STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255302	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR , SENATOBIA, Mississippi, 38668

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with two (2) Complaint Investigations (CI), CI MS #477262 and CI MS #477259 at the facility from 8/4/25-8/7/25. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F553, F636, F640, and F641. The facility was found to be in compliance for CI #477262 related to activities of daily living, pest control and staffing. The facility was also found not in compliance with CI MS #477259 related to narcotic diversion and significant medication errors and cited F602 and F760. Based on implementation of the facility's corrective actions on 6/25/25, the deficient practice was determined to be past noncompliance, and the facility was determined to be in compliance effective 7/3/25 for F602 and F760. The facility held a license for 106 beds, with a census of 88 residents.	F0000		
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items	F0553		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0553 SS = D	Continued from page 1 included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and the facility's policy review, the facility failed to ensure that the residents or their representatives were involved in the care planning process for two (2) of 28 residents reviewed for care planning. Residents # 21 and 87. Findings include: Record review of the facility policy titled, "Care Planning-Resident Participation", revealed, "Policy: This facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care)..." Resident #21 During an interview on 8/4/25 at 10:55 AM, with Resident #21 she stated that she had not attended a care plan meeting but would like to. Record review of the “Admission Record” revealed the facility admitted Resident #21 on 9/6/24 with a diagnosis of Malignant Neoplasm of Endometrium. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/11/25 for Resident #21 revealed a score of nine (9), under Brief Interview for Mental Status (BIMS), indicating that the resident is mildly cognitively impaired. Resident #87	F0553		

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F0553 SS = D	Continued from page 2 In an interview on 8/4/25 at 11:00 AM, with Resident #87 she stated that she cannot remember the last time she had care plan meeting, but it had been a while, and she would like to attend her care plan meetings. Record review of the “Admission Record” revealed the facility admitted Resident #87 on 6/18/24 with a diagnosis of Chronic Atrial Fibrillation. Record review of the MDS with an ARD of 5/26/25 for Resident #87 revealed a score of 15 under BIMS indicating that the resident is cognitively intact. Interview with Social Services (SS) on 8/6/25 at 9:15 AM, she stated that she uses the ARD of the MDS to determine when care plan meetings should be held. She stated she verbally notifies the residents and asks if they want to attend on the day of the care plan but does not document if they attended the care plan or not. She further stated that she usually just calls the resident representative (RR) on the ARD for the care plan meeting, stating that they do not have a form to sign that identifies who attended the care plan meeting. She further stated that Resident #21 and #87 and their RRs had not been invited to the last care plan meeting because she was behind on them. During an interview with the Administrator (ADM) on 8/6/25 at 9:18 AM he agreed it was his expectation that the residents and their representatives would be invited to the care plan meeting.	F0553		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure residents were free from misappropriation of medications for two (2) of eight (8) residents reviewed for drug diversion (Residents #14 and #42).	F0602	"Past Noncompliance - no plan of correction required"	

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F0602 SS = D	Continued from page 3 Findings include: Review of the facility policy titled, “Drug Diversion,” undated, revealed: “Policy: This facility recognizes the risks associated with diversion of controlled medications and monitors staff with access to controlled substances to prevent diversion...” During an interview with the Administrator on 8/5/25 at 12:30 PM regarding the facility-reported incident MS #477259, he stated that during the investigation, it was discovered that on 6/21/25 at 1:45 AM, agency Licensed Practical Nurse (LPN) #2 signed out an oxycodone for Resident #14 on the controlled substance log, but the medication was not documented on the Medication Administration Record (MAR) as given. He stated video from that date and time showed LPN #2 preparing and taking routine medications to Resident #14’s room but not accessing the narcotic lock box. The Administrator stated that during the investigation of another concern, Resident #42 reported he received only one pain pill from the agency nurse working the evening shift on 6/24/25. He stated the resident reported requesting his pain medication later in the shift, but the nurse never returned. The Administrator stated he reviewed video footage from 6/24/25 (3:00 PM to 11:00 PM) and found that LPN #2 did not enter Resident #42’s room at any time after approximately 4:00 PM, when she had administered earlier medications. He stated that at 10:50 PM, LPN #2 signed out one hydrocodone for Resident #42 on the controlled substance log and signed that it was administered; however, the video showed she never entered the resident’s room. The Administrator stated the facility attempted to have LPN #2 return for an interview and drug screen, but she did not report back. He further stated that at the end of her shift, LPN #2 stated she did not have a ride home and slept for several hours on a couch in the day room before leaving the facility. He confirmed that LPN #2 was made a “Do Not Work“ status with the contracted agency. He confirmed that the incident and investigation results were presented to the Quality Assurance (QAPI) committee during the committee meeting on 6/26/25 and again on 7/31/25 in which the Medical Director attended, the facility policy was reviewed with no revisions made. LPN # 2 was not allowed to work at the facility after 6/24/25 and all the required agencies were notified. Resident #14 Record review of the Controlled Substance Record for Resident #14 revealed Oxycodone 5 mg (milligrams) tablet, one tablet, signed out by LPN #2 on 6/21/25 at	F0602		

