STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	6428 US HIGHWAY 11 , LUMBERTON, Mississippi, 39455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey and Complaint Investigation (CI MS #2795726) at the facility from 3/30/26 through 4/2/26. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. CI MS #2795726 was investigated related to nutrition and weight loss, pressure ulcer, and accidents and F610, F657, F686, F692, F697, and F725 were cited. During the recertification survey, F585, F628, F656, F677, F695, F697, F725, F727, F757, F806, F838, and F880 were cited. The facility had a census of 89 and was licensed for 120 beds.	F0000		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance	F0585		

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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F0585 SS = D	Continued from page 1 policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility	F0585		

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F0585 SS = D	Continued from page 2 as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the resident's right to have verbalized grievances addressed and resolved for one (1) of (19) sampled residents. Resident #25. Findings include: On 3/31/26 at 12:25 PM, during an observation and interview with the resident's Resident Representative (RR), she stated she was concerned regarding Resident #25's toenails. The RR removed the resident's socks, and her toenails were thick and had a yellow discoloration to both feet. The RR stated that she had been voicing her concerns for over a year to the facility staff, including Certified Nurse Aide (CNA) #1, that the resident needed to have a podiatry appointment, but nothing had been set up. On 4/1/26 at 2:14 PM, during an interview with Licensed Practical Nurse (LPN) #2, she reported she was aware that Resident #25's family requested for her to go to a podiatry appointment. She explained Resident #25's nails were thick and fungal in nature. On 4/1/26 at 2:22 PM, during an interview with CNA #1, she reported concerns regarding the resident's toenails were brought to her in late February 2026 by the RR and she was aware that the resident had thick, yellow toenails. On 4/2/26 at 9:26 AM, during an interview with CNA #3/Transportation staff, she reported she is responsible for making appointments for residents. She stated she was aware that the RR had requested for Resident #25 to receive podiatry services but confirmed that no appointment had been scheduled.	F0585		

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F0585 SS = D	Continued from page 3 On 4/2/26 at 1:42 PM, during an interview with the Director of Nursing (DON), she reported that when staff became aware of the RR's request, the nursing staff should have obtained a physician's order and scheduled a podiatry visit for Resident #25. A record review of the "Admission Record" revealed the facility admitted Resident #25 on 5/24/24 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/5/26 revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident's cognition was moderately impaired.	F0585		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to conduct a thorough investigation related to a fracture of unknown origin for one (1) of four (4) residents reviewed for accidents. Resident #47. Findings include:	F0610		

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F0610 SS = D	Continued from page 4 A review of the facility's policy, "Abuse Investigation and Reporting," revised July 2017, revealed, "…All reports of resident abuse, neglect…injuries of unknown source…shall be…thoroughly investigated by facility management…Policy Interpretation and Implementation…Role of the Investigator: 1. The individual conducting the investigation will, as a minimum…j. Review all events leading up to the alleged incident…5. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator…" On 4/2/26 at 9:00 AM, a record review of the facility's investigation revealed documentation identified Resident #47's diagnoses including Osteoporosis and Dementia and indicated the resident complained of right lower extremity pain on 10/20/25. The investigation documented the resident was sent to the hospital emergency room on 10/20/25 due to continued pain and returned on 10/21/25 with a diagnosis of Deep Vein Thrombosis (DVT). The investigation further documented the resident continued to complain of right leg and hip pain following return to the facility, and a mobile X-ray obtained on 10/21/25 revealed an acute nondisplaced subcapital femoral neck fracture of the right hip. The investigation indicated the physician and responsible party were notified and the resident was sent back to the hospital for evaluation. The investigation documentation did not include evidence of staff or resident interviews, witness statements, or a documented investigative summary identifying the possible cause of the injury. On 4/1/26 at 10:03 AM, during an observation and interview, Resident #47 was observed lying in bed and was unable to answer questions. On 4/1/26 at 3:10 PM, during an interview, the Social Worker (SW) explained incidents were discussed during daily clinical meetings and she conducted interviews with residents or staff when directed by the Director of Nursing (DON). She reported she was not directed to conduct interviews for the injury of unknown origin involving Resident #47 and was unable to explain why interviews were not completed. On 4/1/26 at 3:30 PM, during an interview, the DON stated the resident was interviewed at the time of the incident and reportedly indicated he fell but was unsure of details. The DON reported staff and other residents were interviewed but was unsure if	F0610		

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F0610 SS = D	Continued from page 5 documentation existed to support those interviews. On 4/2/26 at 10:28 AM, during an interview with Licensed Practical Nurse (LPN) #5, she confirmed she was working on 10/20/25 when Resident #47 complained of right leg pain. She explained she notified the physician and received an order for an X-ray. She reported the resident continued to complain of pain and was sent to the hospital where he was diagnosed with Deep Vein Thrombosis (DVT). She stated after the resident returned and continued to complain of pain, another X-ray was ordered, which revealed a fracture. She explained the facility was unable to determine how or when the fracture occurred and it could have occurred during transport or while at the hospital. On 4/2/26 at 11:19 AM, during a follow-up interview, the DON confirmed although staff and residents were reportedly interviewed, those interviews were not formally documented. After reviewing the facility policy, she acknowledged the facility did not follow their policy for investigating and documenting the injury. On 4/2/26 at 1:23 PM, during an interview, the Administrator reported she expected staff and resident interviews related to the injury of unknown origin for Resident #47 to be completed and documented and confirmed that documentation was not present. Record review of the “Admission Record” revealed the facility admitted Resident #47 on 4/2/19 with diagnoses including Dementia. Record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident’s cognition was severely impaired.	F0610		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.	F0628		

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F0628 SS = D	Continued from page 6 (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F0628		

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F0628 SS = D	Continued from page 7 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F0628		

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F0628 SS = D	Continued from page 8 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F0628		

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F0628 SS = D	Continued from page 9 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to notify the resident representative of the resident's transfer and failed to provide information regarding the bed-hold policy for two (2) of four (4) residents sampled for hospitalizations and closed record review. Residents #7 and #93. Findings include: A review of the facility's policy, "Transfer or Discharge, Facility-Initiated", Revision Date October 2022, revealed, "…Notice of Transfer or Discharge…4. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer…5. Notice of Facility Bed-Hold…policies provided to the resident and representative within 24 hours of emergency transfer…6. Notices are provided in a form and manner that the resident can understand…" Resident #7 A record review of the "Admission Record" revealed the	F0628		

