STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULEVILLE NURSING AND REHABILITATION CENTER LLC	**800 STANSEL DR P O BOX 368, RULEVILLE, Mississippi, 38771**

(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 and Complaint Investigations (CI) MS #472523, CI MS #472548, CI MS #472549, CI MS #472552, CI MS #2576008, and Facility Reported Incident (FRI) MS #2600431 at the facility from 8/25/25 through 8/27/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. CI MS #472523, CI MS #2576008, and FRI MS #2600431 were investigated for allegations of abuse, unresolved grievances, and not reporting investigations, and F565, F609, and F610 were cited. CI MS #472548, CI MS #472549, and CI MS #472552 were investigated with no deficiencies cited. The SA also cited F558, F584, F600, F656, F677, F684, F692, F697, and F842. The facility had a census of 104 and was licensed for 111 beds.	F0000		
F0558 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 interviews, record review, and facility policy review, the facility failed to ensure residents' rights to reasonable accommodation of needs by not providing access to oral hydration for two (2) of ninety-six residents reviewed (Resident #38 and Resident #47). Findings IncludeTop of Form Record review of the facility policy titled, "Resident Bill of Rights" undated, revealed, "Each resident has a right to a dignified existence, self-determination, and communication with access to persons and services	F0558		

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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F0558 SS = D	Continued from page 1 inside and outside the Facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life …" 10. "Reside and receive services in the facility with reasonable accommodation of resident needs…" Resident #38 Observation and interview on 8/25/2025 at 10:25 AM, revealed Resident #38 sitting in her room. No water was observed in either a water pitcher or a cup. The resident stated, "I'll have to go up the hall to get some water." An observation and interview on 8/25/2025 at 12:05 PM, Resident #38 was propelling herself down the hall. State Agent (SA) stopped to speak with the resident and the resident stated, "I need to go get some water." An observation on 8/25/2025 at 4:15 PM revealed no water in Resident #38's room. During an observation and interview on 8/26/2025 at 8:25 AM, it was revealed that Resident #38 was sitting in her room with no water observed. Resident #38 revealed she still has no water; someone took her water pitcher and didn't bring it back. She revealed she has to go up the hall to the nurse's desk and ask for water. An interview on 8/26/2025 at 11:05 AM, Licensed Practical Nurse (LPN) #5 revealed that all residents are to have a water pitcher in their room unless they are on thickened liquids or cannot drink. She revealed that the restorative aides or activities staff are responsible for passing hydration on her shift, usually between 9-10 AM and then again at 2 PM. She revealed that the residents must have accessible hydration at all times. An observation and interview on 8/26/2025 at 11:25 AM, LPN #5 confirmed that Resident #38 had no water in her room. LPN #5 asked Resident #38 where her water pitcher was, and the resident stated, "Someone came and got it and never returned it to me." Record review of the "Admission Record" revealed Resident #38 was admitted to the facility on 12/03/2024 with diagnoses that included Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Atherosclerotic Heart Disease and Major Depressive Disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 7/3/2025 revealed under	F0558		

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F0558 SS = D	Continued from page 2 Section C a Brief Interview for Mental Status (BIMS) score of 13, which indicates that Resident #38 is cognitively intact. Resident #47 During an observation and interview on 8/25/2025 at 12:05 PM, an empty pink plastic water pitcher was sitting across the room on top of Resident #47's chest of drawers. Resident #47 stated, "I can't walk over there to get that." She revealed she had no water at her bedside and just the water she had at lunch. Observation of a white 8-oz Styrofoam cup with her lunch meal was noted. An observation on 8/25/2025 at 4:40 PM revealed no water at Resident #47's bedside, and the pink water pitcher remains across the room on top of the chest of drawers and is empty. An observation and interview on 8/26/2025 at 9:05 AM revealed Resident #47 lying in bed, no water is accessible to the resident, and the water pitcher remains across the room on top of the chest of drawers. Resident #47 revealed she hasn't had a pitcher of water at her bedside in a long time and usually gets some water and tea when she eats her meals. During an observation and interview on 8/26/2025 at 11:10 AM with LPN #5 she confirmed Resident #47's water pitcher was inaccessible and should never just be sitting across the room. She revealed that we are supposed to ensure our residents are always offered hydration, and it is accessible to them at their bedside. Record review of the "Admission Record" revealed Resident #47 was admitted to the facility on 05/21/2024 with diagnoses that included Type 2 Diabetes Mellitus, Vitamin D Deficiency, Heart Failure and Chronic Kidney Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 7/28/2025 revealed under Section C a BIMS score of 15, which indicates that Resident #47 is cognitively intact.	F0558		
F0565 SS = D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.	F0565		

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F0565 SS = D	Continued from page 3 (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on staff and resident interview, record review and facility policy review, the facility failed to resolve a grievance for one (1) of eight (8) residents present at the resident council meeting. (Anonymous Resident). Findings Include Review of the facility policy titled " Grievance/Missing Property" with a revision date of 8/17 revealed under "Purpose...to provide an opportunity for residents, resident representatives and/or family to present concerns or grievance to the proper authorities at the facility and to receive	F0565		

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F0565 SS = D	Continued from page 4 responses to the issue(s) raised". Under "Procedure...A.3...Supervisory personnel shall be responsible for notifying the resident of resolution and so indicate on grievance form..." An interview on 8/25/25 at 10:15 AM, Anonymous Resident complained that Certified Nursing Assistant (CNA) #6 jerked his legs when she turned him and it hurt his back. He admitted that he reported this to the staff, but no one had come to ask him about it. An interview and record review on 8/25/25 at 4:00 PM with the Director of Nurses (DON) confirmed that the Anonymous Resident had complained about CNA #6 and she had filled out a grievance form for him. Record review of the grievance that was completed for the Anonymous Resident revealed that the resident had not signed the grievance form and there was no documentation that the grievance had been resolved or discussed with the resident and DON confirmed. Record review of the grievance log revealed a grievance from Anonymous Resident regarding CNA #6 hurting him when they jerked his turn pad but was listed as a complaint regarding “customer service” and was marked as resolved. An interview with Social Services #2 confirmed that all grievances should be discussed with the residents and signed by the residents before they can be considered resolved.	F0565		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(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.	F0584		