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F0602 SS = D	Continued from page 4 1:45 AM. Record review of the June 2025 MAR for Resident #14 revealed no documentation that the medication was administered on 6/21/25. Record review of the “Admission Record” revealed Resident #14 was admitted on 3/16/25 with a diagnosis of Femur Fracture. Resident #42 Record review of the Controlled Substance Record for Resident #42 revealed Hydrocodone 10/325 mg, one tablet, signed out by LPN #2 on 6/24/25 at 10:50 PM. Record review of the June 2025 MAR revealed the medication was documented as administered. Record review of the “Admission Record” revealed Resident #42 was admitted on 6/13/25 with a diagnosis of osteomyelitis. During an interview with the Director of Nurses (DON) on 8/5/25 at 1:00 PM, she stated LPN #2 worked agency shifts on 6/18/25, 6/19/25, 6/20/25, and 6/24/25. She stated she audited the narcotic records for residents assigned to agency LPN #2 and confirmed that oxycodone had been signed out for Resident #14 on the Controlled Medication form without documentation on the MAR as administered. She stated the nurse was also not observed to access the narcotic box during that time per facility video monitoring. The DON stated diversion of narcotics poses a risk because the medication may be taken by the individual, can lead to adverse consequences for residents, and is not the staff’s property to take. In a continued interview with the DON on 8/6/25 at 12:00 PM, she stated she interviewed Resident #42, who was cognitively intact, on 6/25/25. The resident reported he did not receive his night medications on 6/24/25, including pain medication, and that the nurse never returned after an early evening visit. The DON revealed immediate in-services on diversion and misappropriation was initiated on 6/26/25 and continued until 7/2/25 when all nurses had been educated. She also confirmed narcotic reconciliation audits were completed on five (5) residents weekly for four weeks as well with no concerns. In an interview with LPN #1 on 8/5/25 at 1:30 PM, she stated that on the morning of 6/25/25, Resident #42 complained that the agency nurse had not given him his	F0602		

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F0602 SS = D	Continued from page 5 medication the previous night. LPN #1 stated she immediately informed the DON and the charge nurse. In an interview with Registered Charge Nurse #1 on 8/6/25 at 2:00 PM, she stated that during follow-up assessments of all residents assigned to the agency LPN #2 on 6/24/25 (3:00 PM to 11:00 PM), Resident #42 again reported the nurse only came into his room once early in the shift and never returned to provide pain medication or other evening medications. She stated she assessed the resident to have no adverse findings related to not receiving his medications. She also confirmed that the provider and resident representative was notified for every possible affected resident. Based on the implementation of the facility's corrective actions on 6/25/25, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 7/3/25. Validation: The SA validated on 8/5/2025, through interview and record review that all corrective actions had been implemented as of 7/3/25, and the facility was in compliance as of 7/3/25, prior to the SA's entrance on 8/4/2025.	F0602		
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns.	F0636		

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F0636 SS = D	Continued from page 6 (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months.	F0636		

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F0636 SS = D	Continued from page 7 This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to complete and transmit Comprehensive Minimum Data Set (MDS) assessments within the timeframes required by the Resident Assessment Instrument (RAI) User's Manual for (3) three of 33 MDS assessments reviewed. Residents #39, 69, and 95. Findings Include Record review of the facility policy titled "MDS 3.0 Completion" revealed: "Policy Explanation of Compliance Guidelines: 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. 2. Types of Assessments…b. Admission Assessment – Completed within 14 days of admission counting the day of admission as day #1...Annual Assessment…completed using an Assessment Reference Date (ARD) no greater than 92 days from the most recent quarterly assessment..." Resident #39 Record review of the Annual MDS with an ARD of 7/01/25 revealed the comprehensive assessment was not completed and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Section Z item Z0500B was not dated and signed as complete by the RN (Registered Nurse) Assessment Coordinator. Record review of the "Admission Record" for Resident #39 revealed the resident was admitted on 7/21/23 with a diagnosis including Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. Resident #69 Record review of the Admission/Medicare 5 Day MDS with an ARD of 7/14/25 revealed the comprehensive assessment was not completed and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Record review of the "Admission Record" for Resident #69 revealed the resident was admitted on 7/7/25 with a diagnosis including Periprosthetic Fracture around other internal prosthetic joint, subsequent encounter. Resident #95	F0636		

