STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255213	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADVILLE CONVALESCENT HOME	**300 HWY 556/ROUTE 2 BOX 66 , MEADVILLE, Mississippi, 39653**

(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 a Complaint Investigation (CI) MS# 2661170 at the facility from 11/10/25 through 11/12/25. CI MS# 2661170 was investigated related to accidents, residents' rights and quality of care. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and there were two (2) deficiencies cited, F552 and F555. The facility held a license for 57 beds, with a census of 42.	F0000		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, facility policy review and interviews, the facility failed to ensure the resident's right to be informed of, and participate in,	F0552		

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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F0552 SS = D	Continued from page 1 treatment decisions, including the right to be fully informed in advance of the care to be furnished, the type of practitioner providing treatment, and the risks and benefits of proposed care for one (1) of ten (10) sampled residents (Resident #3). Findings Included: A policy review of the facility's policy titled "Standard of Care," with a revision date of 9/15/25, revealed the policy stated, "It is the policy of this facility to provide a standard of treatment and care most beneficial to residents… Regardless of payment methods, all residents shall have access to… Care that meets their needs, Their attending physician, Clinical and administrative staff… In providing care to all residents our staff will be… effective communicators with one another." A policy review of the facility's policy titled "Medical, Dental and L.I.P. Providers: Selection, Appointments and Communications," with a revision date of 11/28/17, revealed the policy stated, "The facility shall support each resident's right to fully choose a personal physician, dentist, and other licensed independent practitioner. Residents and/or family members may request information regarding the physicians and other practitioners responsible for his/her care. A.H.M. facilities shall provide the health care provider's name, credentials and phone number to the resident/family." A record review of the Admission Record for Resident #3 revealed Resident #3 was admitted on 9/30/25 with an initial admission date of 4/03/24. Diagnoses included osteomyelitis of vertebra, sacral and sacrococcygeal region (onset 4/04/24), peripheral vascular disease, diabetes, dementia, and Stage 3 pressure ulcers of the right heel and other sites. Medical Director (MD) #1 was the documented primary physician, and the resident's power of attorney (POA) was his nephew. A record review of the Quarterly Minimum Data Set (MDS) with Assessment Reference Date 9/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS revealed Resident #3 required supervision for eating, was dependent on all other ADLs, used a wheelchair for mobility, and had unhealed pressure ulcers, including two Stage 3 ulcers and one Stage 4 ulcer. A review of the Wound Log dated 8/06/25 revealed Medical Director #1 documented that wound cultures obtained three months earlier grew Proteus, Staph, and	F0552		

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F0552 SS = D	Continued from page 2 Enterococcus, with sensitivities indicating Zyvox and Vancomycin as drugs of choice. He documented that a repeat culture might be considered the following week and that a Percutaneous Intravenous Central Catheter (PICC) line could be needed if indicated. A record review of a progress note dated 8/11/25 revealed, “Verbal consent obtained per resident’s RP (Family Member/Not Responsible Party) for MDB to see resident,” entered as a late entry by the DON on 8/20/25. A record review of progress notes dated 8/11/25 at 17:28, entered by LPN #1, revealed communication with the Resident Representative (RR) regarding a thyroid nodule and consultation for biopsy. The RR stated, “I say leave it alone.” MD #2, the Director of Nursing (DON), and the administrator in training were notified. The RR was also informed of the residents’ swallowing difficulties. On 11/11/25 at 1:00 PM, an interview with the Administrator revealed the facility decided—without input from affected residents or their representatives—to discontinue sending residents, including Resident #3, to the local wound care clinic where they had been treated by Medical Director #1. Instead, the facility transferred wound care to a certified wound care nurse practitioner providing infacility services. He acknowledged no printed letters were issued, no notifications were made to residents or their RPs, and Resident #3’s RR was not contacted, despite documentation that the facility had communicated with the RR regarding other care matters on 8/11/25. He confirmed the change occurred despite opposition from both MD #1 and MD #2 and stated there was no reason residents could not continue receiving wound care both in the clinic and in the facility. On 11/12/25 at 10:57 AM, a telephone interview with Resident #3’s RR and POA revealed he had not been notified of the change in Medical Director, the revocation of attending physician privileges, or the transition to an infacility wound care. He confirmed he received no verbal, written, or electronic communication regarding changes in providers or treatment locations and had not been informed of any need to make decisions regarding physician participation. He stated he believed Resident #3 had continued attending weekly wound care clinic visits and was unaware that the resident had missed appointments. He reported that Resident #3 could not make medical decisions and that his placement decision was based on his trust in MD #1 and MD #2.	F0552		