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F0584 SS = D	Continued from page 5 (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 §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 maintain a safe, clean, and comfortable environment as evidenced by a bathroom floor covering that had been removed, leaving bare concrete with a black stained area around the toilet for one (1) of 38 residents on sample. Resident #43 Findings Include: Review of a typed statement on facility letterhead revealed the facility did not have a policy regarding maintenance repairs and was signed by the Administrator. On 8/25/25 at 9:05 AM, an observation revealed Resident #43's bathroom floor covering was removed. The floor was bare concrete with a black substance around the toilet base. During an observation and interview with the Housekeeper #1 on 8/26/25 at 11:06 AM, he stated he	F0584		

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F0584 SS = D	Continued from page 6 mopped the area, but the concrete floor could not be cleaned properly and that it had been that way for some time. On 8/26/25 at 11:30 AM, an interview with the Maintenance Staff #2, revealed that when flooring is torn or damaged, linoleum is sometimes removed down to bare concrete. He stated that the aides, nurses, or housekeepers would let him know when repairs needed to be made. During an interview with the Administrator on 8/26/25 at 2:30 PM, she stated she was unaware Resident #43's bathroom floor covering had been removed and acknowledged the resident should have a floor covering. On 8/27/25 at 9:00 AM, a follow-up observation and interview with the Administrator revealed Resident #43's bathroom had new tile-patterned floor covering installed. She stated she observed the Maintenance Supervisor carrying the flooring earlier that day. Record review of Resident #43 's "Admission Record" revealed the resident was admitted to the facility on 8/02/23 with a medical diagnosis that included Huntington's Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/02/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #43 is cognitively intact.	F0584		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F0600		

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F0600 SS = D	Continued from page 7 This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interviews, record reviews and facility policy review the facility failed to protect a resident's right to be free from verbal abuse for one (1) of five (5) residents reviewed for Abuse and Neglect. Resident #3 Findings IncludeTop of Form Top of Form Top of Form Review of the facility policy titled: “Abuse Prevention” undated, revealed, “The facility is committed to protecting the residents from abuse by anyone, including, but not necessarily limited to: facility staff…Definitions: b) Verbal Abuse: The use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents ….” Review of the facility policy titled: “Resident Bill of Rights”, with a revision date of 1/23, revealed “A. Facility residents shall have the right to: 36... be free of abuse, neglect, exploitation, misappropriation of resident property..." A record review of a written statement dated 2/14/25 and signed by Certified Nurse Aide (CNA) #1 revealed, “I, (proper name of CNA #1) was working with Resident #3 on Friday, Feb 14, 2025. We put her in the bed, and she went to crying and I asked her what was wrong, and she said her legs were hurting and I just said your legs ain’t hurting, she told me to shut up and I said you shut up.” During an interview on 8/25/2025 at 11:10 AM, Resident #3 stated, “CNA #1 told me to shut up when I complained about my legs hurting when she put me to bed. I told her I would report her, and she said she didn’t care who I told about it.” She revealed she told the former Administrator about it. During an interview on 8/26/25 at 2:40 PM, the Former Administrator stated, “She got a phone call from the Ombudsman on Saturday night, the Ombudsman reported that Resident #3 had called her and said that CNA #1 had told her to shut up.” The former administrator revealed that she had immediately called the facility and asked the nurse to put Resident #3 on the phone. She revealed that Resident #3 was talking fast and was	F0600		

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F0600 SS = D	Continued from page 8 upset and told her that CNA #1 was trying to prop a pillow under her legs and that she told the CNA that she was hurting her, and the CNA told her that she wasn't hurting her and to shut up. The former Administrator revealed I immediately sent CNA #1 home pending an investigation. She revealed that when I arrived at the facility on Monday, I went to talk with Resident #3 to see what happened. The former Administrator stated, "Resident #3 told me that CNA #1 told her to shut up, and I said Well, what did you say to her? She revealed that Resident #3 told her that she also told CNA #1 to shut up. She revealed that she didn't see that it was abuse because by Monday, Resident #3 said it was okay, but that she didn't want CNA #1 to take care of her anymore. The Administrator revealed she was aware that Resident #3 had a diagnosis of chronic pain. In an interview on 8/26/25 at 3:45 PM, Social Services #2 revealed she remembers the incident of Resident #3 being told to "shut up" and revealed that when she came into work that Monday, she went and spoke with Resident #3, and she was upset and didn't want CNA #1 back in there to take care of her. During an interview on 8/26/2025 at 4:50 PM, Resident #3 revealed that when the incident happened, it was on a weekend, and CNA #1 and another aide were putting her in bed. I complained that my legs were hurting because she didn't put my legs up on the pillow correctly. I told her my leg was hurting, and she said, "Shut up, your legs aren't hurting." Resident #3 stated, "She didn't know how I felt. I was hurting. I have Cerebral Palsy. It made me sad and angry that she said that to me." Resident #3 revealed that CNA #1 still works at the facility. She comes in and takes care of her roommate, but doesn't take care of me, and that's how I want it. In a phone interview on 8/26/2025 at 5:40 PM, CNA #1 confirmed that she did tell Resident #3 to shut up. She revealed that she and another CNA were repositioning Resident #3's legs, and she kept saying her leg was hurting. She revealed I didn't think anything about it when I said, you're okay, you're not hurting then Resident #3 told me to shut up, and I told her to shut up back. CNA #1 acknowledged that she should not have spoken to Resident #3 like that. Record review of the "Admission Record" revealed Resident #3 was admitted to the facility on 08/17/2022 with diagnoses that included Major Depressive Disorder, Anxiety Disorder, Pain, and Cerebral Palsy.	F0600		

