STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PICAYUNE REHABILITATION AND HEALTHCARE CEN	1620 READ ROAD PICAYUNE, MS 39466

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey, along with two (2) Complaint Investigations (CIs), MS #27720 and CI MS #27954 at the facility from 3/11/25 through 3/13/25. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. M500, M815 and M1570 were cited as a result of the annual recertification survey. CI MS #27720 was investigated for the facility being cold, not clean, and quality of care/life and M500 was cited. CI MS #27954 was a facility reported incident (FRI) investigated regarding verbal abuse and resident not treated with respect and dignity. The facility failed to protect a resident's right to be free from verbal abuse and M500 was cited. The facility's failure to protect Resident #17 when Certified Nursing Aide (CNA) #1 engaged in an argument with the resident on 2/8/25, using profanity and picked up a spray bottle of chemicals, pointed toward the resident, in response to the resident's agitation. Resident #17 reported feeling "nervous and afraid" at the time of the incident and the facility did not immediately remove the abuser from the facility. Licensed Practical Nurse (LPN) #1 witnessed the abuse and failed to intervene or report the abuse within the required timeframe and the facility did not report the event until 2/12/25. CNA #1 continued to work, delaying the facility's ability to protect this resident from further harm and placing other residents at risk of similar mistreatment. During the investigation of the FRI, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began	M 000		

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M 000	Continued From page 1 on 2/8/25 and existed at Rule 45.17.2 Residents' Rights (M500) - Level IV The abuser was not immediately removed from the facility which left Resident #17 and other residents in a situation that was likely to result in ongoing serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 3/12/25 at 2:15 PM. Based on the facility's implementation of corrective actions on 2/12/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 2/13/25, prior to the SA's entrance on 3/11/25.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		4/10/25

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M 500	Continued From page 2 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff	M 500		

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M 500	Continued From page 3 and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic	M 500		

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M 500	Continued From page 4 purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.	M 500		

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M 500	Continued From page 5 This Statute is not met as evidenced by: Based on interview, record review and facility policy review the facility failed to protect the residents right to be free from verbal abuse by a staff member (Resident #17), failed to ensure the resident's right to reasonable accommodation as evidenced by a call light that was not within reach (Resident #39), and facility failed to ensure the residents' right to a comfortable, homelike environment related to the facility being an uncomfortably cold temperature for (Residents #82, Resident #43, Resident #45, Resident #5, and Resident # 34) for seven (7) of 21 sampled residents. Resident #17 was verbally abused and threatened on 2/8/25 when Certified Nursing Aide (CNA) #1 used profanity in an argument and aimed a spray bottle of chemical cleaner toward him. The facility's failure to protect Resident #17 resulted in his reporting he felt "afraid and nervous." Additionally, the facility's failure to immediately remove CNA #1 from the facility placed this resident and other residents at risk for similar abuse. The situation was determined to be Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). The State Agency (SA) notified the Administrator of the IJ and SQC on 3/12/25 at 2:15 PM and provided an IJ Template. Based on the facility's implementation of corrective actions on 02/12/25, the SA determined the IJ and SQC to be Past-Non-Compliance (PNC) and the IJ was removed on 02/13/25 prior to the SA's entrance	M 500	F500 1. On 3/11/2025 Resident #39 call light was placed within reach by certified nurse's aide #1 (CNA). On 3/11/25 the Director of Nursing (DON) assessed Resident # 39 for any abnormalities with no negative findings. On 03/11/2025 the Director of Nursing (DON) audited all resident rooms to ensure resident call light was within reach of resident. No further concerns were noted. On 03/11/2025 CNA#1 was in serviced by the Staff Development Coordinator on the call light policy along with Resident Rights. On 03/14/2025 the Maintenance Director verified temperatures in Resident #82, 43, 45, 5, and 34. Resident #82, 43, 45, 5, and 34 all had temperatures that were within the required temperature setting of 71-81 degrees Fahrenheit by state and federal regulations. 2. All residents have the potential to be affected. 3. On 4/1/25 an in-service was initiated and ongoing by the Staff Development Coordinator with all staff on the call light policy and Resident Rights. On 03/14/25 observation rounds were completed on all resident rooms by the DON to check placement of call lights and ensure call lights were within reach. No issues were identified. On 03/13/2025 the Maintenance Director and the Assistant Maintenance Director was in serviced by the Administrator on ensuring that temperature levels are maintained with in the federal temperature requirements but	

