

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 02/05/2026	
NAME OF PROVIDER OR SUPPLIER PICAYUNE REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 READ ROAD , PICAYUNE, Mississippi, 39466			
(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 four (4) Complaint Investigations (CI MS #2733159, CI MS #2719784, CI MS #2712200, and CI MS #2711808), at the facility from 2/2/26 through 2/5/26. CI MS #2733159 was investigated related to neglect, accidents, and quality of care and M500 was cited. CI MS #2719784 was investigated related to nursing services, quality of care, and neglect, and there were no citations. CI MS #2712200 was a facility reported incident (FRI) investigated related to quality of care, rehabilitation services, and infection control, and there were no citations. CI MS #2711808 was investigated related to nursing services, accidents, and neglect, and there were no citations. During the complaint survey, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 1/20/26, when the facility failed to protect Resident #1 from neglect by failing to provide necessary care and services following a fall, resulting in delayed assessment and delayed medical evaluation. The IJ and SQC existed at: Rule 45.17.2 Residents' Rights – M500-Level IV. This failure placed Resident #1 and all residents at risk for falls in a situation that is likely to cause serious injury, serious harm, serious impairment, or death. The facility Administrator was notified of the IJ on 2/4/26 at 4:00 PM. The facility provided an acceptable Removal Plan on 2/4/26, in which they alleged all corrective actions to remove the IJ were completed on 2/4/26, and the IJ removed on 2/5/26. The SA validated the Removal Plan on 2/5/26 and determined the IJ was removed on 2/5/26, prior to exit. Therefore, the scope and severity of Rule 45.17.2 Residents' Rights – M500 was lowered from a Level IV to		M0000				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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M0000	Continued from page 1 a Level II while the facility develops a plan of correction to monitor the effectiveness of systemic changes to ensure sustained compliance with regulatory requirements.	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 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	M0500					

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M0500	Continued from page 2 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 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	M0500					

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M0500	Continued from page 3 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, 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: Based on interviews, record review, and facility policy review, the facility failed to provide necessary care and services to protect residents from neglect when staff failed to ensure safe transfers for a resident who required a mechanical lift, failed to ensure a licensed nurse timely assessed the resident following a fall, failed to initiate timely neurological monitoring, and failed to timely notify the physician		M0500				

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M0500	Continued from page 4 of the fall and subsequent head injury for one (1) of six (6) residents reviewed for falls, Resident #1. The facility's failure to ensure appropriate post-fall assessment, monitoring, communication, and timely medical evaluation resulted in serious harm to Resident #1 and placed other residents with falls at risk for serious harm, serious impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 1/20/26, when Resident #1 fell and was manually lifted back into bed without a licensed nurse assessment and without timely initiation of neurological monitoring or physician notification following a suspected head injury. The facility Administrator was notified of the IJ on 2/4/26 at 4:00 PM. The facility provided an acceptable Removal Plan on 2/4/26, in which they alleged all corrective actions to remove the IJ were completed on 2/4/26, and the IJ was removed on 2/5/26. The State Agency (SA) validated the Removal Plan on 2/5/26 and determined the IJ was removed on 2/5/26, prior to exit. Therefore, the scope and severity for Rule 45.17.2 Residents' Rights (M500) was lowered from a Level IV to a Level II while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility's "Abuse Prohibition Policy", reviewed 6/2/25, revealed "...Intent: This protocol was intended to assist in the prevention of abuse, neglect...Definitions...Neglect is defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, good or services that a resident (s) requires but the facility fails to provide them to the resident (s), that has resulted in or may result in physical harm, pain..." A review of the facility's policy, "Fall Prevention Program," dated 6/18/25, revealed "...5. If a fall occurs, the following will be done: a. The licensed nurse will complete a thorough assessment of the resident to evaluate for injury...k. If the resident with dementia sustains a fall, in addition to the nursing assessment, the facility will also prioritize diagnostics such as STAT (immediate)Xray/transfer to ER		M0500				

