STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255172	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARKVILLE MANOR HEALTH CARE AND REHABILITATION CE	**1001 HOSPITAL ROAD , STARKVILLE, Mississippi, 39759**

(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 re-certification survey with two (2) complaint investigations (CI) MS #482439 and CI MS #482443, at the facility from 9/08/25 through 9/10/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F550, F656, F677, F688, and F851.The SA investigated CI MS #482439, a facility reported incident (FRI) related to resident-to-resident sexual abuse and CI MS #482443 related to quality of care with no deficiencies cited. The census at the time of the survey was 106 and the facility is licensed for 119 beds.	F0000		09/22/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550	Root Cause Analysis was conducted by Quality Assurance Performance Improvement (QAPI) Committee on 9/10/2025 and based on findings the facility failed to ensure the dignity of a resident that needed supervision and/or assistance with meals during dining for resident #4. Resident #4 received assistance on 9/9/2025 at next scheduled meal. Quality Review was initiated on 9/9/2025 by the Director of Nursing (DON) and Assistant Director of Clinical Services (ADCS) to review current residents to identify anyone with similar deficits requiring supervision or assistance during mealtimes. All residents have the potential to be affected by this deficient practice. No other residents were identified. Education initiated on 9/9/2025 with current Certified Nursing Assistants and current Licensed nurses by Director of Clinical Services (DCS) and Assistant Director of Clinical Services (ADCS) on this regulation to ensure the dignity of all residents that need supervision and/or assistance with meals during dining. All new hires will receive education upon hire. Quality Assurance Improvement QAPI) meeting was held on 9/10/2025 to ensure the dignity of all residents that	10/08/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255172	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

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F0550 SS = D	Continued from page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the dignity of a resident that needed supervision and/or assistance with meals for one (1) of five (5) residents reviewed during dining. Resident #4. Findings Include During an observation of the lunch tray pass in the dining room on 9/8/25 at 11:52AM, Resident #4 received his lunch tray from staff as he was sitting in his wheelchair at the table. This observation revealed the resident had no use of his right upper extremity. The meal that was provided included chicken stir-fried rice, a roll, watermelon in a small bowl, and a glass of tea. The resident was observed attempting to feed himself with a fork using his left hand. He repeatedly dropped his fork, had difficulty scooping food from the plate to his mouth, and began using his left fingers to eat. Food was observed spilling onto his clothing and the floor and when he picked up his tea glass, his hand was shaking which caused the tea to spill on his t-shirt and pants. He also had difficulty setting the tea glass back on the table and instead rested it on his leg. There was no observed assistance from the five staff members present in the dining room at the time. After attempting to eat with his left hand, he ate only a few bites and left the table by self-propelling himself down the hall with his left hand. An interview on 9/08/25 at 12:10 PM with the Certified Nurse Aide (CNA) #1 confirmed that staff were responsible for supervising residents during mealtimes	F0550	Continued from page 1 need supervision and/or assistance with meals during dining. Director of Clinical Services (DCS) and Assistant Director of Clinical Services (ADCS) began monitoring on 9/9/2025 and will conduct ongoing Quality Monitoring to ensure the dignity of all residents that need supervision and/or assistance with meals during dining four times weekly for four weeks, then three times weekly for three weeks, then weekly for four weeks, then monthly for six months to ensure all solutions are sustained. On 9/30/2025, a QAPI meeting will be held to review our findings from our Quality Monitoring. We will review all findings from our Quality Monitoring on the last Tuesday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six months to ensure our solutions are sustained.	

