STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255309	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS HEALTH CENTER	**2800 WEST MAIN STREET , TUPELO, Mississippi, 38801**

(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, MS CI # 2662531 at the facility from 11/17/25-11/20/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F584, F656, F677, and F761. There were no deficiencies cited for CI MS# 2662531 related to environment. The census at the time of the survey was 135 and the facility was licensed for 140 beds.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F0584		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0584 SS = D	Continued from page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to maintain a wheelchair in a clean and sanitary manner for one (1) of seven (7) residents using mobility devices in house 600. Resident #92 Findings Include: Review of the facility policy titled “Safe and Homelike Environment” unrevised, revealed under, “Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment.” An observation of Resident #92 on 11/17/25 at 11:35 AM revealed she was sitting in her wheelchair in the front lobby area. The lower wheelchair frame and left wheel were covered in an orange-colored dried substance. An observation and interview with Certified Nurse Aide (CNA) #6 on 11/18/25 at 1:15 PM confirmed Resident #92’s wheelchair was dirty and covered in a dried substance that she thought was food. She stated it was everybody’s responsibility to ensure the resident equipment was clean. An interview with the Administrator (ADM) on 11/18/25 at 2:10 PM revealed her expectations were for staff to	F0584		

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F0584 SS = D	Continued from page 2 ensure the resident equipment was kept clean to provide a sanitary environment. Record review of the “Admission Record” revealed the facility admitted Resident #92 on 11/03/22 with medical diagnosis that included Alzheimer’s Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/19/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 3, which indicated Resident #92 was severely cognitively impaired	F0584		
F0656 SS = E	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.	F0656		

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F0656 SS = E	Continued from page 3 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident, staff, and family interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for personal hygiene and grooming for five (5) of 28 sampled residents. Resident #4, #10, #34, #60, and #92 Findings Include: Review of the facility policy titled “Comprehensive Care Plans” unrevised, revealed under, “Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan Resident #4 Record review of Resident #4's "Care Plan Report" revealed that he needed assistance with ADL's (Activities of Daily Living) related to recent hospitalization for left femur fracture, total hip arthroplasty d/t autoimmune encephalitis, falls, episodes of confusion. He has weakness and requires staff assistance with dressing, bathing, personal hygiene and transfers, w/c for mobility. An observation of Resident #4 and interview with the resident’s sister-in-law at the bedside on 11/17/25 at 11:00 AM revealed the resident was lying in bed and had approximately one-eighth (1/8) inch gray, facial hair. Resident 4's sister-in-law stated he likes to be clean-shaven. An interview on 11/19/25 at 2:00 PM with Certified Nursing Assistant (CNA) #3 and observation of Resident	F0656		

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F0656 SS = E	Continued from page 4 #4, CNA #3 confirmed his face was not shaved, and his hair on his face was long. On 11/20/25 at 9:00 AM, the Assistant Director of Nursing (ADON), stated that the care plan should be implemented for all residents. And, that the expectation is for the staff to follow the care plans, if Resident #4 was supposed to have a shaven face and didn't, the care plan was not followed. Record review of Resident #4's demographic information revealed that the facility admitted Resident #4 on 9/25/2025 with a medical diagnosis that included Encephalitis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/23/2025 revealed under Section C that Resident #4's Brief Interview for Mental Status (BIMS) was 2 and her cognitive skills for daily decision making were severely impaired. An interview on 11/20/25 at 9:00 AM with Assistant Director of Nursing (ADON), revealed that the purpose of the care plan was to develop a plan of individualized care for an elder/resident's specific need. She revealed that the care plan included personal hygiene needs including removal of facial hair. ADON agreed that since Resident # 4's facial hair was not removed, his care plan was not followed. Resident #10 Record review of Resident #10's "Care Plan Report" revealed that he had an ADL self-care deficit related to recent hospitalization for cardiac arrest... His interventions included, "Bathing/Showering: Check nail length and trim and clean on bath day and as necessary..." Observations on 11/18/25 at 8:20 AM and at 1:28 PM revealed Resident #10's fingernails were approximately one-half of an inch long and had brown substance underneath on both hands. An interview on 11/18/25 at 1:30 PM with Resident #10, revealed that he had his shower yesterday and stated, "They don't offer to do my fingernails while I'm in the shower." He also revealed that his fingernails needed to be cleaned and trimmed.	F0656		