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F0600 SS = D	Continued from page 9 Record review of the Minimum Data Set (MDS) with an Assessment Reference Date of June 5, 2025, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates that Resident #3 is cognitively intact.	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure that all alleged abuse violations were reported to the State Survey Agency as required. This deficient practice had the potential to place residents at risk for abuse and/or neglect. For three (3) of the five (5) alleged abuse violations reviewed. Resident #3, Anonymous Resident, and Resident #68. Findings Include Review of the facility policy titled: “Abuse	F0609		

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F0609 SS = D	Continued from page 10 Prevention" dated 10/22, revealed, "The facility is committed to protecting the residents from abuse by anyone, including, but not necessarily limited to: facility staff… under Reporting: Alleged violations involving abuse, neglect, …are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including State Survey Agency…) Under Corrective Action: Any instances of employee disregard for the policies and procedures of this facility are cause for corrective action up to and including suspension, termination, and reporting to licensing agencies." Resident #3 A record review of a written statement dated 2/14/25 and signed by Certified Nurse Aide (CNA) #1 revealed, "I, (proper name of CNA #1) was working with Resident #3 on Friday, Feb 14, 2025. We put her in the bed, and she went to crying and I asked her what was wrong, and she said her legs were hurting and I just said your legs ain't hurting, she told me to shut up and I said you shut up." An interview with Resident #3 on 8/25/2025 at 11:10 AM, she stated, "Certified Nurse Aide (CNA) #1 told me to shut up when I complained about my legs hurting when she put me to bed. I told her I would report her, and she said she didn't care who I told about it." She revealed she told the former Administrator about it." An interview with the Former Administrator on 8/26/25 at 2:40 PM confirmed that Resident #3 had reported that CNA #1 had told her to shut up when she complained of leg pain during repositioning. The former administrator revealed that she had immediately sent CNA #1 home and started her investigation. She confirmed she did not report it to the State Survey Agency because she didn't see that it was abuse, because by Monday, when I returned to work to talk with Resident #3, she said it was okay, but that she didn't want CNA #1 to take care of her anymore. She revealed she took CNA #1 off the schedule for a couple of days, did corrective counseling with her, and allowed her to return to work. Record review of the "Admission Record" revealed Resident #3 was admitted to the facility on 08/17/2022 with diagnoses that included Major Depressive Disorder, Anxiety Disorder, Pain, and Cerebral Palsy.	F0609		

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F0609 SS = D	Continued from page 11 Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of June 5, 2025, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates that Resident #3 is cognitively intact. Anonymous Resident An interview with Anonymous Resident on 8/25/25 at 10:15 AM revealed that he had reported that Certified Nurse Assistant (CNA) #6 and CNA #2 had hurt him during care. He stated that CNA #6 jerked his legs and hurt his back when she turned him and that CNA #2 slapped him in the face with a wet towel when she was bathing him. He admits that no one ever came and talked to him about it, but that neither CNA has returned to his room. An interview on 8/26/25 at 2:30 PM with CNA #6 revealed she recalls the day that the Anonymous Resident complained that they hurt him when they turned him and she was told not to go back to his room. Record review of Anonymous Resident's "Admission Record" revealed the resident was admitted to the facility on 6/6/08 with medical diagnoses that included Paraplegia. Record review of Anonymous Resident's MDS with an ARD of 7/14/25 revealed in Section C, a BIMS score of 15, indicating that the resident was cognitively intact. Resident #68 An interview on 8/25/25 at 11:00AM with Resident #68 revealed that he reported to the Director of Nurses (DON) that he did not want CNA #2 back in his room. He stated that she hurts him when she tries to turn him and sometimes, she talks ugly to him. He admitted CNA #2 does not come to his room anymore, but that no one had questioned him about why he didn't want her in his room anymore. A phone interview on 8/26/25 at 3:15PM with CNA #2 recalled that Anonymous Resident complained that she had wiped his bottom too hard when she was cleaning him, so they told her not to go back in his room. She revealed that last week she was told not to go back into Resident #68's room but was not told why and today she was suspended while they investigated this with Resident #68.	F0609		

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F0609 SS = D	Continued from page 12 Record review of Resident #68's "Admission Record" revealed the resident was admitted on 12/15/22 with medical diagnoses that included Anxiety, Pain and Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side. Record review of Resident #68's MDS with an ARD of 7/17/25 revealed in Section C a BIMS score of 14, which indicates the resident is cognitively intact. An interview on 8/25/25 at 4:00PM with the DON confirmed that she had a complaint on CNA #2 for Resident #68 and CNA #6 for an Anonymous Resident but admitted that she felt like it was more of a customer service issue and therefore did not report it to the state. She confirmed that she removed both CNA's from providing care to these residents and should have reported the allegations to the state. An interview on 8/26/25 at 9:30AM with the ADM confirmed that all allegations of abuse should be reported to the state. She stated she was aware of some complaints on CNA #2 but was not aware of any abuse allegations since she had been here and she started in April 2025.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by:	F0610		

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F0610 SS = D	Continued from page 13 Based on staff and resident interviews, record review and facility policy review the facility failed to investigate allegations of abuse for two (2) of five (5) residents reviewed for abuse. Residents #68 and Anonymous Resident Findings Include Review of the facility policy titled," with a revision date of 10/22 revealed under "Investigate:...the facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation." An interview on 8/25/25 at 10:15AM with an Anonymous Resident revealed that Certified Nurse Assistant (CNA) #6 and CNA #7 came in to turn him and they jerked his legs and hurt his back. He admitted that he reported it to staff that he thought it was CNA #6 and admits that she hasn't worked with him since. He then stated that he reported to the Administrator that CNA #2 was giving him a bed bath and when he ask her to wash his back, she wet the towel and slapped his face with it as she was reaching over him. He admitted that she had not worked with him since, but that no one had come and talked with him about either report. An interview on 8/25/25 at 11:00AM with Resident #68 revealed that CNA #2 tries to turn him every day by herself. He stated that it needs to be two people because it hurts and sometimes, she talks ugly to him. He admitted that he reported CNA #2 to the Director of Nurses (DON) and now CNA #2 does not come to his room anymore, but that no one had come and questioned him about it. An interview on 8/25/25 at 11:40AM with the DON confirmed that there was a resident that complained about CNA #6 and that Resident #68 had complained about CNA #2 and she had removed them from those resident's care but had not completed an investigation. An interview on 8/25/25 at 2:30PM with CNA #7 confirmed that she was present and assisted CNA #6 on the Anonymous Resident the day he complained that we had hurt him. She stated that they did not feel like they did anything wrong or different, but they reported it to the DON. A follow-up interview on 8/25/25 at 4:00PM with the DON confirmed that she had a complaint on CNA #2 for	F0610		

