STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255114	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Community Care Center	4036 Highway 8 East Cleveland, MS 38732

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure a resident's right to dignity, choice, and self-determination by failing to assist one (1) of the twenty-seven sampled residents to attend the facility's beauty shop as requested. Resident #37Findings Include: Review of the facility policy titled, Resident Rights with revision date of December 2016, revealed Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity . On 1/5/26 at 11:45 AM, an observation and interview revealed Resident #37 seated in her wheelchair with visibly overgrown hair, measuring approximately four inches of gray overgrowth with red coloring remaining on the bottom half of her hair. Resident #37 revealed she was admitted to the facility in June 2025 and had been requesting assistance to go to the beauty shop since admission. She stated, It's like it falls on deaf ears. No one ever takes me. The resident further stated, I have never had my hair look so terrible. On 1/6/26 at 8:50 AM, a follow up observation revealed no change in the resident's appearance. During an interview on 1/6/26 at 2:25 PM, Certified Nurse Aide (CNA) #1 confirmed that Resident #37 had previously requested to go to the beauty shop. CNA #1 revealed the beautician was only coming a few times a month, and we didn't know when she would be here, so we would just miss her. Now I don't think we have a beautician. CNA #1 confirmed Resident #37 had visibly overgrown hair and revealed she could understand her wanting to go to the beauty shop. In an interview on 1/6/26 at 3:15 PM, the Administrator (ADM) revealed that he was unaware that Resident #37 had requested to go to the beauty shop and had not been assisted in doing so. He revealed if the resident was requesting to go to the beauty shop and was not assisted to do so, then her rights were violated. During an interview on 1/6/2026 at 4:37 PM, the Social Worker (SW) revealed that we were made aware in the latter part of December that the beautician would not be returning. She stated, Once the staff was made aware that we would not have a beautician, the CNAs were informed that they were going to be responsible for doing the residents' hair when they gave them showers, such as putting in pig tails and braiding their hair. She stated, I don't know who will be responsible going forward with cutting the residents' hair, that's above my pay grade. The SW revealed there were usually certain residents who went to the beauty shop, and she is not sure how Resident #37 got missed. During an interview on 1/6/26 at 5:25 PM, with the Director of Nurses (DON) present, Resident #37 stated, For 39 years, I went to the beauty shop every Friday. I have never had my hair looking this bad in all my life. I have been here since last June and have not had my hair cut or styled. This is really important to me, and I have asked about it several times. The DON assured Resident #37 that the matter would be addressed. An interview on 1/6/26 at 5:30 PM, DON revealed she is new to the facility and was unaware that the resident was requesting beauty shop services. The DON revealed it is the facility's expectation that residents' rights would be honored regarding personal grooming, including hair care, and confirmed the facility failed to ensure Resident #37's rights were honored. A record review of Resident #37's admission Record revealed the facility admitted the resident on 6/23/25 with diagnoses that included Polyneuropathy, Major Depressive Disorder, and anxiety disorder. A record review of Resident #37's (continued on next page)

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 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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/25 revealed, under section C, a Brief Interview of Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on resident and staff interview, record review and facility policy review the facility failed to ensure residents' grievances regarding missing personal clothing were investigated, resolved, and communicated to the resident for two (2) of 27 sampled residents. Resident #29, and Resident #37. Findings Include:Record review of the facility policy titled Resident Care Grievance Policy with an effective date of 6/26/2023 revealed, Grievance decisions should include the following: .