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F0636 SS = D	Continued from page 8 Record review of the Annual MDS with an ARD of 7/2/25 revealed the assessment was not completed and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Section Z0500B (completion date) of the MDS was left unsigned. On 8/5/25 at 12:33 PM, in an interview with the MDS Coordinator, she stated that she was aware that the MDS assessments for Resident #95 had not been completed or transmitted timely. She stated that she had fallen behind due to the number of admissions, readmissions, and discharges. She further stated the assessments should be completed timely in order to provide an accurate depiction of each resident's status. On 8/5/25 at 2:05 PM, during interview, the Administrator (ADM) stated the MDS nurse had informed him of late MDS assessments the previous day. He agreed it was his expectation that MDS assessments be completed timely but attributed the delays to an increase in admissions. Record review of the "Admission Record" for Resident #95 revealed the resident was admitted on 7/29/23 with a diagnosis including Heart Failure.	F0636		
F0640 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	F0640		

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F0640 SS = D	Continued from page 9 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. (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 interview, record review and facility policy review the facility failed to complete and transmit the Quarterly and Discharge Minimum Data Set (MDS) assessments within the required time frame for 10 of 33 MDS assessments reviewed. Residents # 24, #35, #58, #63, #82, #90, #105, #107, #108 and #118. Findings Include Record review of the facility policy titled "MDS 3.0 Completion" date implemented 2/01/2025 revealed: "Policy Explanation of Compliance Guidelines: 1.	F0640		

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F0640 SS = D	Continued from page 10 According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the Resident Assessment Instrument (RAI) specified by the State. 2. Types of Assessments…e. Quarterly Assessment completed using an Assessment Reference Date (ARD) no greater than 92 days from the most recent prior quarterly or comprehensive assessment." f. Discharge Assessment - completed using the discharge date at the ARD. Must be completed within 14 days of the discharge date/ARD….7. Transmission Requirements: a. All assessments shall be transmitted to the designated CMS system (iQIES) within 14 days of completion..." Resident #24 Record review of the Quarterly MDS with an ARD of 7/1/25 revealed the assessment was not completed and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Record review of the "Admission Record" for Resident #24 revealed the resident was admitted on 3/26/25 with a diagnosis including Acute Posthemorrhagic Anemia. Resident #35 Record review of the Quarterly MDS with an ARD of 6/27/25 revealed the assessment was not completed and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Record review of the "Admission Record" for Resident #35 revealed the resident was admitted on 4/5/24 with a diagnosis including Acute on Chronic Diastolic Heart Failure. Resident #58 Record review of the Quarterly MDS with an ARD of 6/30/25 revealed the assessment was not completed and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Record review of the "Admission Record" for Resident #58 revealed the resident was admitted on 5/09/22 with a diagnosis including Aphasia following Cerebral Infarction. Resident #63 Record review of the Discharge MDS with an ARD of 3/22/25 revealed the assessment was not completed	F0640		

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F0640 SS = D	Continued from page 11 and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Record review of the "Admission Record" for Resident #63 revealed the resident was admitted on 2/21/25 with a diagnosis including Fluid Overload. Resident #82 Record review of the Quarterly MDS with an ARD of 7/1/25 revealed the assessment was not completed and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Record review of the "Admission Record" for Resident #82 revealed the resident was admitted on 10/15/24 with a diagnosis including Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. Resident #90 Record review of the Quarterly MDS with an ARD of 6/20/25 revealed the assessment was not completed and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Record review of the "Admission Record" for Resident #90 revealed the resident was admitted on 9/25/24 with a diagnosis including Venous Insufficiency (Chronic) (Peripheral). Resident #105 Record review of the Quarterly MDS with an ARD of 7/2/25 revealed the assessment was not completed and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Record review of the "Admission Record" for Resident #105 revealed the resident was admitted on 3/24/25 with a diagnosis including Diabetes Mellitus. Resident #107 Record review of the Quarterly MDS with an ARD of 6/19/25 revealed the assessment was not completed and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Record review of the "Admission Record" for Resident #107 revealed the resident was admitted on 9/26/17 with a diagnosis including Dementia. Resident #108	F0640		