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F0552 SS = D	Continued from page 3 On 11/13/25 at 10:04 AM, during a telephone interview, Medical Director #1 stated he was concerned about Resident #3's sacral and forefoot wounds, which required ongoing monitoring for infection. He stated he had planned to evaluate the resident for potential intravenous antibiotic therapy, including possible PICC line placement, and that this plan was documented in the Wound Log provided to the facility. He stated he was unable to evaluate the resident's wounds for three weeks in August while the facility diverted the resident to in house treatment by a wound care nurse practitioner.	F0552		
F0555 SS = E	Right to Choose/Be Informed Attendg Physician CFR(s): 483.10(d)(1)-(5) §483.10(d) Choice of Attending Physician. The resident has the right to choose his or her attending physician. §483.10(d)(1) The physician must be licensed to practice, and §483.10(d)(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment. §483.10(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(d)(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options. §483.10(d)(5) If the resident subsequently selects	F0555		

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F0555 SS = E	Continued from page 4 another attending physician who meets the requirements specified in this part, the facility must honor that choice. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and facility policy review the facility failed to inform residents/resident representatives that their chosen attending physician was unable to meet requirements as the facility sought to seek alternate physician for provision of care and treatment without attempt to work with the residents' chosen attending physicians or mediate differences for nine (9) of eleven (11) sampled residents; Resident #2, Residents #3, Resident #4, Resident #5, Resident #7, Resident #8, Resident #9, Resident #10 and Resident #11. Findings Included: Policy review of the facility policy titled, “Standard of Care” with Revision Date 9/15/22 revealed, “It is the policy of this facility to provide a standard of treatment and care most beneficial to residents…Regardless of payment methods, all residents shall have access to…Care that meets their needs, Their attending physician, Clinical and administrative staff…In providing care to all residents our staff will be…effective communicators with one another…” Policy review of the facility policy titled, “MEDICAL, DENTAL AND L.I.P. PROVIDERS: SELECTION, APPOINTMENTS AND COMMUNICATIONS” with Revision Date 11/28/2017 revealed “POLICY: The facility shall support each residents’ right to fully choose a personal physician, dentist and other licensed independent practitioner (L.I.P)…PHYSICIAN COMMUNICATIONS: Residents and/or family members may request information regarding the physicians and other practitioners responsible for his/her care. (Proper Name) facilities shall provide the health care provider’s name, credentials and phone number to the resident/family.”. Record review of Residents’ Rights with Revision Date 10/10/22 revealed, “The resident has the right to a dignified existence, self-determination…3. Choice of attending physician. The resident has a right to choose his or her attending physician.”. On 11/11/25 at 1:00 PM during an interview the facility Administrator stated that the facility decided, without input from residents who received wound care from the Medical Director (MD) at the local wound care clinic, or their resident representatives, that wound care	F0555		

