STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER COUNTY NH	**15 A SOUTH SIXTH STREET PO BOX 527, BAY SPRINGS, Mississippi, 39422**

(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 at the facility from 10/06/2025 through 10/09/2025. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F605, F641, F656, F677, F699, F732, F842, and F880. The facility had a census of 101 and was licensed for 110 beds.	F0000		
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. §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.	F0550		

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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F0550 SS = D	Continued from page 1 §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, record review, and facility policy review, the facility failed to ensure a resident's right to privacy and dignity during medication administration when licensed nursing staff administered prescribed eye drops to a resident in the dining room while other residents were present, for one (1) of three (3) residents reviewed for medication administration, Resident #96. Findings include: A review of the facility's "…Medication Administration Policy," dated 7/30/25, revealed, "…Policy Explanation and Compliance Guidelines…7. Provide privacy…" On 10/7/25 at 8:37 AM, during an observation, LPN #1 administered medications to Resident #96 while the resident was in the dining room. At the time of the observation, nine (9) other residents were also present in the dining room. On 10/7/25 at 8:45 AM, during an interview, LPN #1 stated she normally administered medications in the dining room for residents who were present there during the morning medication pass. She reported that Resident #96 had not expressed a problem with receiving medications in the dining room but acknowledged that privacy could be an issue when medications were given in the presence of other residents. On 10/7/25 at 10:15 AM, during an interview, the Director of Nursing (DON) stated medications should not be administered in the dining room in front of other residents. She stated her expectation was that all medications be administered in a private setting to ensure resident dignity and privacy. A record review of the "Admission Record" revealed the	F0550		

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F0550 SS = D	Continued from page 2 facility admitted Resident #96 on 3/11/24 with current diagnoses including Pulmonary Fibrosis. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/26/25 revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident's cognition was moderately impaired. A record review of the "Order Summary Report" revealed Resident #96 had a physician's order, dated 8/27/24, for Artificial Tears eye drops.	F0550		
F0605 SS = G	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints	F0605		

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F0605 SS = G	Continued from page 3 imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an	F0605		

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F0605 SS = G	Continued from page 4 effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident was free from unnecessary medications when the resident received an antipsychotic medication without an appropriate diagnosis and without informed consent, which resulted in lethargy, weight loss, and poor meal intake for one (1) of five (5) residents reviewed for unnecessary medications. Resident #79. Findings include: A review of the facility's policy titled "…Use of Psychotropic Medication(s)," dated 9/17/25, revealed, "…It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated…" During an observation on 10/6/25 at 12:15 PM, Resident #79 was observed asleep in her wheelchair in the common area. On 10/8/25 at 1:05 PM, Resident #70 was observed asleep in her wheelchair and remained asleep until 5:15 PM. On 10/8/25 at 4:17 PM, during an interview with Certified Nurse Aide (CNA) #1, she explained that	F0605		

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F0605 SS = G	Continued from page 5 Resident #79 had "good days and bad days," often refusing to eat on her bad days. She stated the resident had been refusing meals that day and was uncooperative, often falling asleep during mealtime. She stated that CNAs typically set up the meal tray and later return to check on the resident. On 10/8/25 at 3:00 PM, during an interview with the Nurse Practitioner (NP), she explained that Resident #79 had lost over fifty (50) pounds in the past year. She stated Resident #79 often refused meals and care. She stated the resident was prescribed Geodon for psychosis related to combative behaviors but acknowledged that the resident did not have a diagnosis of bipolar disorder or Schizophrenia. She added that she had intended for the medication to be prescribed as needed (PRN) rather than scheduled daily. She stated that weight loss and lethargy could be side effects of the medication. A record review of the "Behavior Monitoring and Interventions Report" Log" from 9/8/25 through 10/8/25 revealed there were no documented behaviors for Resident #79. On 10/8/25 at 3:30 PM, during an interview with the Director of Nursing (DON), she stated that psychosis was listed in the resident's medical history but acknowledged that it was not an approved indication for Geodon use. She confirmed that while the resident had a history of behaviors, the behavior documentation for the past month did not reflect any recorded behaviors. On 10/8/25 at 5:10 PM, during an interview with Licensed Practical Nurse (LPN) #3, she stated that Resident #79 often slept through meals and that it was difficult to get her to eat due to combativeness. She stated that CNAs had reported the resident's sleepiness and that she had reported these observations to her supervisor. She added that Resident #79 sometimes refused medications or slept through medication passes. On 10/9/25 at 10:00 AM, during an interview with Registered Nurse (RN) #2, Medical Records Nurse, she explained that the facility was unable to provide a signed consent for antipsychotic medication for Resident #79. She stated that Geodon was started in June 2024, prior to the facility's implementation of the consent process for antipsychotic use. She further explained that the medication was prescribed for psychosis, which was not an approved indication for use. She confirmed that the facility did not retroactively seek consent from the resident's representative or family after the regulation regarding	F0605		