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F0610 SS = D	Continued from page 14 Resident #68 and CNA #6 for an Anonymous Resident, but admitted that she had not done an investigation, because she felt like it was more of a customer service issue and therefore did not report it to the state. She confirmed that she removed both CNA's from providing care to these residents. She stated that a couple of days after the Anonymous Resident complained on CNA #6, the resident was sent to the Emergency Room for back pain and admits that an investigation should have been completed. She revealed she would start an investigation now. She stated she does not recall having any complaints from the Anonymous Resident regarding CNA #2. An interview on 8/26/25 at 9:30AM with the ADM confirmed that all allegations of abuse should be investigated. She stated she was aware of some complaints on CNA #2 but was not aware of any abuse allegations since she had been here and she started in April 2025. An interview on 8/26/25 at 2:30PM with CNA #6 revealed she recalls the day that the Anonymous Resident complained that they hurt him when they turned him and she was told not to go back to his room. A phone interview on 8/26/25 at 3:15PM with CNA #2 recalled that Anonymous Resident complained that she had wiped his bottom too hard when she was cleaning him, so they told her not to go back in his room. She revealed that last week she was told not to go back into Resident #68's room but was not told why and today she was suspended while they investigated this with Resident #68. Record review of Anonymous Resident's "Admission Record" revealed the resident was admitted to the facility on 6/6/08 with medical diagnoses that included Paraplegia. Record review of Anonymous Resident's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/14/25 revealed in Section C, a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident was cognitively intact. Record review of Resident #68's "Admission Record" revealed the resident was admitted on 12/15/22 with medical diagnoses that included Anxiety, Pain and Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side.	F0610		
F0656 SS = E	Develop/Implement Comprehensive Care Plan	F0656		

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F0656 SS = E	Continued from page 15 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.	F0656		

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F0656 SS = E	Continued from page 16 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 implement a care plan for resident's dependent on staff for nail care (Resident #6, #16, #102), showers (Resident #88, #94) and pain management (Resident #106) for six (6) of 31 sampled residents. Resident #6, #16, #88, #94, #102, #106 Findings Include: Review of the facility policy titled “Comprehensive Person-Centered Care Plans” unrevised, revealed, “Policy: Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care…” Resident #6 Record review of the “Care plans” for Resident #6 revealed under, “Goals: I will maintain my current level of ADL (activities of daily living) status.” Also revealed under, “Interventions: extensive assist of one for personal hygiene.” On 8/25/2025 at 11:12 AM, during an observation and interview with Resident #6, he held out his right hand and stated, “I have claws,” and voiced that he needed his nails trimmed. The resident’s nails were long, approximately 3/8 (three-eighths) of an inch in length from the fingertip. On 8/25/25 at 11:31 AM, an observation and interview with Registered Nurse (RN) #2 confirmed Resident #6 had long nails that needed to be cut. Record review of the “Admission Record” revealed the facility admitted Resident #6 on 4/23/19 with a medical diagnosis that included Type 2 Diabetes Mellitus without Complications. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/5/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #6 was cognitively intact. RESIDENT #16 Record review of Resident #16's "Care Plan Report" date initiated 10/15/24 revealed that she required staff	F0656		

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F0656 SS = E	Continued from page 17 assistance with ADLs and interventions included total dependence x (times) 1 (one) with dressing, bathing, and personal hygiene. An observation on 08/25/25 at 2:00 PM revealed Resident #16 sitting up in her wheelchair in the dining room. Her fingernails on both hands were approximately one-half inch long and had a brown substance underneath. During an observation and interview on 08/26/25 at 4:55 PM with Certified Nursing Assistant (CNA) #4, she confirmed that Resident #16 had long fingernails with a brown substance underneath. Record review of Resident #16's "Admission Record" revealed an admission date of 01/18/19 and that she had diagnoses that included Bipolar Disorder and Hemiplegia and Hemiparesis following Cerebral Infarction. Record review of Resident #16's MDS with ARD of 08/13/25 under Section C revealed a BIMS Score of 15 which indicated that she was cognitively intact. Section GG revealed Resident #16 was dependent with personal hygiene. Resident #88 Record review of Resident #88's "Care Plan Report" date initiated 3/13/25 revealed that she was at risk for decline in ADLs (Activities of Daily Living) and had interventions that included "Shower every other day with supervision." An observation and interview on 08/26/2025 at 9:18 AM with Resident #88 revealed that she had greasy hair. She revealed that she washed her hair every time she showered and said that she had not had a shower or bath since last Tuesday, 08/19/25. Resident #88 revealed that her hair was oily, and she felt dirty if she didn't get her shower and stated, "I feel dirty now." She also revealed that she did not refuse her showers and that no one offered her shower this past Saturday. She stated, “They must have been too busy.” During an observation and interview on 08/26/25 at 12:10 PM with Licensed Practical Nurse (LPN) #4, she confirmed that Resident #88 had greasy hair and needed a shower. Resident #88 told LPN #4 that she had not had a shower in over a week, and LPN #4 told her that she would make sure she got a shower after lunch. Record review of Resident #88's "Admission Record" revealed an admission date of 11/19/24 and that she had	F0656		