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F0555 SS = E	Continued from page 5 would be changed to in facility wound care performed by a certified wound care nurse practitioner. He stated that no printed letters were posted to residents or their representatives. He stated that Resident #3's contact was contacted but not his RR, even though Progress Note review for Resident #3 revealed that facility staff spoke to the RR on 8/11/25 two days prior to the first wound care clinic appointments missed by the resident with no documentation of change in the plan of care that included setting or provider. The Administrator stated that the change was initiated despite strong opposition of MD #1 and MD #2. He confirmed that there was no reason that the residents could not have received care both at the wound care clinic and in the facility. The Administrator informed the State Agency (SA) that on 10/13/25 he had sent an email to the collaborating physician for Nurse Practitioner (NP) #1, who was MD #1 and to MD #2 for whom the NP also took call, and revoked her privileges in the facility due to a "decision (that) is administrative and compliance-driven—designed solely to unify our clinical processes—and is not a reflection of individual performance." The Administrator reported that on 10/31/25 he sent a letter to the only two attending physicians that practiced in the facility as a "formal notice of termination of admitting and attending privileges". He said that on 10/31/25 he had not identified compliance, safety or care concerns and that he had not used printed, verbal or electronic means to impart any concerns, issues or complaints to NP #1, MD #1 or MD #2. He stated that the decision was made to facilitate a "change of direction" for the facility. On 11/10/25 at 3:50 PM an interview with Resident #11, the Resident Council President, revealed the council met the last Tuesday of each month. She explained that anyone can request to attend the meetings if they feel they need to. She reported that no staff had attended any Resident Council Meeting and notified the council that the facility had changed Medical Directors or explained any reason why MD #1 or MD #2 or NP #1 may have their privileges at the facility revoked. She stated that she had not been notified personally regarding any changes or options for new medical personnel or procedures to see her attending physician of choice. She stated that if she had a choice, she would keep her current attending physician and not have to make an appointment and go to his office to see him. On 11/10/25 at 7:52 AM a telephone interview with MD #2 revealed he was the attending physician for eighteen (18) residents at the facility. He reported that MD #1 was the attending physician for twenty-three (23)	F0555		

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F0555 SS = E	Continued from page 6 residents. He reported that they had received an email on 10/13/25 from the facility administrator in which privileges for Nurse Practitioner (NP) #1 were revoked without cause or reason given. He stated that he had later received a printed, posted letter dated 10/31/25 that stated that his admitting and attending privileges in the facility were revoked effective 11/30/25 without any cause or reason given. He stated that he had never received any explanation for the reason behind the revocations and that the facility had not made any attempts to list, address or mediate any concerns or issues with him. He stated that residents and their representatives had called him with questions and concerns regarding resident care. On 11/11/25 at 1:08 PM an interview with NP #1 revealed she had taken call for MD #1 and MD #2 for their residents at the facility for over a year and that MD #1 was her collaborating physician. She stated that she had visited the facility frequently and made rounds for MD #1 every other month. She added that she usually visited the facility twice weekly. She stated that she had been notified by MD #1 that her privileges at the facility had been revoked without explanation. She stated that the facility had not made her aware of any concerns or complaints regarding her practice or her care of the residents or her documentation. Resident #2: On 11/11/25 at 9:05 AM a telephone interview with the RR for Resident #2 revealed she reported that the Administrator had notified her that the facility was making some changes and that residents would still have access to their primary physician of choice, but that MD #2 would no longer be able to attend to Resident #2 in the facility. She stated that Resident #2 had been receiving wound care from Medical Director #1 at the local wound care clinic except for two weeks in August 2025 and that she did not believe the resident had any negative results from receiving wound care in the facility by a NP, but that she had not been offered a choice. Resident #2's RP stated that Resident #2, "was getting wound care at the hospital wound care clinic. A lady (unable to recall name or title) called me and asked if I would like to do wound care at the hospital with a doctor or just do dressing changes at the facility. We decided to let (Medical Director #2) continue wound care. Then, when I came for a visit a nurse (unable to recall name) told me that the Administrator put a stop to wound care at the hospital. That left the residents without other options.". She said that it was true that she had agreed for Resident #2 to receive dressing changes by the contract NP at	F0555		