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F0605 SS = G	Continued from page 6 consents for psychotropic medications went into effect. On 10/9/25 at 10:30 AM, during an interview with the Administrator and the DON, they stated it was their expectation that residents would be free from unnecessary medications and that medications would be administered only for appropriate diagnoses. On 10/9/25 at 11:04 AM, Resident #79 was observed asleep in her wheelchair in the dining area. A record review of Resident #79's "Admission Record" revealed the facility admitted the resident on 10/17/23 with current diagnoses including Dementia. A record review of the "Order Summary Report" revealed Resident #79 had a physician's order, dated 1/8/25 for "Ziprasidone (Geodon) HCL Cap (Capsule) 20 MG (Milligrams) Give 1 capsule by mouth at bedtime related to Unsp (Unspecified) psychosis not due to a substance or known physiological cond (condition)…." A record review of Quarterly Minimum Data Set (MDS) with an Annual Assessment Reference Date (ARD) of 8/19/25 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated her cognition was moderately impaired. A record review of the "Amount Eaten" from 9/11/25 through 10/8/25 revealed the staff documented that Resident #79 refused her meal 38 times during the month. A record review of the "Vital: Weight" log for Resident #79 revealed that she weighed 214.2 pounds on 10/1/24 and 159.2 pounds on 10/1/25, which was a total of 55 pounds and 25.7 percent total weight loss in twelve (12) months. A record review of the "RD (Registered Dietician) Assessment Summary," dated 10/7/25 revealed Resident #79 the "Reason for Assessment" was "SWLX30/90/180 (Significant Weight Loss times 30/90/180 days) and included "Observations/statements from chart/staff/resident. Assessment due to weight loss…Needs cueing r/t (related to) falling asleep while eating…" A record review of the "Psych (Psychiatric) Progress Note" dated 9/25/25 revealed Resident #79's medication included Geodon 20 mg and the "Case Conceptualization" revealed, "Chart indicates poor appetite and ongoing wt (weight) loss…"	F0605		
F0641 SS = D	Accuracy of Assessments	F0641		

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F0641 SS = D	Continued from page 7 CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) related to an insulin medication for Resident #2 and an anticoagulant medication for Resident #14 for two (2) of (21) sampled residents. Findings include: A review of the facility's policy, "Assessment Frequency/Timeliness" dated 10/1/23, revealed, "The	F0641		

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F0641 SS = D	Continued from page 8 purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI (Resident Assessment Instrument) Manual..." Resident #2 A record review of “Drugs.com” website revealed the drug classification for Trulicity is “GLP-1 receptor agonists.” A review of the “Admission Record” revealed the facility admitted Resident #2 on 6/19/24 with current diagnoses including Type 2 Diabetes Mellitus with Diabetic Neuropathy. A record review of the Quarterly MDS with an ARD of 8/04/2025 revealed Section N, “N0300. Insulin” was marked as Resident #2 had received two (2) insulin injections in the seven (7) day look-back period. A record review of the "Order Summary Report" with “Active Orders As Of 7/01/2025” revealed Resident #2 had a Physician’s Order, dated 9/18/24, for “Trulicity Subcutaneous Solution Pen-Injector 3mg(milli-gram)/0.5 ml (milli-liters) (Dulaglutide) Inject 3 mg subcutaneously one time a day every Wednesday related to Type 2 Diabetes Mellitus Without Complications.” Further review revealed there were no Physician’s Order for an insulin medication. A record review of Resident #2's MAR for July and August 2025, revealed Trulicity was documented as administered. There was no documentation indicating that insulin was administered. Resident #14 A record of the "Admission Record" revealed Resident #14 was admitted by the facility on 11/14/2022 with diagnoses including Hypertensive Heart Disease with heart failure. A record review of the "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 7/28/25 for Resident #14 revealed Section N, “N0415. High-Risk Drug Classes: Use and Indication” was marked as “Yes”, indicating Resident #14 had taken an anticoagulant medication during the seven (7) day look-back period. A record review of the “Order Summary Report” with “Active Orders as of 7/28/2025” revealed there were no Physician’s Orders for an anticoagulant medication.	F0641		