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M0500	Continued from page 5 (emergency room) for appropriate investigation and intervention..." A record review of the "Admission Record" revealed the facility admitted Resident #1 on 01/25/18 and she had current diagnoses including Alzheimer's Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/26 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated her cognition was severely impaired. A record review of the "Orders/Notes", dated 1/20/26, revealed Resident #1 "1/20/26 – Fall (with) injury, large bruise atop R (Right) shoulder." The "Orders/Notes", dated 1/23/26, revealed Resident #1 "1/21 fall (with) bruising to R shoulder/R arm neuro (neurological checks (1/24) ..." A record review of the facility's incident report, dated 1/21/2026 at 6:15 AM, revealed the "Incident Description" included a "Nursing Description" of "CNA (Certified Nurse Assistant) reported to this nurse while given patient care staff stated the resident was turned to the edge of the bed, resident then grabbed the sheet and pulled herself off the bed staff was unable to prevent resident from falling to the floor, and put her back into bed." "Statements," dated 1/22/26, revealed, "...CNA stated while providing incontinent care for (Proper Name of Resident #1), had one hand placed on her hip for support and using other hand to provide perineal care. Resident grabbed the sheet and pulled herself over toward edge of bed, causing her to fall. I was unable to catch resident and prevent from falling." A review of the "Agencies/People Notified" revealed the Physician was notified on 1/21/26 at 8:15 AM of the resident's fall. "Notes," dated 1/22/26, revealed, "Witnessed fall investigated by DON (Director of Nurses). While CNA was performing incontinent care, resident grabbed bed and pulled herself causing her to fall. CNA was unable to stop from hitting floor. The incident report did not include the date and time the fall actually occurred, which was on 1/20/26. The report described "Immediate Action Taken" as "Resident was assessed upon being notified of bruising atop resident's right shoulder. Assessed for ROM (Range of Motion)..." A record review of the "Progress Note", dated 1/21/26 at 10:04 PM, for Resident #1 revealed, "Nurse called to resident's room by the aide to report new found ecchymosis (bruising) to pt's (patient's) right shoulder blade and her neck...Pt reports tenderness to	M0500					

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M0500	Continued from page 6 light palpitation. Range of motion is guarded by resident, but functional. Resident also has bruising to her right side of her head with a hematoma, mild swelling and tenderness. Resident states she doesn't remember what happened..." A record review of the "Progress Note" which indicated "Late Entry" that was "Created" on 1/22/26 at 1:21 PM with an "Effective Date" of 1/21/26 at 6:15 AM, for Resident #1 revealed, "CNA reported to this nurse while giving patient care staff stated the resident was turned to the edge of the bed, resident then grabbed the sheet and pulled herself off the bed staff was unable to prevent resident from falling to the floor. CNA stated they put her back into the bed. Resident was assessed upon being notified of bruising atop resident's right shoulder. Assessed for ROM resident denied pain at that time..." The progress note did not indicate the date or time the fall actually occurred. A record review of the "Order Summary Report" with active orders as of 1/25/26, revealed Resident #1 had a Physician's Order, dated 04/09/20, for Aspirin Tablet 81 milligrams (mg) and Plavix Tablet 75 mg, which are both antiplatelet agents (affects how the blood clots). Further review revealed a Physician's Order, dated 3/21/23 for "Hoyer lift (type of mechanical lift) x (times) 2 people for transfers." A record review of the Medication Administration Record (MAR) for January 2026 revealed Resident #1 continued to be administered aspirin and Plavix from 1/21/26, which was the date her head injury was observed and documented, until 1/26/26 when Resident #1 was transferred to an acute care hospital for altered mental status. A record review of the "Emergency Department Encounter", dated 1/26/26 revealed the "Chief Complaint" as "...Altered Mental Status Patient had fall on 1/21, patient had left sided facial droop...History...staff went to feed her at 1145 and found her confused with a left-sided facial droop...CT (Computed Tomography) Noncontrast head...Findings: There is hemispheric subdural on the right extending from the vertex through to inferior skull base on the right involving the frontal, parietal, temporal and occipital lobes with extension posteriorly medially into the interhemispheric fissure. This measures at least 1.8 cm (centimeter). There is approximately 8 mm(millimeter) of right-to-left midline shift with compression of the right lateral ventricle and slight dilatation of the left lateral ventricle...Medical Decision Making....transferred for...higher level of care..."		M0500				

