Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/08/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND COMMUNITY CARE CENTER	**4036 HIGHWAY 8 EAST P. O. BOX 1688, CLEVELAND, Mississippi, 38732**

(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
M0000	Initial Comments The State Agency (SA) conducted an Annual Recertification survey and four (4) Complaint Investigations (CI) MS #2605579, CI MS #2633318, CI MS #2635388, and CI MS #2656686 at the facility from 1/5/26 through 1/8/26. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm and cited M500, M610, M625, and M640. The SA identified non-compliance and cited M610 regarding Activities of Daily Living (ADL) for CI MS #2633318. The SA investigated CI MS #2605579, CI MS #2635388 and CI MS #2656686 with no deficiencies cited. The census at the time of the survey was 113 and the facility was licensed for 120 beds.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical	M0500		

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

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M0500	Continued from page 1 conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that	M0500		

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M0500	Continued from page 2 warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility,	M0500		

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M0500	Continued from page 3 they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observations, resident and staff interviews, record review, and facility policy review the facility failed to ensure residents' rights by subjecting two (2) residents to involuntary seclusion in a locked unit without proper assessment (Resident #23 and #83) and by failing to honor one resident's request to attend the beauty shop. (Resident #37) This failure affected three (3) of 27 residents sampled. Findings Include: Review of the facility policy titled, "Resident Rights" with revision date of December 2016, revealed "Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. ...a dignified existence; b. ...be treated with respect, kindness, and dignity... " Review of the facility policy titled, " Abuse Component Plan," with an effective date of 10/24/22, revealed under policy, "Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion. ..." Resident #23 An observation and interview on 01/05/2026 at 11:50 AM with Resident #23 revealed him sitting up in a chair watching television in his room. His room was located on the back side of the north hall and was behind locked double doors. Resident #23 revealed that he moved to that room recently because he "was acting a fool" on the other hall. He revealed that they threw	M0500		

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M0500	Continued from page 4 him back there so they wouldn't have to deal with him anymore. Resident #23 revealed that he was begging for snacks on the other hall, they got mad about it and he stated, "they put me back here." He also revealed that he was trying to stay out of trouble now. Resident #23 revealed that back there, the doors were locked, and he couldn't get out without asking someone. An interview on 01/05/26 at 12:25 PM with Registered Nurse (RN) #1, revealed that Resident # 23 was in the "Memory Unit." She revealed that residents with behaviors, residents who wandered in and out of other resident rooms and those who needed close monitoring were placed behind locked doors. She revealed that they allowed residents to come out if they wanted to, the staff had to put in a code to unlock the doors. RN #1 revealed that some of the residents back in the unit were really confused and required close monitoring. She revealed that Resident #23 was in his right mind and had been back there for a short time. She revealed that he was previously on the South Hall but was transferred back to the "Memory Unit" because of his behaviors. RN #1 revealed that Resident #23 was constantly getting snacks out of the refrigerator behind the nursing desk on the South Hall, following the staff around, begging for snacks, money, and talking over them. RN #1 revealed that Resident #23 was getting on their nerves on the South Hall and they moved him to the North Hall, and they could monitor him more closely behind locked doors. An interview on 01/06/26 at 3:00 PM with Assistant Director of Nursing (ADON), revealed that they had residents with dementia and those with psychiatric issues in rooms behind the locked doors. She revealed that Resident #23 had only been back there behind locked doors about a week. She revealed that he was transferred down to this hall from the South Hall due to his behaviors. She revealed that he was constantly asking staff and residents for money, he was going into the refrigerator at the nursing desk and getting snacks. ADON revealed that Resident #23 told her that he felt like they threw him back there so they wouldn't have to deal with him anymore and agreed that it was like they punished him for bad behavior. She also acknowledged that by secluding residents involuntarily could cause increase in behaviors especially in the more cognitive residents. An interview on 01/06/26 at 3:08 PM with Licensed Practical Nurse (LPN) #2, revealed that she was	M0500		