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F0550 SS = D	Continued from page 2 and acknowledged that if a resident had trouble feeding themselves, staff should help. An interview on 9/09/25 at 1:34 PM with the Rehab Director confirmed that if Resident #4 had trouble feeding himself then staff should have stepped in and assisted. An interview with the Certified Occupational Therapy Assistant (COTA) on 9/9/25 at 1:50 PM revealed that with Resident #4 having to eat with his hands, it was a dignity concern. An interview with the Administrator on 9/09/25 at 2:42 PM revealed that it was her expectation for staff to provide supervision and assistance at mealtimes for residents who required it. A record review of the “Admission Record” revealed the facility admitted Resident #4 on 9/21/20 with medical diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the Right Dominant Side, and Need for Assistance with Personal Care. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/05/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 6, indicating Resident #4 had severely impaired cognition. Section GG revealed the resident had upper extremity impairment in range of motion on one side.	F0550		
F0656 SS = E	Develop/Implement Comprehensive Care Plan 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	F0656	Root Cause Analysis was conducted by Quality Assurance Performance Improvement (QAPI) Committee on 9/10/2025 and based on findings, the facility failed to implement a care plan for the application of a splinting device (Resident #4) and failed to implement a resident's ADL (activities of daily living) care plan related to personal hygiene and grooming (Resident #29). Resident #4 splinting device was applied on 9/9/2025 and resident #29 received ADL care on 9/9/2025. Quality Review was initiated on 9/9/2025 by the Director of Nursing (DON) and Assistant Director of Clinical Services (ADCS) to review current residents who have a care plan for the application of a splinting device. Quality Review was initiated on 9/9/2025 by the Director of Clinical Services (DCS) and the Interdisciplinary Team (IDT) to ensure all dependent residents were provided Activities of Daily Living (ADL) care. All residents have the potential to be affected by this deficient practice.	10/08/2025

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F0656 SS = E	Continued from page 3 (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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, family and staff interviews, record review, and facility policy review, the facility failed to implement a care plan for the application of a splinting device (Resident #4) and failed to implement a resident's ADL (activities of daily living) care plan related to personal hygiene and grooming (Resident #29) for two (2) of 21 resident care plans reviewed. Resident #4 and #29. F656 was cited on the last annual survey, therefore the scope and severity is increased to E. Findings Include: Review of the facility policy titled, "Plans of Care" dated 06/01/25 revealed, "Develop and implement an Individualized Person-Centered comprehensive plan of	F0656	Continued from page 3 Education initiated on 9/9/2025 with current Certified Nursing Assistants and current Licensed nurses by Director of Clinical Services (DCS) and Assistant Director of Clinical Services (ADCS) on this regulation to ensure the implementation of care plans for the application of a splinting device and resident's ADL (activities of daily living) care plan related to personal hygiene and grooming. All new hires will receive education upon hire. Quality Assurance Improvement QAPI) meeting was held on 9/10/2025 to ensure the implementation of care plans for the application of a splinting device and resident's ADL (activities of daily living) care plan related to personal hygiene and grooming were implemented. Director of Clinical Services (DCS) and Assistant Director of Clinical Services (ADCS) began monitoring on 9/9/2025 and will conduct ongoing Quality Monitoring to ensure implementation of care plans for the application of a splinting device and resident's ADL (activities of daily living) four times weekly for four weeks, then three times weekly for three weeks, then weekly for four weeks, then monthly for six months to ensure all solutions are sustained. On 9/30/2025, a QAPI meeting will be held to review our findings from our Quality Monitoring. We will review all findings from our Quality Monitoring on the last Tuesday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six months to ensure our solutions are sustained.	

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F0656 SS = E	Continued from page 4 care by the Interdisciplinary Team.....as determined by the resident's needs or as requested by the resident...." Resident #4 Record review of Resident #4's "Care Plan Report" revealed under, "Focus: I have right dominant side hemiplegia/hemiparesis R/T (related to) CVA (cerebrovascular accident)" Also revealed under, "Interventions: "Resting right hand splint 4 (four) hours daily. CNA (certified nurse aide) to apply and remove, nurse to check. Monitor right hand daily for s/s (signs and symptoms) of skin breakdown before and after splint removal every day shift". On 9/08/25 at 11:52 AM and again on 9/09/25 at 10:32 AM, an observation of Resident #4 revealed he was sitting in his wheelchair without a hand splint. During an interview with Licensed Practical Nurse (LPN) #1 on 9/09/25 at 2:00 PM, he confirmed he did not apply Resident #4's hand splint on 9/8/25 or 9/9/25 and did not follow the plan of care. An interview with the Minimum Data Set (MDS) Nurse on 9/10/25 at 8:40 AM revealed the purpose of the care plan was to ensure the staff performed the care the resident needed. She revealed if Resident #4's splint was not applied his care plan was not followed. Record review of the "Admission Record" revealed the facility admitted Resident #4 on 9/21/20 with medical diagnoses including Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side, and Need for Assistance with Personal Care. Record review of the MDS with an Assessment Reference Date (ARD) of 9/05/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 6, indicating Resident #4 had severely impaired cognition. . Resident #29 Record review of Resident #29's "Care Plan Report" revealed that she was dependent on staff for meeting emotional, intellectual, physical, and social needs and that she had an ADL (Activities of Daily Living) self-care performance deficit and required total	F0656		