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F0656 SS = E	Continued from page 5 During an observation and interview on 11/18/25 at 1:35 PM with CNA #1, she confirmed that Resident #10 had long fingernails with a brown substance underneath. She revealed that Resident #10's scheduled shower days were Mondays, Wednesdays, and Fridays and his fingernails should have been taken care of yesterday Record review of Resident #10's "Admission Record" revealed the facility admitted the resident on 07/15/25 and that he had diagnoses that included Other Reduced Mobility, Need for Assistance with Personal Care, and Other Retention of Urine. Record review of Resident #10's MDS with an ARD of 10/14/25 revealed a BIMS Score of 10 which indicated that he had moderate cognitive deficits. An interview on 11/19/25 at 3:00 PM with the Director of Nursing (DON), revealed that the purpose of the care plan was to develop care specific to each resident so that the staff members knew how to care for the individualized needs of the residents. She revealed that the care plan included personal hygiene needs including fingernail care and removal of facial hair on men and ladies. The DON agreed a care plan was not followed if the residents' ADL needs were not completed. Resident #34 Record review of Resident #34's "Care Plan Report" revealed under, "Focus: The elder has an ADL (activities of daily living) self-care deficit r/t (related to) activity intolerance…. Elder requires staff assistance with dressing, bathing, personal hygiene, transfers." During an observation of Resident #34 on 11/17/2025 at 11:39 AM it revealed her sitting in the front lobby with long gray facial hair present on her chin, the sides of her face, and above her lip measuring approximately one-half (1/2) inches in length. On 11/18/25 at 1:10 PM, during an interview with Resident #34, she revealed she did not like to have facial hair. An observation and interview with CNA #6 on 11/18/25 at	F0656		

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F0656 SS = E	Continued from page 6 1:15 PM confirmed Resident #34 had long gray facial hair. An interview with the MDS Nurse on 11/20/25 at 8:40 AM revealed that staff were aware of the residents' care planned interventions related to ADLs because it triggered them to see and sign off under the task section of the electronic medical record (EMR). She stated it was “common sense” for female facial hair to be removed during bathing. She confirmed the care plan was not followed for personal hygiene for Resident #34. Record review of the "Admission Record" revealed the facility admitted Resident #34 on 4/15/25 with a medical diagnosis that included Atherosclerosis of Aorta. Record review of the MDS with an ARD of 10/14/25 revealed under section C, a BIMS summary score of 15, which indicated Resident #34 was cognitively intact. Resident #60 Record review of Resident #60's "Care Plan Report" revealed that she needed assistance with ADL's related to activity intolerance, fatigue, MS (Multiple Sclerosis), Dementia. Observations on 11/17/25 at 12:17 PM and on 11/18/25 at 8:15 AM revealed that Resident #60 had a patch of about 10 - 12 facial hairs on her right and left upper corner of her lip. The facial hairs were approximately three-fourths to one inch long. An interview on 11/17/25 at 12:20 PM with Resident #60 revealed that facial hair was very unattractive and stated, "I don't like it." She revealed that the staff never offered to remove her facial hair and she would like it to be gone. An observation and interview on 11/17/25 at 1:40 PM with CNA #2 confirmed that Resident #60 had patches of gray hairs to her right and left corner of her mouth. revealed that Resident #60's scheduled showers were on night shift on Tuesdays, Thursdays, and Saturdays and that should have been taken off.	F0656		

