STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A422	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER B CROOK NURSING FACILITY	**840 NORTH OAK AVENUE , RULEVILLE, Mississippi, 38771**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey with one (1) complaint investigation (CI) MS # 2666740 at the facility from 11/11/25-11/13/25. 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 F0641 for Accuracy of Assessments, F0656 for Care Plans, F0677 for Activities of Daily Living, F0686 for Pressure Ulcers, F0690 for Bowel/Bladder Incontinence, F0757 for Drug Regimen, and F0880 for Infection Control. There were no deficiencies cited for CI MS# 2666740. The census at the time of the survey was 55 and the facility is licensed for 60 beds.	F0000		
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. §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-	F0641		

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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F0641 SS = D	Continued from page 1 (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 quarterly Minimum Data Set (MDS) assessment for one (1) of 16 MDS assessments reviewed. (Resident #6) Findings Include: Review of the facility policy titled, "Comprehensive Assessments and the Care Delivery Process" with revised date 12/2016, revealed, "Comprehensive assessments will be conducted to...Define current treatments and services..." Record review of Resident #6's quarterly MDS assessment, with an Assessment Reference Date (ARD) date of 10/14/25, noted that Section N - Medications, N0350 revealed the resident had received insulin injections for one (1) day during the last seven (7) days. Record review of Resident #6's Medication Administration Record (MAR) dated 10/1/2025-10/31/2025, revealed Resident #6 did not have an order for insulin, nor did she receive an insulin injection. Record review of Resident #6's Immunizations revealed Resident #6 received an influenza vaccination on 10/8/25. An interview on 11/12/2025 at 12:53 PM, with MDS Coordinator, she confirmed that Resident #6 does not receive insulin injections. She confirmed that the MDS was coded incorrectly. She further confirmed that Resident #6 received her flu shot on 10/8/25 and that was the only injection that she received in October 2025. An interview on 11/12/2025 at 1:00 PM, the Administrator, she expressed her expectation that MDS assessments be completed timely and accurate when completed. Record review of the Admission Record revealed that Resident #6 was admitted to the facility on 3/1/24. Her medical diagnoses included Unspecified Dementia, Unspecified Severity, with Other Behavioral Disturbance. Record review of the quarterly MDS with an ARD of 10/14/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 99, indicating that the resident was unable to complete the interview.	F0641		

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F0641 F0656 SS = D 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 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-	F0641 F0656		

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F0656 SS = D	Continued from page 3 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident and staff interviews, record reviews, and facility policy review, the facility failed to develop a plan of care that included nail care for Activities of Daily Living (ADLs) for two (2) of 16 sampled residents, (Resident #8 and #46); and failed to implement comprehensive care plans for two (2) of 16 sampled residents. (Resident #2 and #7) Findings Include: Review of the facility policy titled, “Care Plans, Comprehensive Person-Centered” with a revision date of December 2016, revealed under “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 #2 and Resident #7 Record review of Resident #2’s Care Plans revealed under, “Focus: I am at risk for adverse effects r/t (related to) use of psychotropic medications for a dx (diagnosis) of Major Depressive d/o (disorder) and anxiety d/o (disorder).” Also revealed under, “Interventions: Monitor for side effects and effectiveness Q (every)-SHIFT.” Record review of Resident #7’s Care Plans revealed under, “Focus: I am prescribed antidepressant medication (Seroquel) for a diagnosis of Major Depressive Disorder.” Also revealed under, “Interventions: Monitor/document side effects and effectiveness Q (every)-SHIFT.” Record review of the November 2025 “Medication Administration Record” for Resident #2 and #7 revealed no documentation of side effect monitoring for either resident. On 11/12/25 at 2:10 PM, an interview with Licensed Practical Nurse (LPN) #1 confirmed side effects were not being monitored for Resident #2 and #7 and should have been according to the care plan. During an interview on 11/13/25 at 8:40 AM, the Care Plan Coordinator confirmed the care plans for Residents #2 and #7 were not followed.	F0656		