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F0656 SS = E	Continued from page 5 assistance with personal hygiene. During an observation and interview on 09/09/25 at 8:05 AM with Resident #29's Resident Representative (RR), she revealed that it had been a while since the staff had washed her (Resident #29) hair. RR revealed that Resident #29's hair was dirty and matted up and stated, "they need to do better." An observation revealed a large amount of thick light brown crusty substance on her scalp, over her entire head and throughout her hair. An observation and interview on 09/09/25 at 8:20 AM with Certified Nursing Assistant (CNA) #2, revealed that she hadn't washed Resident #29's hair in about two weeks. CNA #2 confirmed that Resident #29's hair was matted up and that her hair should be washed and brushed more often. During an observation and interview on 09/09/25 at 9:00 AM with Assistant Director of Nursing (ADON) in Resident #29's room, she confirmed that Resident #29 had a thick brown crusty substance in her hair and confirmed that her hair was matted. The ADON confirmed that personal hygiene included hair washing and grooming and should be completed on bath or shower days unless otherwise indicated, and since Resident #29's hair had not been washed or brushed recently, her care plan was not followed. An interview with MDS Nurse, on 09/10/25 at 8:45 AM, revealed that it was their expectation for residents to get their hair washed on their scheduled shower days three times a week unless otherwise specified. She confirmed that since Resident #29's hair had not been washed on a regular basis, her care plan was not followed. Record review of Resident #29's "Admission Record" revealed an admission date of 07/15/21 and that she had diagnoses that included Unspecified Dementia, Parkinson's Disease, and Need for Assistance with Personal Care. Record review of Resident #29's MDS with an ARD of 07/30/25 under Section C, revealed a BIMS score of 03 which indicated that she had severe cognitive deficits.	F0656		
F0677 SS = E	ADL Care Provided for Dependent Residents	F0677	Root Cause Analysis was conducted by Quality Assurance	10/08/2025

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F0677 SS = E	Continued from page 6 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, interview, record review and facility policy review, the facility failed to provide assistance with meals (Resident #4) and failed to provide personal hygiene and grooming for a dependent resident (Resident #29) for two (2) of 106 residents residing in the facility. Resident #4 and Resident #29. F677 was cited on the last annual survey, therefore the scope and severity was increased to "E". Findings Include: Review of the facility policy "Activities of Daily Living (ADLs)" dated 06/01/25 revealed, "...Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care....4. Eating to include meals and snacks...." Resident #4 An observation on 9/8/25 at 11:52AM in the dining room revealed Resident #4 sitting in his wheelchair at the table, with no use of his right upper extremity. He was provided a meal of chicken stir-fried rice, a roll, watermelon in a small bowl, and a glass of tea. The resident was observed attempting to feed himself with a fork using his left hand. He repeatedly dropped his fork, had difficulty scooping food from the plate to his mouth, and began using his left fingers to eat. Food was observed spilling onto his clothing and the floor and when he picked up his tea glass, his hand was shaking which caused the tea to spill on his t-shirt and pants. He also had difficulty setting the tea glass back on the table and instead rested it on his leg. There was no observed assistance from the five staff members present in the dining room at the time. After attempting to eat with his left hand, he ate only a few bites and left the table by self-propelling himself down the hall with his left hand. An observation and interview with Resident #4 on 9/08/25 at 12:05 PM revealed he was sitting in his wheelchair and propelling himself toward his room. When	F0677	Continued from page 6 Performance Improvement (QAPI) Committee on 9/10/2025 and based on findings, the facility failed to provide assistance with meals (Resident #4) and failed to provide personal hygiene and grooming for a dependent resident (Resident #29). Resident #4 received assistance on 9/9/2025 at next scheduled meal and resident #29 received ADL care on 9/9/2025. Quality Review was initiated on 9/9/2025 by the Director of Nursing (DON) and Assistant Director of Clinical Services (ADCS) to review current residents to identify anyone with similar deficits requiring supervision or assistance during mealtimes. Quality Review was initiated on 9/9/2025 by the Director of Clinical Services (DCS) and the Interdisciplinary Team (IDT) to ensure all dependent residents were provided Activities of Daily Living (ADL) care. All residents have the potential to be affected by this deficient practice. Education initiated on 9/9/2025 with current Certified Nursing Assistants and current Licensed nurses by Director of Clinical Services (DCS) and Assistant Director of Clinical Services (ADCS) on providing assistance with meals and providing personal hygiene and grooming for dependent residents. All new hires will receive education upon hire. Quality Assurance Improvement QAPI) meeting was held on 9/10/2025 to ensure assistance is provided with meals and that personal hygiene and grooming is provided for dependent residents. Director of Clinical Services (DCS) and Assistant Director of Clinical Services (ADCS) began monitoring on 9/9/20252 and will conduct ongoing Quality Monitoring to ensure assistance is provided with meals and that personal hygiene and grooming is provided for dependent residents four times weekly for four weeks, then three times weekly for three weeks, then weekly for four weeks, then monthly for six months to ensure all solutions are sustained. On 9/30/2025, a QAPI meeting will be held to review our findings from our Quality Monitoring. We will review all findings from our Quality Monitoring on the last Tuesday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six months to ensure our solutions are sustained.	

