

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255232		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/09/2026	
NAME OF PROVIDER OR SUPPLIER CORNERSTONE REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 302 ALCORN DRIVE , CORINTH, Mississippi, 38834			
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F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey and Complaint Investigation (CI MS #2800190) at the facility from 4/06/26 through 4/09/26. CI MS #2800190 was investigated for Activities of Daily Living (ADL) and Bowel/Bladder Incontinence; there were two citations related to this complaint, F677 and F690. During the survey, the SA determined that the facility was not in compliance with the Medicare and Medicaid regulations for participation and cited regulatory deficiencies F582, F641, F656, F761, F812 and 851. The facility had a census of 80 and was licensed for 95 beds.		F0000				
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.		F0582				

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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F0582 SS = D	Continued from page 1 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to ensure residents or their representatives were provided with required Beneficiary Notices, including Skilled Nursing Facility Advanced Beneficiary Notices (ABNs) for one (1) of three (3) residents reviewed for Beneficiary Protection Notifications. Residents #4 Findings include: Review of a statement on facility letterhead dated 4/7/26 and signed by the Administrator revealed the facility did not have a policy specific to Beneficiary Notices, including Advanced Beneficiary Notices (ABNs). Review of the Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form revealed that one of the three residents reviewed remained in the facility; however, Resident #4 was not provided with a Skilled Nursing Facility Advanced Beneficiary Notice (ABN).	F0582					

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F0582 SS = D	Continued from page 2 During an interview on 4/7/2026 at 10:36 AM, the Business Office Manager confirmed she did not provide the SNF ABN to the resident or the resident's responsible party. She stated, "I didn't realize that I needed to complete the ABN form. I thought the Notice of Medicare Non-Coverage (NOMNC) was enough and that it covered all of that." During an interview on 4/7/2026 at 11:41 AM, the Administrator confirmed he had the same understanding as the Business Office Manager and believed the Notice of Medicare Non-Coverage (NOMNC) was the only notice required to be provided to the resident or responsible party. Review of the "Admission Record" indicated that the facility admitted Resident #4 on 12/19/2025 with a medical diagnosis that included Heart Failure.		F0582				
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material		F0641				

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F0641 SS = D	Continued from page 3 and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to accurately complete "Section O" of the Minimum Data Set (MDS) quarterly assessment during the 7-day observation look-back period for one (1) of four (4) residents reviewed for dialysis services. Resident #16 Findings Include: Review of the facility policy titled "MDS Coding Policy" dated 8/11/20 revealed, "Proper Name" affiliated facilities utilize the most up to date Resident Assessment Instrument (RAI) manual for determination of coding each section of the Resident Assessment, timely and accurately..." Record review of the "Order Summary Report" revealed that Resident #16 has an order to receive dialysis three (3) days a week, on Tuesday, Thursday, and Saturday, at the "proper name of dialysis" center, with a start date of 7/14/25. Record review of Resident #16's Quarterly MDS with an Assessment Reference Date (ARD) of 1/6/26 revealed under section O that Resident #16 was not coded for receiving dialysis. Record review of Resident #16's Quarterly MDS with an ARD of 4/1/26 revealed under section O that Resident #16 was not coded for receiving dialysis. During an interview on 4/08/26 at 8:30 AM, the MDS Nurse confirmed that Resident #16 receives dialysis services three times weekly. She revealed that, for the past two quarterly MDS assessments, Resident #16 was not coded as receiving dialysis treatments in Section O. The MDS Nurse stated she was instructed not to code dialysis during the seven-day look-back period if all three communication sheets from the dialysis center were unavailable. The MDS Nurse further confirmed that despite the missing documentation, Resident #16 attended and received dialysis treatments on all scheduled days during the look-back period. In an interview on 4/9/2026 at 10:25 AM, the	F0641					

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F0641 SS = D	Continued from page 4 Administrator (ADM) revealed if Resident #16 is receiving dialysis services, then his MDS should accurately reflect that. Record review of Resident #16's "Admission Record" revealed he was admitted to the facility on 7/14/2025 with diagnoses that included End Stage Renal Disease and Dependence on Renal Dialysis. Record review of Resident #16's MDS with ARD of 4/1/26 indicated a Brief Interview for Mental Status (BIMS) of 11, which indicated the resident has moderate cognitive impairment.	F0641					
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F0656					

