STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255212	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS COMM LIVING CENTER	**907 EAST WALKER STREET P.O. BOX 69, FULTON, Mississippi, 38843**

(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 #3005320 at the facility from 5/18/2026 through 5/21/2026. CI MS #3005320 was investigated with no citiations related to allegations of mold in the building. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F677, F880, F550, F584, and F641. The facility had a census of 63 and was licensed for 66 beds.	F0000		
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical	F0656		

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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F0656 SS = E	Continued from page 1 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 observations, staff interviews, facility document review, and record review, the facility failed to ensure comprehensive Activities of Daily Living (ADL) care plans were developed and implemented for two (2) of eighteen (18) residents reviewed. Specifically, the facility failed to develop a comprehensive ADL care plan addressing nail care needs for Resident #8 and failed to implement established ADL care plan interventions related to nail care for Resident #45. The scope and severity for this deficiency were cited at an "E" due to previous citations of F656 on the last two annual recertification surveys completed on 2/20/24 and 5/22/25 representing a pattern of deficiency. Findings include: Review of facility policy titled “Care Plan Policy and Procedure” with no date revealed, “…Each resident’s care plan will remain current and inform staff of resident’s needs, strengths, goals and approaches…” Resident #8 Record review of Resident #8’s ADL care plan, dated 10/29/2024, revealed the comprehensive care plan was not developed to include nail care.	F0656		

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F0656 SS = E	Continued from page 2 On 5/18/2026 at 11:46 AM, during an observation Resident #8's fingernails were observed to be approximately three-fourths (3/4) inch in length with jagged edges. Record review of the Admission Record indicated Resident #8 was admitted to the facility on 2/20/2025 with medical diagnoses that included mild vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and need for assistance with personal care. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/22/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 6, indicating Resident #8 had severe cognitive impairment. Resident #45 Record review of Resident #45's skin integrity care plan, dated 11/6/2025, revealed, "…Keep fingernails short…" During an observation on 5/18/2026 at 3:15 PM, Resident #45's fingernails were observed to be approximately one (1) inch in length with jagged edges. Record review of the Admission Record indicated Resident #45 was admitted to the facility on 11/6/2025 with a medical diagnosis that included hypertensive heart disease without heart failure. Record review of the MDS with an ARD of 2/10/2026, revealed under Section C a BIMS score of 9, indicating Resident #45 had moderate cognitive impairment. During an interview on 5/20/2026 at 3:44 PM, the Minimum Data Set (MDS) Coordinator and the Director of Nursing (DON) confirmed Resident #8's ADL care plan had not been developed to address nail care needs and Resident #45's care plan interventions related to nail care were not implemented by facility staff. The DON confirmed nail care tasks were listed on the Kardex for Certified Nursing Assistants (CNAs) to document on shower days. Both nurses stated the purpose of the care plan was to guide staff in providing appropriate care for the residents.	F0656		
F0677 SS = E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F0677		

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F0677 SS = E	Continued from page 3 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident and staff interviews, record reviews, and facility policy review, the facility failed to provide activities of daily living (ADL) care necessary to maintain personal hygiene for two (2) of sixty (60) residents observed. (Residents #8 and #45) The scope and severity for this deficiency were cited at an "E" due to previous citations of F677 on the last two annual recertification surveys completed on 2/20/24 and 5/22/25 representing a pattern of deficiency. Findings include: Review of the facility policy titled “ADL Care of a Resident Policy and Procedure,” undated, revealed, “…Resident ADL care will be provided to the resident according to the individualized resident needs…” Resident #8 During an observation on 5/18/2026 at 11:46 AM, Resident #8’s fingernails were observed to be approximately three-fourths (3/4) inch in length with jagged edges. During an observation and interview on 5/19/2026 at 1:26 PM, Licensed Practical Nurse (LPN) #1 confirmed Resident #8’s fingernails were long with jagged edges. She further confirmed jagged fingernails could cause the resident to develop a skin tear that could lead to infection. When questioned regarding responsibility for nail care, she stated, “Everyone is responsible unless the resident is diabetic.” Record review of the Admission Record indicated Resident #8 was admitted to the facility on 2/20/2025 with medical diagnoses that included mild vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and need for assistance with personal care. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/22/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 6, indicating Resident #8 had severe cognitive impairment.	F0677		