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M0500	Continued from page 5 familiar with Resident #23. She revealed that he was on the South Hall before he transferred to the North Hall. She revealed that Resident #23 would go behind the nursing desk on the South Hall and get snacks out of the refrigerator. She revealed that he asked for money often to get snacks out of the vending machine. She revealed that they would re-direct him and explain to him that he could not help himself to the snacks and he would leave and come right back. She revealed that they reported to Administrator and that's why they moved him to the locked unit behind the double doors. Record review of Resident #23's "Admission Record" revealed an admission date of 08/25/21 and that he had diagnoses that included Unspecified Impulse Disorder, Restlessness, and Agitation. Record review of Resident #23's "Progress Note" dated 01/02/26, revealed that the Social Worker (SW) made contact with the Responsible Party (RP) over the phone. SW expressed that the Resident was going to have a room move due to his recent behaviors. RP agreed and stated that were going to come and visit. Record review of Resident #23's Minimal Data Set (MDS) with Assessment Reference Date (ARD) of 11/03/25 under Section C, revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that he had no cognitive deficits. Resident #37 On 1/5/26 at 11:45 AM, an observation and interview revealed Resident #37 seated in her wheelchair with visibly overgrown hair, measuring approximately four inches of gray overgrowth with red coloring remaining on the bottom. Resident #37 revealed she was admitted to the facility in June 2025 and had been requesting assistance to go to the beauty shop since admission. She stated, “It’s like it falls on deaf ears. No one ever takes me.” The resident further stated, “I have never had my hair look so terrible.” On 1/6/26 at 8:50 AM, a follow up observation revealed no change in the resident’s appearance. During an interview on 1/6/26 at 2:25 PM, Certified Nurse Aide (CNA) #1 confirmed that Resident #37 had previously requested to go to the beauty shop. CNA #1	M0500		

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M0500	Continued from page 6 revealed the beautician was only coming a few times a month, and we didn't know when she would be here, so we would just miss her. Now I don't think we have a beautician. CNA #1 confirmed Resident #37 had visibly overgrown hair and revealed she could understand her wanting to go to the beauty shop. In an interview on 1/6/26 at 3:15 PM, the Administrator (ADM) revealed that he was unaware that Resident #37 had requested to go to the beauty shop and had not been assisted in doing so. He revealed if the resident was requesting to go to the beauty shop and was not assisted to do so, then her rights were violated. During an interview on 1/06/2026 at 4:37 PM, the Social Worker (SW) revealed that we were made aware in the latter part of December that the beautician would not be returning. She stated, "Once the staff was made aware that we would not have a beautician, the CNAs were informed that they were going to be responsible for doing the residents' hair when they gave them showers, such as putting in pig tails and braiding their hair. She stated, " I don't know who will be responsible going forward with cutting the residents' hair, that's above my pay grade." The SW revealed there were usually certain residents who went to the beauty shop, and she is not sure how Resident #37 got missed. During an interview on 1/06/26 at 5:25 PM, with the Director of Nurses (DON) present, Resident #37 stated, "For 39 years, I went to the beauty shop every Friday. I have never had my hair looking this bad in all my life. I have been here since last June and have not had my hair cut or styled. This is really important to me, and I have asked about it several times." The DON assured Resident #37 that the matter would be addressed. An interview on 1/6/26 at 5:30 PM, DON revealed she is new to the facility and was unaware that the resident was requesting beauty shop services. The DON revealed it is the facility's expectation that residents' rights would be honored regarding personal grooming, including hair care, and confirmed the facility failed to ensure Resident #37's rights were honored. A record review of Resident #37's "Admission Record" revealed the facility admitted the resident on 6/23/25 with diagnoses that included Polyneuropathy, Major	M0500		