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 as a result of the grievance and the date the decision was issued .Resident #29During an interview on 1/05/2026 at 11:45 AM, Resident #29 reported that Unsampled Resident A repeatedly entered her room and removed her clothing from the hangers in her closet. Resident #29 stated she had reported the issue to staff for a long time, yet the problem continued to be unresolved. She further stated she kept her privacy curtain open so she could have a view of her closet to monitor her room and yell if Unsampled Resident A entered.During an interview on 1/06/2026 at 2:30 PM, Certified Nurse Aide (CNA) #1 confirmed that missing clothing was a big problem on this unit and stated the issue was not due to unlabeled clothing but due to Unsampled Resident A, who had dementia and routinely entered other residents' rooms and took their belongings. CNA #1 confirmed that complaints from residents have been reported to nursing staff and the social worker, and that everyone is aware of this problem, but nothing is being done about it.A record review of Resident #29's admission Record revealed the facility admitted the resident on 6/11/24 with diagnoses that included Crohn's Disease, Hemiplegia and Hemiparesis, and Malignant Neoplasm of Colon. A record review of Resident #29's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/25 revealed, under section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Resident #37During an interview on 1/05/2026 at 11:50 AM, Resident #37 revealed that upon admission, she had six pairs of slacks and several shirts and stated that she no longer had any clothing in her closet. She reported repeatedly notifying staff, with no resolution, and further stated, It is so frustrating, I don't know where my clothes are.During a follow-up interview on 1/06/2026 at 8:05 AM, Resident #37 stated she was unable to leave her room due to a lack of clothing. An observation of her closet revealed that no clothing was present, and there were six empty hangers.A record review of Resident #37's admission Record revealed the facility admitted the resident on 6/23/25 with diagnoses that included Polyneuropathy, Major Depressive Disorder, and anxiety disorder. A record review of Resident #37's MDS with an ARD of 12/17/25 revealed, under section C, a BIMS score of 10, indicating moderate cognitive impairment. During an interview and observation on 1/06/2026 at 2:35 PM, Registered Nurse (RN) #1 confirmed that missing clothing was an ongoing issue, stating that staff were aware that Unsampled Resident A removed clothing from residents' rooms and hid it in her wheelchair. Observation revealed Unsampled Resident A seated in the dayroom with a large quantity of clothing concealed in her wheelchair. RN #1 retrieved approximately ten articles of clothing belonging to various residents. RN #1 confirmed staff routinely retrieved clothing and attempted to redirect Unsampled Resident A, but she will resist and fight us. RN #1 revealed our interventions are ineffective, and the missing clothing issue continues daily with no resolution.During an interview on 1/06/2026 at 3:30 PM, the Social Worker confirmed awareness that Unsampled Resident A was taking other residents' clothing and acknowledged that staff were just trying to redirect and return the other residents' clothing. She confirmed no steps had been taken to resolve the issue and that complaints from Residents #29 and #37 remained unresolved.During an interview on 1/07/2026 at 9:14 AM, the Administrator confirmed awareness of Unsampled Resident A's behaviors but stated he was not aware of any specific resident complaints regarding missing clothing. He confirmed that when residents voice complaints, a grievance process (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be initiated and further acknowledged that no grievances had been filed for Residents #29 or #37.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). Based on observations, resident and staff interviews, record review, and a review of facility policy, the facility failed to honor residents' rights by secluding two (2) of twenty (20) residents in a locked Memory Care unit without proper assessment. This practice violated the residents' right to be free from involuntary seclusion. Resident #23 and Resident #83Findings Include: Review of the facility policy titled, Abuse Component Plan, with an effective date of 10/24/22, revealed under policy, Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion. Resident #23 An observation and interview on 01/05/2026 at 11:50 AM with Resident #23 revealed him sitting up in chair watching television in his room. His room was located on the back side of the north hall and was behind locked double doors. Resident #23 revealed that he moved to that room recently because he was acting a fool on the other hall. He revealed that they threw him back here so they wouldn't have to deal with him anymore. Resident #23 revealed that he was begging for snacks on the other hall, and they got mad about it and he stated, they put me back here. He also revealed that he was trying to stay out of trouble now. Resident #23 revealed that back here, the doors were locked, and he couldn't get out without asking someone. An interview on 01/05/26 at 12:25 PM with Registered Nurse (RN) #1, revealed that Resident # 23 was in the Memory Unit. She revealed that residents with behaviors, residents who wandered in and out of other resident rooms and those who needed close monitoring were placed behind locked doors. She revealed that they allowed residents to come out if they wanted to, but that the staff had to put in a code to unlock the doors to let them out. RN #1 revealed that some of the residents back in the unit were really confused