STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255137	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NESHOBA COUNTY NURSING HOME	**1001 HOLLAND AVENUE , PHILADELPHIA, Mississippi, 39350**

(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 9/29/25 through 10/02/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F604, F656, F677, F689, F693, F761, F808, F812, and F880. The census at the time of the survey was 128 and the facility is licensed for 145 beds.	F0000		
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §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 physical . . . 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 physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of	F0604		

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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F0604 SS = D	Continued from page 1 restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to ensure that the use of a bed alarm did not constitute a physical restraint for one (1) of four (4) residents reviewed for restraints (Resident #62). Findings Include: Review of the facility policy titled," Restraint Free Environment" with an approval date of 6/27/2025 revealed, "Each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience, and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints." An observation and interview on 9/29/25 at 1:15 PM with Resident #62, revealed the resident lying in bed with her hands clenched, body appearing stiff and her bed alarm was sounding despite only slight movement. She stated, "If I misbehave, this thing beeps, I have to be still." The alarm kept sounding and Licensed Practical Nurse (LPN) #5. entered the room and adjusted the bed alarm without success. She removed it and placed another one. When asked about the reason for the bed alarm, she stated, "She falls a lot." During an interview on 9/30/25 at 11:06 AM with the Director of Clinical Services, she stated the bed alarm was in place so that the staff could hear her try and get up and they could assist her so that she would not fall. She stated, "The bed alarm should not restrain them or keep them from moving freely and that she was unaware her bed alarm was sounding at the slightest movement." On 9/30/25 at 2:40 PM, an interview with Resident #62, she stated, "I dislike the alarm immensely." She revealed that it wakes her up during the night when it sounds and scares her. Record Review of the "Bed Alarm Assessment" for Resident #62 revealed it was conducted on 9/03/2025. Record Review of the" Use of bed/chair alarm Informed Consent" for Resident #62 revealed the consent was	F0604		

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F0604 SS = D	Continued from page 2 signed on 12/16/24. Record review of Resident #62's demographic information revealed that the facility admitted resident on 11/15/2023 with a medical diagnosis that included Dementia. Record review of Resident #62's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/20/25 revealed under section C, a Brief Interview for Mental Status "BIMS" score of 03 which indicated that the resident was severely cognitively impaired.	F0604		
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 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	F0656		

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F0656 SS = D	Continued from page 3 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 a care plan for Activities of Daily Living (ADLs) (Resident #5, #64, #105), wandering (Resident #57), gastrostomy (Resident #64), and therapeutic diet (Resident #134) for five (5) of 26 resident care plans reviewed. Resident #5, #57, #64, #105, and #134 Findings Include Review of the facility policy titled, “Comprehensive Care Plan” undated revealed under “Policy…It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the resident’s comprehensive assessment”. Resident #5 Record review of Resident #5's "LTC (Long Term Care) ADL (Activities of Daily Living) Function 2 (Two)" Plan revealed that she required extensive assistance with bed mobility, transfer, dressing, and personal hygiene. Her interventions included "provide assistance to support level of need." An observation of Resident #5 on 9/29/25 at 3:58 PM and on 09/30/25 at 2:28 PM, revealed that she had multiple gray chin hairs measuring approximately one-half of an inch in length. Resident #5 was pleasantly confused and unable to answer simple questions. During an interview on 09/30/25 at 2:38 PM with Licensed Practical Nurse (LPN) #1confirmed that	F0656		