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F0656 SS = D	Continued from page 4 Record review of the “Admission Record” revealed the facility admitted Resident #2 on 11/03/17 with a medical diagnosis including Major Depressive Disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/15/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #2 was cognitively intact. Record review of the “Admission Record” revealed the facility admitted Resident #7 on 8/05/25 with a medical diagnosis including Unspecified Dementia with Behavioral Disturbance. Record review of the MDS with an ARD of 8/15/25 revealed under section C, a BIMS summary score of 99, indicating Resident #7 was unable to complete the interview. Resident #8 Record review of care plans for Resident #8 revealed no care plans were developed for nail care. On 11/11/2025 at 11:46 AM and again on 11/12/25 at 10:15 AM, during an observation an interview with Resident #8 revealed the resident had approximately three-fourths (3/4") inch long, jagged fingernails with brown substance underneath. She stated she would like to have her nails cut shorter. On 11/12/2025 at 10:34 AM during an interview with the Director of Nursing (DON), she confirmed that a nail care plan was not developed to include nail care for Resident #8 and that the importance of a care plan is to ensure the resident receives person-centered care, specific to residents’ wants and needs. Record review of Resident #8’s Admission Record revealed that the resident was admitted to the facility on 4/16/2025 with a medical diagnosis that included Cerebral Infarction, Unspecified. Record review of the MDS with an ARD of 9/19/2025 revealed under Section C that Resident #8’s BIMS score was 7, indicating that the resident was severely impaired.	F0656		

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F0656 SS = D	Continued from page 5 Resident #46 Record review of care plans for Resident #46 revealed no care plan was developed for nail care. On 11/11/25 at 11:35 AM and again on 11/12/25 at 10:00 AM an observation of Resident #46 revealed the resident lying in bed with long nails, approximately one-fourth (1/4) inch in length on to the left hand and approximately one-half (1/2) inch in length on the right hand with a brown substance underneath. The right hand was observed as contracted and in a clenched fist. An interview on 11/12/25 at 1:16 PM with LPN #1 revealed that a care plan was not developed to include nail care for Resident #46 and that the importance of a care plan for residents is to ensure a person-centered care specific to residents' wants and needs. Record review of Resident #46 's Admission Record revealed that the facility admitted resident on 7/19/2019 with a medical diagnosis that included Cerebral Infarction, Unspecified. Record review of the MDS with an ARD of 8/29/2025 revealed under Section C that Resident #46's BIMS was 6 and the resident's cognitive skills for daily decision making were severely impaired.	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 observations, resident and staff interviews, record review, and facility policy review, the facility failed to provide proper nail care for two (2) of sixteen 16 sampled residents. (Resident #8 and #46) Findings Include: Record review of the facility policy titled "Activities of Daily Living, Supporting" revised March 2018, revealed "…Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene…"	F0677		

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F0677 SS = D	Continued from page 6 Review of the facility policy titled "Activities of Daily Living" revealed under "Fingernails/Toenails, Care of" with a revision date of February 2018 states, "The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections." Resident #8 During an observation and interview with Resident #8 on 11/11/2025 at 11:46 AM and again on 11/12/25 at 10:15 AM, revealed the resident had approximately three-fourths (3/4") inch long, jagged fingernails with brown substance underneath and she stated she would like to have her nails cut shorter. During an observation and interview on 11/12/2025 at 10:21 AM, Certified Nursing Assistant (CNA) #1, she confirmed Resident #8 had long jagged fingernails. She stated nail care was the responsibility of the treatment nurse. She further stated that long, jagged fingernails could cause skin tears. During an observation and interview on 11/12/2025 at 10:28 AM, with the Treatment Nurse, she confirmed that Resident #8's fingernails were approximately 3/4" in length and had jagged edges. She stated that nail care could be provided by nurses and CNAs unless the resident was a diabetic, then only a nurse could cut their nails. She further stated that when a resident had long, jagged fingernails that puts them at risk for scratches, skin tears, and infections and that proper nail care was just part of hygiene. During an interview on 11/12/2025 at 10:30 AM, with the Administrator, she confirmed that nail care could be provided by all nursing staff, except for diabetic residents, and it should be performed at least weekly. During an interview on 11/12/2025 at 10:34 AM, with the Director of Nursing (DON), she confirmed that CNA's and nurses can perform nail care on residents unless they are diabetic, then it is to be done by nurses only. Record review of Resident #8's Admission Record revealed that the resident was admitted to the facility on 4/16/2025 with a medical diagnosis that included Cerebral Infarction, Unspecified. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/19/2025 revealed under Section C that Resident #8's Brief Interview for Mental Status (BIMS) score was 7, indicating that the resident was severely impaired.	F0677		