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M0500	Continued from page 7 A record review of the "ED Provider Notes," from acute hospital with higher level of care, dated 1/26/26 revealed "History" of "...She has a history of a fall 5 days ago where she struck her head but did not seek medical attention...CT of the head in outlying facility shows large intracranial bleed.." Further review revealed, "...I have discussed with patient's husband via telephone...I was able to detail for him the findings on the head CT identifying both acute and chronic blood...which could enlarge, particularly in a patient who has been on blood thinning medications including aspirin and Plavix..." On 2/3/26 at 2:00 PM, during an interview with CNA #1, she explained that on 1/20/26 at approximately 10:00 PM, Resident #1 fell to the floor after slipping between the bed and the wall and landed on her right side. CNA #1 stated she notified Licensed Practical Nurse (LPN) #3 and LPN #1 of the fall and obtained assistance from CNA #2 to return the resident to bed. CNA #1 also confirmed the resident required the use of a mechanical lift for transfers. CNA #1 was unable to explain why a mechanical lift was not used or why the resident was returned to bed prior to a licensed nurse assessing the resident. CNA #1 was unable to confirm when a licensed nurse assessed Resident #1 following the fall. On 2/3/26 at 2:15 PM, during an interview with CNA #2, she confirmed that she assisted CNA #1, in placing Resident #1 back into the bed. She reported that a mechanical lift was not used and that they manually lifted the resident by her arms and legs to return her to bed. She reported that facility policy requires staff to immediately notify a nurse following a fall so the residents can be assessed and, if needed, a mechanical lift used to assist with transferring. She reported being confused as to why a nurse was not present in the room at that time. On 2/3/26 at 3:30 PM, during an interview with LPN #3, she explained that she was working on 1/20/26. She denied that CNA #1 had informed her that Resident #1 had fallen on 1/20/26. On 2/3/26 at 4:00 PM, during an interview with LPN #1, she reported she was working the night of 1/20/26 and was not informed of Resident #1's fall at the time it occurred. LPN #1 stated she first became aware of the fall at approximately 6:00 AM on 1/21/26 and at that time notified the physician and family and initiated neurological checks. LPN #1 confirmed that she had documented the fall on the 24-Hour report, which is the	M0500					

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M0500	Continued from page 8 "Orders/Notes" notes. LPN #1 confirmed that CNA #1 was present and witnessed the fall. LPN #1 reported she did not complete an incident report or document the event until 1/22/26, which was two (2) days after the fall occurred and explained the documentation was entered as late documentation in a nurse's note per direction of the DON. On 2/3/26 at 4:30 PM, during an interview with LPN #2, she reported that on 1/21/26 at approximately 10:00 PM she observed a hematoma on the right side of Resident #1's head. LPN #2 stated she notified the DON in the early morning hours of 1/22/26. LPN #2 reported she did not notify the medical provider because she believed the injury appeared old based on the yellow discoloration of the surrounding bruising. LPN #2 confirmed she was not aware Resident #1 had fallen on 1/20/26, did not complete neurological monitoring during her shift on 1/21/26, and did not notify the medical provider on 1/21/26 that Resident #1 had a head injury. On 2/4/26 at 9:00 AM, during an interview with the DON, he confirmed he did not become aware of Resident #1's fall until 1/22/26 at approximately 7:41 AM, when LPN #2, contacted him by phone. He reported he was informed that the resident had sustained bruising to her shoulder and was at her neurological baseline at that time. He explained he was not informed of the presence of a hematoma and reported he did not review the nursing notes, dated 1/21/26, that had documented the hematoma. The DON confirmed he assessed the resident on 1/22/26, which was two (2) days after the fall occurred on 1/20/26. He admitted that he did not physically assess the resident's head at that time. The DON confirmed the medical provider was notified of the resident's fall at that time and received a physician order to obtain a right shoulder x-ray for Resident #1. The DON further confirmed that following the notification on 1/22/26, he initiated an investigation into the incident. He identified that CNA #1 did not follow facility expectations by failing to obtain licensed nursing to assess the resident after the fall. He also identified that LPN #2, did not follow facility expectations by failing to notify the medical provider of the resident's hematoma that she discovered on 1/21/26. On 2/4/26 at 12:44 PM, during an interview with the Medical Provider, he confirmed that he was not aware of Resident #1's fall that occurred on 1/20/26 until 1/22/26. At that time, he ordered an x-ray of the right shoulder due to complaints of shoulder pain. He reported he was not informed that Resident #1 had a			M0500			