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F0656 SS = D	Continued from page 5 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 record review, observation, staff interviews, and facility policy review, the facility failed to develop and implement a person-centered comprehensive care plan for three (3) of 38 residents reviewed (Resident #10, #40, and #73). Findings Include: Review of the facility policy titled "Care Plans, Comprehensive Person-Centered" reviewed 1/2023, revealed under, "Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Resident #10 On 4/06/26 at 6:32 PM, and again on 4/07/2026 at 3:38 PM an observation of Resident #10 revealed the resident lying in bed with his hair oily, matted, and tangled. Resident #10 had a foul odor, and his room had a foul odor. On 4/08/26 at 9:25 AM an observation and interview with Certified Nursing Assistant (CNA) #2 confirmed Resident #10's hair was unclean and he had an odor. She stated that she was not on shift the previous day when he had his last shower, and it's necessary for an aide to assist him with soap and shampoo because he will just stand in the shower and let the water splash him, he does not have awareness to bath his body and shampoo his hair. On 4/08/26 at 11:35 AM an observation and interview		F0656				

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F0656 SS = D	Continued from page 6 with the Administrator confirmed Resident #10' s hair had not been washed and was unclear. He stated it is the expectation of the facility for the staff to assist resident in showering and shampooing their hair if resident is unable to. During an interview on 4/08/26 at 3:00 PM with the Minimum Data Set (MDS) Nurse, she confirmed that Resident #10's care plan was not implemented for assistance with showering because she had him marked as independent. Record review of the "Admission Record" revealed the facility admitted Resident #10 on 7/02/2025 with medical diagnoses that included Alzheimer's Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/25/2026 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 1, which indicated Resident #10 was severely cognitively impaired. Resident #40 Record review of Resident #40's "Care Plan Report" revealed under, "Focus: I have an ADL (activity of daily living) self-care performance deficit r/t (related to) weakness, dementia". Also revealed under, "Interventions/Tasks: Bathing/Showering: Provide sponge bath when a full bath or shower cannot be tolerated." On 4/6/26 at 7:29 PM and again on 4/7/2026 at 8:18 AM an observation of Resident #40 revealed the resident lying in bed with her hair uncombed, matted, and tangled. The scalp had visible yellowish, dry, flaky buildup to the entire front scalp area, consistent with lack of washing. On 4/8/26 at 8:04 AM, an observation and interview with Licensed Practical Nurse (LPN) #2 confirmed Resident #40 had unclear hair with visible residue and buildup. During an interview on 4/8/26 at 11:20 AM, the MDS Nurse revealed that she is responsible for developing residents' comprehensive care plans and that care plans are driven by the MDS assessment. She stated the purpose of the care plan is to inform staff on how to care for residents based on their individual needs. Record review of the "Admission Record" revealed the facility admitted Resident #40 on 11/5/21 with medical diagnoses that included Unspecified Dementia, Muscle Weakness, and Need for Assistance with Personal Care.			F0656			

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F0656 SS = D	Continued from page 7 Record review of the MDS with an ARD of 2/12/26 revealed under section C, a BIMS summary score of 3, which indicated Resident #40 was severely cognitively impaired. Resident #73 Record review of Resident #73's "Care Plan Report" revealed no care plan was in place for smoking. Record review of the MDS with ARD of 8/25/25 indicated under Section J that Resident #73 currently uses tobacco. During an interview on 4/7/2026 at 10:44 AM, Resident #73 revealed he is a smoker. During an interview on 4/8/26 at 11:20 AM, the MDS Nurse revealed that she is responsible for developing residents' comprehensive care plans and that care plans are driven by the MDS assessment. She stated the purpose of the care plan is to inform staff on how to care for residents based on their individual needs. The MDS Coordinator further revealed that if a resident smokes, a smoking care plan should be developed to address those needs. She confirmed that, according to the Annual Comprehensive MDS assessment dated 8/25/25, the resident was coded as a current tobacco user. She acknowledged that a smoking care plan had not been developed for the resident and stated the omission occurred in error. Record review of Resident #73's "Admission Record" revealed he was admitted to the facility on 9/9/24 with diagnoses that included Chronic Systolic Congestive Heart Failure, and Hemiplegia and Hemiparesis following Cerebral Infarction. Record review of Resident #73's MDS with an ARD of 4/1/26 indicated a BIMS score of 13, which indicated the resident is cognitively intact.		F0656				
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by:		F0677				