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F0628 SS = D	Continued from page 10 Resident #7 was initially admitted by the facility on 10/3/2025 and she was readmitted on 3/16/26 and she had current diagnoses including Chronic Diastolic Heart Failure. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/16/26 revealed Resident #7 was discharged to an acute hospital and her return was anticipated. A record review of the facility's "Order Summary Report" revealed Resident #7 had a physician's order, dated 03/17/2026, to send the resident to a local hospital related to elevated BNP (brain natriuretic peptide) and tachycardia (increased heart rate). Review of the medical record showed no evidence the RR was notified of the transfer and no documentation that the bed-hold policy was provided at the time of transfer or within the required timeframe. Resident #93 A record review of the "Admission Record" revealed the facility admitted Resident #93 on 11/20/25 with diagnoses including Encounter for Surgical Aftercare following surgery on the Digestive System. A record review of the Discharge MDS with an ARD of 1/17/2026 revealed Resident #93 was discharged from the facility with return anticipated to a short-term general hospital. A record review of the "Order Summary Report" revealed Resident #93 had a physician's order, dated 01/17/2026, to send to the resident to a local hospital Emergency Room (ER) for evaluation. A record review of the facility's document "Private Pay Bed-Holding Agreement," dated 01/23/2026, revealed the notice was completed six (6) days after the resident's transfer/discharge from the facility on 01/17/2026. On 04/02/2026 at 10:35 AM, during an interview, the Accounts Receivable Clerk (AR) confirmed she did not send a bed-hold notice or notice of transfer to Resident #7's Resident Representative (RR) following the resident's transfer to the hospital. The AR stated this occurred because the resident had been discharged from Part A coverage and she had been trained to handle Part A discharges in this manner. The AR also confirmed that for Resident #93, the bed-hold policy was not sent to the RR until six (6) days after the resident's transfer to the hospital. The AR stated she believed	F0628		

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F0628 SS = D	Continued from page 11 she was out of the facility during that time. She stated that when she is not present in the facility, there are no designated staff assigned to process or send bed-hold notifications, resulting in the letters remaining on her desk until her return. The AR acknowledged that it is her responsibility to ensure the required forms, including notification of transfer and bed-hold policy, are provided to the resident or RR at the time of transfer or within 24 hours in the case of an emergency transfer. The AR also stated that RR needs this information to be informed about the resident's status and bed-hold policy. On 04/02/2026 at 11:06 AM, during an interview, the Administrator stated that all hospital transfer notifications are to be sent to the RR regardless of payer source. She stated her expectation is for all residents and/or their RRs are to be notified of a hospital transfer and provided the bed-hold policy at the time of transfer or within 24 hours in the case of an emergency transfer. The Administrator stated that it is the responsibility of AR to communicate with families by preparing and sending all hospital transfer notifications and bed-hold policy letters. The Administrator reported that in the absence of the AR, the Accounts Payable Clerk is expected to assume these responsibilities to ensure timely notification.	F0628		
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).	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0656 SS = D	Continued from page 12 (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 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 interviews, record review and facility policy review, the facility failed to implement comprehensive care plan interventions for three (3) of (19) sampled residents. (Resident #3, Resident #6, and Resident #25) Findings include: Review of the facility policy titled, "Care Plans, Comprehensive Person-Centered" with no date, revealed, “Policy Statement… a comprehensive person- centered care plan that includes measurable objectives and timetables…developed and implemented for each resident…Policy interpretation and Implementation…7. The comprehensive, person-centered care plan…a. includes measurable objectives and timeframes…e. reflects currently recognized standards of practice for problem areas and conditions…”. Resident #3 A record review of Resident #3’s “Care Plan Report” revealed interventions for Seroquel, observe for s/s	F0656		

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F0656 SS = D	Continued from page 13 (signs and symptoms) of SE (side effects) of med (medication): dizziness, drowsiness, changes in cognition, and Remeron, observe for s/s of SE of med: dizziness, drowsiness, increased confusion. Both interventions had an initiation date of 5/22/25. During an interview on 03/31/2026 at 12:05 PM, with Licensed Practical Nurse (LPN) #1, she reported that Resident #3 has had no known side effects from taking antipsychotic and antidepressant medications. LPN #1 confirmed there was no documented evidence of monitoring for the medications side effects. A record review of Resident #3's "Admission Record" revealed the facility admitted him on 05/09/2025 with diagnoses including Alzheimer's Disease. A record review of Resident #3's "Order Summary Report" with active orders as of 04/02/2026 revealed physician orders for Quetiapine Fumarate (Seroquel) Oral Tablet 25 mg to give 12.5 mg by mouth at bedtime related to Alzheimer's Disease, Unspecified (dated 2/10/26) and Remeron (Mirtazepine) Oral Tablet 15 mg Give 7.5 mg by mouth at bedtime (dated 2/10/26). No orders for monitoring the side effects of the medications were identified. A record review of Resident #3's medical records, including the Medication Administration Record (MAR), revealed there was no documentation that the resident was monitored for the side effects of antipsychotic and antidepressant medications. A record review of Resident #3's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/13/2026 revealed he had a Brief Interview for Mental Status (BIMS) score of six (6), which indicated his cognition was severely impaired. A review of Section N revealed he was administered antipsychotic and antidepressant medications. Resident #6 A record review of Resident #6's "Care Plan Report" revealed a care plan focus for Takes psychotropics meds with interventions for Celexa ,observe for s/s of SE (side effects) of med: increased confusion, drowsiness, weakness, dizziness, tremors and Xanax, observe for s/s of SE of med: Dizziness, drowsiness, lethargy, increased confusion, blurred vision. During an interview on 03/31/2025 at 11:40 AM, with LPN #1, she reported that to her knowledge the resident has not had any adverse side effects of her prescribed	F0656		

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F0656 SS = D	Continued from page 14 psychotropic medications. She confirmed there was no place in the medical record for nurses to document that monitoring for side effects occurred. A record review of Resident #6's "Admission Record" revealed the facility admitted the resident on 10/10/25 with diagnoses including Bipolar Disorder, Depression, Unspecified, Anxiety Disorder, Unspecified, Other Psychoactive Substance Use, Unspecified with Psychoactive Substance-Induced Mood Disorder. A record review of Resident #6's "Order Summary Report" with active orders as 4/2/26, revealed physician orders for Abilify (Aripiprazole) Oral Tablet 5 (five) mg (milligram) Give 5 mg by mouth at bedtime relate to Bipolar Disorder Current Episode Manic Without Psychotic Features, Unspecified (dated 11/21/25) Alprazolam (Xanax) Tablet 0.25 mg Give 1(one) tablet by mouth three times a day for anxiety (dated 2/2/26) , Citalopram Hydrobromide (Celexa) Oral Tablet 10 mg Give 1 (one) tablet by mouth one a day related to Anxiety Disorder (dated 10/10/25), and Xanax Oral Tablet 0.25 MG Give 1 (one) tablet by mouth one time a day for anxiety related to Anxiety Disorder, Unspecified (dated 1/31/26). There were no orders identified for monitoring the side effects of the medications. A record review of Resident # 6's medical records, including the MAR, revealed there was no documentation for monitoring side effects of Antipsychotic, Antianxiety, and Antidepressant medications. A record review of Resident #6's "Significant Change MDS" with an ARD of 1/2/26 revealed she had a BIMS summary score of 15, which indicated her cognition was intact. A review of Section N revealed she received Antipsychotic, Antianxiety, and Antidepressant medications. Resident #25 A record review of Resident #25's "Care Plan Report" revealed a care plan focus for High Risk for bruising/bleeding r/t (related to) Anticoagulant with intervention to observe for signs and symptoms of bleeding: unexplained bruising/spreading of an established bruise, frank bleeding, blood in urine/stool (tarry colored stool). During an observation and interview on 03/31/2026 at 10:55 AM, with Resident #25, she stated that she bruises easily and pointed to the top of her right hand, reporting that the discoloration was from a blood draw.	F0656		