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F0677 SS = D	Continued from page 7 Resident #46 An observation on 11/11/25 at 11:35 AM and again on 11/12/25 at 10:00 AM of Resident #46 revealed the resident lying in bed with long nails, approximately one-fourth (1/4) inches in length on the left hand and approximately one-half (1/2) inches in length on the right hand with a brown substance underneath. The right hand was observed as contracted and in a clenched fist. An observation and interview on 11/12/25 at 10:24 AM at Resident #46's bedside with Registered Nurse (RN) #2 confirmed the resident's nails were long and dirty. She opened her hand and revealed that all the 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 11/12/25 at 11:41 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 #46 's Admission Record revealed that the facility admitted resident on 7/19/2019 with a medical diagnosis that included Cerebral Infarction, Unspecified. Record review of the MDS with an ARD of 8/29/2025 revealed under Section C that Resident #46's BIMS was 6 and the cognitive skills for daily decision making were severely impaired.	F0677		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F0686		

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F0686 SS = G	Continued from page 8 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 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 identify, accurately assess, document, and implement treatment for a pressure injury for one (1) of 55 residents. This failure resulted in an avoidable full-thickness tissue loss wound not being treated after identification for ten (10) days because the physician order was not implemented for Resident #5. Findings Include: Review of the facility policy titled “Wound Care Policy and Protocol” dated 1/24/25, revealed under, “2. Policy Statement: Proper name of the facility is committed to 1. Proactive wound prevention through comprehensive assessments. 2. Prompt identification and treatment of wounds. 3. Use of advanced wound care techniques. 4. Minimizing infection risks through proper dressing techniques. 5. Educating staff and residents on wound prevention and care.” The documented practice did not reflect the policy requirements for proactive identification and timely intervention. An observation and interview with Resident #5 on 11/11/25 at 1:16PM revealed he was lying in bed and stated he had a sore on his bottom that he developed after coming to the facility. Record review of the “Progress Notes” dated 11/05/25 revealed Resident #5 had a sacral Stage 3 pressure ulcer measuring 2.4 centimeters in length x (by) 1.3 centimeters in width x (by) 0.2 cm in depth with 100% granulation tissue, confirming advanced tissue loss. An observation of wound care on 11/12/25 at 9:05 AM with the Wound Nurse revealed Resident #5 had the sacral wound for a while. She stated the resident was seen weekly by wound care and the wound had been debrided several times. The wound was circular over the sacral region, edges well-defined, and the wound bed contained 80% (percent) red granulation tissue and 20% yellow adherent slough.	F0686		

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F0686 SS = G	Continued from page 9 Record review of Resident #5's hospital "Discharge Summary" dated 3/18/25 revealed documentation that the "Sacrum and bilateral buttocks were clear of wound" on admission to the facility. Record review of Resident #5's "Skin/Wound Note" dated 4/04/25 revealed, "Nurse called to room regarding resident's sacral area. Nurse noted a stage III pressure ulcer measuring 1.9 centimeters (CM) x 3.0 CM x 0.1 CM. 50% epithelial tissue, 25% slough, 25% eschar noted," confirming full-thickness skin breakdown on this date. Record review of "Weekly Skin Audits" dated 3/22/25 for Resident #5 revealed, "No new skin issues noted." Record review of "Weekly Skin Audits" dated 3/29/25 revealed documentation of "No new skin issues noted at this time per CNA (Certified Nurse Aide)" indicating assessments were inaccurately completed or concerns were not correctly documented. Record review of the April 2025 "Treatment Administration Record (TAR)" revealed an order dated 10/08/24, "Apply lantiseptic ointment to coccyx area every shift related to (R/T) excoriation until resolved," was initialed as completed on 4/1, 4/2, 4/3, with no accompanying documentation indicating a change in skin condition. No evidence was found to show the skin issue was identified or escalated prior to being staged as a Stage III on 4/4/25. An interview with the Wound Nurse on 11/12/25 at 2:20 PM revealed aides were required to complete body map forms for new skin concerns and submit them to the Director of Nursing (DON). The wound nurse stated weekly skin audits were to be completed by the medication cart nurses each week. She acknowledged the wound should have been identified earlier and confirmed the wound was avoidable. An interview with Staff Development Nurse on 11/13/25 at 9:12 AM with the DON present, revealed they had discovered that a night shift CNA found the open area to Resident #5's sacrum on 3/26/25, and she had completed a body audit form and notified the night shift nurse. The night shift nurse received treatment orders from the Emergency room (ER) doctor, but she failed to carry out the order or enter it into the computer system. She explained the nurse left the	F0686		