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F0677 SS = D	Continued from page 8 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure residents who were dependent on staff for hair care and shampooing received the necessary hygiene services to maintain personal cleanliness and grooming for two (2) of eight (8) residents reviewed for activities of daily living (ADL) care during the initial pool. Resident #10 and #40 Findings Include: Review of the facility policy titled "Activities of Daily Living (ADL), Supporting" revised 3/18, revealed under, "Policy Statement: ...Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene..." Resident 10 An observation of Resident #10 on 4/06/26 at 6:32 PM, and again on 4/07/2026 at 3:38 PM revealed the resident lying in bed with his hair oily, matted, and tangled. Resident #10 had a foul odor, and his room had a foul odor. An observation and interview with Certified Nursing Assistant (CNA) #2 on 4/08/26 at 9:25 AM confirmed Resident #10's hair was unclean and he had an odor. She stated that she was not on shift the previous day when he had his last shower, and it's necessary for an aide to assist him with soap and shampoo because he will just stand in the shower and let the water splash him. An observation and interview with the Administrator on 4/08/26 at 11:35 AM confirmed Resident #10's hair had not been washed and was unclean. He stated it is the expectation of the facility for the staff to assist residents in showering and shampooing their hair if resident is unable to. Record review of the "Admission Record" revealed the facility admitted Resident #10 on 7/02/2025 with medical diagnoses that included Alzheimer's Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/25/2026 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 1, which indicated Resident #10 was severely cognitively impaired. Resident #40			F0677			

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F0677 SS = D	Continued from page 9 An observation of Resident #40 on 4/6/26 at 7:29 PM and again on 4/7/2026 at 8:18 AM revealed the resident lying in bed with her hair uncombed, matted, and tangled. The scalp had visible yellowish, dry, flaky buildup to the entire front scalp area, consistent with lack of washing. An observation and interview with Licensed Practical Nurse (LPN) #2 on 4/8/26 at 8:04 AM confirmed Resident #40 had visible hair residue and buildup. She revealed the resident's scheduled bath days were Monday, Wednesday, and Friday and stated that hair shampooing was considered part of bathing and should be completed on those days by the aide to ensure cleanliness. An observation and interview with the Administrator on 4/8/26 at 8:14 AM confirmed Resident #40's hair had not been washed and was unclean. He stated his expectation was for the resident to be clean and that her hair should be washed with bathing on scheduled bath days. Record review of the "Admission Record" revealed the facility admitted Resident #40 on 11/5/21 with medical diagnoses that included Unspecified Dementia, Muscle Weakness, and Need for Assistance with Personal Care. Record review of the MDS with an ARD of 2/12/26 revealed under section C, a BIMS summary score of 3, which indicated Resident #40 was severely cognitively impaired.		F0677				
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;		F0690				

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F0690 SS = D	Continued from page 10 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure proper perineal care practices to prevent the spread of bacteria for one (1) of two (2) residents observed for perineal care. Resident #45 Findings Include: Review of the facility policy titled "Perineal Care" revised 4/16/24, revealed under, "Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition." During an observation of perineal care for Resident #45 on 4/8/26 at 11:15 AM, Certified Nurse Aide (CNA) #2 performed care and, after cleansing the front perineal area, turned the resident onto her side, resident had a bowel movement. CNA 2 then re-dipped previously used washcloths into the water basin after she had used that water to clean the bowel movement and then used the same water to cleanse the back perineal area. The aide stated prior to exiting the room that she realized the practice was incorrect. On 4/8/26 at 11:40 AM, an interview with CNA #2 confirmed she reused washcloths while providing care to Resident #45 because she was out of clean supplies. She confirmed she should have stopped to retrieve extra supplies and that providing improper perineal care increased the resident's risk for spread of bacteria and urinary tract infection.	F0690					

