STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. BUILDING _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE CENTER	111 CHASE STREET BYHALIA, MS 38611

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 6/23/25 through 6/25/25. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements for participation and deficiencies were cited at F552, F 558, F 584, F 641, F 689, and F 690. The census at the time of survey was 50 and the facility was licensed for 60 beds.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to notify a resident and/or a legal representative of the risks	F 552	1. On 6/30/2025, residents # 8, 13, 21, and 23 had an updated psychoactive medication consent form completed with	7/21/25

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

Electronically Signed | 07/08/2025

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F 552	Continued From page 1 and benefits of using a psychotropic medication for four (4) of 42 residents reviewed for psychotropic drug use. Resident #8, #13, #21, and #23 Findings Include: Review of the facility policy titled "Psychotropic/Psychoactive Medication Policy" with a revision date of 6/24/25 revealed under, "Policy Implementation: ... 5. All residents have full rights to participate or refuse treatment. Before initiating or increasing psychotropic medication the resident and or responsible party must be notified of and have the right to participate in their treatment, including the right to accept or decline the medication. The risk and benefits should be clearly explained..." Resident #8 Record review of Resident #8's "Order Summary Listing" revealed the following orders: - Dated 3/06/25: "Buspirone HCL (hydrochloride) oral tablet 5 MG (milligrams) give 1 (one) tablet by mouth three times a day for anxiety; Xanax oral tablet 0.5 MG (milligram) give 1 (one) tablet by mouth at bedtime for anxiety, hold for sedation." - Dated 5/08/25: "Cymbalta oral capsule delayed-release 30 MG give 1 capsule by mouth in the morning for depression." Record review of Resident #8's "Psychoactive Medication Informed Consent" dated 6/20/24 revealed there was no documentation that the risks and benefits were discussed with the resident or their representative when the medication was initiated.	F 552	risk versus benefits included. Risk versus benefits were explained to each resident responsible party by the Social Services Director (SSD). 2. All residents who receive psychoactive medications have the ability to be affected by the deficient practice. 3. On 6/25/2025, the SSD was in-serviced by the facility Administrator to ensure risk versus benefits is discussed with the responsible party prior to obtaining consent. The facility implemented an updated psychoactive medication consent form which lists risk based on the drug classification. 4. Beginning 6/30/2025, the Administrator or Director of Nursing (DON) will conduct audits on five (5) residents that are on psychoactive medications to ensure that consent forms have risk versus benefits 5 times a week for four (4) weeks, then three (3) times a week for 4 weeks, then weekly for 3 months. The results of the audit will be brought to the monthly Quality Assurance (QA) meeting by the Administrator or DON for review and discussion beginning 7/21/2025. The QA meeting will be held monthly going forward to discuss audit results from July 2025 through November 2025. An initial QA meeting was held on 6/27/2025 to discuss and implement the plan of correction.	

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F 552	Continued From page 2	F 552		

Record review of the "Admission Record" revealed Resident #8 was admitted on 5/12/23 with medical diagnoses including Major Depressive Disorder and Anxiety Disorder.

Record review of the Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/15/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment.

Resident #13

Record review of the "Order Summary Report" for Resident #13 revealed the following orders:
- Dated 1/06/25: "Buspirone HCL oral tablet 15 MG give 1 tablet by mouth three times a day for anxiety; Quetiapine Fumarate oral tablet 25 MG give 3 (three) tablets by mouth three times a day for antipsychotic use."
- Dated 6/12/25: "Lorazepam oral tablet 0.5 MG give 1 tablet by mouth every 12 (twelve) hours as needed for anxiety and agitation for 14 days until 6/26/25."

Review of Resident #13's "Psychoactive Medication Informed Consent" dated 7/24/24 revealed there was no documentation that the risks and benefits were discussed with the resident representative when the medication was initiated.

Record review of the "Admission Record" revealed Resident #13 was admitted on 7/09/24 with medical diagnoses including Unspecified Dementia, Major Depressive Disorder, and Anxiety Disorder.

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F 552	Continued From page 3	F 552		

Record review of the MDS with an ARD of 4/14/25 revealed, under section C, Resident #13's cognitive skills for daily decision-making were severely impaired.