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F0555 SS = E	Continued from page 7 the facility, but the way it was explained to her she had not understood that meant Resident #2 would not still receive evaluations and treatments by Medical Director #1 at the clinic. She stated that she had not been notified that NP #1 was no longer able to provide care for Resident #1. Record review of the Admission Record for Resident #2 revealed the facility admitted the resident on 4/10/25 and the resident had diagnoses of congestive heart failure, chronic peripheral venous insufficiency, pressure ulcer of sacral region stage 4. Resident's daughter was her RR. MD #2 was listed as the resident's primary physician. Record review of the Quarterly Minimum Data Set (MDS) for Resident #2 revealed the resident with Assessment Reference Date (ARD) 7/17/25 revealed the resident was not able to complete Brief interview for Mental Status (BIMS). The facility assessment documented that the resident and family participated in assessment and goal setting. Resident #3: On 11/13/25 at 10:26 AM RR for Resident #3 returned call to SA and stated that he had not been notified in August 2025 of change to resident's wound care. He stated that he considered wound care setting and provider from the local wound care clinic by Medical Director #1 to in facility by a contract nurse practitioner a significant change. He stated that he would not have agreed to the change of setting or provider because the providers were one of the deciding factors that led him to seek a referral to the facility. Record review of the Admission Record for Resident #3 revealed the facility admitted the resident on 9/30/25 with Initial Admission Date 4/03/24 and the resident had diagnoses of osteomyelitis of vertebra, sacral and sacrococcygeal region with onset date 4/04/24, peripheral vascular disease, diabetes, dementia and stage 3 pressure ulcer of right heel and other site. MD #1 was listed as the resident's primary physician. Record review of the Quarterly MDS for Resident #3 with ARD of 9/25/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment. The MDS review revealed the facility assessed Resident #3 required supervision for eating and was dependent for all other activities of daily living, required a wheelchair for mobility and had unhealed pressure ulcers and had two	F0555		

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F0555 SS = E	Continued from page 8 (2) Stage 3 pressure ulcers and one (1) Stage 4 pressure ulcer. The facility assessment documented family participated in assessment and goal setting for the resident. Resident #4: On 11/10/25 at 2:00 PM observation and an interview with Resident #4 revealed he stated that he received wound care at the local wound care clinic by Medical Director #1. He stated that his wound was “almost well”. He stated that he was very satisfied with the care he received for his wound and with his attending physician, MD #2. He said that he was not aware of any changes with his medical personnel. Record review of the Admission Record for Resident #4 revealed the facility admitted the resident on 6/25/25 with initial admission date 4/18/24 and the resident had diagnoses of hemiplegia, hemiparesis, dysphagia and aphagia following cerebral infarction affecting left non-dominant side, chronic ulcer of left foot, diabetes and atherosclerotic heart disease. MD #1 was listed as the resident’s primary physician. Record review of the Quarterly MDS with ARD 10/24/25 for Resident #4 revealed the facility assessed the resident had a BIMS score of 14, which indicated no cognitive impairment. The MDS review revealed that the facility assessed Resident #4 required set-up to partial/moderate assistance for activities of daily living, required a wheelchair for mobility, was at risk for developing pressure ulcers and had one diabetic foot ulcer for which he received application of medications and dressing to feet. The facility assessment documented that resident participated in his assessment and goal setting. On 11/11/25 at 9:00 AM SA attempted to contact the RR for Resident #4 via telephone without success. Resident #5: On 11/10/25 at 2:41 PM an interview with Resident #5 revealed she stated that MD #1 was her attending physician of choice and that she was very satisfied with her care. She stated that she considered MD #1 attentive and felt she received adequate medical attention. She stated that no one had notified her of a change of medical director or that she would not be able to be seen by MD #1 in the facility. She stated that she thought it was silly for her to have to make an appointment and wait for the facility van to be available to transport her to the office of the	F0555		