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F0656 SS = E	Continued from page 7 Record review of Resident #60's "Admission Record" revealed the facility admitted the resident on 06/01/24 and that she had diagnoses that included Unspecified Dementia and Primary Progressive Multiple Sclerosis. Record review of Resident #60's MDS with an ARD of 10/28/25 revealed a BIMS Score of 10 which indicated that she had moderate cognitive deficits. Resident #92 Record review of Resident #92's "Care Plan Report" revealed under, "Focus: Elder needs assist with ADL's (activities of daily living) related to Alzheimer's dementia, weakness, activity intolerance." Also revealed under, "Interventions: Elder requires assistance of 1 (one) person with bed mobility, transfers, toileting, bathing, personal hygiene." An observation of Resident #92 on 11/17/25 at 11:35 AM revealed she was sitting in her wheelchair in the front lobby area and her fingernails on both hands were long and dirty. Her nails measured approximately 3/4 (three-quarters) of an inch in length past the fingertips with a thick black substance underneath the thumb and index nails. She also had 4 to 5 long gray hairs observed on her chin measuring approximately one-half (1/2) inch in length. On 11/18/25 at 1:20 PM, during an observation and interview with CNA #6, she confirmed Resident #92 had long dirty nails and facial hair to her chin. An interview with the MDS Nurse on 11/20/25 at 8:40 AM revealed nail care and female facial hair would be addressed as part of personal hygiene during bathing and routine care. She confirmed Resident #92's care plan was not followed for personal hygiene. Record review of the "Admission Record" revealed the facility admitted Resident #92 on 11/03/22 with medical diagnosis that included Alzheimer's Disease. Record review of the MDS with an ARD of 8/19/25 revealed under section C, a BIMS summary score of 3, which indicated Resident #92 was severely cognitively impaired.	F0656		

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F0656 SS = E	Continued from page 8 .	F0656		
F0677 SS = E	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, staff, resident, and resident representative interview, record review, and facility policy review, the facility failed to provide nail care (Resident#10 and Resident #92), and shaving (Resident#4, Resident #34, Resident #60 and Resident #92) for five (5) of 28 sampled residents. Resident #4, #10, #34, #60, and #92 Findings Include: Review of the facility policy titled “Activities of Daily Living” unrevised, revealed under, “Policy Explanation and Compliance Guidelines: … 2. 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 #4 During an observation on 11/17/25 at 11:00 AM it was revealed that Resident #4 was lying in bed unshaved. His facial hair was approximately one-eighth (1/8) inch long and gray. Resident 4's sister-in-law was present at the bedside. During an interview with Resident #4’s sister-in-law on 11/17/25 at 11:05 AM, she stated that he likes to be clean shaved. On 11/19/25 at 2:00 PM Certified Nursing Assistant (CNA) #3 was interviewed regarding Resident #4's facial hair. She stated he gets his shower and shaves on the night shift and he normally doesn't refuse care. She confirmed his face was not shaved, and his hair on his face was long.	F0677		

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F0677 SS = E	Continued from page 9 On 11/20/25 at 9:00 AM, the Assistant Director of Nursing (ADON), stated that it was her expectation for the staff to shave Resident #4. She went on to say the he was supposed to have a shaven face and didn't. Record review of Resident #4's demographic information revealed that the facility admitted Resident #4 on 9/25/2025 with a medical diagnosis that included Encephalitis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/23/2025 revealed under Section C that Resident #4's Brief Interview for Mental Status (BIMS) was 2 and his cognitive skills for daily decision making were severely impaired. Resident #10 An observation on 11/18/25 at 8:20 AM and again at 1:28 PM, revealed Resident #10 lying in bed in his room with his fingernails approximately one-half of an inch long past the fingertips with a brown substance underneath. An interview on 11/18/25 at 1:30 PM with Resident #10 admitted that his fingernails needed trimmed and cleaned. He stated that he had a shower yesterday, but no one offered to take care of his nails. On 11/18/25 at 1:35 PM CNA #1 was interviewed while observing Resident #10 and confirmed that his fingernails were long and dirty. She admitted they needed trimming and had a brown substance underneath that needed to be removed. Resident #10 had long fingernails with brown substance underneath. She revealed that Resident #10's scheduled shower days were Mondays, Wednesdays, and Fridays and his fingernails should have been done yesterday. She stated that with his nails like they were he could scratch himself or someone else. An interview on 11/18/25 at 2:45 PM with the Registered Nurse (RN) Supervisor confirmed that nail care was supposed to be completed during a Resident's shower time. She revealed that by leaving Resident #10's fingernails long and dirty, it could cause him to scratch himself which could lead to sores on his body, or he could hurt someone else. She stated, "We expect them (residents) to feel good and look good." Record review of Resident #10's "Admission Record"	F0677		