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F0677 SS = E	Continued from page 7 asked whether he got enough to eat, the resident shook his head “No.” An interview on 9/08/25 at 12:10 PM with the Certified Nurse Aide (CNA) #1 confirmed that staff were responsible for supervising residents during mealtimes and acknowledged that if a resident had trouble feeding themselves, staff should help. She stated that Resident #4 could feed himself. An interview on 9/09/25 at 1:34 PM with the Rehab Director confirmed that Resident #4 had returned from the hospital recently with a physical decline and admitted that he was on the occupational therapy caseload. She explained that he had positioning concerns due to his stroke. The Rehab Director stated the resident should be allowed to feed himself, but if he had trouble, staff should step in and assist. She confirmed the resident could lose weight if he missed meals and stated the dining room staff should have intervened. An interview with the Administrator on 9/09/25 at 2:42 PM acknowledged Resident #4 could lose weight if staff failed to assist if he was having trouble. She revealed that it was her expectation for staff to provide supervision and assistance at mealtimes for residents who required it. A record review of the “Admission Record” revealed the facility admitted Resident #4 on 9/21/20 with medical diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting the Right Dominant Side, and Need for Assistance with Personal Care. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/05/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 6, indicating Resident #4 had severely impaired cognition. Section GG revealed the resident had upper extremity impairment in range of motion on one side. Resident #29 On 09/09/25 at 8:05 AM during an observation and interview with Resident #29'and her Resident Representative (RR), the resident was sitting in her wheelchair, and the RP was using a comb with a pan of soapy water to comb through the resident’s hair. The RR stated that it had been a while since the staff had	F0677		

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F0677 SS = E	Continued from page 8 brushed or washed her (Resident #29) hair. She revealed that Resident #29's hair was dirty and matted up and stated, "they need to do better." An observation of Resident #29's hair confirmed there was a large amount of a thick light brown crusty substance to the resident's scalp, over her entire head and throughout her hair with matted knots of hair. The RR revealed she was trying to comb out the knots and remove the brown substance from her hair and stated, "She has beautiful hair and I'm thinking about cutting it because of this." The RR then revealed that this was not the first time this had happened and admitted that she had given them the opportunity to wash her hair, but they did not. She revealed that when she reports this to the staff, they take care of it for a moment and then it gets back like it was. An observation and interview on 09/09/25 at 8:20 AM with CNA #2 she stated, "Her daughter will let me know when she wants it done." She admitted that it had been two weeks since she had washed Resident #29's hair. She then confirmed that Resident #29's hair was matted up and had a large amount of brown crusty substance on her scalp and throughout her hair and admitted that it should be washed and brushed more often. An observation of Resident #29 and interview with the Assistant Director of Nursing (ADON) on 9/9/25 at 9:00 AM confirmed the resident had a thick brown crusty substance on her scalp and throughout her hair and that her hair was matted. She stated, "This is not okay". She admitted that the crusty buildup on Resident #29's head could cause itching and the skin to break down. She also revealed that hair washing should be completed during bath or shower time as part of her grooming needs. Record review of Resident #29's "Admission Record" revealed an admission date of 07/15/21 and that she had diagnoses that included Unspecified Dementia, Parkinson's Disease, and Need for Assistance with Personal Care. Record review of Resident #29's MDS with an ARD of 07/30/25 under Section C, revealed a BIMS score of 03 which indicated that she had severe cognitive deficits and under Section GG revealed that she was dependent on staff to provide personal hygiene.	F0677		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility	F0688	Root Cause Analysis was conducted by Quality Assurance Performance Improvement (QAPI) Committee on 9/10/2025	10/08/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255172	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARKVILLE MANOR HEALTH CARE AND REHABILITATION CE	1001 HOSPITAL ROAD , STARKVILLE, Mississippi, 39759