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F0641 SS = D	Continued from page 9 A record review of the Medication Administration Record (MAR) for the month of July 2025 revealed there were no anticoagulant medications administered to Resident #14. On 10/7/25 at 12:41 PM, during an interview with the Registered Nurse/Minimum Data Set (RN/MDS) Coordinator, she confirmed that Resident #14 did not have a Physician's order for an anti-coagulant medication and was not administered an anticoagulant during the look-back period, although the MDS reflected anticoagulant use. The RN/MDS further confirmed Resident #2 was prescribed an insulin medication but was on Trulicity injections. She reported that the MDS was coded incorrectly for both residents. On 10/7/25 at 4:30 PM, during an interview with Director of Nurses (DON), she stated that MDS assessments must be completed accurately and acknowledged the errors for Resident #2 and Resident #14.	F0641		
F0656 SS = D	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 (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	F0656		

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F0656 SS = D	Continued from page 10 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, interviews, record review, and facility policy review, the facility failed to implement resident-specific care plan interventions when staff did not provide personal hygiene (shaving) as identified in the care plans (Residents #6 and #11), and failed to develop a care plan addressing triggers and interventions for a resident with Post-Traumatic Stress Disorder (PTSD) (Resident #2) for three (3) of (21) sampled residents. Findings include: A review of the facility's "Care Plan Assessment (CAA) Care Planning Policy" (undated), revealed, "It is the policy of this facility that the CAA/Care Planning Process will be done as follows: Includes…Each triggered CAA will be assessed to facilitate a plan of care based on problems identified through the assessment process." Resident #2 On 10/06/2025 at 11:55 AM, during an interview with Resident#2 she confirmed she had the diagnosis of PTSD and reported it is related to her husband died due to a stab wound to his leg. He bled out and said he waited to tell her that he loved her, and he died. She no longer likes knives and does not watch knife shows. She	F0656		

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F0656 SS = D	Continued from page 11 thinks staff are aware of the PTSD. A record review of the “Admission Record” revealed the facility admitted Resident #2 on 6/19/24 with current diagnoses including Post-Traumatic Stress Disorder, Unspecified. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/4/25 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Section I indicated she had an active diagnosis of Post-Traumatic Stress Disorder. A record review of the “Psych Eval,” dated 10/10/24, revealed “Past Medical History Active Medical Problems” included Post-Traumatic Stress Disorder. The “Case Conceptualization” section indicated, “… demonstrates how she wrapped her arms around her younger siblings to protect them from hearing her abusive father’s rants … Hesitates and almost tears up before expounding upon these scenarios saying she doesn’t want to be sent to a psychiatric hospital, then exhibits the same display of hesitation near tearfulness when she talks … My husband passed away, and I found him by myself, and they said it was PTSD …” A record review of Resident#2's clinical record revealed there was no care plan developed with interventions that included trauma or triggers. Resident #6 A record review of the “Care Plan Report” revealed Resident #6 had a “Focus” of “Resident requires total ADL assistance …” with “Interventions/Tasks” including “Assist as needed with ADL’S...” A record review of the “Admission Record” revealed the facility admitted Resident #6 on 2/13/23 with diagnoses including Alzheimer’s Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/9/25 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident’s cognition was moderately impaired. Section GG revealed Resident #6 had limitations in range of motion in both lower extremities and was dependent on staff for bathing and personal hygiene. During an observation and interview on 10/06/2025 at 10:44 AM, Resident #6 was noted to have long facial hair. He explained the staff were supposed to shave	F0656		