Resident #23

Record review of the "Order Listing Summary" for Resident #23 revealed the following orders:
- Dated 3/19/25: "Diazepam oral tablet 5 MG give 1 tablet by mouth in the evening for anxiety."
- Dated 4/29/25: "Olanzapine oral tablet 5 MG give 0.5 (one-half) tablet by mouth at bedtime for psychosis."
- Dated 5/15/25: "Zoloft oral tablet 50 MG give 3 (three) tablets by mouth at bedtime for mood total 150 MG."

Review of Resident #23's "Psychoactive Medication Informed Consent" dated 11/5/24 revealed there was no documentation that the risks and benefits were discussed with the resident representative when the medication was initiated.

Review of the "Admission Record" revealed Resident #23 was admitted on 11/01/24 with medical diagnoses including Dementia with Mood Disturbance, Unspecified Psychosis, and Major Depressive Disorder.

Review of the MDS with an ARD of 5/07/25 revealed a BIMS score of 7, indicating severe cognitive impairment.

An interview with Social Services (SS) #1 on 6/24/25 at 1:05 PM revealed she was responsible for calling families to obtain psychotropic consents. She confirmed she did not discuss the

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F 552	Continued From page 4	F 552		

risks and benefits of the medications with the residents or families of Resident #8, #13, #21, and #23. SS #1 stated she did not have a pharmacological (pertaining to medication) background and acknowledged residents and families should be fully informed before consenting to treatment.

An interview with the Director of Nursing (DON) on 6/24/25 at 1:24 PM confirmed she was aware that the risks and benefits of psychotropic medications were not being discussed with the families or the residents. She stated that social services was responsible for obtaining consents and acknowledged that this information must be provided for informed decision-making and consent.

Resident #21

Record review of Resident #21's "Order Summary Listing" revealed an order dated 11/14/24, "Lorazepam oral tablet 0.5 MG give 1 tablet by mouth two times a day for anxiety and agitation."

Record review of Resident #21's "Order Summary Listing" revealed an order dated 2/18/25, "Seroquel oral tablet 100 MG give 1 tablet by mouth three times a day for psychosis, delusions."

Record review of Resident #21's "Order Summary Listing" revealed an order dated 6/5/25, "Zoloft oral tablet 50 MG give 1 tablet by mouth in the morning for Major Depressive Disorder."

Record review of Resident #21's "Psychoactive Consent" dated 6/20/24, revealed no

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	255311	A. BUILDING _____ B. WING _____	06/25/2025

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F 552	Continued From page 5 documentation of the risks and benefits was provided to the resident or the resident representative (RR) when the medication was initiated. A record review of the "Admission Record" indicated the facility admitted Resident #21 to the facility on 4/25/22 with medical diagnosis of Major Depressive Disorder. Record review of the MDS with an ARD of 6/3/2025 revealed under section C, a BIMS score of 15, which indicated the resident was cognitively intact.	F 552		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review, the facility failed to ensure a residents call light was accessible for one (1) of 50 residents in the facility. Resident #155 Findings Include: Review of the facility policy titled "Resident Call System" with a revision date of 3/28/23 revealed under, "Policy Interpretation and Implementation: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from	F 558	1. Resident # 155 call light was placed within reach on 6/23/2025 2. All residents that use a call light have the ability to be affected by the deficient practice. Forty-eight of forty-eight residents have the ability to be affected. 3. On 6/25/2025, in-service was initiated by the Staff Development Coordinator (SDC) for all staff on ensuring the call lights are within reach of the residents while they are in the room.	7/21/25

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F 558	Continued From page 6 toileting/bathing facilities and from the floor..." An observation of Resident #155 on 6/23/25 at 9:26 AM revealed she was lying in bed with the call light on the floor under the bed. During an interview, Resident #155 voiced this happens often. She stated, "The staff walk out and don't give me my call light, and I don't have any way to call them." She explained she prefers her room door left open so she can call out to staff if needed. An observation and interview with Certified Nurse Aide (CNA) #1 on 6/23/25 at 9:36 AM confirmed Resident #155's call light was on the floor. CNA #1 stated the call light should be near the resident so she can call for assistance when needed. An interview with the Director of Nursing (DON) on 6/24/25 at 9:10 AM confirmed staff were expected to ensure call lights were accessible to the residents to promote safety and meet their needs for assistance. Record review of the "Admission Record" revealed the facility admitted Resident #155 on 5/24/25 with medical diagnoses that included History of Falling and Need for Assistance with Personal Care. Record review of the 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/31/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #155 was cognitively intact.	F 558	4. Beginning 6/30/2025, the facility SDC or Registered Nursing (RN) supervisor will conduct room check audits in all rooms five (5) times a week for four (4) weeks, then weekly for four (4) weeks, then monthly for three (3) months to ensure call light is within reach of the resident. The results of the audit will be brought to the monthly QA meeting by the Administrator or Director of Nursing for review and discussion beginning 7/21/2025. The Quality Assurance meeting will be held monthly going forward to review audit results from July 2025 through November 2025. An initial Quality Assurance meeting was held on 6/27/2025 to discuss and implement the plan of correction.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		7/21/25