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F0690 SS = D	Continued from page 11 An interview with the Director of Nursing on 4/9/26 at 2:41 PM revealed the aide should have obtained additional clean washcloths to prevent the spread of germs during perineal care. Record review of the "Admission Record" revealed the facility admitted Resident #45 on 1/24/23 with medical diagnoses that included Epilepsy and Need for Assistance with Personal Care. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/20/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 11, which indicated Resident #45 was moderately cognitively impaired. Further review revealed under section H, the resident was always incontinent of bowel and bladder.		F0690				
F0761 SS = E	Label/Store Drugs and Biologicals 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, and facility policy review, the facility failed to ensure		F0761				

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F0761 SS = E	Continued from page 12 medications were properly labeled and stored in accordance with accepted standards of practice for two (2) of three (3) medication carts observed. Specifically, the facility failed to ensure multi-dose vials were dated upon opening and discarded within the required timeframe. (Residents #4, # 7, #36, #40, #69, and #90) Findings include: Review of the facility policy titled "Medication Labeling and Storage," with a review date of February 2023, revealed, "...Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days..." During an observation of A-Hall medication cart #1 on 4/8/2026 at 2:47 PM with Licensed Practical Nurse (LPN) #2, Resident #4's opened multi-dose vial of Olopatadine HCl Ophthalmic Solution 0.1% had an open date of 2/27/2026; Resident #7's opened multi-dose vial of Latanoprost Ophthalmic Solution 0.005% had an open date of 2/26/2026; Resident #36's multi-dose vial of Lantus Subcutaneous Solution 100 unit/milliliter was observed opened without an open date, and Resident #36's opened multi-dose vial of Artificial Tears Ophthalmic Solution 1.4% had an open date of 2/1/2026; Resident #40's opened multi-dose vial of Timolol Maleate Solution 0.5% had no open date; and Resident #69's opened multi-dose vial of Artificial Tears Ophthalmic Solution had an open date of 2/15/2026. LPN #2 stated, "I think insulin is good for 30 days." She further stated insulin could lose effectiveness over time and referenced pharmacy guidelines. Additionally, she stated other multi-dose vials were good for 30 days after opening. During an observation of B-Hall medication cart #2 on 4/8/2026 at 3:03 PM with LPN #4, Resident #90's opened multi-dose vial of Latanoprost Ophthalmic Solution 0.005% was observed without an open date. During an interview on 4/8/2026 at 3:11 PM, the Assistant Director of Nursing (ADON) confirmed all multi-dose vials should have an open date. She stated insulin is only good for 28 days after opening and that other multi-dose medications, such as eye drops, are typically good for 30 days after opening. Record review of the "Admission Record" indicated that the facility admitted Resident #4 on 12/19/2025 with a medical diagnosis that included Heart Failure. Record review of Resident #4's Order Summary Report dated 4/9/26, revealed an active order for Olopatadine			F0761			

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F0761 SS = E	Continued from page 13 HCl Ophthalmic Solution 0.1% with order date 12/19/2025. Record review of the "Admission Record" indicated that the facility admitted Resident #7 on 7/20/2009 with a medical diagnosis that included Alzheimer's Disease with late onset. Record review of Resident #7 's Order Summary Report dated 4/9/26, revealed an active order for Latanoprost Ophthalmic Solution 0.005% with order date 8/13/2024. Record review of the "Admission Record" indicated that the facility admitted Resident #36 on 5/28/2021 with a medical diagnosis that included Type 2 Diabetes Mellitus without complications. Record review of Resident #36's Order Summary Report dated 4/9/26, revealed an active order for Lantus Subcutaneous Solution 100 unit/milliliter with order date 9/10/2025 and Artificial Tears Ophthalmic Solution 1.4% with order date 7/26/2024. Record review of the "Admission Record" indicated that the facility admitted Resident #40 on 11/5/2021 with a medical diagnosis that included Unspecified Protein-Calorie Malnutrition. Record review of Resident #40's Order Summary Report dated 4/9/26, revealed an active order for Timolol Maleate Solution 0.5% with order date 11/21/2021. Record review of the "Admission Record" indicated that the facility admitted Resident #69 on 1/29/2024 with a medical diagnosis that included Huntington's Disease. Record review of Resident #69's Order Summary Report dated 4/9/26, revealed an active order for Artificial Tears Ophthalmic Solution with order date 2/10/2026. Record review of the "Admission Record" indicated that the facility admitted Resident #90 on 4/7/2026 with a medical diagnosis that included Traumatic Subdural Hemorrhage with loss of consciousness of unspecified duration, subsequent encounter. Record review of Resident #90's Order Summary Report dated 4/9/26, revealed an active order for Latanoprost Ophthalmic Solution 0.005% with order date 4/7/2026.	F0761					
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F0812					