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M0500	Continued from page 7 Depressive Disorder, and anxiety disorder. A record review of Resident #37's MDS with an ARD of 12/17/25 revealed, under section C, a BIMS score of 10, which indicated the resident had moderate cognitive impairment. Resident #83 During an interview on 1/05/26 at 12:45 PM, the Administrator confirmed that the facility maintains a locked unit at the end of the North Hall, with men housed on one side and women on the other. The Administrator revealed that the unit has historically been structured this way and is used not only for residents with Alzheimer's disease but also for residents exhibiting behaviors. The Administrator acknowledged awareness that secluding residents in this locked unit infringes upon their right to be free from involuntary seclusion and stated, "We have a lot of behaviors at this facility." During an interview on 1/05/26 at 4:00 PM, CNA # 6 revealed that this unit back here is basically an Alzheimer's unit, but there are a lot of people back here without Alzheimer's that have behaviors. She revealed that we keep the women behind this locked door, and the men are kept on the other side. An observation and interview on 1/05/2026 at 4:50 PM revealed that Resident #83 was sitting close to the locked double doors in the women's unit. Resident #83 asked the State Agent (SA) if she would go over to the men's side and buy her two drinks out of the vending machine. Resident #83 revealed she was not allowed outside of the double doors and had to wait and ask someone to go to the drink machine for her. Resident #83 revealed she would like to go get things she wants without having to ask someone to do it for her. Resident #83 stated, "I just stay back behind the doors like I'm supposed to, but it would be nice to go outside the doors." Resident #83 retrieved two dollars from inside her boot, and CNA #6 retrieved the drinks for her. CNA #6 stated, "We go and get whatever they want, but they do not leave the unit." During an interview on 1/06/2026 at 9:45 AM, the Corporate Nurse revealed that our corporation recently	M0500		

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M0500	Continued from page 8 purchased this facility in November 2025. I had questioned why those residents were behind locked doors, especially since they were not in a licensed Alzheimer's unit. The Corporate Nurse confirmed that, without proper assessment, the residents were placed in seclusion. A record review of Resident #83's "Admission Record" revealed the facility admitted the resident on 3/4/19 with diagnoses that included Type 2 Diabetes Mellitus, Schizoaffective Disorder and Peripheral Vascular Disease. A record review of Resident #83's MDS with an ARD of 12/5/25 revealed, under section C, a BIMS score of 14, which indicated the resident is cognitively intact.	M0500		
M0610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observations, resident and staff interview, record review, and facility policy review, the facility failed to provide activities of daily living care of three (3) of 113 residents residing in the facility. Resident # 29, #64, and # 105 Findings Include: Review of the facility policy titled, "ADLs Supporting" undated, revealed "...Residents who are unable to carry out activities of daily living independently will	M0610		

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M0610	Continued from page 9 receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene..." Review of the facility policy titled, “Fingernail Care, Foot Care, and Podiatry Referral,” effective date 4/18/2017, revealed the stated purpose was to “provide guidelines for the delivery of safe, evidence-based nail and foot care which promote good personal hygiene, prevent hand, foot, and nail infections, soft tissue injury, and foot ulcers...” Resident #29 An observation and interview on 1/05/2026 at 11:30 AM revealed that Resident #29 was lying in bed, with her hair disheveled, and was wearing a white gown with dried liquid in various circles, visible on her gown. The resident revealed that she is supposed to get a shower each Tuesday, Thursday, and Saturday. She confirmed that she did not get a shower on Saturday and was not offered one. She revealed that the last time I had a shower was last Thursday, and that was the last time I had my clothes changed, so I have been wearing the same outfit for four (4) days. The resident revealed she had not had her hair combed since two days before Thanksgiving. During an observation and interview on 1/06/2026 at 8:28 AM, Resident #29 was again observed lying in bed with disheveled hair and unchanged appearance from the previous day, wearing the same gown. The resident stated, “Today is Tuesday, so I’m supposed to get my shower today.” In an interview and observation on 1/06/2026 at 11:05 AM, with Certified Nursing Assistant (CNA) #1 confirmed that the resident gets her showers on Tuesday, Thursday and Saturday and stated, “The resident does not refuse care.” CNA #1 revealed I’m not sure what happened with her not getting a shower this past weekend, but she is supposed to get a shower today. She confirmed the resident’s hair was disheveled and unkempt. Observation and interview on 1/06/2026 at 3:10 PM revealed Resident #29’s clothing had changed; however, her hair remained disheveled and unkempt. Resident #29 revealed, I got my shower today, but the girl didn’t comb my hair. She said she doesn’t know how to braid my	M0610		