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M0500	Continued from page 9 hematoma to her head and that no one had called him at the time it was documented on 1/21/26 by the nurse. He stated that had he been notified of the hematoma, he would have ordered the resident to be transferred to the local emergency room for further evaluation. On 2/4/26 at 2:06 PM, during an interview with the Administrator, she confirmed she was not aware of Resident #1's fall that occurred on 1/20/26 until 1/22/26, two (2) days after the fall occurred. The Administrator confirmed facility policy required CNAs to immediately report any resident fall to the nurse in charge. She confirmed CNA #1 did not notify nursing staff of the fall on 1/20/26 and that the resident was transferred back to bed without a licensed nurse assessment. The Administrator further confirmed LPN #1 did not report the fall to nursing leadership, including the DON on 1/20/26 or 1/21/26. The facility submitted the following acceptable Removal Plan on 2/4/26. On 01/20/2026 at approximately 10:00 PM, Resident #1 experienced a fall during activities of daily living (ADL) care. Certified Nursing Assistant (CNA) #1 was assisting with ADL care when Resident #1, while being repositioned onto her side, grasped the bed and inadvertently pulled herself off, resulting in a fall to the floor. Licensed Practical Nurse (LPN) #1 was notified at 6:15 am on 01/21/2026 and began neuro checks that day. On 01/26/2026, Resident #1 showed left facial droop and slurred speech and was sent to the hospital. The investigation found staff did not use proper lifting techniques, assess Resident #1 quickly, or notify the physician promptly after the fall and head injury. Corrective Actions On 01/22/2026, at approximately 7:41 a.m., the Director of Nursing (DON) was notified by Licensed Practical Nurse (LPN) #2 regarding discoloration observed on Resident #1's right shoulder. On 01/22/26 at approximately 8:15 a.m., the Registered Nurse (RN)#1 assessed Resident #1 and obtained an order for right shoulder X-ray. On 01/22/26 at approximately 09:20 a.m., the Director of Nursing (DON) contacted Licensed Practical Nurse (LPN) #3 to inquire about any knowledge regarding Resident #1's fall. Licensed Practical Nurse (LPN) #3 reported having no knowledge of the incident.	M0500					

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M0500	Continued from page 10 On 1/22/2026 at approximately 9:30 a.m, the Director of Nursing (DON) interviewed Certified Nurse Assistant (CNA) #1 regarding Resident #1's fall. Certified Nurse Assistant (CNA) #1 gave a verbal account of the incident. On 1/22/2026 at approximately 9:40 am, the Director of Nurses interviewed Licensed Practical Nurse (LPN)#1 regarding Resident #1's fall. Licensed Practical Nurse (LPN) #1 gave a verbal account of the incident. On 01/22/2026 at approximately 11:15 a.m., X-ray findings for Resident #1's right shoulder indicated no evidence of acute fracture or dislocation. On 01/22/2026 at approximately 1:00 pm, Licensed Practical Nurse (LPN) #1 initiated a facility-based incident report regarding Resident #1's fall and subsequently completed the associated documentation of the event. On 01/22/2026 at approximately 1:15pm, Director of Nurses reviewed Resident #1 Neuro check log to ensure no abnormalities. Resident #1 remained at baseline with current neuro checks in place every four hours to monitor neuro deficits. On 01/22/2026 at approximately 10:00pm Neuro checks continued Resident #1 at every eight (8) hours intervals. No neurological deficits were found. The resident remained at the baseline. On 01/24/2026 at approximately 6:15am, Neuro checks were completed for Resident #1. On 01/26/26 at approximately 12:30pm Resident #1 was noted to have drooped to left side and slurred speech. Nurse Practitioner (NP) #1 was notified, and orders were obtained to transfer to local hospital. On 01/26/2026 at approximately 12:34 Resident #1 was transferred to local hospital via stretcher. On 01/29/2026 at approximately 6:45pm, the Director of Nursing (DON) received notification from Licensed Practical Nurse (LPN) #1 that she resigned from employment effective immediately. On 01/30/2026 at approximately 10:00am an audit was conducted by the Director of Nursing (DON) on all current residents that had an accident or incident occur in the past thirty (30) days to determine the potential of any further residents affected. The results indicated no negative outcomes.			M0500			