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F0656 SS = D	Continued from page 4 Resident #5 had multiple gray hairs on her chin. She revealed that the Certified Nurse Assistants (CNA) were supposed to remove facial hair if needed during their bath time and it was included in the residents Care Plan about personal grooming. An interview on 09/30/25 at 4:11 PM with the Director of Nursing (DON) revealed that the purpose of the care plan was to formulate a plan of care specific to each resident so the staff can refer to it and know what care each resident needs. DON confirmed that ADL care was included on Resident #5's Care Plan and since her facial hair was left unattended, her care plan was not followed and she stated, "We will get that taken care of." An interview on 10/02/25 at 8:25 AM with Certified Nursing Assistant (CNA) #1 revealed that bathing, grooming and personal hygiene care was on the care plans, and this included facial hair removal. Record review of Resident #5's "Profile History Report" revealed under "ADLs" to "ensure facial hair is removed as needed." Record review of Resident #5's demographic information revealed that she admitted on 11/19/24 and that she had diagnoses that included Alzheimer's, Unspecified Dementia, and Insomnia. Record review of Resident #5's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 03 which indicated that she had severe cognitive deficits. Resident #57 Record review of Resident #57's "Elopement Risk POC (plan of care)" revealed under Interventions: "Utilize wander alert device" During an observation with Resident #57 on 9/29/25 at 12:40 PM and again on 9/30/25 at 9:42 AM she was sitting in her recliner in her room reading a book and a wander alert bracelet was observed lying on a built-in cabinet in the room. During an observation and interview with Registered Nurse (RN) #1 on 9/30/25 at 2:36 PM, she confirmed Resident #57 was not wearing her wander alert device. An interview with the MDS Nurse on 10/2/25 at 10:01 AM	F0656		

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F0656 SS = D	Continued from page 5 confirmed that the purpose of the care plan was to make the staff aware of the type of care to provide for the residents. She confirmed the care plan was not followed for Resident #57's wander alert bracelet. Record review of Resident #57's demographic information revealed the facility admitted the resident on 10/14/24 with medical diagnoses that included Alzheimer's Disease. Record review of the MDS with an ARD of 9/26/25 revealed under Section C, a BIMS score of 3, indicating Resident #57 was severely cognitively impaired. Resident #64 Review of the "LTC ADL FUNCTION" for Resident #64 revealed: "The resident requires total staff assist with all his ADL care." Record review of Resident #64's "Feeding Tube POC (Plan of Care)" revealed under, Interventions: "Ensure tube placement, auscultation, aspiration prior to use." On 9/29/25 at 2:35 PM and again on 9/30/25 at 2:55 PM and observation of Resident #64 revealed long, thumb nails, approximately one-eighth (1/8) in length, jagged with a brown substance underneath. Resident #64's fingers on both hands were closed tightly. On 9/30/25 at 12:10 PM, and observation with Resident #64 revealed LPN #5 flushed the resident's enteral tube with water and administered medications without first verifying placement of the tube. During an interview with LPN #5 on 9/30/25 at 12:21 PM, she confirmed she did not check placement of Resident #64's gastrostomy tube prior to flushing and giving the ordered medications. An interview with the MDS Nurse on 10/2/25 at 10:04 AM confirmed the care plan was not followed for Resident #64's enteral tube. Record review of Resident #64's demographic information revealed the facility admitted the resident on 1/23/19 with medical diagnoses that included Anoxic Brain Injury and that the resident receives feeding through a gastrostomy.	F0656		

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F0656 SS = D	Continued from page 6 Record review of the MDS with an ARD of 7/14/25 revealed under Section C that cognitive skills for daily decision making were severely impaired. Resident #105 Record review of Resident #105's "LTC (Long Term Care) ADL Function 2 (Two) Plan, revealed that he required mainly extensive assistance with his ADL self-performance and is dependent for shower/bath and personal hygiene. Resident #105's interventions included, "Nail care weekly-keep nails clean and neat." Observations on 09/29/25 at 1:10 PM and on 09/30/25 at 2:53 PM, revealed that Resident #105 had long fingernails on both hands that were approximately one-half of an inch long past the tips of the fingers. During an observation and interview on 09/30/25, at 2:55 PM with LPN #1 in Resident #105's room, she confirmed that the resident's nails were long and needed to be clipped. She revealed that resident fingernails were supposed to be trimmed weekly and was included in the care plan. An interview on 09/30/25 at 4:09 PM with the DON confirmed that ADL care was included on Resident #105's Care Plan and since his fingernails were left long, his care plan was not followed. Record review of Resident #105's demographic information revealed that the facility admitted the resident on 03/06/25 with diagnoses that included Left Hemiplegia, Acute Brainstem Stroke, and Dementia. Record review of Resident #105's MDS with an ARD of 08/27/25 revealed under Section C a BIMS Score of 03 which indicated that he had severe cognitive deficits. RESIDENT #134 Record review of Resident #134's "Nutritional Status Care Plan" effective 09/24/25, revealed interventions to include a pureed diet with nectar thickened liquids. An observation and interview on 09/30/25 at 11:32 AM of Resident #134's lunch meal revealed that he had nectar thickened water, nectar thickened sweet tea, and a carton of regular consistency creamy strawberry Glucerna on his tray. An observation also revealed Certified Nursing Assistant (CNA) #2, open his Glucerna and insert a straw into the container for him to drink. CNA #2 confirmed that the Glucerna was not nectar	F0656		