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M0610	Continued from page 10 hair. During an interview and observation on 1/06/2026 at 5:15 PM, with the Director of Nurses (DON) present, Resident #29 reiterated her hair had not been combed since two days before Thanksgiving. The resident's hair remains disheveled and unkempt. The DON confirmed that the resident's hair required attention and that she would ensure it was taken care of. The DON revealed that each of our residents should always be adequately groomed and presentable. A record review of Resident #29's "Admission Record" revealed the facility admitted the resident on 6/11/24 with diagnoses that included Crohn's Disease, Hemiplegia and Hemiparesis, and Malignant Neoplasm of Colon. A record review of Resident #29's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/25 revealed, under section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Resident #64 Review of the facility policy titled "Mouth Care," revised February 2018, indicated that "The purposes of this procedure are to keep the resident's lips and oral tissue moist, to cleanse and freshen the resident's mouth, and to prevent oral infection..." Observations and interviews conducted on 01/05/2026 at 11:00 AM and on 01/06/2026 at 4:35 PM revealed Resident #64 lying in bed and receiving nutrition through his Percutaneous Endoscopic Gastrostomy (PEG) tube. The resident stated that he was unable to take anything by mouth due to difficulty swallowing. Observation revealed a yellowish-tan substance present along the lower gum line and between each tooth. Resident #64 stated that staff did not brush his teeth or keep his mouth clean and reported that he would feel better and cleaner if his teeth were brushed. He further stated that staff "didn't have time, but they needed to take time" to provide this care. During an observation and interview on 01/06/2026 at 4:40 PM, Licensed Practical Nurse (LPN) #4 confirmed the presence of a yellowish-tan substance along Resident #64's lower gum line and between his teeth.	M0610		

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M0610	Continued from page 11 LPN #4 stated that mouth care was to be completed every shift and that failure to provide oral care could result in tooth decay, pain, gingivitis, and possible infection. An observation and interview on 01/06/2026 at 4:50 PM with the DON confirmed that Resident #64's teeth were visibly soiled and required brushing. DON stated that CNAs were responsible for providing mouth care every shift. DON further stated that failure to provide appropriate mouth care could result in tooth decay, mouth sores, foul odors, and possible infection and stated that staff would address the issue. An interview conducted on 01/07/2026 at 10:37 AM with CNA #5 revealed that she had provided care for Resident #64 the previous day. CNA #5 stated that mouth care was expected to be completed every shift but confirmed that she did not brush the resident's teeth. She stated that providing mouth care was difficult due to the resident's PEG tube feeding and the need for the resident to remain upright during that time. CNA #5 further stated that she would want her own teeth brushed daily and agreed that Resident #64 should have his teeth cleaned as well. Record review of the Admission Record indicated that Resident #64 was admitted on 08/22/2024 with diagnoses including dysphagia, hemiplegia, and hemiparesis. Record review of the MDS with an ARD of 12/23/2025 revealed a BIMS score of 9, indicating moderate cognitive impairment. Section GG indicated that Resident #64 was dependent on staff for oral hygiene. Resident #105 An observation on 1/05/26 at 11:30 AM revealed Resident #105's bilateral hands appeared contracted in appearance, and his fingernails were approximately one inch in length. An observation on 1/05/26 at 3:00 PM revealed Resident #105's fingernails remained approximately one inch in length. An observation of Resident #105's hands with CNA #2 on 1/06/26 at 2:18 PM revealed he confirmed the resident's fingernails were very long and needed to be trimmed. He stated the nurses are responsible for trimming residents' nails. Upon continued observation of the resident's right hand, it was observed that the first and second fingernails were digging into the resident's	M0610		