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F0640 SS = D	Continued from page 12 Record review of the Quarterly MDS with an ARD of 6/23/25 revealed the assessment was not completed and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Record review of the "Admission Record" for Resident #108 revealed the resident was admitted on 4/17/23 with a diagnosis including Heart Failure, Unspecified. Resident #118 Record review of the Quarterly MDS with an ARD of 6/20/25 revealed the assessment was not completed and/or transmitted within the required timeframes as outlined in the RAI User's Manual. Record review of the "Admission Record" for Resident #118 revealed the resident was admitted on 6/20/24 with a diagnosis including Metabolic Encephalopathy. An interview with the MDS Coordinator on 8/5/25 at 12:30 PM confirmed that she was aware that the MDS assessments had not been completed or transmitted timely per the RAI Manual. She stated that with the number of admissions, readmissions, and discharges, assessments had fallen behind. She stated the Administrator (ADM) had been notified and was planning to hire a part-time staff member to assist with completing MDS assessments. She further stated the assessments should be completed timely in order to provide an accurate depiction of each resident's status. An interview with the ADM on 8/5/25 at 2:00 PM confirmed that he was aware that the MDS assessments were late. He stated the MDS nurse had informed him the previous day. He agreed it was his expectation that MDS assessments be completed timely but attributed the delays to an increase in admissions.	F0640		
F0641 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.	F0641		

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F0641 SS = D	Continued from page 13 §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. §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 ensure the Minimum Data Set (MDS) assessment was accurately coded for one (1) of 33 MDS assessments reviewed. Resident #122. Findings Include Record review of the facility policy, “Minimum Data Set (MDS) 3.0 Completion” revealed “Policy Explanation of Compliance Guidelines: 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident’s functional capacity, using the Resident Assessment Instrument (RAI) specified by the State." Record review of the "Progress Note " for Resident #122, dated 7/17/25, revealed that the resident was discharging home. Record review of Section A2105 of the Discharge MDS for Resident #122, with an Assessment Reference Date (ARD)	F0641		

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F0641 SS = D	Continued from page 14 of 7/18/25, revealed the discharge status was coded as "short-term general hospital." During an interview with the MDS nurse on 8/6/25 at 9:21 AM, she confirmed that the discharge MDS for Resident #122 was inaccurately coded. She stated the resident was discharged home and acknowledged she had completed the assessment. She agreed that the purpose of ensuring accurate assessment coding is to reflect an accurate depiction of the resident's status and discharge disposition. In an interview with the Administrator (ADM) on 8/6/25 at 10:00 AM, he verified that it was his expectation that the MDS would be coded accurately. Record review of the" Admission Record" revealed Resident #122 was admitted to the facility on 7/1/25 with a diagnosis of Fracture of Right Femur.	F0641		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure residents were free from significant medication errors for six (6) of 29 residents reviewed for medication administration. (Residents #12, #42, #79, #84, #108, and #111) Findings include: Review of the facility policy titled "Medication Errors," last reviewed 6/30/25, revealed: "Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors..." During an interview with the Administrator on 8/5/25 at 12:30 PM regarding facility-reported incident, he stated that on the morning of 6/25/25, the day shift nurse reported that several of the evening shift medications from 6/24/25 were still in sealed packets on the unopened medication cart. He stated that agency	F0760	"Past Noncompliance - no plan of correction required"	

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F0760 SS = D	Continued from page 15 Licensed Practical Nurse (LPN) #2, who had worked the medication cart on that shift, had signed all of the medications as administered in the electronic record. The administrator confirmed he expected nursing staff to follow the facility policy and current standards of practice for medication administration to prevent significant medication errors. He confirmed that the incident and investigation results were presented to the Quality Assurance (QAPI) committee during the committee meeting on 6/26/25 and again on 7/31/25, in which the Medical Director attended, the facility policy was reviewed with no revisions made. LPN # 2 was not allowed to work at the facility after 6/24/25 and all the appropriate agencies were notified. Resident #12 Record review of the June 2025 Medication Administration Record (MAR) for Resident #12 revealed Midodrine 5 mg (milligrams) (alpha-1 adrenergic agonist – vasopressor), three tablets by mouth three times daily for low blood pressure, documented as administered by agency LPN #2 on 6/24/25. Record review of the “Admission Record” revealed Resident #12 was admitted on 1/21/25 with diagnosis including heart failure. Resident #42 Record review of the June 2025 MAR for Resident # 42 revealed Fluconazole 200 mg (antifungal) one tablet four times daily for Candida infection, documented as administered by agency LPN #2 on 6/24/25. Record review of the “Admission Record” revealed Resident #42 was admitted on 6/13/25 with a diagnoses including local infection of the skin and subcutaneous tissue and osteomyelitis. Review of the Admission Minimum Data Set (MDS) dated 6/13/25, Section C, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident #79 Record review of the June 2025 MAR for Resident # 79 revealed Divalproex Sodium (Depakote) 500 mg (anticonvulsant) one tablet by mouth twice daily for partial seizures, documented as administered by agency LPN #2 on 6/24/25. Record review of the “Admission Record” revealed	F0760		