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M 500	Continued From page 6 on 03/11/25. Findings include: A review of the facility's, "Abuse Prohibition Policy," dated 5/17/24, revealed, "Intent ...Each resident has the right to be free from abuse, mistreatment ...Policy: 1. The facility will prohibit neglect, mental or physical abuse ...of residents ...Definitions ...Verbal abuse is defined as the use of, oral, written or gestured language that willfully includes disparaging or derogatory terms to residents ...within their hearing distance ...Examples of verbal/mental abuse include ...cursing, yelling, saying things to frighten a resident ..." A record review of the facility's Certified Nursing Assistant (CNA) "Job Description" dated March 2017, revealed, " ...Function: Cares for Residents under the direction and supervision of a registered nurse or a licensed practical/vocational nurse...Knows how to respond to Residents' behaviors ...Demonstrates a basic understanding of behavior ....treats Residents with dignity and respect ..." A record review of the facility's investigation, dated 02/15/25, revealed "On Saturday, February 8, 2025, Certified Nursing Assistant (proper name) was entering the dining room and encountered (Resident proper name)...(Resident proper name) began yelling expletives at (CNA proper name)...(CNA proper name) began arguing back with the resident using profanity... (Resident proper name) was interviewed and stated he was speaking with Licensed Practical Nurse (LPN) proper name) in the dining area when (CNA proper name) entered. He began cursing and calling CNA names and (CNA proper	M 500	are also checked in various locations to ensure that desired temperature levels are achieved with consideration of humidity and air movement in the building. On 04/01/2025an in-service was initiated and ongoing by the Staff Development Coordinator with all staff on the importance of ensuring resident rights are followed by maintaining air temperatures and reporting any resident concerns. 4. Beginning 3/17/25 the Director of Nursing will conduct observations rounds on ten resident room weekly for four (4) weeks and then monthly for three (3) months and quarterly thereafter to ensure the call light policy and procedures are being followed and call lights remain within reach of residents. Beginning the week of 03/17/2025 the Maintenance Director will audit resident rooms to check on temperatures in a variety of high air flow resident care areas (5) five rooms weekly times (4) four weeks and monthly for (3) three months and quarterly thereafter A report will be submitted to the Quality Assurance Performance Improvement on 04/01/2025 for review and recommendations then and monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

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name) became argumentative and also used profanity. He stated that Nurse (proper name) took him back to his room and calmed him down...(CNA proper name) was interviewed. CNA stated (Resident proper name) began screaming swear words at her and then proceeded to roll his wheelchair towards her threatening to slap her in the face. Employee said this made her feel scared so she picked up a spray bottle and told him not to come any closer....LPN (proper name) was interviewed. Nurse stated that her and (Resident proper name) were indeed having a conversation in the dining area when (CNA proper name) entered. Nurse stated that (Resident proper name)began cursing at (CNA proper name) and the employee began arguing back. Both (CNA proper name) and (Resident proper name) were using profanity. (CNA proper name) then picked up a spray bottle and pointed towards (Resident proper name) but did not spray the bottle. The resident was then taken back to his room...Life rounds were completed and residents with a BIMS (Brief Interview of Mental Status) of 12 or higher. One resident stated that CNA (proper name) had a smart mouth and another resident stated that he hears her being loud and using profanity in the hallway. Life rounds completed with staff with no issues noted. In services initiated with staff on Resident Rights, Vulnerable Adult, Abuse, Neglect and Customer Service. Currently, the facility decided to terminate employee (proper name) due to multiple policy violations..."

A record review of the time sheet for CNA #1 revealed on 2/8/25 she worked from 7:31 AM to 6:45 PM. On 2/9/25 she worked from 8:20 AM to 7:26 PM, and on 2/12/25 she worked from 7:56 AM to 11:30 AM, which was after the abuse occurred on 2/8/25.