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F0677 SS = E	Continued from page 10 revealed the facility admitted the resident on 07/15/25 and that he had diagnoses that included Other Reduced Mobility, Need for Assistance with Personal Care, and Other Retention of Urine. Record review of Resident #10's MDS with an ARD of 10/14/25 revealed under Section C a BIMS Score of 10 which indicated that he had moderate cognitive deficits. Resident #34 On 11/17/25O at 11:39AM Resident #34 was observed sitting in the front room of the facility with visible gray hair on her face. The facial hair was approximately one half (1/2) of an inch long on her chin, sides of her face and above her lip. During an interview on 11/18/25 at 1:10 PM Resident #34 stated that some girl was supposed to have shaved her face last week, but she told me she could not find a razor. The resident admitted that she did not like to have facial hair. An observation and interview on 11/18/25 at 1:15 PM with CNA #6 confirmed that Resident #34 needed to be shaved. She revealed the aides were responsible for shaving facial hair during the resident's bath or whenever it needed to be done. She stated that the 3-11 shift was responsible for doing the bath and stated, "But anybody could do it." Record review of Resident #34's ADL Task for November 2025 revealed, "ADL- Bathing as scheduled on Mon (Monday), Wed (Wednesday), Frid (Friday) 2pm-10pm" initialed as done on 11/17/25. An interview with RN #1 on 11/18/25 at 1:28 PM revealed the aides were responsible for shaving the residents as part of hygiene during bathing. RN #1 acknowledged she was responsible for ensuring that the aides provided the care. Record review of the "Admission Record" revealed the facility admitted Resident #34 on 4/15/25 with a medical diagnosis that included Atherosclerosis of Aorta.	F0677		