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F0656 SS = D	Continued from page 15 During an interview on 03/31/2026 at 11:35 AM, with LPN #4, she stated that Resident #25 was prescribed Eliquis as an anticoagulant medication. She reported the resident was monitored for medication side effects; however, she was not aware of any documentation reflecting the monitoring. LPN #4 further stated that CNAs report any skin changes and that nurses complete weekly body audits for the residents. A record review of Resident #25's "Admission Record" revealed the facility admitted her on 05/24/2024 with diagnoses including Chronic Atrial Fibrillation, Unspecified. A record review of Resident #25's "Order Summary Report" with active orders as of 04/02/2026 revealed a physician's order for Eliquis Oral Tablet 2.5 mg (Apixaban), dated 1/31/25, to give 1 (one) tablet by mouth every morning and at bedtime related to Chronic Atrial Fibrillation, Unspecified. There were no orders for monitoring for side effects of medications. A record review of Resident #25's medical records, including the MAR, revealed there was no documentation to monitor for bleeding or side effects of anticoagulant medication. A record review of Resident #25's "Quarterly MDS with an ARD of 02/05/2026 revealed she had a BIMS Summary Score of 12, which indicated her cognition was moderately impaired. A review of Section N revealed she was administered anticoagulant medication. During an interview on 04/01/2026 at 4:04 PM, with the Director of Nursing (DON), she stated that the nurses are responsible for entering physician orders, including required parameters for monitoring medications. The DON confirmed that orders for medications, including anticoagulants and antipsychotics, should include monitoring for side effects and be reflected on the MAR for ongoing nurse oversight. The DON acknowledged that the care plan interventions for monitoring medication side effects were not implemented. During an interview on 04/02/2026 at 2:15 PM, with Registered Nurse (RN) #1, she reported that she expects all staff to follow the resident care plans. She acknowledged that the care plans include an intervention to "observe"; however, she confirmed there is no documentation to support that this intervention is being carried out.	F0656		

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F0656 SS = D	Continued from page 16 During an interview on 04/02/2026 at 2:23 PM, with the Administrator, she stated her expectation is for all staff to document care and duties required for their shift.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to revise a comprehensive care plan for one (1) of (19) resident care plans reviewed. Resident #47 Findings include: A record review of the “Care Plan Report” revealed Resident #47 had an individual care plan with “Focus” of “Impaired Skin Integrity…Stage III wound to	F0657		

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F0657 SS = D	Continued from page 17 sacrum-Healing Stage IV wound." The care plane included an intervention initiated on 1/28/26 to "Remove old dressing, cleanse with wound cleanser, apply plurogel to wound to sacrum, use polymem AG (alginate) as the primary dressing, use allevyn border dressing as the secondary dressing, the order is to be carried out daily and PRN…" This was inconsistent with the current physician order for wound treatment dated 2/19/26. A record review of the "Admission Record" revealed the facility admitted Resident #47 on 10/31/25 with diagnoses including Pressure Ulcer of Sacral Region, Stage 4. A record review of the "Order Summary Report" with active orders as of 04/02/2026, revealed Resident #4 had a physician's order, dated 2/19/26, to "Remove old dressing, cleanse with wound cleaner, apply Santyl to wound to sacrum as the primary dressing, apply Calcium Alginate, gauze and cover with Allevyn border dressing as the secondary dressing, the order is to be carried out daily and PRN (as needed)…" A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) Summary Score of 04, which indicated his cognition was severely impaired. A review of Section M revealed he had unhealed Pressure Ulcers/Injuries including one (1) Stage 3 Pressure Ulcer. On 04/02/2026 at 2:10 PM, during an interview, Registered Nurse (RN) #1 stated she updates care plans with each new order and believed she had done so for Resident #47's wound care order. RN #1 reviewed the physician orders and care plan for Resident #47 and confirmed the care plan had not been updated and reflected outdated wound care orders. On 04/02/2026 at 2:23 PM, during an interview with the Administrator, she reported that she expects resident care plan to be revised as needed.	F0657		
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 18 Based on observation, interviews, record review, and facility policy review, the facility failed to provide assistance with activities of daily living (ADLs) related to toenail care for one (1) of three (3) residents reviewed for ADL/Nail Care. Resident #76. Findings include: A review of the facility's policy, "Fingernails/Toenails, Care of", dated 02/2018, revealed, "…The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection…General Guidelines…6. Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease…Documentation…6. If the resident refused the treatment, the reason(s) why and the intervention taken…" On 3/30/26 at 2:39 PM, during an observation and interview, Resident #76's toenails were observed to be thick, long, curved, and excessive in length. The resident reported his toenails needed to be cut and stated he was unsure how long they had been in that condition. On 3/31/26 at 10:34 AM, during an interview with Certified Nurse Aide (CNA) #2, she reported Resident #76 required extensive assistance with Activities of Daily Living (ADLs) except feeding and that staff assisted with bed baths. She reported that CNAs are expected to notify nursing staff if nail care is needed and stated she had not noticed any concerns with the resident's toenails. On 3/31/26 at 11:10 AM, during an interview with Licensed Practical Nurse (LPN) #1, she reported the facility does not have an in-house podiatrist and residents must be sent out for podiatry services. She reported she had not been notified of any concerns regarding Resident #76's toenails. On 4/1/26 at 10:45 AM, during an observation and interview with LPN #5, Resident #76's toenails were observed to be long and thick. LPN #5 confirmed the toenails were abnormal and stated the condition should have been reported and followed through by nursing staff. Resident #76 stated that "something needed to be done" and stated willingness to see a podiatrist. On 4/1/26 at 11:05 AM, during an interview with the Director of Nursing (DON), she reported staff are expected to report changes in condition, including nail	F0677		

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F0677 SS = D	Continued from page 19 care, and ensure follow-up. She stated she had attempted to file the resident's toenails months prior, but the resident refused, and confirmed no follow-up was completed. She reported she was unsure whether a podiatry appointment had ever been scheduled. On 4/1/26 at 11:36 AM, during an interview with CNA #3/Transportation Aide, she reported she had recently been notified the resident needed a podiatry appointment; however, no appointment had been scheduled. On 4/2/26 at 2:50 PM, during an interview with the Administrator, she reported staff are expected to ensure residents' care needs are met. A record review of the "Admission Record" revealed the facility admitted Resident #76 on 6/28/22 and readmitted on 1/22/26 with diagnoses including Encounter for Surgical Aftercare Following Surgery on the Genitourinary System. A record review of the "Significant Change Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 1/29/26 revealed Resident #76 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A review of Section GG revealed he required assistance with self-care, including bathing and personal hygiene. A record review of the "Order Summary Report" revealed Resident #76 had a physician's order, 9/8/22 for weekly head-to-toe body audits and to inform the supervisor or physician of any new skin concerns.	F0677		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional	F0686		