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F0656 SS = D	Continued from page 12 him, but he had not been shaved in a long time. He expressed that he wished to be shaved. During an observation on 10/07/2025 at 12:32 PM, Resident #6 continued to have long facial hair. During an interview on 10/7/25 at 3:00 PM, Certified Nurse Aide (CNA) #2, confirmed Resident #6 had long facial hair that appeared not to have been shaved in several days, possibly a week. She reported that Resident #6 preferred to be clean-shaven and that she had last shaved him approximately two (2) weeks ago when his facial hair was also long. Resident #11 A record review of the “Care Plan Report” revealed Resident #11 had a “Focus” of Resident requires ADL assistance” with “Interventions/Tasks” of “Assist As Needed With ADL’S...” A record review of the “Admission Record” revealed the facility admitted Resident #11 on 12/13/18 with diagnoses including Alzheimer’s Disease. A record review of the Quarterly MDS with an ARD of 8/13/25 revealed a BIMS score of 3, which indicated the resident’s cognition was severely impaired. Section GG revealed Resident #11 had limitations in range of motion in both lower extremities and was dependent on staff for bathing and personal hygiene. During an observation on 10/06/2025 at 12:11 PM, Resident #11 had numerous long stray hairs that were several inches long on her chin. During an interview and observation on 10/6/25 at 12:15 PM, CNA #3 confirmed Resident #11 had long chin hair and that shaving should be completed during showers. During an observation on 10/7/25 at 12:31 PM, Resident #11 had long chin hair visible. During an observation on 10/8/25 at 8:35 AM, Resident #11 was lying in bed and continued to have long chin hair. During an interview on 10/09/2025 at 12:00 PM, Registered Nurse (RN)#1 explained that the purpose of the care plan was to guide staff in providing individualized care for each resident. She stated that she expected all staff to follow the care plans as written to ensure residents received the highest quality of care. She reviewed Resident #2’s care plan	F0656		

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F0656 SS = D	Continued from page 13 and confirmed that no care plan had been developed for Post-Traumatic Stress Disorder (PTSD) and that no triggers were identified for prevention of recurrence. She stated that since the diagnosis was present on admission, a care plan might have been in the medical record but confirmed that if it was not included in the comprehensive care plan, staff would not be aware of the triggers or how to prevent recurrence. During an interview on 10/09/2025 at 1:01 PM, the Administrator and the Director of Nursing (DON) stated that they expected staff to follow each resident's care plan and provide quality care to support residents in achieving their highest practicable level of well-being. They stated that care plans should be developed based on each resident's comprehensive assessment and confirmed that Resident #2 should have had a care plan addressing Post-Traumatic Stress Disorder (PTSD), and that Residents #6 and #11 should have been shaved in accordance with their care plans for activities of daily living (ADL) care.	F0656		
F0677 SS = D	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, interviews, record review, and facility policy review, the facility failed to provide shaving for residents who were dependent on staff for Activities of Daily Living (ADLs) for two (2) of (21) sampled residents, Residents #6 and #11. Findings include: A review of the facility's "Shaving Policy," (undated) revealed, "It is the policy of this facility that male residents will be shaved as follows: – Encouraged to be shaved daily and as needed …" Resident #6 A record review of the "Admission Record" revealed the facility admitted Resident #6 on 2/13/23 with diagnoses including Alzheimer's Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/9/25	F0677		

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F0677 SS = D	Continued from page 14 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident's cognition was moderately impaired. Section GG revealed Resident #6 had limitations in range of motion in both lower extremities and was dependent on staff for bathing and personal hygiene. A record review of the facility's "Bath Schedule – Group C" revealed Resident #6 received a pan bath daily on the night shift. On 10/6/25 at 10:44 AM, during an observation and interview, Resident #6 was lying in bed with long facial hair. He stated that staff were responsible for shaving him, but he had not been shaved in a long time and wished to be shaved. On 10/7/25 at 12:32 PM, during an observation, Resident #6 was observed sitting in his wheelchair with long facial hair. On 10/7/25 at 3:00 PM, during an interview with Certified Nurse Aide (CNA) #2, she stated that Resident #6 received a bed bath daily on the evening shift (7:00 PM–7:00 AM) and required total assistance for all ADLs except feeding. She stated the resident was cooperative and never refused care, including baths. CNA #2 stated that shaving was part of the bath or shower routine and should occur daily or at least every other day. She confirmed Resident #6 had long facial hair that appeared not to have been shaved in several days, possibly a week. She reported that Resident #6 preferred to be clean-shaven and that she had last shaved him approximately two (2) weeks ago when his facial hair was also long. On 10/7/25 at 3:30 PM, during an interview with Licensed Practical Nurse (LPN) #4, she stated that Resident #6 was cooperative and dependent on staff for all ADLs except feeding. She confirmed the resident received a bed bath nightly, which included shaving. She stated the resident had long facial hair and that she had not been informed of any refusals. Resident #11 A record review of the "Admission Record" revealed the facility admitted Resident #11 on 12/13/18 with diagnoses including Alzheimer's Disease. A record review of the Quarterly MDS with an ARD of 8/13/25 revealed a BIMS score of 3, which indicated the resident's cognition was severely impaired. Section GG revealed Resident #11 had limitations in range of	F0677		