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F0688 SS = D	Continued from page 9 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure a resident with a contracture received the necessary treatment and services to prevent a decline in range of motion (ROM), as evidenced by the failure to apply a physician-ordered hand splint for one (1) of four (4) residents reviewed for ROM. Resident #4 Findings Include: The facility provided a statement on letterhead dated 9/10/25 and signed by the Administrator, “We do not have a specific policy related to splints.” Record review of Resident #4’s September 2025 “Treatment Administration Record (TAR)” revealed an order dated 4/15/25: “Resting right hand splint 4 (four) hours daily. CNA (Certified Nurse Aide) to apply and remove, nurse to check. Monitor right hand daily for s/s (signs and symptoms) of skin breakdown before and after splint removal every day shift” and was documented that the splint was applied at 9:00 AM on 9/8/25 and 9/9/25. An observation of Resident #4 on 9/08/25 at 11:52 AM and again on 9/09/25 at 10:32 AM revealed he was sitting in his wheelchair without a hand splint.	F0688	Continued from page 9 and based on findings, the facility failed to ensure a resident with a contracture received the necessary treatment and services to prevent a decline in range of motion (ROM), as evidenced by the failure to apply a physician-ordered hand splint (Resident #4). Resident #4 splinting device was applied on 9/9/2025. Quality Review was initiated on 9/9/2025 by the Director of Nursing (DON) and Assistant Director of Clinical Services (ADCS) to ensure that residents with a contracture receive the necessary treatment and services to prevent a decline in range of motion (ROM) and physicians’ orders are followed. All residents have the potential to be affected by this deficient practice. Education initiated on 9/9/2025 with current Certified Nursing Assistants and current Licensed nurses by Director of Clinical Services (DCS) and Assistant Director of Clinical Services (ADCS) on ensuring that residents with a contracture receive the necessary treatment and services to prevent a decline in range of motion (ROM) and physicians’ orders are followed. Quality Assurance Improvement QAPI) meeting was held on 9/10/2025 to ensure that residents with a contracture receive the necessary treatment and services to prevent a decline in range of motion (ROM) and physicians’ orders are followed. Director of Clinical Services (DCS) and Assistant Director of Clinical Services (ADCS) began monitoring on 9/9/2025 and will conduct ongoing Quality Monitoring to ensure that residents with a contracture receive the necessary treatment and services to prevent a decline in range of motion (ROM) and physicians orders are followed four times weekly for four weeks, then three times weekly for three weeks, then weekly for four weeks, then monthly for six months to ensure all solutions are sustained. On 9/30/2025, a QAPI meeting will be held to review our findings from our Quality Monitoring. We will review all findings from our Quality Monitoring on the last Tuesday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six months to ensure our solutions are sustained.	