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F0656 SS = D	Continued from page 7 consistency like the water and sweet tea. An interview on 09/30/25 at 4:05 PM with Director of Nursing (DON) confirmed that Resident #134's Pureed Diet with Nectar thickened liquids was included on his care plan and because he was provided with regular consistency Glucerna, his care plan was not followed Record review of Resident #134's meal ticket dated 09/30/25, revealed that he was ordered to have Mechanical Soft, Nectar Thick Diet and this included Glucerna (Thicken) on his meal tray. Record review of Resident #134's "Physician Order Review" revealed a diet order dated 09/24/25 for nectar/mildly thick beverage, Glucerna with L/S (Lunch/Supper). Aspiration Precautions Needed. Record review of Resident #134's demographic information revealed the facility admitted the resident on 09/24/25 with diagnoses that included Right Thalamic Infarction, Stroke, and Communication Impairment. Record review of Resident #134's MDS with an ARD of 03/12/25 under Section C revealed a BIMS Score of 15 which indicated that he had no cognitive deficits.	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, interview, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care related to nail care (Resident #64, Resident #105) and shaving (Resident #5) for 3 (three) of 50 sampled residents. Findings Include: Review of the facility policy titled "Activities of Daily Living" revealed under "Policy Explanation and Compliance Guidelines:...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene…" Resident #5	F0677		

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F0677 SS = D	Continued from page 8 On 9/29/25 at 3:38 PM and again on 9/29/25 at 3:58 PM Resident #5 was observed with multiple scattered gray chin hairs that measured approximately one-half (½) inch. She was pleasantly confused and unable to answer simple questions. On 09/30/25 at 2:38 PM, an observation and interview with Resident #5 and Licensed Practical Nurse (LPN #1) confirmed that the resident had multiple gray hairs on her chin. She admitted that the resident's facial hair should have been removed when she received her bath and that Certified Nurse Assistants (CNA) were supposed to assess facial hair as part of their personal hygiene but that this was not done. On 09/30/25 at 4:11 PM, an interview with the Director of Nursing (DON) stated that she expected residents to be well groomed and that includes facial hair." She confirmed that the CNAs were supposed to remove facial hair on the resident's shower days. On 10/02/25 at 8:25 AM, an interview with CNA #1 confirmed that they were supposed to assess residents during their bath and if we see facial hair, we take care of it. She admitted that Resident #5 was bad to have facial hair and wouldn't want to be seen that way. She stated that Resident #5 should not be presented in public around other residents with that facial hair. On 10/02/25 at 8:30 AM, an interview with LPN #2, confirmed that personal hygiene included removal of facial hair and if women have peach fuzz or any facial hairs, we are supposed to take care of it. LPN #2 also stated, "I don't want to walk around with a beard being a woman". Record review of Resident #5's "Removal of Facial or Bodily Hair Consent" revealed that the consent was signed allowing the staff to shave her face/body hair and was signed on 11/19/24. Record review of Resident #5's "Profile History Report" revealed that under "ADLS", to ensure facial hair is removed as needed. Record review of Resident #5's demographic information revealed that the facility admitted the resident on 11/19/24 with diagnoses that included Alzheimer's, Unspecified Dementia, and Insomnia. Record review of Resident #5's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/25 under Section C revealed a BIMS score of 03 which	F0677		