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M 500	Continued From page 8 On 03/11/25 at 9:00 AM, during an interview Resident #17 confirmed that he and CNA #1 had a disagreement that occurred during the smoke break on 2/7/25. He stated that the CNA had refused to go back into the facility to get his cigarettes. The resident reported that on 2/8/25, he and LPN #1 were in the dining area talking, when CNA #1 entered the dining area. The resident stated he was still upset about the incident from the smoke break and stated to LPN #1 that CNA #1 was a lazy (expletive). CNA #1 then approached him and started using profanity toward him, and she then grabbed a bottle containing cleaning solution, that was sitting on a housekeeping cart and pointed it toward him. Resident #17 stated she did not spray it on him, but he was "nervous and afraid" because he thought she might spray him. On 03/11/25 at 10:03 AM, during an interview with the Risk Manager (RM) she acknowledged that she was made aware of the incident on 2/12/25 by the Administrator, which was four (4) days after the abuse occurred. The RM stated she and the Administrator called CNA #1 in for an interview, and she was then suspended. The RM stated CNA #1 fully admitted the details of the incident as reported by Resident #17 and LPN #1. On 03/11/25 at 3:40 PM, during an interview, LPN #1 stated that on 2/8/25, while walking down the hall, she encountered Resident #17, who looked toward CNA #1 and said, "Go hit that (expletive) in the back of the head." LPN #1 stated she initially thought the resident was joking, as he is typically pleasant. As they continued speaking, CNA #1 approached and confronted the resident, saying, "Are you talking about me? You better keep my name out of your mouth." LPN #1 stated	M 500		

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M 500	Continued From page 9	M 500		

the resident then called CNA #1 a lazy (expletive), and CNA #1 walked away, but the resident followed her and the two continued yelling at each other. CNA #1 then asked LPN #1 if she was going to intervene to de-escalate the situation. LPN #1 reported that CNA #1 grabbed a spray bottle from a housekeeping cart, pointed it at the resident, and yelled, "Back the (expletive) up, back the (expletive) up! I'm going to get [another resident] to come down here to beat you in the head." LPN #1 stated the resident backed away and CNA #1 walked off. LPN #1 reported the incident to LPN #2, the Charge Nurse. Shortly afterward, LPN #3 informed LPN #1 and LPN #2 that CNA #1 had also reported the incident to her. LPN #1 stated that as LPN #3 was preparing to call the Director of Nursing (DON), CNA #1 approached them and began yelling about what should be done to Resident #17. LPN #3 escorted CNA #1 back to her unit and called the Director of Nursing (DON), who later spoke with LPN #2 and advised that he would handle the incident on Monday. LPN #1 stated she was not instructed to send CNA #1 home and did not tell CNA #1 to leave out of fear the hostility might escalate. LPN #1 acknowledged she was aware that Resident #17 was being verbally abused and threatened by CNA #1. She stated she believed reporting the incident to the Charge Nurse fulfilled her obligation but admitted she should have removed the resident once the situation escalated. LPN #1 confirmed that CNA #1 completed her shift on 2/8/25 and was still working at the facility when LPN #1 returned on 2/12/25. She also confirmed she had not been contacted by the DON for a statement prior to meeting with the Administrator on 2/12/25. LPN #1 stated that staff receive frequent in-service training on abuse prevention through computer-based modules, which include topics

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on de-escalation and resident safety.

On 03/11/25 at 4:15 PM, during an interview, the DON stated that on 2/8/25 at approximately 10:00 AM, he received a phone call from LPN #3 reporting that Resident #17 had directed profanity toward CNA #1. The DON stated that he instructed LPN #3 to ensure that CNA #1 did not assist Resident #17 with smoke breaks moving forward. The DON further explained that around 12:00 PM that same day, he contacted LPN #2 and was informed that CNA #1 had raised her voice at Resident #17 and had been separated from the resident. The DON reported that based on the information provided at the time, he did not view the incident as abuse and, therefore, did not instruct staff to send CNA #1 home.