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M0610	Continued from page 12 palm. CNA #2 stated that untrimmed fingernails could lead to skin breakdown. An observation of Resident #105's fingernails with LPN #1 on 1/06/26 at 2:35 PM revealed he confirmed the resident's fingernails were long, bent inward toward the palm of the hand, and needed to be trimmed. He stated the nurses are responsible for trimming the resident's fingernails due to the resident being diabetic. An interview with the DON on 1/06/26 at 3:00 PM revealed she had observed the resident's contracted hands and that the fingernails on the right hand were digging into the palm and required trimming. She stated failure to provide nail care services could result in worsening skin breakdown and accidents. Record review of the Admission Record revealed Resident #105 was admitted on 8/28/13 with diagnoses including type 2 diabetes and contracture of the right hand. Record review of the BIMS for Resident #105 dated 11/20/25 revealed a score of 9, indicating the resident was moderately cognitively impaired.	M0610		
M0625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide range of Motion (ROM) services for (2) two of 60 residents requiring splints for limited ROM. (Resident #24 and #105) Findings include: Review of the facility policy titled, "Resident Mobility and Range of Motion," with no revision date, revealed the policy statement: "Residents with limited range of motion will receive treatment and services to increase and/or prevent further decrease in range of motion..." Resident #24	M0625		

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M0625	Continued from page 13 An observation and interview on 01/05/2026 at 11:17 AM with Resident #24, revealed him sitting up in his wheelchair in his room. He had contractures to the second, third, fourth, and fifth digits on his left hand. His fingers were stiff and bent inward, and his fingernails were touching the palm of his hand. Resident #24 stated he had a brace that he wore sometimes, and it was located in the top drawer of his dresser. Resident #24 revealed that the last time he had therapy, the Certified Occupational Therapy Assistant (COTA) told him to let the nurses or aides help him put the brace on. He also revealed that sometimes he had a hard time applying the brace because part of it would fold up and due to his limited use of his hand, he had problems with it. Resident #24 revealed that not everyone knew how to put the brace on and sometimes he didn't get to wear it. He also confirmed that the nurses nor aides offered to put his hand splint on, and he had to go to them and ask for them to put it on him. He confirmed that now since his fingers are touching his palm of his hand that it is harder to get the splint on by himself and he needs help. An interview on 01/06/26 at 3:41 PM with Registered Nurse (RN) #1, revealed that Resident #24 was somewhat independent and liked to do what he could for himself. She revealed that he had a hand splint and the therapy department trained them on how to apply it when he was discharged from therapy. RN #1 revealed that Resident #24 knew he was supposed to ask for help getting it on, sometimes he did, and sometimes he didn't and stated, "It was nothing he had to wear every day." RN #1 confirmed that the nurses did not make sure Resident #24 applied the brace as recommended, but they helped him if he asked. An interview on 01/07/26 at 12:03 PM with Director of Nursing (DON), confirmed that there was no order for the use of a hand splint for Resident #24. She agreed that a nurse should have been monitoring, assisting the resident with the splint and ensuring the brace was applied as recommended to prevent worsening of the contracture. She revealed that she did not know how this got missed. An interview on 01/07/26 at 2:41 PM with the COTA, revealed that Resident #24 had therapy for his left-hand contracture about a year ago. She revealed that he had a resting hand splint that the staff were	M0625		