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F0686 SS = D	Continued from page 20 standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure weekly wound assessments that included wound dimensions and characteristics were completed and documented for one (1) of two (2) residents reviewed for pressure ulcers. Resident #47. Findings include: A review of the facility's policy, "Pressure Ulcers/Skin Breakdown-Clinical Protocol," revised April 2018 revealed, "… Assessment and Recognition … 2…the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue …" A record review of the "Order Summary Report" revealed a physician's order dated 2/19/26 to remove old dressing, cleanse with wound cleaner, apply Santyl to the sacral wound as the primary dressing, apply Calcium Alginate, gauze, and cover with Allevyn border dressing as the secondary dressing, to be completed daily and as needed. A record review of the "Wound Care Visit," dated 3/10/26 revealed Resident #47 attended wound care at an outpatient provider. The visit documentation included assessment information that consisted of the wound dimensions, drainage, and wound characteristics and the "Impression" included that the wound had improved. A review of the next "Wound Care Visit," dated 3/31/26 (three weeks later) revealed Resident #47 had another wound care visit at the outpatient provider. The documentation had wound information that included a complete assessment of the wound and documented the dimensions, drainage, and wound characteristics. The "Impression" included that the ulcer had improved. A record review of the medical record for Resident #47 revealed there was no wound assessment documented by the facility between the outpatient wound care visits on 3/10/26 and 3/31/26. On 3/30/26 at 11:24 AM, during an observation, Resident #47 was lying in bed on an air mattress with a positioning wedge in place between his knees. On 3/30/26 at 11:50 AM, during an observation and	F0686		

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F0686 SS = D	Continued from page 21 interview with Resident #47 and his Responsible Representative (RR), the RR expressed concerns regarding the resident's sacral pressure wound and reported she was unsure if the wound was being treated appropriately. On 3/31/26 at 11:55 AM, during an interview with Licensed Practical Nurse (LPN) #1, she reported Resident #47 had a longstanding sacral wound and stated the facility does not have a dedicated wound care nurse. She explained that medication cart nurses complete wound care and treatments daily for assigned residents. She confirmed Resident #47 attended outpatient wound care and reported the outpatient provider assessed the wound and provided treatment orders. On 3/31/26 at 3:43 PM, during an interview with the Director of Nursing (DON), she reported the facility did not have weekly wound reports that include measurements or assessments describing wound characteristics available. She confirmed there is no dedicated wound care nurse and that medication cart nurses completed treatments. She reported the facility relied on the outpatient wound care provider for wound assessments and monitoring. She acknowledged that pressure wounds should be assessed, measured, and documented weekly and explained that the facility did not have sufficient Registered Nurse (RN) staffing to complete weekly wound assessments. On 4/2/26 at 10:01 AM, during a phone interview with the Registered Dietician (RD), she reported she completed onsite visits to the facility twice monthly and reviewed residents with wounds. She explained that she often has to request information from the DON because there are no weekly wound reports available in the medical record. On 4/2/26 at 2:23 PM, during an interview with the Administrator, she reported she expected wound assessments to be completed as required. A record review of the "Admission Record" revealed the facility admitted Resident #47 on 10/31/25 with diagnoses including Pressure Ulcer of Sacral Region, Stage 4. A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated his cognition was severely impaired. A review of Section M revealed he had unhealed pressure ulcers,	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	6428 US HIGHWAY 11 , LUMBERTON, Mississippi, 39455

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F0686 SS = D	Continued from page 22 including one (1) Stage 3 pressure ulcer.	F0686		
F0692 SS = G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident received necessary nutritional and hydration care and services to maintain nutritional status, including failing to offer alternative food items when meals were refused, failing to consistently document meal intake and weights, and failing to monitor, evaluate, and implement timely interventions, which contributed to a delay in identifying and addressing significant weight loss for one (1) of two (2) residents reviewed for nutrition. Resident #47 Findings include: A record review of the “Admission Record” revealed the facility admitted Resident #47 on 10/31/25 with diagnoses including Pressure Ulcer of Sacral Region, Stage 4. A record review of the “Order Summary Report” with active orders as of 4/2/26, revealed Resident #47 had a	F0692		

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F0692 SS = G	Continued from page 23 physician's order, dated 3/9/26, for double portions of ordered diet for lunch and supper tray. Mighty shakes or equivalent supplement to be added to each tray and as a bedtime snack. Add a magic cup to lunch and supper tray. There were physician's orders, dated 3/2/26 to document the percentage of meal intake at each meal and document total fluid intake at end of each shift. There was a physician's order, dated 3/12/26 to check the resident's weight each Thursday while RP (Responsible Party) in the room. A record review of the "Weights and Vitals Summary" revealed Resident #47's weight decreased from "128.0 pounds" on 9/10/25 to "123 pounds" on 1/22/26. It further decreased to "112.8 pounds" on 2/26/26, and then to "94.4 pounds" on 3/4/26 (six days later), representing a weight loss of 26.25% over six (6) months (9/10/25 to 3/4/26) and 16.46% within a 30-day period (2/26/26 to 3/4/26). A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident's cognition was severely impaired. A review of Section K revealed his weight was recorded as 123 pounds and did not indicate a significant weight loss. A record review of the "Documentation Survey Report" recorded by the Certified Nurse Aides (CNAs) for Resident #47 for February 2026 revealed documentation representing the amount eaten at each meal was not recorded for all meals on 2/2, 2/3, 2/6, 2/7, 2/8, 2/11, 2/14, 2/16, 2/17, 2/20, 2/21, 2/22, 2/25, 2/26, and 2/27 and for the supper meal on 2/12. This was a total of 46 times the resident's meal intake was not recorded for the month of February. A record review of the Medication Administration Record (MAR) for March 2026, revealed there was no documentation recording the percentage of meal intake for Resident #47 for 15 meals recorded by the nurses on 3/2 (lunch and dinner), 3/6 (breakfast, lunch and dinner), 3/11 (dinner), 3/13 (dinner), 3/16 (dinner), 3/17 (breakfast, lunch and dinner), 3/21 (dinner), 3/22 (lunch and dinner), and 3/29 (dinner). A record review of "Progress Notes" for Resident #47 revealed a Registered Dietician (RD) Assessment Summary, dated 02/28/2026 at 2:07 PM for "... wt.: (weight) 123-January; February weight is pending ..." There was also an RD Assessment Summary, dated 03/05/2026 at 7:25 AM, for "…wt.: 94 lb. weight is down	F0692		