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F0656 SS = E	Continued from page 18 diagnoses that included Type II Diabetes Mellitus and Bipolar Disorder. Record review of Resident #88's MDS with ARD of 05/14/25 under Section C revealed a BIMS Score of 15 which indicated that she had no cognitive deficits. RESIDENT #94 Record review of Resident #94's "Care Plan Report" date initiated 04/8/25 revealed under focus that she had limited physical mobility and required extensive assistance x (times) 2 (two) with bed mobility, dressing, bathing, and toileting. An observation and interview on 08/25/2025 at 11:53 AM with Resident #94 revealed her lying in bed and she had greasy hair and a mild body odor. Resident #94 revealed that she hadn't had a shower or bath in a week, and she needed one. She revealed that the staff were not giving showers and baths like they were supposed to. During an observation and interview on 08/26/25 at 12:20 PM with Licensed Practical Nurse (LPN) #4, she confirmed that Resident #94 had greasy hair and a mild body odor. LPN #4 revealed that Resident #94's bath/shower days were Mondays, Wednesdays and Fridays and that she should have gotten a shower yesterday. Record review of Resident #94's "Admission Record" revealed an admission date of 03/21/25 and that she had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction. Record review of Resident #94's MDS with ARD of 06/25/25 under Section C revealed a BIMS Score of 15 which indicated that she had no cognitive deficits. Resident #102 Record review of the “Care plans” date initiated 08/29/25 for Resident #102 revealed under, “Goals: I will maintain my current level of ADL (activities of daily living) status.” Also revealed under, “Interventions: extensive assist”. Observations on 08/25/25 at 11: 00 AM and on 08/26/25 at 11:02 AM, revealed that Resident #102 had long fingernails approximately one-half inch long past the nail bed on both hands with a brown substance underneath.	F0656		

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F0656 SS = E	Continued from page 19 During an observation and interview on 08/27/25 at 8:55 AM with the Administrator (ADM), she confirmed that Resident #102 had long fingernails with a brown substance underneath. She revealed that nail care should be completed by CNAs during their bath/shower times. Record review of the “Admission Record” revealed the facility admitted Resident #102 on 08/04/25 with a medical diagnosis that included Major Depressive Disorder and Acquired Absence of Left Leg Below Knee. Record review of the MDS with an ARD of 08/13/25 revealed under section C, a BIMS summary score of 15, indicating Resident #102 was cognitively intact. An interview with the MDS Nurse #1 on 08/27/25 at 10:30 AM revealed the purpose of the care plan was to let staff know what was going on with the residents and what interventions were needed. She explained the care plan was a way of communicating with the staff. She confirmed Resident #6, 16, 88, 94, and 102's care plans were not followed related to personal hygiene. Resident #106 Review of Resident #106's “Care Plans” revealed under, “Focus: I complain of chronic pain and acute pain to different areas of my body, I have dx (diagnosis) of polyarthritis.” Also revealed under, “Interventions: Give meds as order for pain: Fentanyl patch.” On 8/25/2025 at 10:55 AM, an observation and interview with Resident #106 revealed he was lying in bed and reported experiencing chronic pain every day. The resident stated, "I hurt in 26 different areas on my body." He explained he had been using fentanyl patches for about 19 months and took gabapentin and oxycodone twice daily to help manage his pain. The resident further reported he also used lidocaine patches, bio freeze, and Tylenol as needed. He explained that a nurse on the 3-11 shift repeatedly failed to apply his fentanyl patch as ordered, and he had not received it correctly on four separate occasions during his stay. The resident stated, “The last time she neglected to apply my patch was on August 5th; I didn’t get it until August 6th, after I reported it, which was 14 hours later.” Record review of the July and August 2025 “Medication Administration Record (MAR)” for Resident #106 revealed an order dated 7/24/25, “Fentanyl transdermal patch 72-hour 75 MCG (microgram)/HR (hour) apply 1 patch	F0656		

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F0656 SS = E	Continued from page 20 trans dermally every 72 hours for pain unspecified and remove per schedule." Record review of Resident #106's Fentanyl "Controlled Drug Record" confirmed a dose was not signed out on 7/30 and 8/5, indicating he did not receive the patch as ordered. On 8/27/25 at 7:55 AM, an interview with Registered Nurse (RN) #2 on 8/27/25 at 7:55 AM confirmed Resident #106 missed fentanyl doses on 7/30 and 8/5. An interview with MDS Nurse #1 on 8/27/25 at 11:57 AM revealed the care plan was not followed to give the fentanyl patch as ordered for pain management. Record review revealed the facility admitted Resident #106 on 7/18/25 with medical diagnoses that included Unspecified Injury at Unspecified Level of Cervical Spinal Cord, Hereditary and Idiopathic Neuropathy, Chronic Pain, and Polyosteoarthritis. Record review of the MDS with an ARD of 7/25/25 revealed under section C, a BIMS summary score of 15, indicating Resident #106 was cognitively intact.	F0656		
F0677 SS = E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide basic hygiene care by not ensuring that a dependent resident received showers (Resident #88 and Resident #94) and routine nail care (Resident #6, Resident #16, and Resident #102) for five (5) of eight (8) residents reviewed for activities of daily living (ADLs). Findings Include Review of the facility policy titled "Fingernails/Toenails Care" unrevised, revealed, "Policy: The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections."	F0677		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULEVILLE NURSING AND REHABILITATION CENTER LLC	800 STANSEL DR P O BOX 368, RULEVILLE, Mississippi, 38771

