

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255334		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/01/2025	
NAME OF PROVIDER OR SUPPLIER TUNICA COUNTY HEALTH & REHAB, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1024 HIGHWAY 61 SOUTH , TUNICA, Mississippi, 38676			
(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 at the facility from 09/29/25 through 10/01/25. During the survey, the SA determined that the facility was not compliance with the requirements for participation in Medicare and Medicaid. During the survey the SA cited F584, F641, F656, F677, F688, F812 and F825. The census at the time of the survey was 53 and the facility is licensed for 60 beds.		F0000				
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in		F0584				

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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F0584 SS = D	Continued from page 1 good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to maintain a safe, clean, comfortable, and homelike environment by not repairing or reporting leaking air-conditioning (AC) units in two (2) of 30 resident rooms reviewed. Rooms 121 and 131. Findings included: Record review of the facility policy "Quality of Life-Homelike Environment" revised April 2014, revealed "Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment..." An observation of room 121 on 9/29/25 at 11:05 AM, revealed a sheet on the floor pushed under the AC unit. An observation of room 131 on 9/29/25 at 11:45 AM revealed a sheet and blanket on the floor under the AC unit. A follow-up observation of room 121 and 131 on 9/30/25 at 8:30 AM, revealed both rooms continued to have sheets and a blanket pushed under the AC units. An interview with Licensed Practical Nurse (LPN #1) on 9/30/25 at 1:46 PM verified that the sheet remained on the floor under the AC unit in room 121 because the AC unit was leaking. She further stated that it is their practice to notify maintenance and log the issue on the "Maintenance Requisition". An interview with Certified Nursing Assistant (CNA #1)	F0584					

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F0584 SS = D	Continued from page 2 on 9/30/25 at 1:50 PM, verified that there were a sheet and blanket on the floor of room 131 because the AC unit was leaking. She was unsure of how long the unit had been leaking. Record review of the "Maintenance Requisitions" for August 2025 and September 2025, revealed the leaking AC unit in room 131 had not been logged onto the Maintenance Requisition form until 9/30/25 at 1:50 PM, which was after the State Agency entrance into the facility on 9/29/25. LPN #1 confirmed after reviewing the requisitions that the leaking AC units had not been logged prior to 9/30/25. In an interview with Maintenance staff on 9/30/25 at 1:53 PM, he verified that he had not previously been notified of the leaking AC units. He was unsure how long the units had been leaking. He stated that when it is hot outside it causes condensation which causes the drain pan to overflow on to the floor, and it has to be cleaned out. An interview with the Director of Nursing on 10/1/25 at 9:00 AM, revealed that placing sheets and blankets under the AC units and not notifying maintenance staff of the leaking had the potential to place residents at risk for falls from slipping on wet floors, exposure to an unsanitary environment, and a diminished sense of comfort and homelike surroundings. She stated that it was her expectation that the staff would notify the maintenance department and log the problem onto the appropriate form when it occurred.	F0584					
F0641 SS = D	Accuracy of Assessments 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.	F0641					

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F0641 SS = D	Continued from page 3 §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 interviews, record review and facility policy review, the facility failed to accurately code a Minimum Data Set (MDS) for one (1) of (24) resident assessments reviewed (Resident #2). Findings include: Review of the facility policy, "Certified Accuracy," last revised December 2009, revealed "Policy Statement: All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment..." Record review of the Quarterly MDS for Resident #2 dated 8/20/25 revealed Section P0100 (Restraints) coded "Bed rail used daily." Record review of the restraint assessment form "RESTRAINT-PHYSICAL" dated 8/18/25 for Resident #2 revealed "No restraints used at this time." During an interview on 9/30/25 at 1:55 PM, the Director of Nursing confirmed that Resident #2 used bilateral side rails to aid in mobility and define bed boundaries, and these were not considered restraints. During an interview on 9/30/25 at 2:16 PM, the MDS nurse confirmed Resident # 2 had been assessed for side rail use, and the side rails were not restraints. She confirmed the MDS was inaccurately coded and stated the			F0641			