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M0625	Continued from page 14 trained on how to apply when Resident #24 was discharged. She revealed that he could apply the hand splint sometimes himself. She revealed that when they discharged him from therapy, they educated the nursing staff and CNAs (Certified Nursing Assistants) on how to apply the resting hand splint, and they took it over. She revealed that the purpose of wearing the hand splint was to prevent the fingers from tightening back up causing worsening contractures and confirmed that if the resident has not worn the splint consistently then the contracture would worsen. An interview on 01/07/26 at 3:03 PM with Assistant Director of Nursing (ADON), revealed that Resident #24 had a splint in his room and they were trained on how to apply and take off. She revealed that Resident #24 applied his own brace sometimes and sometimes he didn't. She revealed that when Resident #24 was discharged from therapy, COTA came down to them and trained the Certified Nursing Assistants (CNA)s and trained the nurses on how to apply correctly. She revealed that it was the CNAs responsibility to apply and ensure that the splint stays on for the appropriate time and to report to the nurse if there were any problems. The ADON revealed that she knew there was no order for the hand splint to be applied and stated, "This is a learning experience, and we as a whole dropped the ball and will have to fix it." The ADON revealed that they had new staff in and out and she would have COTA to train all staff again on the floor now so that the splint was applied properly. She also confirmed that the nurses were supposed to oversee the CNAs and ensure the splint was applied according to therapy recommendations. Record review of Resident #24's "OT (Occupational Therapy) Discharge Summary" dated 01/29/25 revealed under "Discharge Recommendations" that he had a left resting hand splint. Therapist has trained staff on self-range of motion exercises using Right upper extremity to perform Left Upper Extremity Passive Range of Motion exercises and on splint wear to apply three times a week for two to four hours to maintain good Range of Motion and decrease further risk for contracture. "Dates of service 12/05/24-01/24/25; Prognosis to maintain Current Level of Functioning (CLOF)= Good with consistent staff follow through" Record review of Resident #24's "Order Summary Report" and his "Visual/Bedside Kardex Report" documented no orders to apply his hand splint.	M0625		

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M0625	Continued from page 15 Record review of Resident #24's "Admission Record" revealed an admission date of 02/21/24 and that he had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side and Unspecified Pain. Record review of Resident #24's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/03/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that he had no cognitive deficits. Record review of Resident #24's MDS with ARD of 10/03/25 under Section GG revealed under "Functional Limitation in Range of Motion" that he had upper extremity impairment on one side. Resident #105 An observation on 1/05/26 at 11:30 AM revealed the resident's bilateral hands appeared contracted in appearance, with no positioning devices in place. An observation on 1/05/26 at 3:00 PM revealed the resident's hands remained in a contracted position. An observation of Resident #105's hands with CNA #2 on 1/06/26 at 2:18 PM revealed he confirmed the resident's bilateral hands were contracted, with the right hand more severely affected. Upon continued observation of the right hand, it was observed that the first and second fingernails were digging into the resident's palm. CNA #2 stated he frequently provided care to the resident and confirmed he did not perform range of motion exercises to the resident's hands due to the severity of the contractures. He further revealed splinting devices were present in the resident's dresser drawer and stated restorative services were responsible for applying the splints; however, the splints had not been applied for approximately two days. He stated failure to provide range of motion and apply splints could result in worsening of the resident's contractures. An observation of Resident #105's hands with Licensed Practical Nurse (LPN) #1 on 1/06/26 at 2:35 PM revealed he confirmed the resident's bilateral hands were contracted and his fingernails were long and bent inward toward the palms of the hands and the resident	M0625		