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F0677 SS = E	Continued from page 21 Record review of undated facility policy, "Bath/Shower-Dependent" revealed, "A bath (shower/tub) for cleanliness and comfort is scheduled at least weekly for each resident." Resident #6 An observation and interview with Resident #6 on 8/25/2025 at 11:12 AM in the resident's room, he held out his right hand and stated, "I have claws," and voiced that he needed his nails trimmed. He explained he had been trying to get someone to help him for a couple of days. The resident's nails were long, approximately 3/8 (three-eighths) of an inch in length from the fingertip. His left fingers were contracted and turned inward toward his palm. Record review of the August 2025 "Treatment Administration Record" revealed no indication of nail care orders for Resident #6. An observation and interview with Registered Nurse (RN) #2 on 8/25/25 at 11:31 AM confirmed Resident #6 had long nails. She stated the resident was diabetic and that his nails had to be trimmed by a nurse. She revealed his nails should be checked weekly to determine if they needed cutting and confirmed that he could develop an infection or skin breakdown on his contracted hand from long nails. Record review of the "Admission Record" revealed the facility admitted Resident #6 on 4/23/19 with a medical diagnosis that included Type 2 Diabetes Mellitus without Complications. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/5/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #6 was cognitively intact. RESIDENT #16 An observation on 08/25/25 at 2:00 PM and again on 08/26/25 at 8:38 AM, revealed that Resident #16 had long fingernails approximately one-half inch long on both hands with a brown substance underneath. During an observation and interview on 08/26/25 at 4:55 PM with Certified Nursing Assistant (CNA) #4, she confirmed that Resident #16 had long fingernails with a brown substance underneath. CNA #4 revealed that long, dirty fingernails could cause infection and stated,	F0677		

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F0677 SS = E	Continued from page 22 “She could scratch herself.” During an observation and interview on 08/26/25 at 5:00 PM with Licensed Practical Nurse (LPN) #3, she confirmed that Resident #16 had long fingernails with a brown substance underneath. She revealed that nail care should be completed by CNAs during their bath/shower times. LPN #3 also revealed that fingernails should be cleaned every day and as needed. Record review of Resident #16's "Admission Record" revealed an admission date of 01/18/19 and that she had diagnoses that included Bipolar Disorder and Hemiplegia and Hemiparesis following Cerebral Infarction. Record review of Resident #16's MDS with ARD of 08/13/25 under Section C revealed a BIMS score of 15 which indicated that she was cognitively intact and under Section GG that she was dependent with her personal hygiene needs. RESIDENT #88 An observation and interview on 08/26/2025 at 9:18 AM with Resident #88 she stated that her hair was oily, and she felt dirty if she didn't get her shower and stated, "I feel dirty right now." This observation confirmed that the resident’s hair appeared greasy. She stated that she washed her hair every time she showered and said that she had not had a shower or bath since last Tuesday, 08/19/25. She revealed that she normally got her shower on Tuesdays, Thursdays, and Saturdays. She also revealed that she did not refuse her showers and that no one offered her a shower this past Saturday. She stated, “They must have been too busy.” An interview on 08/26/25 at 12:00 PM with Resident #88, revealed that the CNA’s sometimes told her that they were too busy to help her with a shower. An observation and interview on 08/26/25 at 12:08 PM with CNA #5, confirmed that Resident #88’s hair appeared greasy and that she should receive her showers on Tuesdays, Thursdays and Saturdays. During an observation and interview on 08/26/25 at 12:10 PM with LPN #4, she confirmed that Resident #88 had greasy hair and needed a shower. An observation also revealed Resident #88 report to LPN #4 that she had not had a shower in over a week. Record review of Resident #88's "Admission Record" revealed an admission date of 11/19/24 and that she had diagnoses that included Type II Diabetes Mellitus and	F0677		

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F0677 SS = E	Continued from page 23 Bipolar Disorder. Record review of Resident #88's MDS with ARD of 05/14/25 under Section C revealed a BIMS Score of 15 which indicated that she had no cognitive deficits and in Section GG that she required supervision or touching assistance with showering and bathing. RESIDENT #94 An observation and interview on 08/25/25 at 11:53 AM and again on 8/26/25 at 11:13 AM with Resident #94 revealed she had a mild body odor and hair that appeared greasy. Resident #94 revealed that staff were not giving baths like they were supposed to, and it had been about a week since she had one. She stated she was supposed to take a bath or shower yesterday but did not. During an observation and interview on Tuesday, 08/26/25, at 12:20 PM with LPN #4, she confirmed that Resident #94 had greasy hair and a mild body odor and confirmed that she should have received one yesterday. Record review of Resident #94's "Admission Record" revealed an admission date of 03/21/25 and that she had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction. Record review of Resident #94's MDS with ARD of 06/25/25 under Section C revealed a BIMS score of 15 which indicated that she had no cognitive deficits and Section GG that she was dependent with her bathing/showering and personal hygiene needs. RESIDENT #102 An observation on 08/25/25 at 11:00 AM and again on 08/26/25 at 11:02 AM, revealed that Resident #102 had long fingernails approximately one-half inch long on both hands with a brown substance underneath. During an observation and interview on 08/25/25 at 11:05 AM with CNA #2, she confirmed that Resident #102 had long fingernails with a brown substance underneath. She revealed that his long, dirty fingernails could cause infection and stated, “He could scratch himself.” During an observation and interview on 08/27/25 at 8:55 AM with the Administrator (ADM), she confirmed that Resident #102 had long fingernails with a brown substance underneath. She revealed that nail care should be completed by CNAs during their bath/shower times.	F0677		

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F0677 SS = E	Continued from page 24 Record review of Resident #102's "Admission Record" revealed an admission date of 8/04/25 and that he had diagnoses that included Major Depressive Disorder and Acquired Absence of Left Leg Below Knee. Record review of Resident #102's MDS with ARD of 8/13/25 under Section C revealed a BIMS Score of 15 which indicated that he was cognitively intact and in Section GG that he was substantial/maximal assistance with his personal hygiene needs.	F0677		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to provide restorative nursing services for residents with contractures for two (2) of 31 sampled residents. Resident #16 and Resident #94. Findings Include: Review of the facility policy, "Range of Motion" revealed that "A range of motion program will be developed for a resident as indicated.....Purposes of ROM (Range of Motion) 1. Maintain or improve joint and soft tissue mobility. 2 Minimize contractures...." RESIDENT #16 An observation and interview on 08/25/25 at 2:45 PM with Resident #16, revealed her sitting in her wheelchair in the dining room. She had a contracture to her left wrist/hand and there was no orthotic device in use. An observation on 08/26/25 at 8:38 AM revealed Resident #16 lying in bed in her room. She had contracture to her left wrist/hand, and she had no orthotic device in place. She revealed that they sometimes rolled a towel	F0684		