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F0641 SS = D	Continued from page 4 purpose of accurate MDS coding is to correctly depict the resident's clinical status and needs.	F0641					
F0656 SS = G	Record review of the Resident #2's "Admission Record" revealed the facility admitted the resident on 1/17/23 with diagnoses that included Alzheimer's disease. 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 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	F0656					

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F0656 SS = G	Continued from page 5 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, staff interviews, record review, and facility policy review, the facility failed to develop comprehensive person-centered care plans to address identified care needs. This deficient practice was identified for two (2) of (53) residents reviewed for care planning. (Residents #6 and #33). Findings include: Review of the facility policy titled, "Care Plans, Comprehensive Person-Centered," last revised December 2016, revealed: "Policy Statement: A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident..." Resident # 6 On 9/29/25 at 1:30 PM, Resident #6 was observed lying in bed with her left leg bent at an approximate 90-degree angle at the knee. The resident stated she was unable to straighten her leg and that it was "stuck" in that position. She denied receiving range of motion (ROM) exercises or splinting of her left leg. Record review of the Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/17/25, revealed in Section GG that Resident #6 had functional limitation in range of motion on one side. Record review of all of Resident #6's care plans revealed there was not a care plan developed to address goals or interventions for risk for contracture or the need for ROM exercises. Record review of the "Admission Record" revealed that the facility admitted Resident #6 on 10/11/24 with diagnoses that included Cerebral Infarction. Resident #33 An observation on 9/29/25 at 10:45 AM, revealed		F0656				

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F0656 SS = G	Continued from page 6 Resident #33's fingernails were approximately ½ inch long past the fingertips with a thick, dark brown substance under the nail beds. Record review of all the care plans for Resident # 33 revealed there was not a care plan developed that addressed fingernail care. During an interview with the MDS Nurse on 9/30/25 at 1:16 PM she verified that Resident #6's care plan did not address her risk for contracture or the need for range of motion exercises and agreed that it should have and then confirmed after review of Resident #33's care plans that fingernail care was not addressed. She stated nail care should have been included within the diabetic care plan. She revealed the purpose of a care plan is to direct resident-specific care needs, and failure to develop the plan could result in the residents not receiving needed care. Record review of the "Admission Record" for Resident #33 revealed the facility admitted the resident on 8/26/25 with diagnoses that included Type 2 Diabetes Mellitus. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date of 9/8/25 revealed in Section GG0130 (Self-Care) that Resident #33 was coded 3 which indicated partial/moderate assistance was required.		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, resident and staff interviews, record review, and facility policy review, the facility failed to ensure fingernail care was provided for one (1) of (53) residents reviewed for activities of daily living (ADLs). (Resident #33). Findings include: Review of the facility policy titled, "Care of Fingernails/Toenails," last revised October 2010, revealed: "Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to		F0677				

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F0677 SS = D	Continued from page 7 prevent infections..." On 9/29/25 at 10:45 AM, Resident #33's fingernails were observed to be long and dirty. They were approximately ½ inch long past the tips of his finger and had a thick, dark brown substance under the nail beds. During an interview at this time, the resident stated he felt his nails were too long and dirty and reported he had not received any nail care since admission. An observation and interview on 9/30/25 at 1:06 PM with Licensed Practical Nurse (LPN) #1 confirmed Resident #33's fingernails were long with a dark buildup under the beds. She confirmed the nails required attention and stated failure to provide nail care could cause the resident to scratch himself and develop a skin infection. During an interview on 9/30/25 at 1:15 PM, the Director of Nursing (DON) confirmed Resident #33 is a diabetic and his nails should be assessed at least every two weeks by a Registered Nurse (RN) and trimmed as needed. She stated that failure to provide nail care places residents at risk of skin injury and infection. Record review of the "Admission Record" for Resident #33 revealed the facility admitted the resident on 8/26/25 with diagnoses that included Type 2 Diabetes Mellitus. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date of 9/8/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact, and Section GG0130 (Self-Care) coded 3 partial/moderate assistance.		F0677				
F0688 SS = G	Increase/Prevent Decrease in ROM/Mobility 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.		F0688				