On 03/11/25 at 4:33 PM, during an interview, LPN #2 confirmed that on 2/8/25, LPN #1 approached her at the nurse's station and informed her about the incident between Resident #17 and CNA #1. Shortly after, LPN #3 arrived from the other unit to inquire about what had occurred. LPN #2 stated that CNA #1 then came to the nurse's station, visibly agitated and upset, and said, "Who the (expletive) are you sending home?" LPN #2 reported that LPN #3 subsequently escorted CNA #1 back to the other unit and placed a call to the DON to report the situation. LPN #2 stated that when the DON called her later that day, she relayed what LPN #1 had reported, and suggested that the DON follow up directly with LPN #1. LPN #2 confirmed that she specifically informed the DON that CNA #1 had verbally retaliated against Resident #17, stating, "Who the (expletive) are you talking to? Who the (expletive) are you calling a (expletive)?" LPN #2 also reported that she told the DON about the allegation that CNA #1 had aimed a

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chemical-filled spray bottle at the resident and threatened to recruit another resident to physically harm him. LPN #2 stated that the DON responded that he would handle the situation on Monday. LPN #2 explained that she did not send CNA #1 home that day, as she was waiting for direct instructions from the DON.

On 3/12/25 at 10:02 AM, during a phone interview, CNA #1 stated that on 2/8/25, she was in the dining area when she noticed Resident #17 speaking with his nurse (LPN#1). CNA #1 reported that she approached them and asked, "Is there something you need to tell me?" According to CNA #1, Resident #17 began using profanity toward her. CNA #1 stated she turned to the nurse and asked, "Are you going to intervene with your resident?" CNA #1 reported that Resident #17 then threatened to slap her. In response, she stated that she grabbed a spray bottle of cleaning solution from a nearby cart, aimed it at the resident, and told him not to put his hands on her. CNA #1 said she did not view pointing the spray bottle at the resident as a threatening act but rather as a defensive measure. CNA #1 acknowledged that the facility regularly provides abuse prevention training, which includes guidance on appropriate responses to escalating situations.

On 03/12/25 at 12:15 PM, during an interview, LPN #3 stated that she did not personally witness the incident involving CNA #1 and Resident #17 on 2/8/25. She reported that CNA #1 informed her that Resident #17 had cursed at her, and in response, she cursed back and aimed a spray bottle of cleaning fluid at him. LPN #3 stated that CNA #1 was frustrated because LPN #1 had been standing next to the resident during the incident and did not intervene. LPN #3 explained

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that she went to the Unit 2 nurse's station to discuss the matter with LPN #1 and LPN #2. According to LPN #3, LPN #2 instructed her to notify the DON. LPN #3 stated that she contacted the DON and informed him that CNA #1 admitted to cursing at Resident #17 and pointing a spray bottle of cleaner at him. LPN #3 reported that the DON instructed her to document a statement and assured her that he would address the issue on Monday. LPN #3 added that she also reminded the DON about CNA #1's responsibility for taking residents to their scheduled smoke breaks.

On 03/12/25 at 12:51 PM, during an interview, the Administrator stated she became aware of the incident from 2/8/25 when CNA #4 approached her on 2/12/25 and asked if she had been made aware of what had occurred. The Administrator explained that, following this, she immediately spoke with Resident #17, the DON, the involved nurses, and CNA #1. The Administrator reported that CNA #1 admitted to the incident as described and was subsequently sent home on 2/12/25. She further stated that in-services were held with all staff to reinforce how to identify and report abuse, which included drills and refresher training. The Administrator confirmed that all staff are regularly trained on appropriate actions in response to allegations or incidents of abuse. She acknowledged that the nursing staff did not follow the facility's abuse policy and protocol, specifically stating that CNA #1 should have been removed from duty immediately.

A record review of the "Admission Record" revealed the facility admitted Resident #17 on 7/15/24 with diagnoses including Anxiety Disorder.