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F0677 SS = D	Continued from page 15 motion in both lower extremities and was dependent on staff for bathing and personal hygiene. A record review of the facility's "Bath Schedule – Group A" revealed Resident #11 received a pan bath daily on the day shift. On 10/6/25 at 12:11 PM, during an observation, Resident #11 was sitting in her wheelchair with multiple long hairs several inches in length noted on her chin. On 10/6/25 at 12:15 PM, during an interview and observation with CNA #3, she confirmed Resident #11 had long chin hair and that shaving should be completed during showers. She stated the resident received her showers on the evening shift. On 10/7/25 at 12:31 PM, during an observation, Resident #11 was sitting in the dining room with long chin hair visible. On 10/7/25 at 12:35 PM, during an interview and observation with CNA #4, she stated that she worked restorative care and also assisted on the floor as needed. She confirmed that ADL care included bathing, brushing teeth, dressing, and shaving as needed on shower days. She stated Resident #11 had long chin hair that appeared to have been there for some time. On 10/7/25 at 2:20 PM, during an interview and observation with CNA #5, she stated that Resident #11 was totally dependent for all ADLs and was scheduled for showers on the evening shift, which included shaving. She stated the resident was usually cooperative with care, though occasionally confused. She confirmed the resident had long chin hairs that appeared to have not been recently shaved. On 10/7/25 at 3:25 PM, during an interview with LPN #4, she stated that Resident #11 received showers on the evening shift and that she had not been informed of any refusals of care. She stated the resident was confused but easily redirected and cooperative. On 10/8/25 at 8:35 AM, during an observation, Resident #11 was lying in bed and continued to have long chin hair. On 10/8/25 at 9:00 AM, during an observation and interview with the Director of Nursing (DON), Resident #6 was sitting in the dining room eating breakfast. The DON stated that both men and women were expected to be shaved as part of bathing or shower care. She stated that, as a woman, she would not want to have long chin	F0677		

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F0677 SS = D	Continued from page 16 hair and expected staff to shave or pluck such hairs as needed. She confirmed that Resident #6 had long facial hair and stated she would follow up on Resident #11. On 10/9/25 at 1:01 PM, during a follow-up interview with the DON, she confirmed Resident #11 had numerous chin hair and stated she expected staff to provide shaving for all residents as needed to meet each resident's individual needs and ensure quality care.	F0677		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to ensure triggers and resident specific interventions were identified and initiated for a resident with Post Traumatic Stress Disorder (PTSD) for one (1) of (21) sampled residents. Resident #2. Findings include: A review of a written statement provided and signed by the Administrator revealed, "(Proper Name) Nursing Home does not have a policy on Post-Traumatic Stress Disorder." A record review of the "Admission Record" revealed the facility admitted Resident #2 on 6/19/24 with current diagnoses including Post-Traumatic Stress Disorder, Unspecified. A record review of the "Order Summary Report" revealed orders for "…May consult (Proper Name) Health Services for Psych (Psychiatric)…as needed," dated 9/4/24, and "May have Psych consult as needed," dated 11/26/24. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/4/25 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Section I indicated she had an active diagnosis of Post-Traumatic Stress Disorder.	F0699		