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F0692 SS = G	Continued from page 24 -16.8% x 30 days, 23.6% x 90 days, and 26.6% x180 days..." A record review of Resident #47's Progress notes revealed a nurses note dated 03/04/2026 at 4:02 PM, revealed, "… dietician contacted to look at resident's weight decline and make any suggestions that may benefit resident ..." On 3/30/26 at 11:21 AM, during an observation, Resident #47 was observed lying in bed with a thin appearance and visible bony prominences. On 3/30/26 at 11:50 AM, during an observation and interview with Resident #47 and the resident's Responsible Representative (RR), the RR expressed concerns regarding Resident #47's weight loss and reported she had been visiting daily to assist with meals due to concerns that Resident #47 was not eating. She also expressed concerns that his weight was not being consistently monitored. On 3/30/26 at 12:01 PM, during an observation, CNA #4 was assisting Resident #47 with feeding. Resident #47 attempted to push staff away, refused food, and told staff to eat the food. On 3/30/26 at 2:00 PM, during an interview with CNA #4, she reported Resident #47 continued to refuse meals and demonstrated variable intake, sometimes eating and other times refusing. She reported Resident #47 could become combative during care and would push staff away during feeding attempts. CNA #4 reported that when Resident #47 refused meals, staff would encourage him to eat; however, she did not indicate that alternative food items were routinely offered following refusals. On 3/31/26 at 11:25 AM, during a follow up interview with CNA #4, she reported Resident #47 again refused lunch despite encouragement from staff and nursing. She reported Resident #47 was not offered an alternative meal or substitute food items after refusing the meal. On 3/31/26 at 11:55 AM, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed Resident #47 had experienced ongoing weight loss and frequently refused meals. She reported the facility had attempted interventions including supplements, appetite stimulants, and double portions. She confirmed weights were obtained by CNAs but were not obtained on consistent days, and she reported that all staff were able to the document meal intake of residents. On 4/1/26 at 3:30 PM, during an interview with the	F0692		

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F0692 SS = G	Continued from page 25 Dietary Manager, she reported Resident #47 had periods of refusing meals and had been provided supplements, including Ensure Plus. She reported the RD monitors residents with weight loss and wounds. On 4/1/26 at 4:30 PM, during an interview with the Director of Nursing (DON), she reported there was no staff member designated to consistently obtain weights and confirmed weights were not consistently obtained or entered into the medical record in a timely manner. She confirmed delays in documenting weights resulted in delayed identification of weight loss and delayed implementation of interventions. She reported interventions were initiated for Resident #47 after family concerns were raised. She confirmed Resident #47 had significant weight loss and acknowledged the lack of consistent monitoring contributed to delayed intervention. On 4/2/26 at 10:01 AM, during a phone interview with the facility's RD, she reported she had been coming to the facility for years and visits twice a month to review residents, including those with significant weight loss. She reported she accesses weights through the computer during her visits and explained that when she documents weights as “pending,” it indicates no weight has been entered into the record. She reported that weights have been “hit and miss” at the facility for several months. She explained the DON contacted her on 3/5/26 regarding Resident #47’s weight loss, and after reviewing the medical record, she identified inconsistencies with both weights and meal intake documentation. She reported she reviewed Resident #47's weights and stated the amount of weight loss, including approximately 18 pounds in six (6) days, was not normal and would not be expected from refusal of some meals alone. She reported she communicated with the facility, including the DON and Dietary Manager, and recommended providing Ensure Plus to increase protein intake and to continue offering Magic Cup supplements for Resident #47. On 4/2/26 at 2:23 PM, during an interview with the Administrator, she reported she expects staff to obtain and document weights consistently and to notify the physician and RD of any significant weight loss in a timely manner.	F0692		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F0695		

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F0695 SS = D	Continued from page 26 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure required cautionary signage was in place for a resident receiving oxygen therapy for one (1) of (1) resident reviewed for respiratory care. Resident #45. Findings Include: A review of the facility's policy, "Oxygen Administration" revised October 2010, revealed, "…Equipment and Supplies…4. No smoking/oxygen in use signs…Steps in the Procedure…2. Place an oxygen in use sign on the outside of the room entrance door…3. Place an oxygen in use sign in a designated place on or over resident's bed". On 3/30/26 at 12:55 PM, during an observation, Resident #45 was in bed receiving oxygen at two (2) liters per minute via nasal cannula. No oxygen-in-use signage was observed on or near the resident's door or above the resident's bed. On 4/1/26 at 2:25 PM, an interview with Licensed Practical Nurse (LPN) #2 revealed the resident was placed on oxygen in January 2026 due to flu and pneumonia and stated that she received oxygen therapy continuously. LPN #2 confirmed that oxygen-in-use signage is required to be posted on the doors of residents receiving oxygen. On 4/2/26 at 1:42 PM, in an interview with the Director of Nursing (DON), she stated that it was her expectation that oxygen signage be posted on the doors for residents receiving oxygen therapy. She confirmed that nursing staff are responsible for ensuring the cautionary signage is present. A record review of the "Admission Record" revealed the facility admitted Resident #45 on 10/15/18, with diagnoses including Alzheimer's Disease. A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/7/26, revealed Resident #45 had a Brief Interview for Mental	F0695		

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F0695 SS = D	Continued from page 27 Status (BIMS) score of 03, which indicated her cognition was severely impaired. A review of Section O indicated Resident #45 received oxygen therapy. A record review of the “Order Recap Report” revealed Resident #45 had a physician’s order, dated 1/7/26, for oxygen at (2) liters via nasal cannula every shift for shortness of breath.	F0695		
F0697 SS = G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure appropriate pain management when nursing staff failed to assess and manage pain prior to and during wound care for Resident #4 which resulted in the resident experiencing avoidable pain during wound care and failed to administer ordered pain medication for Resident #47 for two (2) of three (3) residents reviewed for pain management. Findings include: A review of the facility’s policy, “Pain – Clinical Protocol,” undated, revealed, “Assessment and Recognition…2. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever this is a significant change in condition, and when there is onset of new pain or worsening of existing pain…4. The nursing staff will identify any situations or interventions where an increase in the resident’s pain may be anticipated; for example, wound care…Monitoring…2. The staff will evaluate and report the resident/patient’s use of standing and PRN (as needed) analgesics. A. Depending on the characteristics of pain, the physician may start with PRN doses or supplement standing doses with PRN doses for breakthrough pain…” Resident #4 A record review of the “Order Summary Report” revealed	F0697		

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F0697 SS = G	Continued from page 28 Resident #4 had a physician's order dated 12/9/25 for wound care to the left heel two times daily and an additional order dated 2/27/26 for wound care to the left heel two times daily. The record review further revealed an order dated 2/18/26 for Acetaminophen (Tylenol) 500 milligrams (mg) three times daily for pain. A record review of the electronic Medication Administration Record (eMAR) for March 2026 revealed Resident #4 was scheduled to receive Acetaminophen at 1:00 PM on 3/31/26, however, the eMAR was reviewed prior to observing wound care and Resident 4's Acetaminophen was not documented as administered at that time. On 3/31/26 at 1:45 PM, during an observation, Licensed Practical Nurse (LPN) #1 performed wound care to Resident #4's left heel. During the procedure, the resident vocalized that he was in pain, stated the treatment hurt, and began crying. The nurse continued the wound care procedure without stopping to assess pain or provide pain medication. On 3/31/26 at 2:00 PM, during an interview, LPN #1 reviewed the physician's orders and initially indicated the resident did not have pain medication ordered. Upon further review, she confirmed Resident #4 had a scheduled order for Acetaminophen at 1:00 PM and acknowledged the medication had not been administered prior to performing wound care. On 3/31/26 at 2:20 PM, during an interview, the Director of Nursing (DON) stated the expectation was for nursing staff to assess pain prior to wound care and administer pain medication before initiating treatment when pain was anticipated. On 4/1/26 at 4:30 PM, during an interview, the Administrator stated the expectation was for staff to follow the facility's pain management policy and ensure residents received appropriate pain control during treatments such as wound care. A record review of the "Admission Record" revealed the facility admitted Resident #4 on 10/10/25 with diagnoses including Acute Kidney Failure. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/7/26 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident's cognition was severely impaired.	F0697		