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F0555 SS = E	Continued from page 9 physician she had chosen upon admission by the facility who was familiar with her and her care. She stated, “I would much rather have my local doctor who has been taking care of me for years.”. She stated that no staff had notified her that NP #1 was no longer able to come to the facility to see her. She reported that she was notified of changes to medical personnel by her RR. On 11/10/25 at 5:15 PM an interview with the RR for Resident #5 revealed she had been contacted by the Administrator regarding a change in medical personnel at the facility and Resident #5’s care needs. She said she had not signed a change of physician request because she, nor Resident #5, wanted to change attending physicians, and she was afraid that if she didn’t the facility may treat Resident #5 differently or try to discharge Resident #5. She confirmed that she felt the Administrator had attempted to manipulate her into signing the change form by listing the benefits of new physicians, but that she didn’t understand the benefit for Resident #5 since her attending physician and NP #1 had always provided excellent care. Record review of the Admission Record for Resident #5 revealed the facility admitted the resident on 10/30/25 and she had initial admission date 4/01/24. The resident had diagnoses listed as bilateral primary osteoarthritis of knees, metabolic encephalopathy, asthma, chronic kidney disease stage 3, dysphagia following cerebral infarction and atrial fibrillation. MD #2 was listed as the resident’s primary physician. Record review of the Quarterly MDS with ARD 10/08/25 for Resident #5 revealed the resident had a BIMS score of 15, which indicated no cognitive impairment. The MDS documented that the resident and her family were active participants in the assessment prose and goal setting. Resident #7: On 11/10/25 at 1:46 PM observation and interview with Resident #7 revealed the resident was alert, oriented to person and place and was operating his mechanical wheelchair in the hallways without assistance. He stated that MD #2 was his doctor and visited him at the facility at least every week. He stated that NP #1 had visited multiple times a week and that he had not been notified that she was not going to be coming back. He said that he was very satisfied with the care provided by MD #2 and by NP #1 and that no one had explained anything to him regarding changing physicians. He adamantly expressed that MD #2 was his physician and he did not want any other physician. He confirmed that he	F0555		

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F0555 SS = E	Continued from page 10 was his own RR and made decisions for himself. Record review of the Admission Record for Resident #7 revealed the facility admitted the resident on 4/13/24 with Initial Admission Date 9/08/08 and the resident had diagnoses of congenital malformation of nervous and musculoskeletal systems, atherosclerotic heart disease and peripheral vascular disease. MD #1 was listed as the resident's primary physician and the resident was documented as his own Responsible Party (RP). Record review of the Quarterly MDS for Resident #7 with ARD 9/30/25 revealed the resident had a BIMS score of 14, which indicated no cognitive impairment. MDS review revealed the facility assessed the resident participated in the assessment and goal setting. Resident #8: On 11/10/25 at 2:20 PM an interview with Resident #8 revealed that his attending physician was MD #2. He stated that no one had discussed change in his medical care providers with him except MD #2. He stated that he had not been notified of a change of medical directors by any staff at the facility and that he only found out that NP #1 was no longer providing care for him after he asked someone. He said that he hated that because NP #1 visited every week and checked on him and he missed her. He stated that he was worried and upset because no facility staff had notified him of changes and he wanted MD #2 to continue to be his primary and attending physician and that no one had explained the need to change to him or his RR. On 11/12/25 at 2:00 PM an interview with the RR for Resident #8 revealed she described Resident #8 as "very upset" regarding the changes in his medical team. She stated that no one had contacted her or provided any notification or explanation for the revocation of the resident's attending physician's privileges or offered any alternative options for care. She stated that she had not been notified of the change of medical directors. The RR explained that her first concern was the availability of access to the resident's primary physician. The RR for Resident #8 stated that she had visited the facility on 11/12/25 and attended a care plan meeting for Resident #8 during which there had been no mention of change of medical director or information regarding options for attending physician until she asked staff about the subject at the end of the meeting. She said that when she asked, she was told that all inquiries were being directed to the Administrator and she and Resident #8 had met with the Administrator and AIT. She said that she was afraid of	F0555		