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F0677 SS = D	Continued from page 9 indicated that she had severe cognitive deficits. Resident #64 An observation on 9/29/25 at 2:35 PM and again on 9/30/25 at 2:55 PM of Resident #64 revealed the resident lying in bed with long, thumb nails, approximately one-eighth (1/8) in length, jagged with a brown substance underneath and his hands were closed into a fist. An observation and interview on 9/30/25 at 3:00 PM at Resident #64's bedside with the Director of Clinical Services confirmed the resident's thumb nails were long and dirty. She opened his hands and revealed that all his fingernails were long with a brown substance underneath. No broken skin was observed on either hand. She stated, "If his nails are not kept trimmed and clean, he could easily get a break in his skin and develop an infection." On 10/01/25 at 9:00 AM the DON was interviewed regarding the facility's expectations for fingernail care. The DON stated, " Staff are expected to keep residents' fingernails trimmed and clean. Long or dirty nails could cause a break in the skin and lead to infection." Record review of Resident #64's demographic information revealed that the facility admitted resident on 2/11/19 with a medical diagnosis that included Anoxic brain injury. Record review of the MDS with an ARD of 7/14/25 revealed under Section C that cognitive skills for daily decision making were severely impaired. Resident #105 On 09/29/25 at 1:10 PM and again on 09/30/25 at 2:53 PM, Resident 105 was observed with long fingernails on both hands that were approximately half of an inch long past the fingertips. On 09/30/25 at 2:55 PM, an observation and interview with LPN #1 confirmed that Resident #105's fingernails were long and needed trimming. She revealed that long fingernails could cause skin tears and possible skin infections. She admitted that Resident #105 was on the schedule for his nails to be clipped every Friday on the day shift and she confirmed that his fingernails had not been clipped in a while.	F0677		

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F0677 SS = D	Continued from page 10 On 09/30/25 at 4:09 PM, an interview with the DON confirmed that the CNA's were supposed to check fingernails and clip them if needed unless the resident was a diabetic. She revealed that fingernail care was supposed to be done weekly on every resident as part of their personal hygiene and grooming needs and expected residents to be well-groomed which included nail care. Record review of Resident #105's demographic information revealed that the facility admitted the resident on 03/06/25 with diagnoses that included Left Hemiplegia, Acute Brainstem Stroke, and Dementia. Record review of Resident #105's MDS with an ARD of 08/27/25 revealed under Section C a BIMS Score of 03 which indicated that he had severe cognitive deficits.	F0677		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure that a resident identified as an elopement risk had the physician prescribed wander alert bracelet applied for one (1) of four (4) residents reviewed for accident hazards. Resident #57 Findings Include: Review of the facility policy titled "Code Alert Policy," unrevised, revealed under Policy: "To prevent wandering residents from leaving the facility or attempting to leave the facility by alerting the nursing staff of their exit through the doors... Procedure: Wandering residents who are deemed to be a Flight Risk will have a code alert bracelet placed on their wrist or ankle…The staff nurse will check each	F0689		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = D	Continued from page 11 transmitter and the door each shift and document on the code alert TAR (treatment administration record) in the EHR (electronic health record) if the transmitters and doors are functioning correctly..." An observation and interview with Resident #57 on 9/29/25 at 12:40 PM revealed she was sitting in her recliner in her room reading a book with a wander alert bracelet lying on a book shelf. Resident #57 stated, "That's something somebody gave me." An observation of Resident #57 on 9/30/25 at 9:42 AM revealed she was again in her recliner reading and the wander alert bracelet remained on the book shelf. Record review of Resident #57's "Physician Orders" revealed an order dated 10/14/24: "Code Bracelet/Wander Alert TAR (treatment administration record) BID (twice daily), code alert, ensure code alert is intact." An observation and interview with Registered Nurse (RN) #1 on 9/30/25 at 2:36 PM revealed Resident #57 was supposed to be wearing a wander alert bracelet because she had Alzheimer's disease and was ambulatory. RN #1 stated Resident #57 had the bracelet for her safety so she would not get out of the facility. During the observation with Resident #57, RN #1 confirmed the resident did not have the bracelet on and stated the nurses were responsible for checking the placement of the device twice daily and documenting it under the task section in the medical record. An interview with the Director of Nursing (DON) on 9/30/25 at 4:06 PM confirmed Resident #57 was at risk for elopement by not wearing the wander device as ordered. Record review of Resident #57's demographic information revealed the facility admitted the resident on 10/14/24 with medical diagnoses that included Alzheimer's Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/26/25 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 3, indicating Resident #57 was severely cognitively impaired.	F0689		