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F0697 SS = G	Continued from page 29 Resident #47 A record review of the facility's investigation revealed Resident #47 complained of right lower extremity pain on 10/20/25 and was sent to the hospital on 10/20/25 and returned on 10/21/25 with a diagnosis of Deep Vein Thrombosis (DVT). The record review revealed the resident continued to complain of right leg and hip pain and a mobile X-ray obtained on 10/21/25 revealed an acute nondisplaced subcapital femoral neck fracture. A record review of the "Progress Notes" revealed on 10/20/25 at 4:37 PM, a Certified Nurse Aide (CNA) reported Resident #47 was experiencing pain throughout the shift when being changed. The nurse documented the resident yelled out and would not move his leg and the physician was notified and an X-ray was ordered. The progress note did not address how the resident's pain was managed. A progress note dated 10/20/25 at 8:15 PM revealed the resident continued to complain of pain with movement of the right leg and was sent to the emergency department. There was no documentation pain medication was administered. A progress note dated 10/21/25 at 11:48 PM revealed the resident continued to complain of pain to the right leg and hip and did not address how his pain was managed. A record review of the "Order Summary Report" revealed Resident #47 had a physician's order with a start date of 10/3/24 for Acetaminophen (Tylenol) 325 milligrams (mg) to be given every eight (8) hours as needed for pain. A record review of the Medication Administration Record (MAR) for October 2025 revealed Resident #47 was assessed for pain each shift and was documented as having a pain level of "0" on 10/20/25 and did not receive any documented pain medication, including Acetaminophen, during the month. On 4/1/26 at 10:03 AM, during an observation and interview, Resident #47 was observed lying in bed and was unable to answer questions. On 4/2/26 at 10:28 AM, during an interview, Licensed Practical Nurse (LPN) #5 confirmed she worked on 10/20/25 when Resident #47 complained of right leg pain. She stated she notified the physician and received an order for an X-ray. She reported she thought she had administered Tylenol but was unable to recall and confirmed there was no documentation to support that pain medication was administered.	F0697		

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F0697 SS = G	Continued from page 30 On 4/2/26 at 11:19 AM, during an interview, the Director of Nursing (DON) confirmed the resident complained of pain and there was no documentation that pain medication was administered despite an order being in place. She stated she expected nursing staff to provide pain relief when residents complained of pain. On 4/2/26 at 1:23 PM, during an interview, the Administrator stated it was the expectation that nursing staff provide pain relief to residents when they complained of pain. A record review of the “Admission Record” revealed the facility admitted Resident #47 on 4/2/19 with diagnoses including Dementia. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident’s cognition was severely impaired.	F0697		
F0725 SS = F	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F0725		

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F0725 SS = F	Continued from page 31 (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, and facility policy review, the facility failed to ensure Registered Nurse (RN) staffing was adequate to meet the needs of residents and failed to designate a licensed nurse to serve as the designated charge nurse for each tour of duty for one (1) of four (4) days of survey. Findings include: A review of the facility's policy, "Staffing, Sufficient and Competent Nursing", revised August 2022 revealed, "…Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment…Policy Interpretation and Implementation Sufficient Staff…2. A licensed nurse is designated as a charge nurse on each shift…b. A "charge nurse" is a licensed nurse with designated responsibilities that may include staff supervision, emergency coordination, provider or physician support and direct resident care…" A record review of the Facility Assessment revealed, "Staffing Hours per Resident Day" data for October 1 through December 31, 2025, revealed Registered Nurse (RN) hours were reported as 0.173 hours per resident per day, which equals ten (10) minutes of RN time per resident per day. The report documented an average resident census of 88.6 residents, which equals 15.3 RN hours per day based on the facility's reported staffing levels. A record review of the facility's daily assignments revealed that on 3/30/26, there was no designated Charge Nurse or RN Supervisor for the 6PM or 6AM shift. On 3/31/26 at 3:43 PM, during an interview with the Director of Nursing (DON), she reported the facility did not have sufficient RN staffing to complete weekly wound assessments for residents with pressure ulcers. The facility relies on the outpatient wound clinic to complete these assessments. She explained there was no weekly wound documentation that include measurements or	F0725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	6428 US HIGHWAY 11 , LUMBERTON, Mississippi, 39455

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F0725 SS = F	Continued from page 32 assessments describing wound characteristics available for residents with wounds. On 4/1/26 at 2:35 PM, during an interview, the DON explained she also served in the capacity of the Infection Preventionist and was responsible for staffing, scheduling, and daily facility operations. She reported she had not had time to complete infection surveillance, track infections, or conduct infection control rounds for several months because she was working the medication cart or functioning as the nursing supervisor. On 4/1/26 at 3:00 PM, during an interview, the Administrator stated that the DON had sufficient time to complete infection prevention duties in addition to her other responsibilities. On 04/02/2026 at 7:45 AM, during an interview with the DON, she confirmed there was no designated charge nurse indicated on the daily assignment sheets because it was known by the staff that the Licensed Practical Nurse (LPN) or cart nurse for the hall was in charge. The DON confirmed there was no charge nurse with specific duties including staff supervision, emergency coordinator, physician liaison and direct resident care. The DON said she was unaware she was unable to function in the role of Nursing Supervisor due to the facility's census. The DON stated that the facility has posted job openings and has tried to hire RNs. On 04/02/2026 at 1:17 PM, during an interview with the Administrator, she stated that the benefit to having a licensed nurse designated as the charge nurse is to cut down on confusion and to allow the staff to know who is in charge. She stated she did not know that due to the facility census being over 60 residents, that the DON could not function in the capacity of the charge nurse or RN Supervisor. The Administrator reported that the facility has placed job listings to recruit RNs.	F0725		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): §483.35(b)(1)-(3) §483.35(b) Registered Nurse §483.35(b)(1)Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F0727		

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F0727 SS = F	Continued from page 33 §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, facility policy review and staff interview, the facility failed to ensure the Director of Nursing (DON) did not function in the capacity of the charge nurse when the facility had more than 60 residents for four (4) of (15) days reviewed for staffing. (3/16/26, 3/17/26, 3/26/26, and 3/30/26). Findings Include: A review of the facility's policy, "Staffing, Sufficient and Competent Nursing", Revision Date August 2022 revealed, "Sufficient Staff…2...c. The director of nursing services (DNS) may serve as the charge nurse only when the average daily occupancy of the facility is 60 or fewer…" A record review of the facility's daily assignment document revealed the DON was listed as the "RN (Registered Nurse) Supervisor" on 3/16/26 and the census was listed as 88. On 3/17/26, the DON was listed as the RN Supervisor and the census was 90, on 3/26/26 the DON was listed as the RN Supervisor and the census was 94, and on 3/30/26 the DON was listed as the RN Supervisor and the census was 93. On 04/02/2026 at 7:45 AM, in an interview with the DON, she stated that she was unaware she was unable to function in that role due to facility census. The DON stated that the facility has posted job openings and has tried to hire RNs. On 04/02/2026 at 1:17 PM, in an interview with the Administrator, she stated she did not know that due to the facility census being over 60 residents, that the DON could not function in the capacity of the charge nurse or RN Supervisor. The Administrator reported that the facility has placed job listings to recruit RNs.	F0727		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F0757		