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F0688 SS = G	Continued from page 8 §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, resident and staff interview, record review, and facility policy review the facility failed to ensure that a resident received adequate services to prevent an avoidable decline and the development of a contracture for one (1) of three (3) residents reviewed for range of motion (ROM). Resident #6. (Cross-reference- F825) Findings included: Review of the facility policy "Functional Impairment-Clinical Protocol", revised April 2013, revealed "Assessment and Recognition...2.The staff will identify individuals with a significant decline in function, including ability to perform activities of daily living...Treatment/Management...2.In conjunction with the physician and staff, therapist will propose a rehabilitation or restorative care plan that provides an appropriate intensity, frequency and duration of interventions to help achieve anticipated goals and expected outcomes efficiently using available resources..." Review of the facility policy "Range of Motion Exercises", undated, revealed "The purpose of this procedure is to exercise the resident's joints and muscles..." On 9/29/25 at 1:30 PM, Resident #6 was observed lying in bed with her left leg bent at an approximate 90-degree angle at the knee. The resident stated she was unable to straighten her leg and that it was "stuck" in that position. She denied receiving ROM exercises or splinting of her left leg. Record review of the "Physical Therapy Evaluation and Plan of Treatment" dated 10/13/24 documented no contractures to the left lower extremity. A subsequent "Physical Therapy Evaluation and Plan of Treatment" dated 7/31/25 revealed the presence of a 100-degree flexion contracture at the left knee and abduction at the hip joint.			F0688			

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F0688 SS = G	Continued from page 9 A record review of the "Progress Notes" dated 7/28/25 revealed that Resident #6's left knee was "swelling...LT (left) extremity appears to be contracting..." An interview with Licensed Practical Nurse (LPN #1) on 10/1/25 at 9:00 AM, confirmed that Resident #6's left leg had been in the contracted position since July 2025. She stated she was unaware of the resident receiving therapy and had not witnessed Certified Nursing Assistants (CNA) performing ROM exercises. During an interview on 10/1/25 at 10:15 AM, the Rehabilitation Director (RD) confirmed that the delay in evaluation and lack of documented ROM services could have contributed to worsening of the resident's contracture. The RD stated the facility did not have a Restorative Program and that he assumed CNAs were providing ROM during care but was unable to provide documentation. An interview with the Administrator on 10/1/25 at 12:15 PM confirmed that no documentation was available to show that CNAs or therapy staff had performed ROM exercises to prevent the contracture. She stated it was her expectation that therapy would evaluate residents within 24 to 48 hours of referral and that CNAs would provide ROM exercises during care. Record review of the "Admission Record" revealed that the facility admitted Resident #6 on 10/11/24 with diagnoses that included Cerebral Infarction. Record review of the Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/17/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that Resident #6 was cognitively intact. Section GG indicated Resident #6 had functional limitation in range of motion on one side.	F0688					
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from	F0812					

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F0812 SS = F	Continued from page 10 local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews, and facility policy review, the facility failed to ensure food was prepared and served under sanitary conditions and failed to label and store food properly for one (1) of three (3) kitchen tours. Findings include: Review of the facility policy titled, "005 Food Preparation Service" revised October 2017, revealed, "Policy Statement: Food and nutrition services employees shall prepare and serve food in a manner that complies with safe food handling practices...Food Service Distribution...23. Food and nutrition services staff shall wear hair restraints (hair net, bat, beard restraint, etc.) so that hair does not contact food..." Review of the facility policy titled, "006 Food Receiving Storage" revised October 2017, revealed, "Policy Statement: Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation...8. All food stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date). Review of the facility policy titled, "Food Storage Labeling" reviewed: 3/24, revealed, "Policy: The facility will ensure the safety and quality of food by following good storage and labeling procedures... Procedure...3. Foods that are prepared and stored for later service must be labeled and dated...10. Product Placement: Food is stored in containers intended for food that are durable, leak proof and can be tightly sealed or covered and labeled."	F0812					