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F0760 SS = D	Continued from page 16 Resident #79 was admitted on 9/12/22 with a diagnosis of symptomatic epilepsy and epileptic syndrome with partial seizures. Resident #84 Record review of the June 2025 MAR for Resident # 84 revealed Hydralazine 50 mg (vasodilator antihypertensive) 1.5 tablets by mouth three times daily for hypertension, documented as administered by agency LPN #2 on 6/24/25. Record review of the “Admission Record” revealed Resident #84 was admitted on 3/14/25 with a diagnosis of essential hypertension. Resident #108 Record review of the June 2025 MAR for Resident # 108 revealed Carvedilol 25 mg (beta-blocker – antihypertensive) one tablet twice daily for hypertension. … Baclofen 10 mg (skeletal muscle relaxant) one tablet three times daily for muscle spasms. … and Losartan 25 mg (angiotensin II receptor blocker – antihypertensive) one tablet twice daily for hypertension, all documented as administered by agency LPN #2 on 6/24/25. Record review of the “Admission Record” revealed Resident #108 was admitted on 4/17/23 with a diagnosis of hypertensive heart disease with heart failure and muscle spasm of the back. Resident #111 Record review of the June 2025 MAR for Resident # 111 revealed Levetiracetam (Keppra) 750 mg (anticonvulsant) 1.5 tablets by mouth twice daily for seizure disorder, documented as administered by agency LPN #2 on 6/24/25. Record review of the “Admission Record” revealed Resident #111 was admitted on 12/31/15 with a diagnosis of symptomatic epilepsy and epileptic syndrome with partial seizures. An interview with the Director of Nursing (DON) on 8/5/25 at 1:00 PM revealed she reviewed the medication records for all residents assigned to LPN #2 on 6/24/25 and confirmed that multiple medications were documented as given but were still in sealed packets on the medication cart the next morning. She stated that missed scheduled medications could result in adverse consequences, including elevated blood pressure, elevated pulse, anxiety, depression, and seizure	F0760		

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F0760 SS = D	Continued from page 17 activity. She confirmed the missed doses for Residents #12, #42, #79, #84, #108, and #111 were considered significant medication errors. During a continued interview with the DON on 8/6/25 at 12:00 PM, she stated she interviewed Resident #42, who reported he did not receive his night medications on 6/24/25, including pain medication, and that the nurse never returned to his room despite his calls. She stated LPN #2 later claimed she had computer issues, was behind on med pass, and signed off the medications in the system after giving them, not realizing some remained on the cart. The DON confirmed all nursing staff were educated on medication administration and medication errors immediately starting 6/26/25 -7/2/25 when the in-services were completed. She stated medication skills checkoffs were also completed on three nurses weekly times four weeks. An interview with LPN #1 on 8/5/25 at 1:30 PM confirmed that she found multiple sealed medication packets on the cart during her morning medication pass on 6/25/25. She stated she assessed the affected residents and found no one in pain or distress, with only Resident #42 voicing a complaint that his medications were not given. An interview with the Registered Charge Nurse on 8/6/25 at 2:00 PM confirmed she was aware residents did not receive their evening medications on 6/24/25. She stated the unopened packets were found on the cart, and all affected residents were assessed for adverse consequences, with no negative findings noted. Resident #42 again reported the nurse only came into his room once early in the shift and never returned with his medications. She also confirmed that the provider and resident representative was notified for every affected resident. Based on the implementation of the facility's corrective actions on 6/25/25, the deficient practice was determined to be past noncompliance, and the facility was found in compliance effective 7/3/25. Validation: The SA validated on 8/5/2025, through interview and record review that all corrective actions had been implemented as of 7/3/25, and the facility was in compliance as of 7/3/25, prior to the SA's entrance on 8/4/2025.	F0760		