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F0699 SS = D	Continued from page 17 A record review of the Certified Nurse Aide (CNA) Kardex for the “Behavior Monitoring and Interventions Report” for October 2025 revealed staff were to indicate behaviors observed, interventions attempted, and outcomes. There were no resident-specific triggers identified in the document related to PTSD. A record review of the “Psych Eval,” dated 10/10/24, revealed “Past Medical History Active Medical Problems” included Post-Traumatic Stress Disorder. The “Case Conceptualization” section indicated, “… demonstrates how she wrapped her arms around her younger siblings to protect them from hearing her abusive father’s rants … Hesitates and almost tears up before expounding upon these scenarios saying she doesn’t want to be sent to a psychiatric hospital, then exhibits the same display of hesitation near tearfulness when she talks … My husband passed away, and I found him by myself, and they said it was PTSD …” A record review of Resident #2’s medical record revealed there was no documentation indicating that the resident had been evaluated to identify PTSD triggers or that any resident-specific interventions had been developed or implemented. On 10/6/25 at 11:55 AM, during an interview, Resident #2 confirmed she had been diagnosed with PTSD and stated it was related to the death of her husband, who had died from a stab wound to his leg. She explained she no longer likes knives and does not watch television shows involving knives. She stated she believed the staff were aware of her PTSD diagnosis. On 10/7/25 at 2:20 PM, during an interview with Certified Nurse Aide (CNA) #6, she stated that Resident #2 had never mentioned PTSD or exhibited complaints about triggers. She reported the resident occasionally became anxious and complained about various issues. She reviewed the Kardex and stated that the resident was monitored every shift for behaviors, but neither the resident nor staff had ever identified PTSD-related triggers. On 10/7/25 at 3:10 PM, during an interview with Licensed Practical Nurse (LPN) #4, she stated she was not aware of Resident #2 having PTSD, and the resident had never discussed it or any triggers. She confirmed that Resident #2 spoke frequently about anxiety and had medications for anxiety management. After reviewing the resident’s admitting diagnoses, LPN #4 confirmed that PTSD was listed among them.	F0699		

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F0699 SS = D	Continued from page 18 On 10/9/25 at 11:01 AM, during an interview with the Director of Nursing (DON), she stated she was not aware of any trauma-informed or PTSD-specific assessments being completed for residents. She explained she had been employed at the facility since August and was not aware of any existing assessments. The DON stated she would verify whether Resident #2 had received a psychiatric evaluation addressing PTSD. She reported she had consulted with the Assistant Director of Nursing (ADON), who informed her that Resident #2 was admitted with the PTSD diagnosis but that neither she nor the ADON knew the associated triggers. The DON confirmed that there was no documentation identifying PTSD-related triggers and acknowledged that without such information, staff would be unable to recognize or avoid potential triggers. The DON provided a copy of Resident #2's initial "Psych Eval Note," dated 10/10/24—four (4) months after admission—which listed PTSD under past medical history and included trauma-related content, but no identified triggers or interventions. The DON confirmed that while the resident was seen by a Mental Health Nurse Practitioner quarterly and a psychotherapist weekly, the facility had not conducted an assessment to identify triggers or develop corresponding interventions. She stated the facility did not have a PTSD policy.	F0699		
F0732 SS = B	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F0732		

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F0732 SS = B	Continued from page 19 §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure nurse staffing information was posted in a location daily that was visible to residents and the public for two (2) of four (4) survey days. Findings include: A review of the facility's "Posting Daily Staffing Information Policy" (undated) revealed, "It is the policy of this facility that Nurse Staffing information will be posted as follows…The information will be posted daily…This form will be posted in the foyer of the building…" On 10/6/25 at 11:05 AM, during an observation of the common areas, including the facility's foyer, and surrounding the nursing stations on Unit 200, Unit 300, and Unit 400, there was no posted nurse staffing information visible. On 10/7/25 at 2:09 PM, during an observation of the common areas, including the facility's foyer, and surrounding the nursing stations on Unit 200, Unit 300, and Unit 400, there was no posted nurse staffing	F0732		

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F0732 SS = B	Continued from page 20 information visible. On 10/7/25 at 3:25 PM, during an interview with the Assistant Director of Nursing (ADON), she explained that the daily nurse staffing information was completed daily but was posted inside a locked room near the time clock with a sign on the door that read “Staff Only.” She further stated that the staffing information was also kept in a binder behind the nursing station counter. The ADON confirmed that no staffing information was posted in the common areas surrounding any of the three nursing stations. On 10/7/25 at 3:40 PM, during an interview with the Director of Nursing (DON), she confirmed that there was no nurse staffing information posted in the common areas near Units 200, 300, or 400. She explained that while the nurse staffing information was completed, it was kept in binders behind the nursing station counter. The DON stated that posting nurse staffing information is important to demonstrate that the facility has adequate staff to meet residents’ needs and provide appropriate care.	F0732		
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. §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	F0842		