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F0812 SS = F	Continued from page 11 On 9/29/25 at 10:10 AM, during the initial observation, Dietary Aides #1, #2, and #3 were observed in the kitchen area without wearing a hair restraint. An interview on 9/29/25 at 10:11 AM with Dietary Aide #1 revealed that the facility had ran out of hair nets and did not have any available at that time. She confirmed that breakfast had been prepared and served without any of the dietary staff wearing a hair restraint. An observation during the initial tour on 9/29/25 at 10:20 AM, with Dietary Aide #1, revealed in Refrigerator #1 a tray of 15 individual cups of pineapple, which were found without any covering or date. The walk-in cooler included enchilada sauce, Thousand Island dressing, shredded parmesan cheese, lettuce, shredded coconut, sliced cheese, sliced ham, sliced bologna, and chicken, all of which were present without dates indicating when they were opened or when they expired. During an observation and interview with the Dietary Manager (DM) on 9/29/25 at 10:35 AM, confirmed that the facility did not have hair nets available for the dietary staff. Observation of the dry goods storage area with the DM, revealed multiple items were noted without open dates and were not stored in sealed containers. These items included corn meal, basil leaves, poultry seasoning, cake mix, and graham cracker crumbs. The DM confirmed that no open food items should be stored without an open date and emphasized that this practice is unacceptable as it could lead to foodborne illnesses. An interview with the Administrator on 9/29/25 at 10:50 AM, confirmed that hair restraints should always be worn in the kitchen and that open food items should always be stored in sealed containers with an open date. She further stated that her expectations were for the dietary staff to constantly follow food safety guidelines as they were trained to do.	F0812					
F0825 SS = G	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and	F0825					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255334		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/01/2025	
NAME OF PROVIDER OR SUPPLIER TUNICA COUNTY HEALTH & REHAB, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1024 HIGHWAY 61 SOUTH , TUNICA, Mississippi, 38676			
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F0825 SS = G	Continued from page 12 rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interview, record review and facility policy review the facility failed to ensure timely provision of therapy services for one (1) of three (3) resident reviewed for contractures (Resident #6). Cross-reference- F688 Findings included: Review of the facility policy titled "Scheduling Therapy Services" revised July 2013, revealed "Policy Statement, Therapy Services shall be scheduled in accordance with the resident's treatment plan..." Record review of the "Nursing/Therapy Communication Form" dated 7/16/25 documented a request for physical and occupational therapy for Resident #6 due to complaints of left leg stiffness. Further review of the "Physical Therapy (PT) Evaluation and Plan of Treatment" revealed that therapy did not evaluate the resident until 7/31/25, which was (15) days after the consultation was initiated. An interview with the Administrator (ADM) on 10/1/25 at 9:45 AM, confirmed that therapy was consulted on 7/16/25 when the resident was complaining of leg stiffness. She verified that at the time of the referral; the resident's knee was slightly bent but not contracted. An interview with the Rehabilitation Director (RD) on 10/1/25 at 10:15 AM, revealed that the referral was delayed because a physical therapist was not available to complete the evaluation. The RD stated that physical	F0825					

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F0825 SS = G	Continued from page 13 therapy does not work full time at the facility and that therapy assistants are not permitted to perform the initial evaluation. The RD agreed that the delay in evaluation and treatment could have contributed to the worsening of Resident #6's contracture. A follow-up interview with the ADM on 10/1/25 at 12:15 PM, confirmed that it was her expectation that physical therapy evaluations would be completed within 24 to 48 hours after receiving a referral. She stated that the delay in Resident #6's evaluation did not meet this expectation. Record review of the "Admission Record" revealed that the facility admitted Resident #6 on 10/11/24 with diagnoses that included Cerebral Infarction. Record review of the Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 9/17/25, revealed in Section GG that Resident #6 had functional limitation in range of motion on one side.			F0825			