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 02/05/2026	
NAME OF PROVIDER OR SUPPLIER PICAYUNE REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 READ ROAD , PICAYUNE, Mississippi, 39466			
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M0500	Continued from page 11 On 02/03/2026 at approximately 5:30 p.m., the Director of Nurses provided education to all licensed nurses and Certified Nursing Assistants on fall prevention, safe handling, and proper resident transfers. Training also included fall prevention along with neuro checks. change in condition notifications, Abuse and Neglect protocols, Resident Rights, and the Vulnerable Adult Act. All staff must complete this training before returning to work. On 2/4/2026 at 4:00 P.M. Agency (SA) notified Administrator of Immediate Jeopardy. State Agency (SA) provided the facility with the Immediate Jeopardy templates. On 02/04/2026 at approximately 5:00pm Medical Director, Administrator, Director of Nursing, Infection Preventionist, Assistant Director of Nursing, and Corporate Clinical Specialist held Ad hoc Quality Assurance Performance Improvement Meeting to include Resident #1 fall occurring on 01/20/2026 along with investigation, immediate jeopardy, along with the corrective action plan. The fall prevention policy was evaluated and reviewed to incorporate updated procedures and training for new staff on adhering to the Interact Care Path for acute mental status changes. On 02/04/2026 at approximately 6:00 P.M., a Resident Council Meeting was held with the Assistant Director of Nursing, the Resident Council President, and eleven (11) resident members. They were informed that the facility received one Immediate Jeopardy citation due to inadequate lifting techniques and failure to assess a resident after a fall. On 02/04/2026 at approximately 6:15 p.m., the Administrator, Director of Nursing, and Corporate Clinical Specialist conducted a comprehensive review of the investigation, including all relevant components such as interviews, statements, and electronic records, to perform a root cause analysis. The outcome of this analysis identified a failure in communication as the primary issue. On 02/04/2026 at approximately 6:30 p.m., Certified Nurse Assistant (CNA) #2 received individual training from the Administrator on how to identify each resident's lifting status according to their specific care plan, as well as safe handling and lifting procedures along with receiving a disciplinary action. On 02/04/2026 at approximately 6:45pm Licensed Practical Nurse (LPN) #2 received one to one Inservice	M0500					

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M0500	Continued from page 12 from the Administrator and Director of Nurses on Abuse and Neglect, Resident Rights, Vulnerable Adults act, notification of change in condition, fall prevention, and safe patient handling and moving protocols along with receiving a disciplinary action. On 02/04/2026 at approximately 6:50 p.m., Certified Nursing Assistant (CNA) #1 received individual training from the Administrator regarding how to identify each resident's lifting status according to their specific care plan, as well as safe handling and lifting procedures along with receiving a disciplinary action. On 02/04/2026 at approximately 7:30 p.m., the Director of Nursing (DON) conducted a training session for all licensed nursing staff regarding adherence to the Interact Care path for acute mental status changes following post-fall assessments. Completion of this training is mandatory for all staff prior to their return to work. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 02/04/2026 and the Immediate Jeopardy was removed on 02/05/2026. Validation: The SA validated the removal plan through observations, interviews, and record reviews on 2/5/26 and the immediacy was removed on 2/5/26 prior to exit.			M0500			