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F0555 SS = E	Continued from page 11 what might happen because when she voiced concerns about the quality of care the AIT had said, “Well, he can go somewhere else”. The RR stated she considered the comment a threat that the facility may try to discharge Resident #8 and “That pissed me off and made me not want to hear anymore from her”. The RR confirmed that Resident #8 was cognitively intact and very much involved in decision making regarding his care. She stated, “We make decisions together, but we were not offered a choice.”. Record review of the Admission Record for Resident #8 revealed the facility admitted the resident on 10/30/25 with initial admission date 10/19/23, and the resident had diagnoses of diabetes, legal blindness, chronic kidney disease and hypertension. MD #1 was listed as the resident’s primary physician and his wife was his RR. Record review of the MDS with ARD 11/06/25 for Resident #8 revealed the resident had a BIMS score of 15, which indicated no cognitive impairment. MDS review revealed the resident and his family participated in assessment and goal setting. On 11/12/25 at 4:15 PM an interview with the Social Services Director (SSD) that she assisted the resident council with monthly meetings and arranged and attended care plan meetings. She stated that the Administrator or anyone that wanted, could request to attend the resident council meeting through her or the Activity Director or the Resident Council President. She reported that no one had requested an audience with the council to discuss change of Medical Director. She stated that the RR for Resident #8 brought up possible physician change during the Quarterly Care Plan Meeting on 11/12/25 and, following the instructions of the Administrator and AIT, the RR was instructed to direct questions related to medical personnel changes to the Administrator and AIT. The SSD stated that Resident #6’s RR had also voiced questions about physician choice during care plan meeting on 11/12/25 and the AIT had escorted him to the Administrator’s office to discuss those changes. She said that the RR for Resident #6 wanted to know who his mother’s doctor was going to be. She confirmed that the health care team involved in the care plan meeting did not present to, or discuss with, any resident or RR the fact that the facility had a new Medical Director and had not notified anyone that there may be a need to make decisions regarding their choice of attending physician to take effect in a matter of days. Resident #9:	F0555		

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F0555 SS = E	Continued from page 12 On 11/11/25 at 10:35 AM during a telephone interview the RR for Resident #9 reported, “the Administrator called and explained everything and had made it sound like we could switch doctors, but I expressed doubts about changing physicians, he told me that she could ‘find another nursing home’. She said that her main concern was centered around what the Administrator said about how the resident would have to go to MD #2’s office to see her current attending physician of choice, MD#2. She stated, “I don’t like it. I’m very pleased with the way he (MD #2) cared for my mama. He is attentive and visits often. She (Resident #10) really likes him. I don’t know how well my mom will handle it; she’s elderly and has dementia and doesn’t handle change well”. Record review of the Admission Record for Resident #9 revealed the facility admitted the resident on 9/02/25 with initial admission date of 9/09/24 and the resident had diagnoses of osteoarthritis, diabetes, dementia and hypertension. Record review of the Quarterly MDS for Resident #9 with ARD 9/30/25 revealed Resident #3 had a BIMS score of 9, which indicated moderate cognitive impairment; the MDS review revealed the facility assessment documented that the resident’s family were involved in assessment and goal setting. Resident #10: On 11/11/25 at 9:50 AM a telephone interview with the Rr for Resident #10 revealed she stated that Resident #10’s physician of choice was MD #2, she stated, “We love him and we don’t want to change.”. She said that the Administrator had contacted her by telephone and, “he said I would have to come in and sign paperwork to change from Medical Director #2. If we don’t change, we don’t want to get kicked out. I told him we want (MD #2).”. The RR said that the Administrator had told her that MD #2 would not be a doctor allowed to see residents in the facility after 12/01/25. She said that after he “finished his spill about everything he told me that I needed to come on by and sign because (MD #2) won’t be a doctor there anymore after December first.”. She said that she felt the Administrator had tried to manipulate her into accepting a different physician for the resident and was afraid that if she did not Resident #10 may face retribution or be forced to move to a different facility. She reported that no one had notified her that NP #1 was no longer providing care for Resident #10.	F0555		