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F0684 SS = D	Continued from page 25 and put it in her hand, but she couldn't remember the last time they applied it. Record review of Resident #16's "Occupational Therapy Discharge Summary" revealed that she discharged from therapy services on 01/10/25 with an orthotic. "RNP (Restorative Nursing Program) staff trained on performance of PROM (Passive Range of Motion) exercises as well as donning/doffing orthotic with nursing staff verbalizing understanding and providing return demonstration with 100% accuracy...." Record review of Resident #16's "Admission Record" revealed an admission date of 01/18/19 and that she had diagnoses that included Bipolar Disorder and Hemiplegia and Hemiparesis following Cerebral Infarction. Record review of Resident #16's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/13/25 under Section C revealed a BIMS Score of 15 which indicated that she was cognitively intact. RESIDENT #94 An observation and interview on 08/25/2025 at 11:53 AM with Resident #94 revealed her lying in bed feeding herself lunch using her right hand. She had a contracture to her left wrist/hand and there was no orthotic device in place. She revealed that they used to put something in her hand to help keep it open, but it had been over a month since they used it. Record review of Resident #94's "Occupational Therapy Discharge Summary" revealed that she discharged from therapy services on 05/14/25. "RNP (Restorative Nursing Program) has been established for orthotic wear/management which will maintain current ROM (Range of Motion) and reduce risk for further contracture." Record review of Resident #94's "Admission Record" revealed an admission date of 03/21/25 and that she had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction. Record review of Resident #94's MDS with ARD of 06/25/25 under Section C revealed a BIMS score of 15 which indicated that she had no cognitive deficits. An interview on 08/26/25 at 3:55 PM with the Director of Nurses (DON) revealed that once they received recommendations from the therapy department, it was the restorative department's responsibility to carry them out. She revealed that if recommendations included an orthotic device, an order needed to be put in place to	F0684		

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F0684 SS = D	Continued from page 26 include how to apply the device, when to put it on, how long to leave it and when to take it off. The DON reviewed the recommendations from the therapy department for Resident #16 and Resident #94 and confirmed that there were no orders in the system for orthotics and that the orthotics had not been implemented per recommendations. She revealed that they needed a better system and better communication between the departments to prevent any further recommendations from being missed. The DON agreed that failing to apply the orthotic devices for Residents #16 and #94 could result in a decline in range of motion, mobility, and worsening contractures. An interview on 08/26/25 at 4:16 PM with Occupational Therapy (OT), revealed that once a resident was discharged from therapy services, they referred them to restorative or to the functional maintenance program. She revealed that they instructed the staff on how to apply devices per recommendation and instructed them on the range of motion exercises. OT revealed that they made recommendations per specific needs of the residents, that devices be applied 3-5 days a week for so many hours per day per individual resident tolerance. She revealed that Resident #94 was discharged from therapy on 05/14/25 with recommendations for restorative caregivers to apply orthotic to contracted left wrist/hand to maintain current range of motion and prevent further contracture. OT revealed that Resident #16 was discharged from therapy on 01/10/25 with recommendations to continue orthotic/hand roll to the left hand. An interview on 08/26/25 at 4:30 PM with Restorative Licensed Practical Nurse (LPN), revealed that when a resident discharged from therapy for restorative services with a splint or other device, they go by the recommendations. She revealed that she did not put orders into the computer, that they communicated on paper. Restorative LPN confirmed that she did not have Resident #16 or Resident #94 on her current caseload list and was not aware of the prior recommendations for orthotic devices. She agreed that not following the recommendations for orthotics could result in decrease range of motion and worsening contractures.	F0684		
F0697 SS = G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is	F0697		

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F0697 SS = G	Continued from page 27 provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure a resident received treatment and services to manage pain as evidenced by the facility failing to administer fentanyl patches as ordered for one (1) of five (5) medication reviews (Resident #106). This failure resulted in missed doses of prescribed pain medication and escalating pain levels causing actual harm through unnecessary suffering. Resident #106 Findings Include: Review of the facility policy titled “Pain Evaluation/Management” reviewed 8/25 revealed under, “Policy: All residents will be evaluated for pain at the time of administration, readmission, quarterly and as needed.” An interview on 8/25/2025 at 10:55 AM with Resident #106 revealed he hurt in 26 different areas of his body and had chronic pain every day. He explained he had been using fentanyl patches for about 19 months and took gabapentin and oxycodone twice daily to help manage his pain. The resident further reported he also used lidocaine patches, bio freeze, and Tylenol as needed. He explained that a nurse on the 3-11 shift repeatedly failed to apply his fentanyl patch as ordered, and he had not received it correctly on four separate occasions during his stay. The resident stated, “The last time she neglected to apply my patch was on August 5th; I didn’t get it until August 6th, after I reported it, which was 14 hours later.” Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/25/25 revealed under section J, Resident #106 experienced occasional pain during the 5-day look back period and rated his worst pain as an 8 on a scale of 0 (no pain) to 10 (worst pain). Record review of the July 2025 “Medication Administration Record (MAR)” for Resident #106 revealed an order dated 7/24/25: “Fentanyl transdermal patch 72-hour 75 mcg (microgram)/hr. (hour), apply 1 patch	F0697		