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F0757 SS = D	Continued from page 34 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure appropriate monitoring and documentation of potential adverse consequences for psychotropic and high-risk medications, including anticoagulants, for three (3) of five (5) residents sampled for unnecessary medications. Resident #3, Resident #6, and Resident #25. Findings include: A review of the facility's policy "Adverse Consequences and Medication Errors" with the revision date of February 2023 revealed "… The interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such are adverse drug reactions (ADRs) and side effects… Policy Interpretation and Implementation Adverse Consequences 1. An "adverse consequence: refers to an unwanted, uncomfortable or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction. b. side effect … 3. Residents receiving	F0757		

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F0757 SS = D	Continued from page 35 medication are monitored for adverse consequences … Procedures … 4. Monitor the resident for medication-related adverse consequences …" Resident #3 On 03/31/2026 at 11:25 AM, during an observation and interview, Resident #3 was awake and lying in bed and he stated that he is sometimes forgetful. On 03/31/2026 at 12:05 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated that Resident #3 has dementia and confusion but has not exhibited any type of behaviors or agitation. She reported that he has had no known side effects from taking antipsychotic medications. LPN #1 confirmed there was no documented evidence of the monitoring for the medication side effects. She stated she was aware of the potential side effects of the medications and that staff monitored his behaviors. A record review of Resident #3's "Admission Record" revealed the resident was admitted on 05/09/2025 with diagnoses including Alzheimer's Disease. A record review of Resident #3's "Order Summary Report" with active orders as of 04/02/2026 revealed physician orders for Quetiapine Fumarate (Seroquel) Oral Tablet 25 mg (milligrams) to give 12.5 mg by mouth at bedtime related to Alzheimer's Disease, Unspecified (dated 2/10/26) and Remeron (Mirtazepine) Oral Tablet 15 mg Give 7.5 mg by mouth at bedtime (dated 2/10/26). There were no orders for monitoring the side effects of the medications. A record review of Resident #3's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/13/2026 revealed a Brief Interview for Mental Status (BIMS) score of six (6), which indicated his cognition was severely impaired. A review of Section N revealed he was administered antipsychotic and antidepressant medications. A record review of Resident #3's medical records, including the Medication Administration Record (MAR), revealed there was no documentation that the resident was monitored for the side effects of the medications. Resident #6 On 03/31/2025 at 11:40 AM, during an interview with LPN #1, she reported that Resident #6 was currently out of facility with her boyfriend. LPN #1 reported that to her knowledge the resident has not had any adverse side	F0757		

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F0757 SS = D	Continued from page 36 effects of her prescribed psychotropic medications. She confirmed there was no place in the medical record for nurses to document that monitoring for side effects occurred. A record review of Resident #6's "Admission Record" revealed the facility admitted the resident on 10/10/25 with diagnoses including Bipolar Disorder, Depression, Unspecified, Anxiety Disorder, Unspecified, Other Psychoactive Substance Use, Unspecified with Psychoactive Substance-Induced Mood Disorder. A record review of Resident #6's "Order Summary Report" with active orders as 4/2/26, revealed physician orders for Abilify (Aripiprazole) Oral Tablet 5 (five) mg (milligram) Give 5 mg by mouth at bedtime relate to Bipolar Disorder Current Episode Manic Without Psychotic Features, Unspecified (dated 11/21/25) Alprazolam (Xanax) Tablet 0.25 mg Give 1(one) tablet by mouth three times a day for anxiety (dated 2/2/26) , Citalopram Hydrobromide (Celexa) Oral Tablet 10 mg Give 1 (one) tablet by mouth one a day related to Anxiety Disorder (dated 10/10/25), and Xanax Oral Tablet 0.25 MG Give 1 (one) tablet by mouth one time a day for anxiety related to Anxiety Disorder, Unspecified (dated 1/31/26). There were no orders for monitoring the side effects of the medications. A record review of Resident #6's "Significant Change MDS" with an ARD of 1/2/26 revealed she had a BIMS summary score of 15, which indicated her cognition was intact. A review of Section N revealed she received Antipsychotic, Antianxiety, and Antidepressant medications. A record review of Resident # 6's medical records, including the MAR, revealed there was no documentation for monitoring side effects of Antipsychotic, Antianxiety, and Antidepressant medications. Resident #25 On 03/31/2026 at 10:55 AM, during an interview and observation, Resident #25 was lying in bed. She stated that she bruises easily and pointed to the top of her right hand, reporting that the discoloration was from a blood draw. On 03/31/2026 at 11:35 AM, during an interview, LPN #4 stated that Resident #25 was prescribed Eliquis as an anticoagulant medication. She reported the resident was monitored for medication side effects; however, she was not aware of any documentation reflecting the monitoring. LPN #4 further stated that CNAs report any	F0757		

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F0757 SS = D	Continued from page 37 skin changes and that nurses complete weekly body audits for the residents. A record review of Resident #25's "Admission Record" revealed the facility admitted her on 05/24/2024 with diagnoses including Chronic Atrial Fibrillation, Unspecified. A record review of Resident #25's "Order Summary Report" with active orders as of 04/02/2026 revealed a physician's order for Eliquis Oral Tablet 2.5 mg (Apixaban), dated 1/31/25, to give 1 (one) tablet by mouth every morning and at bedtime related to Chronic Atrial Fibrillation, Unspecified. There were no orders for monitoring for side effects of medications. A record review of Resident #25's "Quarterly MDS with an ARD of 02/05/2026 revealed she had a BIMS Summary Score of 12, which indicated her cognition was moderately impaired. A review of Section N revealed she was administered anticoagulant medication. A record review of Resident #25's medical records, including the MAR, revealed there was no documentation to monitor for bleeding or side effects of anticoagulant medication. On 04/01/2026 at 4:04 PM, during an interview, the Director of Nursing (DON) stated that the nurses are responsible for entering physician orders, including required parameters for monitoring medications, and are trained to do so. The DON confirmed that orders for medications, including anticoagulants and antipsychotics, should include monitoring for side effects and be reflected on the MAR for ongoing nurse oversight. The DON acknowledged there are certain medications that require monitoring for side effects, which should be documented, with the physician notified of any adverse findings. On 04/02/2026 at 2:23 PM, during an interview, the Administrator stated her expectation is for all staff to document care and duties required for their shift.	F0757		
F0806 SS = F	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident	F0806		