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F 584	Continued From page 7 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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F 584	Continued From page 8 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide a resident with a wheelchair in good repair for one (1) of 50 residents requiring a wheelchair in the facility. Resident #49 Findings Include: The facility provided a statement on letterhead that read, "(Proper name of facility) does not have a policy specifically regarding wheelchair good repair/condition." During an observation of Resident #49 on 6/23/25 at 10:38 AM, he was propelling himself in his wheelchair down the hallway and into his room. Both arm rest were in disrepair, torn and tattered with the white foam visible and a silver screw head exposed on both sides. An observation and interview with Registered Nurse (RN) #1 on 6/24/25 at 7:55 AM confirmed Resident #49's wheelchair arm rest were in poor condition and stated he could get injured or scraped. An interview with the Director of Nursing (DON) on 6/24/25 at 9:10 AM revealed the wheelchair for Resident #49 was provided by the facility when he was admitted. She confirmed his chair should be in good repair and stated the resident could get his arm injured. Record review of the "Admission Record" revealed the facility admitted Resident #49 on	F 584	1. Resident # 49 wheelchair was replace by the facility maintenance director on 6/23/2025. 2. All residents that receive and use a wheelchair have the ability to be affected by the deficient practice. On 6/23/2025, the maintenance director inspected all wheelchairs in the facility to determine any that needed to have the armrest replaced or repaired. Five (5) of forty-eight (48) residents were identified needing their wheelchair armrest repaired/replaced. 3. On 6/25/2025, the facility Staff Development Coordinator initiated an in-service with all staff regarding wheelchair repair identification as well as creating a work-order for any issues that are identified. On 6/25/2025, the maintenance director was in-serviced by the facility Administrator regarding work orders including daily monitoring and addressing any work orders that are created. 4. Beginning 6/30/2025, the maintenance director or Administrator will conduct wheelchair inspections on five (5) wheelchairs 5 times week for four (4) weeks, then three (3) times a week for 4 weeks, then weekly for three (3) months to ensure armrest are in good working condition. The Administrator or maintenance director will bring the results	

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F 584	Continued From page 9 5/13/25 with a medical diagnosis that included Traumatic Hemorrhage of Left Cerebrum. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/20/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #49 was severely cognitively impaired.	F 584	of the audit to the monthly Quality Assurance meeting for review and discussion beginning 7/21/2025. The Quality Assurance meeting will be held monthly going forward to discuss audit results from July 2025 through November 2025. An initial QA meeting was held on 6/27/2025 to discuss and implement the plan of correction.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 641		7/21/25