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F0677 SS = E	Continued from page 4 Resident #45 During an observation on 5/18/2026 at 3:15 PM, Resident #45's fingernails were observed to be approximately one (1) inch in length with jagged edges. During an observation and interview on 5/19/2026 at 1:15 PM, Resident #45 stated his fingernails had been cut that morning. He stated, "Someone cut them this morning. They were twice as long yesterday." During an interview on 5/19/2026 at 1:20 PM, Registered Nurse (RN) #1 confirmed Resident #45's fingernails had been trimmed that day except for the thumbnails. She further confirmed residents with long fingernails and jagged edges were at increased risk for skin tears and infection. Record review of the Admission Record indicated Resident #45 was admitted to the facility on 11/6/2025 with a medical diagnosis that included hypertensive heart disease without heart failure. Record review of the MDS with an ARD of 2/10/2026, revealed under Section C a BIMS score of 9, indicating Resident #45 had moderate cognitive impairment. During an interview on 5/19/2026 at 2:44 PM, the Director of Nursing (DON) confirmed that fingernails should be kept clean and trimmed as needed. She stated, "The Certified Nursing Assistants (CNAs) should trim them on shower days as needed unless the resident is diabetic. Diabetic nails are trimmed by the Registered Nurses (RNs)."	F0677		
F0880 SS = E	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	F0880		

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F0880 SS = E	Continued from page 5 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; §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.	F0880		

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F0880 SS = E	Continued from page 6 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: Based on observation, staff interviews, record review and facility policy review the facility failed to maintain infection control practices by failing to ensure respiratory equipment was stored in a sanitary manner to prevent contamination (Resident #30) and by failing to ensure soiled items were properly discarded (Resident #55) for two (2) of eighteen sampled residents. The scope and severity for this deficiency were cited at an "E" due to previous citations of F880 on the last two annual recertification surveys completed on 2/20/24 and 5/22/25 representing a pattern of deficiency. Findings Include: Review of the facility policy titled, “Infection Control Policy and Procedure”, undated, revealed “Purpose: To 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…” Review of a statement typed on facility letterhead dated 5/21/26 and signed by the Administrator revealed, “We do not currently have a specific Policy and Procedure for the nebulizer mouthpiece to be covered in a bag.” Resident #30 An observation on 5/20/2026 at 9:17 AM revealed Registered Nurse (RN) #2 administered a nebulizer treatment to Resident #30. Prior to administration, the nebulizer mouthpiece was observed not stored in a protective bag and was not cleaned prior to use. On 5/20/2026 at 11:05 AM, RN #2 confirmed the mouthpiece was not in a protective bag. RN #2 acknowledged improper storage of the mouthpiece presented an infection control concern. During an interview on 5/20/2026 at 3:54 PM, the	F0880		