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F0812 SS = F	Continued from page 14 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview and facility policy review, the facility failed to store and serve foods in a sanitary manner and maintain a clean dietary department for two (2) of four (4) days of survey. Findings include: Record review of facility policy titled, "Environment," dated 06/2025, stated, "All food preparation areas, food services, and dining areas will be maintained in a clean and sanitary condition. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation." Record review of policy titled, "Food Storage: Cold Foods," dated 02/2026, stated, "Freezer temperatures will be maintained as a temperature of 0 degrees or below." Observation on 04/06/2026 at 6:20 PM revealed on initial tour of the dietary department that a large amount of food debris and spilled liquids was observed on the floors throughout the dietary department. Along with discarded silverware, discarded pieces of paper,	F0812					

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F0812 SS = F	Continued from page 15 packs of butter, packs of jelly, dried pieces of pasta, shredded cheese and lettuce were observed on the floors in the dietary department. The floor in the dietary department was extremely sticky and the whole area was very unkept. During this observation on 04/06/26, it was noted that a large amount of grease and food build up was on the glass of the steam table backsplash. Observation revealed a gallon size plastic bag dated 02/24/26 with around 20 breadsticks, on a cart beside a blender. Observation revealed "Freezer 2" had a temperature of 48 degrees Fahrenheit (F) with thawed biscuits, rolls, and breaded chicken strips inside the freezer that were mushy to the touch and not frozen. A clean dish rack in the dish room was observed to have dirty gloves laying on the dish rack with the clean dishes, discarded salt and pepper packets and a large amount of food debris on the bottom rack of the clean dish rack. Interview on 04/06/26 at 6:25 PM with Dietary Employee #1 confirmed that she had been there since early that morning and that usually they try to clean up after each meal, but they have not cleaned the dietary area today. Interview and observation with the Dietary Manager (DM) on 04/06/26 at 6:38 PM confirmed that the breadsticks should have been discarded and that they were over a month old. The DM confirmed the temperature in the freezer was 48 degrees F and she stated, "We had a freezer break down about a week ago and we moved the items to this freezer (Freezer 2), but I thought it was working." The DM confirmed that the dietary department was unkempt and needed to be cleaned and swept. She confirmed the large amount of food debris on the floor, the floor having large amounts of grease build up and sticky and agreed that the dietary department needed to be cleaned. DM confirmed that this rack should be clean and the dirty gloves and food debris should not be on the clean dish rack. Observation of the food tray line and interview with the DM on 04/08/26 at 12:15 PM it was observed during food tray line assembly that Dietary Employee #2 had soiled gloves on and touched the dinner rolls with the soiled gloves when assembling the lunch trays. The DM confirmed that dietary employees should not touch food with dirty gloves.			F0812			
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information			F0851			

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F0851 SS = F	Continued from page 16 based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format.		F0851				

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F0851 SS = F	Continued from page 17 The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to submit accurate staffing data into the Payroll-Based Journal (PBJ) system for one (1) of four (4) quarters reviewed. (4th Quarter 2025 July 1-September 30). Findings include: Review of the facility policy titled "Reporting Direct-Care Staffing Information (Payroll-Based Journal)," with a review date of 4/2026, revealed, "Policy Statement: Staffing and census information will be reported electronically to Centers for Medicare and Medicaid Services (CMS) through the PBJ system in compliance with Section 6106 of the Affordable Care Act..." Record review of "PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 4 2025 (July 1-September 30)", revealed the facility triggered on this report for excessively low weekend staffing. During an interview on 4/8/2026 at 2:12 PM, the Administrator and PBJ Coordinator (via telephone) confirmed the facility included Director of Nursing (DON) hours, Registered Nurse (RN) with administrative duties hours, and Licensed Practical Nurse (LPN) with administrative duties hours in PBJ reporting, even when those staff did not provide direct resident care. She stated, "We are within CMS guidelines to claim those hours, and it helps our 5-star rating to do so." The Administrator confirmed that entering those hours incorrectly would show an increased number of staff throughout the week and the staffing numbers would fall on the weekends.	F0851					