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F0555 SS = E	Continued from page 13 On 11/11/25 at 1:55 PM an interview with Resident #10 revealed Resident #10 stated, “My doctor is (MD #2). He is a good doctor. I like him. Nobody checked with me about changing doctors.”. Record review of the Admission Record for Resident #10 revealed the facility admitted the resident on 12/20/23 and the resident had diagnoses of dementia, diabetes and heart failure. Record review of the Quarterly MDS with ARD 8/28/25 for Resident #10 revealed the resident had a BIMS score of 07, which indicated severely impaired cognition. Resident #11 Record review of the Admission Record for Resident #11 revealed the facility admitted the resident on 10/03/25 and the resident had diagnoses of dysphagia following cerebral infarction and anxiety. Record review of the Quarterly MDS with ARD 9/12/25 for Resident #11 revealed she had a BIMS score of 15, which indicated no cognitive impairment and the facility assessment documented that the resident participated in assessment and goal setting. On 11/11/25 at 4:09 PM an interview with LPN #1 and record review of the Physician Change Form dated 10/17/25 confirmed that she had encountered Resident #11 sitting on the front porch of the facility on 10/17/25 and the resident told her that she had not been notified that NP #1 was no longer providing care for residents in the facility and voiced concern regarding her care. Resident #11 and her RR completed and signed a Physician Change Form which documented the physician choice of Resident #1 and her RR. On 11/12/25 at 12:00 PM an interview with the Administrator revealed the stated, “We needed to change medical directors, and we hired the best. He uses his own nurse practitioners and uses a team approach. (Medical Director #2) had noticed some issues and said that he didn’t want (NP #1) on his team. I told (MD #1) and (MD #2) I hoped we could work something out. In the beginning when we let go of (Medical Director #1) I told (MD #2) that I wasn’t planning to make any changes to attending physicians. I talked with (Medical Director #2) and he said he didn’t want to work with (NP #1) because he wasn’t satisfied with her charting. He called me after reviewing the charts”. He said that Medical Director #2 told him that given the hostility and refusal of MD #2 to listen it would be better to	F0555		

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F0555 SS = E	Continued from page 14 move all residents to his care. The Administrator stated, “My intent was to send out letters and emails I contacted ninety-five percent (95%) of all the RRs, all that I could get ahold of. They will have a choice of having (Medical Director #2) as their attending”. He stated that Medical Director #2 had advised him not to communicate with attendings whose privileges were revoked to discuss concerns or deficient practices. He said that he had attempted to talk with MD #2 after sending letters of revocation of privileges, but that he stopped when MD #2 called him names. He stated, “I didn’t tell them (residents/RRs) they had a choice of attending because of the way it had played out.”. The Administrator confirmed that the facility informed residents and/or their RRs of their right to choose their own physician, which physicians had attending privileges at the facility and how to contact their chosen physician during the admission process with the SSD. He stated that residents chose their physician prior to admission. He confirmed that he had met with the AIT, Resident #8 and his RR on the morning of 11/12/25. He confirmed that all staff had been instructed to refer any questions regarding changes in medical director or attending physicians to him or the AIT. On 11/12/25 at 5:15 PM an interview with the Administrator revealed he stated that he had not met with the resident council to provide information regarding change in facility medical director. He confirmed that he had not met with, discussed or sought the input of residents or their responsible parties regarding revocation of privileges of MD #1, MD #2 or NP #1. He stated that he had not considered meeting or contacting MD #2 or MD #1 to review concerns or expectations or differences to determine whether they or NP #1 were able and willing to meet facility, state and federal requirements to continue to practice admitting and attending privileges in the facility using printed or electronic communication.	F0555		