A record review of the Quarterly Minimum Data

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M 500	Continued From page 13 Set (MDS) with an Assessment Reference Date (ARD) of 01/16/25 revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A review of Section E revealed the resident had not exhibited any verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). Facility Corrective Action Plan: On 03/12/2025 at 3:15 PM State Agency (SA) notified facility Administrator of Immediate Jeopardy (IJ). State Agency Surveyor provided the facility with the Immediate Jeopardy (IJ) templates. Facility respectfully submits this corrective action plan. Brief Summary of Events On 02/12/2025 at 10:45AM the Administrator was notified of allegation of verbal abuse involving Resident #17 and CNA (Certified Nursing Assistant) #1. On 02/08/2025 CNA #1 was delivering a resident tray when she overheard Resident #17 and staff member laughing. The CNA #1 questioned the contents of their conversation. Resident #17 started using profanity directed at her. CNA #1 picked up a spray bottle pointing it in the direction of Resident # 17. CNA # I was using profanity as she was walking away from Resident # 17. CNA #1continued to work in facility in separate care area until allegation was reported to administration on 2/12/2025. Corrective Actions 1. On 02/12/2025 at 9:30am. The Treatment Nurse conducted a routine head-to-toe body	M 500		

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assessment on Resident #17 to review for any skin abnormalities or concerns. Resident #17 had no negative skin issues or concerns.
2. On 02/12/2025 at 10:55am The Director of Nursing and Administrator interviewed Resident #17 regarding the allegation of abuse. Resident #17 provided statement of events.
3. On 2/12/2025 at 1130am, CNA (Certified Nursing Assistant) #1 was interviewed, statement obtained and suspended pending investigation by the Administrator. CNA #1 was subsequently terminated.
4. On 02/12/2025 at approximately 11:30am an allegation of abuse involving Resident #17 was reported to the State Agency (SA) by the Facility Risk Manager.
5. On 02/12/2025 at approximately 1140am an allegation of abuse involving Resident #17 was submitted to the Attorney General (AG) complaint website by the Risk Manager regarding allegation of abuse.
6. On 2/12/2025 at 11:40am, Referral was sent to Psychologist Nurse Practitioner by the Director of Nursing for evaluation and follow up.
7. On 2/12/2025 at 11:40am, The Medical Director was notified of the allegation by the Administrator.
8. 02/12/2025 at 12:00pm The Administrator notified ombudsman with no answer and left message.
9. On 2/12/2025 at 12:14pm, The DON conducted Trauma Assessment on Resident #17 with no negative findings.
10. On 2/12/2025 at 12:30pm, The Risk Manager initiated Life satisfaction rounds on with residents with BIMS (Brief Interview of Mental Status} of 12 or higher regarding Abuse and Safety in the facility. two negative findings on unprofessional behavior resulted with a report of being rude and loud. No allegations of abuse resulted.

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M 500	Continued From page 15 11. On 2/12/2025 at 1:30pm, Peer reviews initiated by Risk Manager regarding Abuse and Safety in the facility involving CNA #1. One finding resulted in witnessing the allegation involving Resident #17. On 2/12/2025 at 1:30-1:45pm, An Abuse Drill Evaluation completed with Station I and II by the DON and Administrator as part of an ongoing monitoring plan. Life satisfaction rounds with two residents having a BIMS of twelve or higher will be completed by the Administrator/DON or Risk Manager weekly times four weeks, every other week times eight and monthly thereafter for three months. The QAPI committee will evaluate additional action based on results. The DON will conduct two random interviews on residents with BIMS of twelve or higher for any allegations of abuse or neglect weekly times four weeks, every other week times eight weeks and monthly times three months thereafter. The DON, Assistant Director of Nursing, or Risk Manager will conduct two random body audits on residents with BIMS below twelve for any indicators of abuse or neglect weekly times four weeks, every other week for eight weeks and monthly times three months thereafter. The QAPI committee will evaluate additional action based on results. The QAPI Committee will review potential trends and patterns and provide recommendations as needed. 12. On 2/12/2025 at 2:30pm, an in-service initiated by Risk Manager/ DON/ADM on Abuse and Neglect, Resident Rights, Vulnerable Adult, along with the reporting guidelines including how to address if abuse is noted. No staff was allowed to return to work prior to completion. 13. On 2/12/2025 at 3:00pm, QAPI Committee held a Quality Assurance Meeting to include Medical Director, Director of Nursing, Assistant Director of Nursing, Risk Manager/Infection	M 500		

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Preventionist, Medical Records, Director of Rehabilitation, Billing Office Manager, Activity Director and Minimum Data Set Nurse to discuss allegations of abuse along with corrective action and monitoring in place. Policies were reviewed with no revisions needed.
14. On 3/12/2025 at 3:15pm. State Agency (SA) notified the Administrator of Immediate Jeopardy with past noncompliance of 02/12/2025. The State Agency (SA) provided the facility with the Immediate Jeopardy templates.
15. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 02/12/2025 and the Immediate Jeopardy was removed 02/13/2025.