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F 641	Continued From page 10 §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately code a Minimum Data Set (MDS) for one (1) of 16 residents' MDS reviewed (Resident #52). Findings include: Review of the facility policy titled, "MDS Coding Policy," last reviewed 6/02/2025, revealed, "Proper Name" affiliated facilities utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident Assessment, timely, and accurately. ... Review of the "Interdisciplinary Discharge Summary" revealed Resident #52 was discharged to "Proper Name" Health and Rehab on 3/26/25. Review of the Admission/Discharge MDS for Resident #52 revealed Section A2105 - Discharge Status was coded 04 - "Short-Term General Hospital." During an interview with the MDS nurse on 6/24/25 at 12:00 PM, she confirmed after review of the Admission/Discharge MDS that it was not accurately coded because Resident #52 was discharged to another rehabilitation facility and not to the hospital. She stated the purpose of accuracy of the MDS is to ensure there is an accurate depiction of the resident.	F 641	1. On 6/24/2025, resident # 52's discharge assessment with Assessment Reference Date (ARD) of 3/26/2025 was modified to accurately reflect a discharge to another nursing home facility by the Minimum Data Set (MDS) nurse. 2. All residents that are required to have a discharge MDS assessment has the ability to be affected by this deficient practice. 3. MDS nurse was in-serviced on 6/24/2025 by the facility Administrator regarding coding regulations as set forth in the Resident Assessment Instrument (RAI) manual. On 6/27/2025, both MDS/RN's were in-serviced by the facility Administrator regarding coding regulations as set forth in the RAI manual. 4. Beginning 6/30/2025, the Director of Nursing or Administrator will review all discharge MDS assessments to ensure accurate coding of discharge assessment related to location of discharge five (5) times a week for four (4) weeks, then three (3) times a week for 4 weeks then weekly for three (3) months. The Director of Nursing or Administrator will bring the results of the audits to the monthly Quality Assurance meeting for review and discussion beginning 7/21/2025. The Quality Assurance meeting will be held monthly going forward to discuss results	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 11 Record review of the "Admission Record" revealed Resident #52 was admitted by the facility on 3/20/25 with a diagnosis of Chronic Obstructive Pulmonary Disease.	F 641	of audits from July 2025 through November 2025. An initial QA meeting was held on 6/27/2025 to discuss and implement the plan of correction.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to ensure a safe environment by not preventing hazardous substances from being stored in a resident's room, thereby creating the potential for accidental ingestion and harm. Specifically, the facility failed to prevent a resident's family from placing two homemade containers of ant bait (containing boric acid) in the resident ' s room, which remained accessible to Resident #15 and potentially to other cognitively impaired, wandering residents. This deficient practice affected one (1) of fifty (50) residents reviewed (Resident #15). Findings Include: Review of the typed statement on facility letterhead revealed the facility did not have a policy regarding storing hazardous materials in residents rooms and was signed by the	F 689	1. On 6/23/2025, the homemade ant bait was removed from resident # 15's room. On 6/23/2025, the family of resident # 15 was notified by the Administrator that the resident could not have hazardous materials left in the room. Resident # 15 was assessed with no negative findings. The facility Administrator and Maintenance Director completed a facility wide audit on 6/23/2025 to identify any other hazardous material with no other materials identified. 2. All residents whose family leaves unattended hazardous materials in the room can be affected by the deficient practice as well as any cognitively impaired residents that wander. 3. On 6/25/2025, the facility Staff Development Coordinator (SDC) initiated	7/21/25

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	255311	A. BUILDING _____ B. WING _____	06/25/2025

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F 689	Continued From page 12 Administrator. During an observation and interview in Resident #15's room on 6/23/25 at 12:00 PM with Licensed Practical Nurse (LPN) #1, she confirmed the presence of two (2) four-ounce, white, round, wide-mouth plastic jars, each with a matching white screw-on lid featuring a pencil-sized hole in the center of the lid. The words "Ant Bait" were written on the side of the jars in marker. Additionally, the ingredients were listed as follows: honey, water, and boric acid. The LPN stated that these items were apparently brought in by the family but should not have been left in the room, as they pose a danger to confused, wandering residents. She further expressed that if anyone were to ingest this mixture, "a lot of bad things could happen." The LPN disposed of the containers. During an interview on 6/24/25 at 9:40 AM with the Director of Nursing (DON), she confirmed that such homemade insect repellant/bait should not be left in the rooms. She stated, "We want them to feel that this is their home, but we have to stay within the guidelines and keep all other residents safe at the same time." She further verified that if another resident had ingested the contents, it could have been dangerous for them. A record review of the "Admission Record" for Resident #15 revealed that she was admitted to the facility on 5/14/25 with medical diagnoses that included Unspecified Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Heart Failure, Unspecified, and Cerebral Aneurysm, Non-ruptured. Record review of the Minimum Data Set (MDS),	F 689	in-services with all staff regarding storing hazardous material in residents' rooms which is not allowed and notifying the Director of Nursing or Administrator if any such material is found in a resident's room. On 7/2/2025, the Administrator mailed letters to each resident responsible party informing them that hazardous materials can't be left in a resident's room. 4. Beginning 6/30/2025, the facility SDC or Administrator will perform visual room check audits on each room to ensure there are no hazardous materials in the room five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, then weekly for three (3) months. The facility SDC or Administrator will bring the results of the audits to the monthly Quality Assurance (QA) meeting for review and discussion beginning 7/21/2025. The QA meeting will be held monthly going forward to discuss audit results from July 2025 through November 2025. An initial QA meeting was held on 6/27/2025 to discuss and implement the plan of correction.	