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F0697 SS = G	Continued from page 28 transdermal every 72 hours for pain unspecified and remove per schedule." The patch was due to be changed on 7/30/25 at 8:00 PM and was documented as administered. Record review of Resident #106's Fentanyl "Controlled Drug Record" revealed a dose was not signed out on 7/30/25, indicating he did not receive the fentanyl patch as ordered and missed this dose. The next dose was administered on 8/2/25. Record review of the August 2025 "Medication Administration Record (MAR)" for Resident #106 revealed and order dated 7/24/25: "Fentanyl transdermal patch 72-hour 75 mcg (microgram)/hr. (hour), apply 1 patch transdermal every 72 hours for pain unspecified and remove per schedule." The patch was due to be changed on 8/5/25 at 8:00 PM and was documented as administered. Record review of Resident #106's Fentanyl "Controlled Drug Record" revealed a dose was not signed out on 8/5/25, indicating he did not receive the patch as ordered. Record review of the August 2025 MAR revealed the fentanyl order was revised on 8/6/25 to be applied every 72 hours at 9:00 AM, and a patch was applied that morning. An interview with Registered Nurse (RN) #2 on 8/27/25 at 7:55 AM confirmed Resident #106 missed fentanyl doses on 7/30/25 and 8/5/25, which the resident himself reported. She acknowledged physician orders were not followed and stated she notified the physician, who changed the order to day shift administration effective 8/6/25. RN #2 further admitted the missed doses could have caused the resident increased pain and confirmed she reported the incident to the Director of Nursing (DON). Record review of Resident #106's July 2025 "Medication Administration Record (MAR)" revealed a documented pain level on 7/30/25 of 4 out of 10. Record review of the August 2025 "MAR" revealed the following documented pain levels; On 8/1 pain 5 out of 10, on 8/2 pain 5 out of 10, and on 8/5 pain 10 out of	F0697		

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F0697 SS = G	Continued from page 29 10, aligning with the missed or delayed administration of fentanyl. An interview with the Director of Nursing (DON) on 8/27/25 at 8:06 AM revealed she was unaware Resident #106 had missed fentanyl doses. She stated her understanding was the administration time was changed because the patch had to be ordered from the pharmacy, which was what RN #2 told her. She acknowledged after reviewing Resident #106's narcotic record, the fentanyl patches were available, and the nurse failed to administer it. The DON confirmed the physician orders were not followed and acknowledged this could have caused Resident #106 increased pain. An interview with the Administrator on 8/27/25 at 12:02 PM revealed she was not aware Resident #106 had missed fentanyl doses or voiced concerns. She stated her expectation was that nurses administer medications exactly as ordered and sign off immediately after giving them. She acknowledged the resident could have experienced increased pain due to the missed fentanyl doses. Record review of the “Admission Record” revealed the facility admitted Resident #106 on 7/18/25 with medical diagnoses that included Unspecified Injury at Unspecified Level of Cervical Spinal Cord, Hereditary and Idiopathic Neuropathy, Chronic Pain, and Polyosteoarthritis. Record review of the Minimum Data Set (MDS) with an ARD of 7/25/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #106 was cognitively intact.	F0697		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F0842		

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F0842 SS = D	Continued from page 30 §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	F0842		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = D	Continued from page 31 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to maintain accurate medical records for one (1) of five (5) medication reviews. Resident #106 Findings include: Review of the facility policy titled “Medication Administration -General Guidelines” revised 8/16 revealed under, “Policy: Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so.” Also revealed under, “Procedure: … 9... This individual records the administration on the resident’s MAR/eMAR (medication administration record) and TAR/eTAR (treatment administration record) after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR/TAR to ascertain that all necessary doses were administered and all administered doses were documented...” During an interview with Resident #106 on 8/25/2025 at 10:55 AM, he revealed he had a problem with a nurse on 3-11 shift not applying his fentanyl patch and stated he was not getting it like he should be. He explained that he did not get his fentanyl patch correctly four (4) separate times since he had been at the facility. The resident stated, “The last time she neglected to	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

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F0842 SS = D	Continued from page 32 apply my patch was on August 5th; I didn't get it until August 6th." Record review of the July 2025 "Medication Administration Record (MAR)" for Resident #106 revealed an order dated 7/24/25, "Fentanyl transdermal patch 72-hour 75 MCG (microgram)/HR (hour) apply 1 patch transdermal every 72 hours for pain unspecified and remove per schedule" which was due to be changed 7/30/25 and was initialed on the MAR as administered. Record review of Resident #106's Fentanyl "Controlled Drug Record" revealed a dose was not signed out on 7/30/25, which indicated he did not receive the fentanyl on this day as ordered. Record review of the August 2025 "Medication Administration Record (MAR)" for Resident #106 revealed an order dated 7/24/25, "Fentanyl transdermal patch 72-hour 75 MCG (microgram)/HR (hour) apply 1 patch transdermal every 72 hours for pain unspecified and remove per schedule" which was due to be changed on 8/5 was initialed on the MAR as given. Record review of Resident #106's Fentanyl "Controlled Drug Record" revealed a dose was not signed out on 8/5/25, which indicated he did not receive the fentanyl on this day as ordered. During an interview with the Director of Nursing (DON) on 8/27/25 at 8:06 AM revealed after reviewing Resident #106's fentanyl narcotic record she confirmed the patch was not given on 7/30 and 8/5 but was signed off on the medication record as given. She stated medications should not be signed as administered if they were not and confirmed this was inaccuracy of the resident's medical record. During an interview with the Administrator on 8/27/25 at 12:02 PM, she revealed her expectations were for the nurses to give the medications as ordered and sign off on the medication record immediately after giving them. She agreed Resident #106's medical record would not be accurate. Record review of the "Admission Record" revealed the facility admitted Resident #106 on 7/18/25 with medical diagnoses that included Unspecified Injury at Unspecified Level of Cervical Spinal Cord, Hereditary and Idiopathic Neuropathy, Chronic Pain, and Polyosteoarthritis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/25/25 revealed	F0842		

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F0842 SS = D	Continued from page 33 under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #106 was cognitively intact.	F0842		