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F0880 SS = E	Continued from page 7 Administrator acknowledged the nebulizer mouthpiece should be stored in a protective bag and confirmed improper storage presented an infection control concern. Record review of Resident #30's "Order Summary Report" revealed an order with effective date of 5/7/2026, "Albuterol Sulfate Nebulization Solution (2.5 MG (milligrams/3ML(milliliters) 0.083% 3 ml inhale orally via nebulizer four times a day for Shortness of Breath related to Mild Persistent Asthma, Uncomplicated; Primary Spontaneous Pneumothorax." Record review of Resident #30's "Order Summary Report" revealed an order with effective date of 5/7/2026, "Pulmicort Suspension 0.5 MG/2ML (Budesonide) 2 ml inhale orally every 12 hours related to Mild Persistent Asthma, Uncomplicated; Primary Spontaneous Pneumothorax." Record review of "Admission Record" revealed Resident #30 was admitted to facility on 5/7/2026 with diagnoses that included Encounter for Surgical Aftercare Following Surgery on the Nervous System, Unspecified Systolic (Congestive) Heart Failure, and Mild Persistent Asthma. Record review of "BIMS (Brief Interview for Mental Status) Interview MDS 3.0" with effective date of 5/7/2026 revealed a BIMS summary score of 9 indicating Resident #30 is moderately cognitively impaired. Resident #55 An observation from the hallway on 5/19/2026 at 1:59 PM revealed Resident #55 lying in bed. On the resident's floor were two soiled gloves lying near the door, two (2) separate unidentified clothing articles lying on the floor, and a pile of white bath towels containing a large amount of soiled incontinence wipes with a brown substance noted on the wipes. During an observation and interview on 5/19/2026 at 2:04 PM, Certified Nurse Aide (CNA) #1 entered Resident #55's room carrying a disposable blue pad. CNA #1 stated, "I had to run and get a blue pad," and further stated, "It's been a day, yeah, I know I'm going to need to get my mess cleaned up off the floor." CNA #1 confirmed that she had thrown the soiled items she used while rendering peri-care to the resident onto the floor instead of properly discarding them. She confirmed that this practice was unsanitary and posed an infection-control	F0880		

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F0880 SS = E	Continued from page 8 concern. During an interview on 5/19/2026 at 2:10 PM, the Infection Preventionist (IP) revealed that staff have been educated that, while providing peri-care, they are to place soiled items in bags and properly dispose of them. She revealed that it is never acceptable to put any items on the floor, as it could cause cross-contamination. During an interview on 5/19/2026 at 2:25 PM, the Director of Nursing (DON) confirmed that placing soiled items on the floor was unsanitary and posed an infection control concern. She revealed staff were expected to properly dispose of soiled items and stated it was never acceptable to place them on the floor. Record review of the "Admission Record" revealed Resident #55 was admitted to the facility on 09/26/2025 with diagnoses that included Major Depressive Disorder, and Systolic (Congestive) Heart Failure. Record review of the MDS with an ARD of 3/4/26 revealed a BIMS score of 03 which indicated Resident #55 was severely cognitively impaired.	F0880		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550		

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F0550 SS = D	Continued from page 9 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to ensure the residents were treated with dignity and respect by failing to maintain privacy during the provision of care for one (1) of 18 sampled residents. Resident #55 Findings include: Review of the facility policy titled, "Residents Rights and Quality of Life Policy and Procedure" undated, revealed "All residents have the right to a dignified existence. ..." An observation from the main hallway on 5/19/2026 at 1:59 PM revealed Resident #55 lying in bed, uncovered, with her incontinent brief and legs exposed. The privacy curtain was not drawn, and the room door remained open to the hallway. During the observation, hospice personnel and maintenance staff passed by the resident's room while the resident remained exposed, and the door remained open. An observation and interview on 5/19/2026 at 2:04 PM, Certified Nurse Aide (CNA) #1 entered Resident #55's room carrying a disposable blue pad. CNA #1 stated, "I had to run and get a blue pad," and further stated, "It's been a day." CNA #1 confirmed she left the room door open and acknowledged Resident #55 had been left exposed to individuals passing in the hallway. CNA #1 stated she should have closed the resident's door.	F0550		

