.

On 03/19/25 at 3:20 PM, during an interview with LPN #2, she explained that care plans are updated daily and used by staff to guide resident care. She reported that staff are expected to follow the care plan to meet residents' needs.

On 03/20/25 at 9:00 AM, during an interview with the DON and Assistant DON, the DON acknowledged facility does not have a contract hospice agency and instead provides comfort measures following their own internal palliative care protocol, which includes administration of Ativan as needed.

On 03/20/25 at 12:20 PM, during an interview with LPN #5, she reviewed Resident #10's care plan and confirmed it lacked detailed comfort care interventions. She noted the care plan did not outline specific interventions related to behavioral management or psychotropic

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F 656	Continued From page 19 medications. On 03/20/25 at 1:00 PM, during an interview with the Administrator, she acknowledged Resident #10's clinical decline and stated that she expects staff to complete care plans accurately and in a timely manner. She reported that all regulations regarding care planning should be followed.	F 656		
F 740 SS=G	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 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, interview, and record review, the facility failed to ensure the ongoing provision of behavioral health services for a cognitively impaired resident with severe, escalating behaviors following discharge from a behavioral health unit and despite continued aggression, delusions, and medication refusal, the facility discontinued behavioral health services without a documented rationale, contributing to ongoing physical aggression toward staff and others for one (1) of 23 sampled residents. Resident #10 Findings include:	F 740	F740 (1) Resident # 10 was reviewed by Medical Director on 3/20/25 with no changes noted to treatment. Resident #10 is to be seen by psychiatric Nurse Practitioner (NP) on 4/11/2025. (2) The facility has determined that all residents with a mental illness diagnosis have the potential to be affected by the failure to ensure the ongoing provision of behavioral health services for a cognitively impaired resident with escalating behaviors. (3) On 3/26/25, the Quality Assurance and	4/16/25

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F 740	Continued From page 20 On 03/17/25 at 1:16 PM, during an observation and interview, Resident #10 pleasantly confused, verbalizing that she needed to go home. A record review of the "Admission Record" revealed the facility admitted Resident #10 on 10/01/21 with diagnoses including Bipolar Disorder, Unspecified, Psychotic Disorder with Hallucinations Due to Known Physiological Conditions, Psychotic Disorder with Delusions, and Other Symptoms and Sign Involving Cognitive Function and Awareness. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/09/25 revealed Resident #10 required a Staff Assessment for Mental Status, which indicated a memory problem for short term memory, memory okay for long term memory, and moderately impaired for cognitive skills for daily decision making. A review of Section E revealed Resident #10 delusions, physical, verbal, and other behavior symptoms directed towards others during the (7) day look back. The behavior of "Rejection of Care" occurred daily. A record review of the "Behavior Monitoring and Interventions" documentation, completed by Certified Nursing Assistants (CNAs), for March 2025 revealed Resident #10 exhibited frequent behavioral symptoms, including physical aggression, verbal outbursts, and refusal of care. Behavioral episodes were documented on multiple dates across all shifts, including 03/01, 03/04, 03/09, 03/10, 03/11, 03/12, 03/13, 03/14, 03/15, 03/16, 03/17, 03/18, 03/19, and 03/20, often involving grabbing, hitting, screaming, cursing, and threatening staff. The interventions	F 740	Assessment (QAA) Committee met and reviewed the Palliative Care and the Dementia and Behavioral Health Services policies with no changes recommended. On 3/24/25 the Administrator in-serviced the Director of Nursing (DON) to review the Palliative Care and the Dementia and Behavioral Health Services policies. Behavior documentation will be reviewed on weekdays during the daily stand up meeting. The medical records of residents with behaviors will be reviewed for completed care plans, interventions and documentation. Corrective action will be taken at the time if issues are identified. (4) Beginning 3/24/25, the DON or Assistant Director of Nursing (ADON) will monitor the care plans, interventions, and documentation using the Behavior Documentation Monitoring Audit form. The audit will be performed weekly for three (3) months. Audit reports will be reviewed by QAA monthly beginning 4/16/25, for 3 months. The committee will make any changes if needed to ensure compliance.	

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included redirecting the resident, providing food/drink, re-approach, and offering comfort measures such as massage or repositioning. However, the documented outcomes were consistently noted as either "same" (unchanged) or "worsened." There was no documentation the CNA notified the nurse of the resident's behaviors or that the behaviors were unchanged or had worsened after attempting the documented interventions.