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F0686 SS = G	Continued from page 10 information in a binder at the nurse's desk for the incoming Registered Nurse (RN) charge nurse, which then called in the following morning, resulting in the order not being completed or carried out. The DON and the Staff Development Nurse confirmed this failure allowed the wound to remain unrecognized and untreated until 4/4/25, when it had progressed to full-thickness tissue loss. The nurse that was responsible was an agency staff nurse and she was no longer allowed to work at the facility. The facility provided documentation for Resident #5 that was left in a binder at the nurse's station dated 3/26/25 and read, "Small open area to coxy area." There was a written note attached that read, "Emergency room (ER) doctors said clean with wound cleanser (WC) and apply Duoderm. Stage 2. Turn every (Q) two (2) hours and notify wound care. I didn't put order in yet," confirming staff acknowledgment of a wound. There was no documentation in the Electronic Medical Record (EMR) regarding new skin concerns, and no orders were carried out. Wound was later re-identified on 4/4/25 as a Stage III. Record review of the "Admission Record" revealed the facility admitted Resident #5 on 3/19/25 with a medical diagnosis including Multiple Sclerosis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/22/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 14, indicating Resident #5 was cognitively intact.	F0686		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F0690		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER B CROOK NURSING FACILITY	840 NORTH OAK AVENUE , RULEVILLE, Mississippi, 38771

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F0690 SS = D	Continued from page 11 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews and record review, the facility failed to provide bowel and bladder training services to reduce incontinence for one (1) of 16 sampled residents. (Resident #10) Findings include: Review of "Facility Statement Regarding Bowel and Bladder Policy" with no date revealed the facility did not have a policy for Bowel and Bladder. Record review of Resident #10's Bowel/Bladder Screenings dated 8/15/24 and 11/8/24 revealed Resident #10 was a good candidate for retraining. The Bowel/Bladder Screenings dated 2/3/25, 4/29/25, and 7/23/25, revealed Resident #10 was a candidate for schedule toileting. An interview on 11/12/2025 at 4:00 PM, with the Administrator and Director of Nursing (DON), revealed the facility did not currently have a bowel/bladder (B/B) toileting program. They stated that after the screenings are completed that a Registered Nurse (RN) reviews the screening and makes a decision or recommendation accordingly. Record review of Resident #10's plan of care, "I sometimes have trouble getting to the bathroom in time. Staff are helping me retrain my bladder and bowel so I can stay dry and comfortable as much as possible" developed 10/10/25, revealed the following goals, "I will improve or maintain my bladder and bowel control by participating in my individualized toileting program..." with the following interventions noted, "Adjust schedule based on identified bladder pattern or resident feedback...Interdisciplinary team reviews	F0690		

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F0690 SS = D	Continued from page 12 during quarterly and significant change assessments to determine continued appropriateness of retraining program...Nurse reviews weekly for progress or modification needs..." During an interview on 11/13/2025 at 8:27 AM, with the DON and the RN #1, Care Plan Coordinator, confirmed that Resident #10 has incontinent episodes and is not on a toileting program because they don't currently have a toileting program. Both nurses confirmed that there was no documentation following each B/B screening by a RN assessing the need for the program. RN #1, Care Plan Coordinator, stated, "There is a note in for October only." The DON stated they do remind her to toilet every few hours but there is not documentation for that. She confirmed that Resident #10 should be on a toileting program to help maintain her current level of independence. Record review of progress note dated 10/10/2025 revealed, "Care plan review and update performed regarding bowel and bladder program screener. Resident scored as a candidate for scheduled toileting or timed voiding. Staff are providing regular, scheduled toileting assistance with the goal of helping the resident stay dry and maintain skin integrity. Resident is cooperative with toileting efforts. Progress and response to the toileting schedule will be monitored and documented, and care plan will be updated as needed."Record review of Resident #10's Admission Record revealed that the resident was admitted to the facility on 2/23/2024 with a medical diagnosis that included Multiple Sclerosis and Epilepsy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/17/2025 revealed under Section C that Resident #10's Brief Interview for Mental Status (BIMS) score was 15, indicating that the resident was cognitively intact.	F0690		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F0757		