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F0550 SS = D	Continued from page 10 During an interview on 5/19/2026 at 2:10 PM, Licensed Practical Nurse (LPN) #1 stated that no resident should ever be left exposed in that manner and the situation was “totally not acceptable practice in the facility.” An interview on 5/19/2026 at 2:25 PM, the Director of Nursing (DON) revealed that leaving Resident #55 exposed with the door open was a dignity concern and should not have occurred. The DON further stated the privacy curtain should have been drawn to provide Resident #55 with complete privacy. On 5/19/2026 at 2:40 PM, the facility Administrator revealed it is the facility’s expectation that all residents’ dignity be maintained and that resident room doors remain closed while care is being provided. The Administrator further revealed that this was not considered normal practice within the facility. Record review of the "Admission Record" revealed Resident #55 was admitted to the facility on 09/26/2025 with diagnoses that included Major Depressive Disorder, and Systolic (Congestive) Heart Failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/4/26 revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicated Resident #55 was severely cognitively impaired.	F0550		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F0584		

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(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
F0584 SS = D	Continued from page 11 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to ensure a clean homelike environment for one (1) of 38 resident rooms. Resident #2 Findings Include: Record review of facility policy titled “Cleaning and Disinfection of Environmental Services” revised August 2009 revealed, “...14. Horizontal surfaces will be wet dusted regularly (e.g., daily, three times per week) using clean cloths moistened with an EPA-registered hospital disinfectant (or detergent). The disinfectant (or detergent) will be prepared as recommended by the manufacturer...” In an interview on 5/18/2026 at 12:30 PM, Resident #2 stated that her room was dusty and she needed to clean it herself. Resident #2 stated she also needed to clean the bathroom. When asked if	F0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255212	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

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F0584 SS = D	Continued from page 12 housekeeping staff cleaned her room, Resident #2 stated they only removed the trash. Resident #2 stated that she does not like her room to be dusty. Observations made on 5/18/2026 at 12:35 PM and again on 5/19/2026 at 3:50 PM of Resident #2's room revealed, heavy accumulations of dust on chest of drawers, radio, photo frames, overbed light, wardrobe, television, bathroom sink, bathroom light fixture, and baseboards. An observation and interview on 5/19/2026 at 4:00 PM, the Housekeeping Supervisor confirmed Resident #2's room appeared inconsistent with the facility's routine cleaning schedule. On 5/20/2026 at 3:52 PM, the Administrator confirmed the expectation of the facility is for resident rooms to be cleaned thoroughly and regularly. Record review of "Admission Record" revealed Resident #2 was admitted to facility on 11/12/2025 with diagnoses of Chronic Obstructive Pulmonary Disease, Vascular Dementia, and Anxiety Disorder. Record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/10/2026 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 13 indicating Resident #2 was cognitively intact.	F0584		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255212	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

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F0641 SS = D	Continued from page 13 §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for one (1) of eighteen (18) residents reviewed. (Resident #21) Findings include: Review of the facility policy titled "Resident Assessment Policy and Procedure," undated, revealed, "…The facility shall complete residents' assessments via MDS 3.0 according to the Resident Assessment Instrument (RAI) guidelines…" Record review of Resident #21's Significant Change MDS assessment, with an Assessment Reference Date (ARD) of 7/21/2025, revealed under Section J1900C (Number of Falls Since Admission/Entry or Reentry or Prior Assessment – Major Injury), the assessment was coded to indicate the resident experienced a fall with major injury during the look-back period. Record review of Resident #21's progress notes and the facility Incident Log revealed no record of a fall with major injury for Resident #21. During an interview on 5/19/2026 at 3:00 PM, the Director of Nursing (DON) confirmed Resident #21 did not experience a fall with major injury and stated	F0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255212	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

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F0641 SS = D	Continued from page 14 the MDS assessment had been coded incorrectly. During an interview on 5/21/2026 at 10:20 AM, the Minimum Data Set (MDS) Nurse confirmed Resident #21's Significant Change Assessment was incorrectly coded for a fall with major injury. During an interview on 5/21/2026 at 11:35 AM, the Administrator stated her expectation was for MDS assessments to be completed accurately and reflect the resident's status. Record review of the Admission Record indicated Resident #21 was admitted to the facility on 6/27/2025 with a medical diagnosis that included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side.	F0641		