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F0689 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure proper placement of a gastrostomy tube prior to medication administration for one (1) of two (2) enteral tubes reviewed. Resident #64 Findings Include: Review of the facility policy titled “Enteral Tube Medication,” unrevised, revealed under Policy Explanation and Compliance Guidelines: “8. Enteral tube placement must be checked via auscultation and/or aspiration before any fluids or medication are administered.” During an observation on 9/30/25 at 12:10 PM with Resident #64, Licensed Practical Nurse (LPN) #5 flushed the resident’s enteral tube with water and administered medications without first verifying placement of the tube.	F0689 F0693		

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F0693 SS = D	Continued from page 13 An interview with LPN #5 on 9/30/25 at 12:21 PM confirmed that she did not check placement of Resident #64's enteral tube prior to administering medications and that it should have been done to ensure the tube was in the proper place to prevent aspiration. She admitted that the nursing staff was supposed to follow standards of practice by aspirating gastric contents of the tube to verify placement. An interview with the Director of Nursing (DON) on 9/30/25 at 4:02 PM confirmed enteral tube placement should be verified prior to flushes or medication administration to ensure the tube had not migrated, which could lead to aspiration. Record review of Resident #64's demographic information revealed the facility admitted resident on 1/23/19 with medical diagnoses that included Anoxic Brain Injury and that the resident receives feedings through a gastrostomy.	F0693		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F0761		

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F0761 SS = D	Continued from page 14 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 the safe storage and security of medications for one (1) of 128 residents reviewed during initial tour. Resident #101 Findings Include: Review of the facility policy titled “General Rules for Residents and Sponsors” (undated) revealed under section .5: “Residents are not permitted to keep any medications in their room unless the interdisciplinary team has determined that this practice is safe and ordered by the physician.” An observation and interview with Resident #101 on 9/29/25 at 12:42 PM revealed she was lying in bed with a Symbicort inhaler and a Spiriva inhaler lying on a table in the room. Resident #101 stated the nurse had forgotten to come back and get them after she took them that morning. Record review of the “Medication Administration Record (MAR)” revealed an order dated 7/14/25, “Tiotropium (Spiriva Respimat) 1.25 mcg(microgram)/INH (inhalation aerosol), inhale 2 puffs daily.” The MAR also revealed an order dated 7/22/24, “Budesonide-formoterol 80 mcg (microgram)– 4.5 mcg(microgram)/INH (inhalation aerosol), inhale 1 puff BID (twice daily).” An interview with Registered Nurse (RN) #1 on 9/30/25 at 2:30 PM revealed Resident #101 did not have an order to self-administer medications. RN #1 stated the nurse should always remain in the room and watch the resident take the medication appropriately, and medications should never be left unattended. She explained that leaving medications in the room could result in the resident taking too much or another resident gaining access to the medication. An interview with Licensed Practical Nurse (LPN) #3 on 9/30/25 at 2:49 PM confirmed she was responsible for leaving the inhalers in Resident #101’s room. She explained she had to step next door to assist another resident and left the medications on the TV stand. LPN #3 acknowledged that leaving medications at the bedside could harm Resident #101 if she took too much or could	F0761		