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F0806 SS = F	Continued from page 38 allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide residents with alternate food options of similar nutritive value for one (1) of (19) sampled residents with the potential to affect all 89 residents in the facility. Residents #12 Findings included: A review of the facility's policy "Alternate Foods for Food Preferences" with reviewed date of 12/23 revealed "… Alternate foods and beverages are offered to residents who refuse offered off regular menu and is, served to meet individual … preferences, or requests. Procedure: … 4. The nursing assistant, on observing that a resident is refusing food, offers the always available alternate food to the resident…" A record review of the facility's "Always Available Menu" revealed "Grilled cheese, hamburger, chicken tenders, soup/salad (and/or) half of a sandwich, pimento cheese sandwich, peanut butter and jelly sandwich, and deli sandwich." A record review of the facility's menu, "Fall/Winter 2025/2026 Week 1 Alternates and Modified Items" revealed there were menu alternatives for each meal and each day of the week. The alternative menu included full meal options that included items such as sliced turkey, steak fingers, smoked sausage, but did not include the items listed on the "Always Available Menu." The alternative menu was signed by the Registered Dietician (RD). Resident #12 On 03/30/2026 at 11:55 AM, during an observation and interview, Resident #12 was eating the lunch meal which consisted of coleslaw, pulled pork, and baked beans. He reported that he doesn't always like what is served. On 03/31/2026 at 10:54 AM, during an interview, Certified Nurse Assistant (CNA) #4 stated that Resident #12 eats well depending on the menu. She reported that	F0806		

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F0806 SS = F	Continued from page 39 on the previous evening, the resident did not like the chicken alfredo served for dinner. CNA #4 explained the facility does not offer alternate meals, but that residents can get an item from the “Always Available” menu. A record review of Resident #12 “Admission Record” revealed the facility admitted the resident on 7/22/24 with diagnoses including Unspecified Dementia. A record review of Resident #12’s “Order Summary Report” revealed he had a physician’s order, dated 7/22/24 for a regular diet, regular texture, and regular/thin consistency. A record review of Resident #12’s Quarterly Minimum Data (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed he had a Brief Interview for Mental Status (BIMS) Summary Score of 07, which indicated his cognition was severely impaired. On 04/01/2026 at 2:00 PM, during an observation, signage was posted outside of the main dining room that included the menu for breakfast, lunch, and dinner, but there was no alternative menu listed for lunch or dinner. On 04/01/2026 at 3:30 PM, during an interview, Dietary Manager #1 stated the facility does not offer alternative meals for lunch or dinner, because the facility has an “Always Available” menu in place. The Dietary Manager confirmed the always-available options included items such as soup, sandwiches, grilled cheese, burgers, salads, and chicken tenders. On 04/02/2026 at 10:01 AM, during a phone interview, the facility’s RD stated she was not aware that alternative meals were not being prepared and offered per the alternate menu that she signs and approves for the facility. She reported that she knew the facility provided additional items to the residents from the “Always Available” menu” but she was unaware that the facility had replaced the alternate menu she approves with the “Always Available” menu. She confirmed that selecting items from the “Always Available” menu alone may not provide equivalent nutritional value, as meals are required to include meat, starch, and vegetables to meet nutritional standards. On 04/02/2026 at 2:23 PM, during an interview with the Administrator, she reported that currently the facility did not prepare meals using both the regular menu and the alternate menu. She expected staff to honor residents' choices and offer other meal items from the	F0806		

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F0806 SS = F	Continued from page 40 “Always Available” menu when residents do not eat the meal provided.	F0806		
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but	F0838		

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F0838 SS = F	Continued from page 41 not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility	F0838		

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F0838 SS = F	Continued from page 42 assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to develop and maintain a comprehensive facility assessment to determine the appropriate number of qualified staff needed to meet residents' needs, including sufficient licensed nursing staff coverage, affecting (89) of (89) residents in the facility. Findings include: A review of the facility's policy, "Facility Assessment," revised June 2024, revealed, "…Facility Assessment…4. The facility assessment is used to inform staffing decisions. a. The assessment is used to ensure there is enough staff with appropriate competencies and skill sets to meet the needs of the residents identified through the review of resident assessments and plans of care…b. The facility is used to develop and maintain a direct-care staff recruitment and retention plan…"	F0838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255338	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0838 SS = F	Continued from page 43 A record review of the “Facility Assessment” revealed “Staffing Hours per Resident Day” data for October 1 through December 31, 2025, documented Registered Nurse (RN) hours as “0.173” hours per resident per day, which equals ten (10) minutes of RN time per resident per day. The document further revealed an average resident census of “88.6” residents, which equals 15.3 RN hours per day based on the facility’s reported staffing levels. The facility assessment did not include a breakdown of the number and type of direct care staff needed by shift did not include documentation of how resident acuity and care needs were used to determine staffing levels and did not include a documented recruitment and retention plan or a contingency plan to ensure licensed nurse coverage. On 4/2/26 at 1:17 PM, during an interview with the Administrator, she reported the facility considers census, staffing hours, and resident needs when compiling the facility assessment. She confirmed the facility assessment does not document specific staffing needs by shift and there was no documented recruitment or retention plan within the facility assessment.	F0838		
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F0880		

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F0880 SS = F	Continued from page 44 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by:	F0880		

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F0880 SS = F	Continued from page 45 Based on staff interview, record review, and facility policy review, the facility failed to establish and maintain an effective infection prevention and control program when the designated Infection Preventionist, who was the Director of Nursing (DON), did not have sufficient time to perform infection prevention and control duties, resulting in a failure to conduct infection surveillance, track and trend infections, and perform infection control rounds for three (3) of five (5) months reviewed, which had the potential to affect all (89) residents in the facility. Findings include: A review of the facility's policy, "Surveillance for Infections," revised July 2016, revealed, "…Policy Interpretation and Implementation…1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiological significant organism and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections…8. The Charge Nurse will notify the Attending Physician and the Infection Preventionist of suspected infections. a. The Infection Preventionist and the Attending Physician will determine if laboratory tests are indicated…b. The Infection Preventionist will determine if the infection is reportable…9. If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, the Infection Preventionist will collect date to help determine the effectiveness of such measures…" A review of the facility's policy, "Compliance Rounds," revised January 2012, revealed, "…The Infection Preventionists shall conduct unannounced periodic infection control rounds. Policy Interpretation and Implementation…2. Infection control compliance rounds should be conducted at least quarterly or at a frequency determined by the IC (Infection Control) Committee or Quality Assurance and Assessment Committee…3. The 'Monitoring Compliance with Infection Control Checklist' should be completed during each periodic compliance round." A review of the facility's infection control records revealed there were no infection surveillance logs available to review that documented infection tracking or trending. There were also no infection control meeting minutes to review that documented infection control meetings were conducted for oversight. On 4/1/26 at 2:35 PM, during an interview, the Director of Nursing (DON) explained she also served as the	F0880		

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F0880 SS = F	Continued from page 46 Infection Preventionist and was responsible for staffing, scheduling, and daily facility operations. She reported she had not had time to complete infection surveillance, track infections, or conduct infection control rounds for several months because she was working the medication cart or functioning as the nursing supervisor. On 4/1/26 at 3:00 PM, during an interview, the Administrator explained she believed the DON had sufficient time to complete infection prevention duties in addition to her other responsibilities.	F0880		