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F0677 SS = E	Continued from page 11 Record review of MDS with an ARD of 10/14/25 revealed under section C, a BIMS summary score of 15, which indicated Resident #34 was cognitively intact. Resident #60 Observations on 11/17/25 at 12:17 PM and on 11/18/25 at 8:15 AM revealed that Resident #60 had two patches of about 10 - 12 facial hairs on her right and left upper corner of her lip. The facial hairs were approximately three-fourths to one inch long. An interview on 11/17/25 at 12:20 PM with Resident #60 revealed that facial hair was very unattractive and stated, "I don't like it." She revealed that the staff never offered to remove her facial hair and she would like it to be gone. An observation and interview on 11/17/25 at 1:40 PM with CNA #2 confirmed that Resident #60 had patches of gray hair on her upper lip area. She admitted that the resident's scheduled showers were on night shift on Tuesdays, Thursdays, and Saturdays. She stated, "I don't like facial hair so I pluck mine, and Her's should have been taken off. An interview on 11/18/25 at 2:35 PM with the RN Supervisor revealed that she expected the CNAs to shave facial hair on men and ladies, shampoo their hair if they wanted it, and trim, clean and file fingernails if needed during their scheduled shower time. She stated, "No woman wants to be seen like that." She also revealed that she expected the residents to look and feel good about themselves Record review of Resident #60's "Admission Record" revealed the facility admitted the resident on 06/01/24 and that she had diagnoses that included Unspecified Dementia and Primary Progressive Multiple Sclerosis. Record review of Resident #60's MDS with an ARD of 10/28/25 revealed a BIMS Score of 10 which indicated that she had mild cognitive deficits. Resident #92	F0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255309	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0677 SS = E	Continued from page 12 Resident #92 was observed on 11/17/25 at 11:35 sitting in the front lobby with fingernails that were approximately three fourths (3/4) of an inch long past the tips of her fingers with a thick brown substance under her thumb and index nails. She also had 4 to 5 long gray hairs observed on her chin measuring approximately one-half (1/2) inch in length. An interview with CNA #6 on 11/18/25 at 1:20 PM confirmed Resident #92 had long dirty nails and facial hair to her chin. She stated the aides were responsible for ensuring the nail care and facial hair was addressed with bathing. CNA #6 explained that Resident #92 gets a bath on 3-11 shift and stated it should be addressed during that time or anytime that it was noted. She confirmed the resident could get bacteria under the nails and scratch herself. Record review of Resident #92's ADL Task for November 2025 revealed, "ADL- Bathing- give bed bath or shower every Monday, Wednesday, and Friday & (and) as needed" initialed as done on 11/17/25. An observation and interview with RN #1 on 11/18/25 at 1:31 PM revealed the aides were responsible for nail care including cutting and cleaning and removing facial hair as part of personal hygiene during bathing. RN #1 acknowledged she was responsible for making sure that the care was provided. She revealed Resident #92 could scratch herself and cause skin concerns. An interview with the Administrator (ADM) on 11/18/25 at 2:10 PM revealed her expectations were for the nail care and facial hair to be addressed with bathing or anytime it was needed. Record review of the “Admission Record” revealed the facility admitted Resident #92 on 11/03/22 with medical diagnosis that included Alzheimer’s Disease. Record review of the MDS with an ARD of 8/19/25 revealed under section C, a BIMS summary score of 3, which indicated Resident #92 was severely cognitively impaired.	F0677		
F0761 SS = D	Label/Store Drugs and Biologicals	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255309	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/20/2025

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F0761 SS = D	Continued from page 13 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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to monitor refrigerated medications for proper temperature control to ensure safe medication storage for one (1) of 11 medication refrigerators in facility. Rehabilitation Unit refrigerator Findings include: Record review of the facility policy titled, "Storage of Medication Requiring Refrigeration", dated 4/2025 revealed, "It is the policy of this facility to assure proper and safe storage of medications requiring refrigeration and to prevent the potential alteration of medication by exposure to improper temperature controls. ... Refrigerators used for the storage of medications and biologicals: e. Temperature should be maintained between 36 - 46 degrees F (Fahrenheit). f. Temperature to be monitored daily to ensure proper temperature control and documented on the temperature	F0761		

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F0761 SS = D	Continued from page 14 log with the date, time, and signature of person performing the check clearly written". During an observation of the medication storage room in the rehabilitation/therapy area of the facility, it was noted that the temperature log was incomplete for multiple days in the month of November. The review of the "Medication Refrigerator Temp Logs" dated November 2025 revealed the temperature was not monitored and documented on 11/1/25, 11/2/25, 11/4/25, 11/5/25, 11/7/25, 11/8/25, 11/9/25, 11/10/25, 11/11/25, 11/13/25, 11/17/25, and 11/19/25. An interview on 11/19/25 at 10:40 AM with Licensed Practical Nurse (LPN) #2 revealed the temperature checks of the medication refrigerators were scheduled to be monitored each night shift. During an interview on 11/19/25 at 10:45 AM, the Director of Nursing (DON) confirmed the facility failed to monitor and document the refrigerated medication temperatures which could alter the effectiveness of the medication. She then revealed that it was her expectation for each medication refrigerator's temperature to be monitored and documented each night shift to ensure the medications were stored properly in the appropriate temperature medication. An interview with the Administrator (ADM) on 11/19/25 at 1:55 PM confirmed that the facility failed to ensure proper and safe medication storage by the failure to monitor and document medication refrigerator temperatures. She stated that it was the facility's policy to ensure medications, including refrigerated medications, were stored properly. She acknowledged that medication effectiveness could be altered by inappropriate storage	F0761		