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F0761 SS = D	Continued from page 15 pose a risk if another resident accessed the medication. An interview with the Director of Nursing (DON) on 9/30/25 at 4:00 PM revealed her expectations were that all medications must be securely stored in the medication carts and never left in a resident's room. Record review of Resident #101's demographic information revealed the facility admitted resident on 8/17/20 with a medical diagnosis that included Atherosclerotic Heart Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/10/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 13, indicating Resident #101 was cognitively intact.	F0761		
F0808 SS = D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide a prescribed therapeutic diet for one (1) of 50 sampled residents. Resident #134. Findings Include: Review of the facility policy titled, "Thickened Liquids" revealed, "It is the policy of the (proper name) facility that residents receive liquids as they are ordered and recommended by their physician and or speech language pathologist. An observation and interview on 09/30/25 at 11:32 AM of Resident #134's lunch meal revealed that he had nectar	F0808		

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F0808 SS = D	Continued from page 16 thickened water, nectar thickened sweet tea, and a carton of regular consistency creamy strawberry Glucerna on his tray. An observation also revealed Certified Nursing Assistant (CNA) #2, open his Glucerna and insert a straw into the container for him to drink. CNA #2 confirmed that the Glucerna was not nectar consistency like the water and sweet tea. During an observation and interview on 09/30/25 at 11:36 AM in Resident #134's room with Registered Nurse (RN) #1, she confirmed that the Strawberry Glucerna that was on Resident #134's meal tray was regular consistency. She revealed that not providing his prescribed nectar thickened liquids could cause him to choke and aspirate. She also confirmed that Resident #134's meal ticket on his tray showed that he was supposed to be getting thickened Glucerna with his meal. RN #1 removed the Glucerna from Resident #134's tray and left the room. An interview on 09/30/25 at 4:05 PM with the Director of Nursing (DON), revealed that Resident #134's meal was supposed to come from the kitchen ready to consume and this included the addition of thickener to his Glucerna. She also confirmed that by not providing Resident #134 with the thickened Glucerna, this could result in aspiration and lead to respiratory problems. An interview on 10/01/25 at 9:40 AM with the Dietary Manager (DM) confirmed that Resident #134 should have received thickened Glucerna from the kitchen. He also confirmed that all staff who prepared resident plates for meals were supposed to look at meal tickets and make sure they matched what was on the trays. He admitted that it was ultimately the responsibility of the Dietary Supervisor to ensure that a resident received the proper prescribed diet. An interview on 10/01/25 at 11:05 AM with the Dietary Supervisor (DS) #2 confirmed that Resident #134 should have received nectar thickened Glucerna yesterday and by not receiving the prescribed diet, he could have gotten strangled. She revealed that when a resident had a meal ticket that included Glucerna (thickened), they were supposed to pour the Glucerna in a separate glass and add thickener to it to make the right consistency. She admitted that everyone on the serving line was supposed to check to ensure the meal ticket orders matched what they served. Dietary Supervisor #2 added that she normally caught those mistakes and stated, "I just missed it yesterday." Record review of Resident #134's meal ticket dated 09/30/25, revealed that he was ordered to have a	F0808		

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F0808 SS = D	Continued from page 17 Mechanical Soft, Nectar Thick Diet and this included Glucerna (Thicken) on his meal tray. Record review of Resident #134's "Physician Order Review" revealed a diet order dated 09/24/25 for nectar/mildly thick beverage, Glucerna with L/S (Lunch/Supper). Aspiration Precautions Needed. Record review of Resident #134's "Face Sheet" revealed an admission date of 09/24/25 and that he had diagnoses that included Right Thalamic Infarction, Stroke, and Communication Impairment. Record review of Resident #134's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 03/12/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that he had no cognitive deficits.	F0808		
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 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 observation, interview, record review, and facility policy review, the facility failed to ensure the kitchen equipment and surrounding areas were	F0812		