A record review of the Medication Administration Record (MAR) for March 2025 revealed that Resident #10 refused medications except for Morphine and Lorazepam. Resident #10 received Lorazepam 03/01, 03/02, 03/03, 03/05, 03/06, 03/09 (twice), 03/10, 03/11, and 03/13 (three times), 03/14, 03/15, 03/16 (twice), 03/17, 03/18 (twice), and 03/19 (twice). Resident #10 received Morphine on 03/01, 03/02, 03/05, 03/06, 03/09, 03/10, 03/13 (three times), 03/14, 03/15, 03/16 (twice), 03/18 (twice), and 03/19 (twice). There is no documentation on the MAR indicating resident-specific behaviors, interventions, and effectiveness of interventions.

A record review of the Social Services Quarterly Note dated 01/09/25 revealed Resident #10 had was irritable, agitated, refused meds, and resistant of care during brief changes and bath. It was noted that every day the resident exhibited restlessness and annoyance/short temper and had refused to eat. The note indicated Resident #10 has had a "Change in status" in her cognitive status, social interaction, mood status, behavioral status, and rejection of care/resident choices. The document also indicated that psychological/psychiatric services were currently indicated for the resident with documentation

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including "Resident is seen by Psychiatric Nurse Practitioner (NP) (10/11 and 12/13/2024) for follow-up/medication review/support."

A record review of the "Physician's Order Sheet" revealed Resident #10 had a Physician's Order, dated 08/29/2024 to send the resident to an emergency room for evaluation of increased behaviors, and another physician's order, dated 11/14/2024, to send the resident to a Behavioral Health Unit (BHU) for further evaluation.

A record review of the BHU documentation "Discharge Instructions", dated 9/10/24, and 11/23/24, revealed Resident #10 received treatment from an inpatient BHU.

A record review of the Psychiatric NP visit documentation, dated 12/13/24, for Resident #10 revealed " ... Anxiety not controlled, Psychosis not controlled ... often refuses medications due to paranoid ideations, believing meds have been poisoned ..."

On 03/17/25 at 1:25 PM, during an interview with CNA #3, she stated that Resident #10 is consistently confused and exhibits daily behavioral symptoms. She explained that the resident is often noncompliant with care and becomes physically aggressive during care. CNA #3 added that these behaviors have been ongoing for several months.

On 03/18/2025 at 11:15 AM, during an interview with CNA #3, she stated that Resident #10's behaviors include kicking, spitting, hitting, and smearing anything she can get her hands on, including food and feces. On the morning of 3/18/2025, Resident #10 threw a full tray on her

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	255336	A. BUILDING _____ B. WING _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES CO REST HOME	683 COUNTY HOME ROAD ELLISVILLE, MS 39437

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during breakfast.

On 03/18/2025 at 1:00 PM, during an interview with the Director of Nursing (DON), he stated the facility offers psychiatric services, but once the resident was on palliative or comfort care, those services were discontinued. He reported that Resident #10 had previously seen psych services but was removed from the caseload after transitioning to Comfort Measures Only. He stated that Resident #10 continues to experience behavioral outbursts, hallucinations, and delusions, and was sent to the BHU twice. He explained that after one of the BHU visits, medications including Depakote were discontinued due to high lab levels. Since that time, the resident experienced a significant decline, refusing medications and eating very little.

On 03/18/2025 at 3:00 PM, during an interview with Licensed Practical Nurse (LPN) #3, she explained that Resident #10 had exhibited ongoing behavioral symptoms for several months and had remained in a prolonged state of psychosis following the discontinuation of Depakote. She reported that the resident had not consistently taken any oral medications for months; however, earlier that day, she was able to administer oral Morphine and Ativan. LPN #3 stated that while attempting to provide wound care to a skin tear on the resident's right forearm, Resident #10 became physically aggressive, striking her on the arm and using profane language. She reported that this type of behavior occurs regularly, and that facility management is aware. According to LPN #3, the Resident #10 often refuses oral medications, believing them to be poisoned and had knocked the medications

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out of her hand earlier that day. The physician had considered discontinuing all oral medications, but the resident's daughter requested that they be continued in case the resident became willing to take them in the future. LPN #3 further explained that Resident #10 routinely throws items at staff, including food, trash, and bodily fluids. That morning, the resident reportedly threw an entire breakfast tray at a CNA. LPN #3 stated that the family had requested the resident remain at the facility under Comfort Measures Only.