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F0842 SS = D	Continued from page 21 §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 (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;	F0842		

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F0842 SS = D	Continued from page 22 (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 interview, record review and facility policy review, the facility failed to maintain an accurate resident clinical record related to a physician's order for a resident hospital transfer for one (1) of (21) sampled residents. Resident #7 Findings include: A review of the facility's "Physician's Orders Policy," revised 8/29/17 revealed "…Reminders…The nurse noting the order is responsible for…Transcribing the orders to the appropriate place…" A record review of the facility's "Admission Record" revealed the facility admitted Resident #7 on 4/23/2019 with current diagnoses including Type 2 Diabetes Mellitus.. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/25/25 revealed Resident #7 was transferred from the facility due to a unplanned discharge to a Short-Term General Hospital on 7/25/2025. A record review of "Progress Notes" revealed Resident #7 had a "Transfer to Hospital Summary" note, dated 7/25/2025, which indicated she had been sent to an acute hospital for further evaluation. A review of the clinical record for Resident #7 revealed there was no physician order documented related to the 7/25/25 transfer to the hospital. On 10/08/2025 at 11:56 AM, during an interview with the Assistant Director of Nursing (ADON), she acknowledged there was no Physician's order in the medical record related to Resident #7's transfer to an acute hospital on 7/25/25. She stated it was the responsibility of the nurse that receives the order to transcribe it and	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0842 SS = D	Continued from page 23 follow it through. On 10/08/2025 at 1:21 PM, during an interview with the Director of Nursing (DON), she confirmed there was no physician's order in the clinical record for Resident #7 when she was transferred to the hospital on 7/25/25. The DON stated that when a verbal order is received from the physician the nurse must put that information in the computer immediately or as quickly as possible.	F0842		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be	F0880		

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F0880 SS = E	Continued from page 24 followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow infection prevention and control practices, as evidenced by failure to wear gloves during the administration of eye drops and by placing medication containers on contaminated surfaces without cleaning or using a barrier for two (2) of three (3) residents observed for medication administration (Residents #14 and #96). Findings include: A review of the facility's "…Medication Administration Policy, dated 7/30/25, revealed, "… "Medications are	F0880		

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F0880 SS = E	Continued from page 25 administered by licensed nurses…as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection..." Resident #14 A record review of the "Admission Record" revealed the facility admitted Resident #14 on 11/14/22 with current diagnoses including Unspecified Glaucoma. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/28/25 revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact. A record review of the "Order Summary Report" revealed Resident #14 had a Physician's Order for Combigan Opthalmic Solution 0.2-0.5%, dated 11/14/2022. On 10/7/25 at 8:18 AM, during an observation, Licensed Practical Nurse (LPN) #2 was observed administering medications to Resident #14 during the morning medication pass. LPN #2 administered one (1) drop of eye drops to each of the resident's eyes without wearing gloves. She then placed the plastic medication bag on the resident's bed, retrieved it, and returned it to the medication cart without sanitizing the container. On 10/7/25 at 8:21 AM, during an interview, LPN #2 stated that gloves should have been worn during eye drop administration to prevent the spread of infection through bodily fluids or potential eye infections such as conjunctivitis (pink eye). She further stated medication containers should not be placed on the resident's bed or returned to the cart without sanitizing. She stated that a barrier, such as a paper towel, should be used between items and contaminated surfaces to prevent infection transmission. Resident #96 A record review of the "Admission Record" revealed the facility admitted Resident #96 on 3/11/24 with current diagnoses including Pulmonary Fibrosis. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/26/25 revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident's cognition was moderately impaired.	F0880		

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F0880 SS = E	Continued from page 26 A record review of the "Order Summary Report" revealed Resident #96 had a physician's order, dated 8/27/24, for Artificial Tears eye drops. On 10/7/25 at 8:37 AM, during an observation, LPN #1 administered eye drops to Resident #96 without wearing gloves. On 10/7/25 at 8:45 AM, during an interview, LPN #1 stated she should have worn gloves while administering eye dops to Resident #96. On 10/7/25 at 10:15 AM, during an interview with the Director of Nursing (DON), she stated that any items placed on a resident's bed or bedside table must have a clean barrier and should be sanitized before being returned to the medication cart. She further stated that gloves should always be worn for procedures involving the eyes to prevent the spread of infection.	F0880		