Validation:

The SA validated on 3/13/2025, through interview and record review that all corrective actions had been implemented as of 2/12/25, and the facility was in compliance as of 2/13/25, prior to the SA's entrance on 3/11/2025.

Accommodation of needs:

A review of the facility's policy titled "Resident Call System," dated 3/28/23, revealed, " ... Residents are provided with a means to call staff for assistance... Policy Interpretation and Implementation 1. Each resident is provided with a means to call staff directly for assistance..."

On 03/11/2025 at 11:38 AM, during an observation, Resident #39's call light was observed draped over a shelf and out of reach. Certified Nurse Aide (CNA) #1 confirmed the call light was not within reach of Resident #39.

On 03/12/2025 at 10:08 AM, during an interview,

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Licensed Practical Nurse (LPN) #1 stated that call lights are supposed to be left within reach of the resident after each visit, and that CNAs are expected to make rounds every two (2) hours.

On 03/13/2025 at 8:51 AM, during an interview, CNA #2 stated that on every visit to a resident's room, CNAs are trained to ensure the resident is comfortable, the call light is within reach, and that the resident does not need anything else. CNA #2 further explained the importance of answering call lights quickly to ensure residents receive the help they need.

On 03/13/2025 at 2:40 PM, during an interview, the Administrator stated that staff are expected to have the call light within reach and to answer call lights in a timely manner.

On 03/13/2025 at 2:45 PM, during an interview, the CNA Supervisor stated that staff completed in-services in February 2025 and that call light procedures are reviewed at orientation, quarterly, and as needed. The CNA Supervisor confirmed that CNAs are expected to leave call lights within reach of residents before exiting the room.

On 03/13/2025 at 3:21 PM, during an interview, the Director of Nursing (DON) stated that CNAs are expected to leave call lights within reach of residents upon exiting the room and to answer call lights in a timely manner.

A record review of the "Admission Record" revealed the facility admitted Resident #39 on 12/12/2021 and he had current diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side.

A record review of Resident #39's Quarterly

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M 500	Continued From page 18 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/2024 revealed the resident required a staff interview to assess cognition and his cognition was severely impaired. A review of the facility's "In-service Training" with a subject of "answering call lights in a timely manner, dated 02/27/2025 revealed the facility staff received education to " ... Make sure call lights are always within reach of your Residents every time you enter and exit the room ..." Comfortable environment: A review of the facility's policy titled "Resident Rights," revised April 2017, revealed, "...Residents shall...r. Live in a physical environment which ensures their physical and emotional security and well-being ..." Resident #82 On 03/11/2025 at 9:30 AM, during an interview and observation, the room was cold and Resident #82 stated that it is always cold in her room. She was observed wearing long sleeves, a blouse, a jacket, and was covered with a blanket. A record review of the "Admission Record" revealed the facility admitted Resident #82 on 06/07/2024 with current diagnoses including Alzheimer's Disease with Late Onset. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/13/2025 revealed Resident #82 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	M 500		

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M 500	Continued From page 19 Resident #43 On 03/11/2025 at 10:48 AM, during an observation and interview, Resident #43 complained about the cold temperature in his room. The resident had two blankets on his bed, while two additional blankets were folded on his roommate's bed. Resident #43 stated it was always too cold in his room. On 03/11/2025 at 2:35 PM, Resident #43's family member confirmed that his father consistently complains about being cold, and that both his father and the roommate have jackets and extra blankets. A record review of the "Admission Record" revealed the facility admitted Resident #43 on 06/10/2024 with current diagnoses including Chronic Diastolic (Congestive) Heart Failure. A record review of the Quarterly MDS with an ARD of 12/18/2024 revealed Resident #43 had a BIMS score of 3, which indicated severe cognitive impairment. Resident #45 On 03/11/2025 at 9:41 AM, Resident #45 was observed sitting in the hallway wearing a jacket. Resident #45 reported that his room is always too cold, which is why he wears his jacket and stays in the hallway. A record review of the "Admission Record" revealed the facility admitted Resident #45 on 11/18/2021 with current diagnoses including Peripheral Vascular Disease.	M 500		

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A record review of the Quarterly MDS with an ARD of 11/29/24 revealed Resident #45 had a BIMS score of 15, which indicated the resident was cognitively intact.