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F0812 SS = F	Continued from page 18 maintained in a clean and sanitary condition for two (2) of three (3) kitchen tours. Findings Include Record review of the facility policy titled, “General Sanitation of the Kitchen” undated, revealed "The staff shall maintain the sanitation of the kitchen through compliance with a written comprehensive cleaning schedule. …4. A cleaning schedule will be posted. Employees will be trained on the cleaning schedule and how to perform duties. Employees will initial and date tasks when completed..." During the initial kitchen tour on 9/29/25 at 12:20 PM, observation of the deep fryer revealed a thick yellow and black substance with food particles built up down the entire right side of the fryer. The left side of the stove had splattered buildup, and underneath the fryer was a thick, greasy substance with food particles extending across the surrounding floor. On 10/01/25 at 9:15 AM, during an interview and concurrent observation, the Dietary Manager (DM) revealed that fryer oil is to be changed weekly and that the fryer’s exterior is to be cleaned at that time, with staff required to initial and date the task upon completion. The DM confirmed that the fryer’s right side had thick yellow and black buildup with food particles, and the left side of the stove had splattered buildup. He stated, “It looks like it has not been cleaned in a while.” The DM further confirmed the greasy buildup underneath and around the fryer should have been mopped and acknowledged that cleaning the floors was not currently included in the cleaning schedule, but should be, to ensure completion. On 10/01/25 at 9:25 AM, an interview and review of the “Weekly Cleaning Schedule” for September 2025 with the DM revealed initials indicating fryer cleaning was completed. The DM confirmed that the fryer cleaning task specifies “Interior/Exterior.” He acknowledged, “I can see where this could be just initialed as done without it actually being done, because obviously by the looks of things we can see that it was not cleaned like it should have been and that is unacceptable.” On 10/01/25 at 9:30 AM, an interview with Dietary Supervisor (DS) #1 stated that cleaning the floors is everyone’s responsibility, even if not listed on the schedule, and confirmed that the greasy buildup under the fryer and the dirty fryer and stove were not acceptable. She stated the kitchen should always be kept clean and sanitary.	F0812		

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F0812 SS = F	Continued from page 19 During an interview on 10/01/25 at 3:45 PM, the Administrator (ADM) revealed that the expectation is that the kitchen where resident meals are prepared is always kept clean and sanitary to prevent any potential foodborne illness.	F0812		
F0880 SS = D	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 followed to prevent spread of infections; (iv)When and how isolation should be used for a	F0880		

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F0880 SS = D	Continued from page 20 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 observations, interviews, record review and facility policy review, the facility failed to ensure the possibility of the spread of infection by respiratory equipment not being stored properly for one (1) of two (2) residents observed receiving nebulizer treatments (Resident # 53). Findings Include Review of the facility policy titled "Nebulizer Therapy" with an approval date of 8/06/25 revealed, "It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions." An observation on 9/29/25 at 4:30 PM and again on	F0880		

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F0880 SS = D	Continued from page 21 9/30/25 at 1:45 PM revealed Resident #53's nebulizer was sitting on top of the resident's oxygen concentrator with the mouthpiece uncovered and not stored in a clean or protected manner. During an observation and interview with the Clinical Services Director on 9/30/25 at 3:30 PM, she confirmed that Resident # 53's mouthpiece was not stored properly. She stated that "It should be covered, stored in a clean bag or container because leaving it out like that could cause an infection." On 10/01/25 at 10:15 AM an interview with the Director of Nursing (DON) confirmed that nebulizer mouthpieces should always be stored in a bag to prevent contamination. Record Review of "LTC Physician Order Review/Renewal" reveals Resident #53 has an order for Ipratropium-Albuterol 3 mL (milliliters) Inhale solution two times a day as needed for wheezing. Record review of the "Face Sheet" revealed that the facility admitted Resident #53 on 9/15/2022 with a medical diagnosis that Airway-centered interstitial fibrosis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/01/25 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 12 which indicated Resident #64 was moderately cognitively impaired.	F0880		