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F0757 SS = D	Continued from page 13 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to monitor for side effects of psychotropic medications for two (2) of five (5) residents reviewed for unnecessary medications. Resident #2 and #7 Findings Include: Review of the facility policy titled “Antipsychotic Medication Use” revised 12/16, revealed under, “Policy Statement: Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. Also revealed under, “Policy Interpretation and Implementation: … 17. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician..." Record review of Resident #2’s Medication Administration Record (MAR) revealed an order dated 9/11/25, “Quetiapine Fumarate (antipsychotic) Tab (tablet) 25 milligrams (MG) give one (1) tablet orally three times a day related to Major Depressive Disorder.” There was no indication on the MAR that side effects were being monitored. Record review of Resident #7’s MAR revealed an order dated 8/12/25, Seroquel (antipsychotic) oral tablet 50 MG (Quetiapine Fumarate) give 1 tablet by mouth in the evening related to Major Depressive Disorder.” There	F0757		

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F0757 SS = D	Continued from page 14 was no indication on the MAR that side effects were being monitored. An interview with Licensed Practical Nurse (LPN) #1 on 11/12/25 at 2:10 PM revealed side effects were supposed to be monitored on all residents that take psychotropic medication to ensure the residents can tolerate the medication. After reviewing the MAR, she confirmed side effects were not being monitored for Resident #2 and #7. An interview with LPN #2 on 11/12/25 at 3:59 PM revealed when the facility swapped over charting systems in July 2024, the side effects monitoring did not carry over into the new medical record charting system. She stated side effect monitoring needed to be done to ensure the residents side effects did not go unrecognized. Record review of the “Admission Record” revealed the facility admitted Resident #2 on 11/03/17 with a medical diagnosis including Major Depressive Disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/15/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #2 was cognitively intact. Record review of the “Admission Record” revealed the facility admitted Resident #7 on 8/05/25 with a medical diagnosis including Unspecified Dementia with Behavioral Disturbance. Record review of the MDS with an ARD of 8/15/25 revealed under section C, a BIMS summary score of 99, indicating Resident #7 was unable to complete the interview.	F0757		
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	F0880		

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F0880 SS = D	Continued from page 15 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 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.	F0880		

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F0880 SS = D	Continued from page 16 §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, staff interviews, record review and facility policy review, the facility failed to ensure infection control practices were maintained for two (1) of three (3) care opportunities. (Resident #13) Findings include: A review of the policy titled, “ENHANCED BARRIER PRECAUTIONS (EBP)" effective 4/1/24 revealed, "For residents whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Device care of use: Central line, urinary catheter, feeding tube, etc.” During an observation of medication administration on 11/12/2025 at 9:08 AM for Resident #13 with Licensed Practical Nurse (LPN) #3, it was observed that the nurse failed to use EBP while administering Percutaneous Endoscopic Gastrostomy (PEG) medications. During an interview on 11/12/25 at 9:25 AM with LPN #3, she confirmed that EBP should have been used during medication administration for residents with PEG tubes. She further stated that EBP was ordered to help prevent the spread of infection and she forgot to put the gown on herself prior to administering the medications. During an interview on 11/12/25 at 9:38 AM with the Director of Nursing (DON), she stated EBP should be used with any tubes or wounds to prevent possible cross contamination. She further stated that her expectations were for staff to follow EBP with all care provided for residents with a tube or wound.	F0880		

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F0880 SS = D	Continued from page 17 Record review of the Admission Record that Resident #13 was admitted to the facility on 12/24/2013 with medical diagnoses that included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/10/2025 revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 0 indicated that an interview should not be conducted because the resident was rarely/never understood.	F0880		