Resident #5

On 03/11/2025 at 2:25 PM, in an observation and interview, Resident #5 reported that her room is cold. She was observed wearing a gown and a thick robe near the window and the room was cold.

A record review of the "Admission Record" revealed the facility admitted Resident #5 on 05/11/2022 with current diagnoses including Unspecified Dementia.

A record review of the Quarterly MDS, with an ARD of 12/16/2024 revealed Resident #5 had a BIMS score of 9, which indicated moderate cognitive impairment.

Resident #34

On 03/11/2025 at 11:18 AM, during an observation and interview, Resident #34's room was cold. The resident had placed a sheet in the window to block the draft and reported that his room is normally cold, especially after showers. The resident stated that staff informed him the facility has to remain cold.

A record review of the "Admission Record" revealed the facility admitted Resident #34 on 10/18/2024 with current diagnoses including Acute and Chronic Respiratory Failure with Hypoxia.

A record review of the Quarterly MDS with an

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M 500	Continued From page 21 ARD of 1/17/2025 revealed Resident #34 had a BIMS score of 15, which indicated the resident was cognitively intact. On 03/11/2025 at 3:12 PM, temperatures were checked in multiple rooms after residents complained about feeling cold. The following temperatures were observed: Resident #5's room at 3:15 PM measured 67.5 degrees (°) Fahrenheit (F); Resident #82's room at 3:20 PM measured 69°F; Resident #34's room at 3:23 PM measured 65°F; Resident #43 and Resident #45's room at 3:26 PM measured 65.5°F. The Maintenance Director confirmed that thermostats were set at 72°F on the cool setting. On 03/11/2025 3:30 PM, during an interview, the Maintenance Director stated that he typically keeps the thermostats set at 72°F, but adjustments are made based on resident complaints. He explained that maintaining consistent temperatures is difficult due to varying preferences, building layout, and vent placement. He also mentioned that an igniter malfunctioned in January 2025 on one of the halls and took three days to repair. On 03/12/2025 10:50 AM, during an interview the Administrator stated that she believed the facility usually meets the federal requirement of 71°F but acknowledged that the building's age, traffic patterns, and vent placements can affect room temperatures. On 03/12/2025 at 3:00 PM, during an interview, Certified Nurse Aide (CNA) #10 stated that rooms 34, 35, 36, and 37 are always cold and that blankets are placed in the windows to block the cold air. CNA #10 confirmed that residents frequently complain about the cold and that staff	M 500		

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M 500	Continued From page 22 provide extra blankets. On 03/12/2025 at 3:45 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated that rooms near doors throughout the facility have always been colder than other rooms. LPN #1 confirmed that residents frequently complain, and that staff provide extra blankets and block window drafts with blankets. She confirmed that maintenance and management have been informed of the issue. On 03/12/2025 at 3:50 PM, during an interview with LPN #2 revealed that about one (1) or two (2) residents on each hall occasionally complain about the cold, but staff typically notify maintenance and provide residents with extra blankets or jackets. On 03/12/2025, at 3:55 PM, during an interview with CNA #9 revealed that some residents occasionally complain about cold rooms, but maintenance usually addresses complaints within approximately 30 minutes, and staff provide extra blankets as needed. On 03/13/2025 at 10:47 AM, the Maintenance Director verified room temperatures again. The temperatures were as follows: Resident #5's room was measured at 70.5°F; Resident #82's room at 71°F; Resident #43 and Resident #45's room at 70°F; Resident #34's room measured 70.5°F by the door and 67.5°F by the window; Room 61 measured 69.5°F. Thermostats were set at 74°F on the cool setting.	M 500		