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F0688 SS = D	Continued from page 10 An interview with CNA #3 on 9/09/25 at 1:31 PM revealed she was assigned to Resident #4 today. She stated the resident had not been wearing a hand splint and she was not aware she was supposed to apply one. An interview with the Rehab Director on 9/09/25 at 1:38 PM revealed Resident #4's hand splint was ordered during a previous therapy session to prevent his right-hand contracture from worsening. She explained that the occupational therapist (OT) had trained and educated staff on how to apply the splint before the resident's therapy discharge. She confirmed that if the resident was not wearing the splint, his contracture could worsen. Record review of Resident #4's "Therapy Follow-Up Recommendation" dated 4/10/25 confirmed under "Overall Goals: Prevent contractures in right hand and place hand in optimal functional position." Documentation revealed that the occupational therapist conducted a staff in-service training on applying the hand splint, with staff signatures recorded. An interview with Licensed Practical Nurse (LPN) #1 on 9/09/25 at 2:00 PM confirmed he did not apply Resident #4's hand splint on 9/8 or 9/9. He acknowledged signing the treatment administration record (TAR) and explained there was miscommunication regarding who was responsible for applying the splint. He confirmed that not applying the splint as ordered could cause worsening contractures. An interview with the Administrator on 9/09/25 at 2:42 PM revealed her expectation was for splinting devices to be applied according to physician orders. Record review of the "Admission Record" revealed the facility admitted Resident #4 on 9/21/20 with medical diagnoses including Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side, and Need for Assistance with Personal Care. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/05/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 6, indicating Resident #4 had severely impaired cognition. Section GG also revealed upper extremity impairment in range of motion on one side.	F0688		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5)	F0851	Root Cause Analysis was conducted by Quality Assurance Performance Improvement (QAPI) Committee on 9/10/2025 and based on findings, the facility failed to ensure	10/08/2025

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F0851 SS = F	Continued from page 11 §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.	F0851	Continued from page 11 complete and accurate staffing data was submitted to the Centers for Medicare & Medicaid Services (CMS) through Payroll-Based Journal (PBJ) reporting during Quarter 3 of Fiscal Year (FY) 2025 (April 1 – June 30). The facility reviewed and reconciled all staffing data for the affected reporting period. No residents were negatively impacted by this deficiency. A full audit of all PBJ submissions from the past three quarters were completed to verify accuracy and timeliness on 9/9/2025 by the Director Healthcare Analytics & Reporting. No additional residents were identified as being affected. The Executive Director and Human Resource Director will jointly complete weekly reconciliation of hours worked versus hours entered into PeopleNet and PBJ beginning on 9/9/2025. Quality Assurance Improvement QAPI) meeting was held on 9/10/2025 to ensure complete and accurate staffing data is submitted to the Centers for Medicare & Medicaid Services (CMS) through Payroll-Based Journal (PBJ). Director Healthcare Analytics & Reporting began monitoring on 9/9/2025 and will conduct ongoing Quality Monitoring to ensure complete and accurate staffing data is submitted to the Centers for Medicare & Medicaid Services (CMS) four times weekly for four weeks, then three times weekly for three weeks, then weekly for four weeks, then monthly for six months to ensure all solutions are sustained. On 9/30/2025, a QAPI meeting will be held to review our findings from our Quality Monitoring. We will review all findings from our Quality Monitoring on the last Tuesday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for six months to ensure our solutions are sustained.	

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F0851 SS = F	Continued from page 12 §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure complete and accurate staffing data was submitted to the Centers for Medicare & Medicaid Services (CMS) through Payroll-Based Journal (PBJ) reporting during Quarter 3 of Fiscal Year (FY) 2025 (April 1 – June 30). Findings include: Review of the facility policy titled, “Payroll Based Journal,” implemented 6/1/25, revealed: “Policy: It is the policy of the facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS...” Review of the facility’s PBJ Staffing Data Report revealed the facility triggered for low weekend staffing for FY Quarter 3 2025 (April 1 – June 30). Review of the PBJ hours submitted for 6/8/25, 6/15/25, 6/22/25, and 6/28/25 revealed fewer direct care staff hours submitted than documented on the facility staffing grid. 6/8/25: PBJ submitted 301.98 hours; staffing grid documented 317 actual hours. 6/15/25: PBJ submitted 312 hours; staffing grid documented 327.75 actual hours. 6/22/25: PBJ submitted 315.80 hours; staffing grid documented 322.68 actual hours. 6/28/25: PBJ submitted 317.45 hours; staffing grid	F0851		

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F0851 SS = F	Continued from page 13 documented 325.42 actual hours. During an interview with the Administrator on 9/10/25 at 7:49 AM, she confirmed that on those four dates, on-call salaried administrative nursing staff worked but their hours were not included in the PBJ data submitted to CMS and confirmed their hours should have been included. She stated the purpose of accurate PBJ reporting is to provide an accurate depiction of the number of staff available to provide quality care to the residents.	F0851		