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M0625	Continued from page 16 did not have a splint on his hands. An interview with the DON on 1/06/26 at 3:00 PM revealed she stated she had observed the resident's contracted hands and that the fingernails on the right hand were digging into the palm. She stated the resident was supposed to have splints applied to his hands. She further stated failure to provide range of motion services and apply splints could result in worsening contractures. The DON confirmed the facility did not have restorative services at that time and stated she was unable to locate documentation in the resident's record related to range of motion services or application of splints. Record review of an Occupational Therapy Discharge Summary for Resident #105 dated 3/05/25 revealed the resident had a right wrist-hand-finger orthosis (WHFO) to promote wrist extension, digit extension, and thumb abduction to prevent further risk for joint contracture. The summary further revealed therapy staff had trained facility staff on the resident's restorative program, including splint wear, hand hygiene, and passive range of motion. An interview with the COTA on 1/07/26 at 11:00 AM revealed she stated the resident should wear hand positioning devices daily and receive passive range of motion. She stated she was unaware of when or why the facility stopped applying the devices but confirmed the resident required them to aid in prevention of worsening contractures. Record review of the Admission Record revealed Resident #105 was admitted on 8/28/13 with diagnoses including type two diabetes and contracture of the right hand. Record review of the BIMS for Resident #105 dated 11/20/25 revealed a score of 9, indicating the resident was moderately cognitively impaired.	M0625		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II	M0640		

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M0640	Continued from page 17 Based on observation, staff interviews, and record review, the facility failed to provide adequate supervision to prevent accidents for one (1) of twenty-seven (27) residents on the sample (Resident #22). Findings include: Review of a facility policy titled, “Safety and Supervision of Residents,” with no revision date, revealed the policy statement: “Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities...” An observation and interview with Resident #22 on 1/05/2026 at 11:40 AM revealed the resident stated he wanted to go back to where he came from, and the conversation with the resident continued for approximately five minutes. When asked if the gentleman asleep in a chair in the room was his family member, Resident #22 stated, “No, he is supposed to be watching me but just look at him sleeping.” The gentleman asleep in the chair did not awaken during the observation and interview. During a continued observation and interview on 1/05/26 at 11:48 AM Certified Nurse Assistant (CNA) #3 entered the room and revealed that the gentleman asleep in Resident #22’s room was the Transporter assigned to sit with the resident due to one-on-one supervision related to behaviors. The CNA loudly called the Transporter’s name three times, and he did not awaken. CNA #3 then went and got the nurse and the State Agency continued to stay in the room. An observation from the doorway of Resident #22’s room on 1/05/26 at 11:50 AM revealed the Transporter remained asleep in the chair. An observation on 1/05/26 at 11:52 AM revealed the Transporter was awakened by another staff member who entered Resident #22’s room. An interview with the Transporter on 1/05/26 at 11:54 AM revealed he stated he was sitting with the resident and guessed he had dozed off. He stated he knew he was not supposed to sleep while on duty. An interview with Licensed Practical Nurse (LPN) #2 on 1/05/26 at 11:58 AM revealed Resident #22 had been on one-on-one supervision since the end of December due to behaviors, including threats to kill staff and other	M0640		

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M0640	Continued from page 18 residents. She stated that while staff were asleep, the resident was not being supervised and could have acted on his threats or experienced worsening behaviors. Record review of the Order Recap Report for Resident #22 revealed an order dated 12/31/25 for one-on-one precautions related to aggressive behaviors for seven days. An interview with the Director of Nursing on 1/07/26 at 9:34 AM revealed she confirmed Resident #22 was on one-on-one supervision related to behaviors. She stated that if staff were asleep and not monitoring the resident as directed, it could have led to increased behaviors. An interview with Social Services Staff #2 on 1/07/26 at 11:00 AM revealed he confirmed Resident #22 was to remain on one-on-one supervision due to behaviors and aggression. He stated the resident would continue on one-on-one supervision until appropriate placement was determined through the court system. Record review of the Admission Record revealed Resident #22 was admitted on 10/07/24 with diagnoses including paranoid schizophrenia and bipolar disorder. Record review of the Brief Interview for Mental Status (BIMS) for Resident #22 dated 12/12/25 revealed a score of 15, indicating the resident was cognitively intact.	M0640		