STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	Initial Comments The State Agency (SA) conducted an Annual Recertification survey and six (6) Complaint Investigations CI MS #472523, CI MS #472548, CI MS #472549, CI MS #472552, CI MS #2576008, and Facility Reported Incident (FRI) CI 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 Minimum Standards for Institutions for the Aged or Infirm and cited M500, M610, M625, and M735. The SA identified non-compliance and cited M500 regarding resident rights for CI MS #472523, CI MS #2576008 and CI MS #2600431. The SA investigated CI MS# 472548, MS #472549, and MS #472552 with no deficiencies cited. The census at the time of the survey was 104 and the facility was licensed for 111 beds	M0000		
M0500	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; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse	M0500		

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

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M0500	Continued from page 1 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 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	M0500		

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M0500	Continued from page 2 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 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	M0500		

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M0500	Continued from page 3 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. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III 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 (Resident #3), unresolved grievance (Anonymous Resident), free from pain (Resident #106) for two (2) of five (5) residents reviewed for Resident Rights. Resident #3, #106 and Anonymous Resident Findings Include Resident #3 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	M0500		

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M0500	Continued from page 4 #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 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	M0500		

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M0500	Continued from page 5 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. 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. Grievances Anonymous Resident 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 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.	M0500		

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M0500	Continued from page 6 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. Resident #106 Pain 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 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.	M0500		

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M0500	Continued from page 7 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 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	M0500		

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M0500	Continued from page 8 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.	M0500		
M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Pattern Based on observation, resident and staff interviews, record review, and facility policy review, the facility	M0610		

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M0610	Continued from page 9 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 review for activities of daily living (ADLs). Resident #6, #16, #88, #94, and #102 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." 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	M0610		

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M0610	Continued from page 10 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, “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.	M0610		

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M0610	Continued from page 11 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 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	M0610		

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M0610	Continued from page 12 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. 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.	M0610		
M0625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II 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	M0625		

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M0625	Continued from page 13 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 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.	M0625		

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M0625	Continued from page 14 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 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	M0625		

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M0625	Continued from page 15 recommendations for orthotics could result in decrease range of motion and worsening contractures.	M0625		
M0735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge.	M0735		

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M0735	Continued from page 16 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on resident and staff interviews, record review, and facility policy review, the facility failed to maintain accurate medical records on a resident 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 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	M0735		

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M0735	Continued from page 17 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 under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #106 was cognitively intact.	M0735		