On 03/18/2025 at 4:10 PM, during an interview with CNA #5, she explained that Resident #10 had consistently exhibited behavioral concerns, with some evenings being more challenging than others. She stated that providing care always requires at least two staff members due to the resident's behaviors. Even with the assistance of two CNAs, the resident often remains combative, frequently kicking, scratching, and pinching during care. CNA #5 added that while the resident can occasionally be distracted, these moments are brief, and the resident is generally not easily redirected.

On 03/19/2025 at 10:05 AM, during an interview with LPN #4, she explained that Resident #10 exhibited ongoing behavioral symptoms, including scratching herself and staff, hitting, cursing, and throwing food and bodily waste at staff on a daily basis. She stated that earlier that morning, the resident refused all oral medications and became physically aggressive toward the CNA during breakfast assistance. LPN #4 reported that she was able to administer the resident's anxiety and pain medications using an oral syringe, which resulted in the resident calming somewhat afterward.

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On 03/19/25 at 12:15 PM, during an interview and observation of incontinence care for Resident #10, CNA #4 and CNA #6 reported that the resident has behaviors that occur on a near daily basis. Resident #10 was observed to be resisting care and fighting the CNAs.

On 03/19/25 at 2:25 PM, during a follow up interview with the DON, he confirmed that Resident #10 had been transferred to a BHU on two occasions-once in September 2024 and again in November 2024-due to escalating behavioral concerns, refusal to take medications, and decreased oral intake. Following the last BHU admission, the resident's family elected to initiate comfort measures only, and the facility honored that decision. The DON stated that despite the transition to comfort-focused care, Resident #10 continued to exhibit frequent behavioral disturbances and remained noncompliant with oral medications and nutrition. He acknowledged that there had been no improvement in the resident's behaviors since returning from the BHU. The DON could not recall the specific recommendations provided at the time of discharge from the BHU but noted the facility opted to manage her symptoms through its Comfort Measures protocol using anxiety and pain medications.

On 03/20/25 at 9:00 AM, during an interview with the DON and the Assistant Director of Nursing (ADON), the DON explained Resident #10 had become increasingly combative with all aspects of care. The DON also clarified that the facility does not contract with an external hospice agency; instead, they provide in-house palliative care under a comfort measures protocol, which

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includes the use of Ativan as needed.

On 03/20/25 at 10:40 AM, during a phone interview with Resident #10's granddaughter, she stated that both she and her mother are nurses and have been actively involved in the resident's care. She explained that over the past six (6) months to a year, there had been a noticeable decline in her grandmother's mental status. The resident had a longstanding history of mental health issues, including behavioral disturbances and dementia. She confirmed that Resident #10 had recently been admitted to a geriatric psychiatric facility on two (2) occasions. Following the most recent discharge, the resident initially showed slight improvement but quickly returned to her prior state. Based on the resident's continued decline and stated wishes, the family collectively agreed to place her on comfort measures only. The granddaughter shared that the resident continues to exhibit significant behavioral symptoms, including delusions, hallucinations, and verbal aggression. Due to the severity of these behaviors, family visits are often brief. She acknowledged that her grandmother consistently refuses medications and has poor nutritional intake but believes alternative behavioral medications or formulations could be explored. She confirmed awareness of the resident's significant weight loss but stated that the family made the decision not to pursue feeding tube placement.

On 03/20/25 at 12:25 PM, during an interview with Social Services #1, she stated that she is part of the interdisciplinary team responsible for referring residents to behavioral health services. She acknowledged that Resident #10 had ongoing behavioral issues but reported that

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behavioral services were discontinued when the resident was placed on comfort measures.

On 03/20/25 at 01:40 PM, during a phone interview with the Psychiatric NP, she explained that her services for Resident #10 were discontinued once the resident was placed on comfort measures. She stated that during her visits, Resident #10 often became upset and agitated by her presence, frequently refusing to participate in care. The NP shared that Resident #10 would regularly display aggressive behavior, including calling her derogatory names and exhibiting paranoid ideations. She noted that Resident #10 had been noncompliant with both care and medications for several months prior to the initiation of comfort measures and had experienced a noticeable decline in behavior. The NP consulted with colleagues due to the resident's worsening symptoms and it was eventually determined that her ammonia levels were elevated, prompting the discontinuation of Depakote. Although alternative medications were trialed, the resident continued to exhibit paranoid delusions and hallucinations. The NP confirmed that she was aware the resident was not taking prescribed medications, which contributed to the decision to begin comfort care. She stated that during her final visit in December 2024, Resident #10 was still experiencing uncontrolled anxiety and psychosis. She clarified that under the facility's palliative care approach, comfort measures are limited to managing symptoms without further psychiatric intervention.