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F 689	Continued From page 13 with an Assessment Reference Date (ARD) of 5/21/2025, revealed Resident #15 did not have a Brief Interview for Mental Status (BIMS) because the resident is rarely/never understood. Staff Assessment for Mental Status revealed the resident had a problem with short-term and long-term memory.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		7/21/25

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F 690	Continued From page 14 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure that an indwelling urinary catheter was clinically indicated and ordered by the provider for one (1) of three (3) residents reviewed with catheters (Resident #105). Findings include: Review of the facility policy titled, "Indwelling (Foley) Catheter Insertion, Male Resident," revised March 2024, revealed "Preparation: 2.) Verify that there is a physician's order..." An observation on 6/23/25 at 10:00 AM revealed Resident #105 had an indwelling urinary catheter. A continued interview with the resident revealed he stated that they put the catheter in him while in the hospital and never took it out, but confirmed he did not know why he had it. During an interview with Registered Nurse (RN) #1 on 6/24/25 at 9:00 AM, she revealed after review of the hospital "After Visit Summary" for Resident #105 that there was no mention of the resident having a catheter order. She stated that it is not uncommon for a resident to be admitted to the facility with a catheter and no orders. She stated the nurse that admitted the resident should have notified the provider to obtain orders to keep	F 690	1. On 6/24/2025, the facility Medical Director was notified that resident # 105 was admitted to the facility with no orders or directions from the referring hospital regarding a Foley catheter and an order obtained to leave the Foley catheter in place and consult urology. On 6/24/2025, the Director of Nursing (DON) completed an audit on all residents with a foley catheter present. 2. Any resident who admitted to the facility with a foley catheter present has the ability to be affected by the deficient practice. 3. On 6/24/2025, Licensed Practical Nurse (LPN) # two (2) was in-serviced by the facility Staff Development Coordinator (SDC) on communicating with the Medical Director or Nurse Practitioner if a resident is admitted to the facility with a foley catheter present but no orders from referring hospital. The facility SDC also in-serviced all LPN's and RN's regarding communicating with the Medical Director or Nurse Practitioner if a resident admitted with a foley catheter present but no orders from referring hospital on 6/24/2025. 4. Beginning 6/30/2025, facility Medical	

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F 690	Continued From page 15 the catheter, discontinue it, or obtain a urology referral. She also stated that keeping the catheter in without an appropriate diagnosis places the resident at increased risk of infections. Record review of the "After Visit Summary" for Resident #105 dated 6/18/25 revealed no documentation of orders for an indwelling catheter. A phone interview with Licensed Practical Nurse (LPN) #2 on 6/24/25 at 9:15 AM confirmed she admitted Resident #105 on 6/19/25 and stated that the resident was admitted from the hospital with the catheter. She confirmed she did not notify the provider or the nurse practitioner to obtain any orders related to the need to keep the catheter. She stated that it was not their practice, and stated they just put the facility orders in for the catheter, and the nurse practitioner would make that decision when she sees the resident if the catheter is needed or not. Record review of the "Order Summary Report" of active orders for Resident #105 revealed no order for the justification of the need for the indwelling catheter. In a follow-up interview with RN #1 on 6/24/25 at 9:25 AM, she confirmed that Resident #105 had not yet been seen by the provider or the nurse practitioner. During an interview with the Director of Nursing (DON) on 6/24/25 at 9:34 AM, she confirmed that if a resident admits from the hospital with a catheter, the admitting nurse should notify the provider for orders to either leave the catheter in or discontinue it, and confirmed the nurse should	F 690	Records Nurse or Director of Nursing (DON) will audit any admissions to determine if resident had foley catheter present on admission, if hospital discharge orders included foley catheter and if not was the facility Medical Director or Nurse Practitioner notified five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, then weekly for three (3) months. Medical Records Nurse or DON will bring results of the audit to monthly Quality Assurance meeting for review and discussion beginning 7/21/2025. The Quality Assurance meeting will be held monthly going forward to discuss audit results from July 2025 through November 2025. An initial Quality Assurance meeting was held on 6/27/2025 to discuss and implement the plan of correction.	

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F 690	Continued From page 16 not put in the batched facility standing catheter orders without the provider's approval for the need of the catheter. She stated concerns about leaving a catheter in without a proper reason is the increased risk of infection. Record review of the "Admission Record" revealed Resident #105 was admitted by the facility on 6/19/25 with a diagnosis of benign prostatic hyperplasia without lower urinary tract symptoms. Record review of Resident #105's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/19/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident is cognitively intact.	F 690		