and required close monitoring. She revealed that Resident #23 was in his right mind and had been back there for a short time. She revealed that he was previously on the South Hall but was transferred back to the Memory Unit because of his behaviors. RN #1 revealed that Resident #23 was constantly stealing snacks out of the refrigerator behind the nursing desk on the South Hall, following the staff around, begging for more snacks, money, and talking over them. RN #1 revealed that Resident #23 was getting on their nerves on the South Hall and they moved him to the North Hall, and they could monitor him more closely behind these locked doors. An interview on 01/06/26 at 3:00 PM with Assistant Director of Nursing (ADON), revealed that they had residents with dementia and those with psychiatric issues in rooms behind the locked doors. She revealed that Resident #23 had only been back there behind locked doors for about a week. She revealed that he was transferred down to this hall from the South Hall due to his behaviors. She revealed that he was constantly asking staff and residents for money, he was going into the refrigerator at the nursing desk and getting snacks. ADON revealed that Resident #23 told her that he felt like they threw him back there so they wouldn't have to deal with him anymore and agreed that it was like they punished him for bad behavior. She also acknowledged that by secluding residents involuntarily could cause increase in behaviors especially in the more cognitive residents. She confirmed that the resident did not have a psychiatric evaluation or any other services prior to moving the resident to the locked unit. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/06/26 at 3:08 PM with Licensed Practical Nurse (LPN) #2, revealed that she was familiar with Resident #23. She revealed that he was on the South Hall before he transferred to the North Hall. She revealed that Resident #23 would go behind the nursing desk on the South Hall and get snacks out of the refrigerator without permission. She revealed that he asked for money often to get snacks out of the vending machine. She revealed that they would re-direct him and explain to him that he could not help himself to the snacks and he would leave and come right back. She revealed that they reported this to the Administrator and that's why they moved him to the locked unit behind the double doors. Record review of Resident #23's admission Record revealed an admission date of 08/25/21 and that he had diagnoses that included Unspecified Impulse Disorder, Restlessness, and Agitation. Record review of Resident #23's Progress Note dated 01/02/26, revealed that the Social Worker (SW) made contact with the RP (Responsible Party) over the phone. SW expressed that the Resident was going to have a room change due to his recent behaviors. RP agreed and stated that were going to come and visit. Record review of Resident #23's Minimal Data Set (MDS) with Assessment Reference Date (ARD) of 11/03/25 under Section C, revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that he had no cognitive deficits. During an interview on 1/05/26 at 12:45 PM, the Administrator confirmed that the facility maintains a locked unit at the end of the North Hall, with men housed on one side and women on the other. The Administrator revealed that the unit has historically been structured this way and is used not only for residents with Alzheimer's disease but also for residents exhibiting behaviors. The Administrator acknowledged awareness that secluding residents in this locked unit infringes upon their right to be free from involuntary seclusion and stated, We have a lot of behaviors at this facility. During an interview on 1/05/26 at 4:00 PM, Certified Nursing Assistant (CNA) # 6 revealed that this unit back here is basically an Alzheimer's unit, but there are a lot of people back here without Alzheimer's that just have behaviors that they can't control out in the main unit. She revealed that we keep the women behind this locked door, and the men are kept on the other side of the locked door. Resident #83 An observation and interview on 1/05/2026 at 4:50 PM revealed that Resident #83 was sitting close to the locked double doors in the women's unit. Resident #83 asked the State Agent (SA) if she would go over to the men's side and buy her two drinks out of the vending machine. Resident #83 revealed she was not allowed outside of the double doors and had to wait and ask someone to go to the drink machine for her. Resident #83 revealed she would like to go get things she wants without having to ask someone to do it for her. Resident #83 stated, I just stay back behind the doors like I'm supposed to, but it would be nice to go outside the doors. Resident #83 retrieved two dollars from inside her boot, and CNA #6 retrieved the drinks for her. CNA #6 stated, We go and get whatever they want, but they don't come out of the locked unit. During an interview on 1/06/2026 at 9:45 AM, the Corporate Nurse revealed that our corporation recently purchased this facility in November 2025, and they had questioned why those residents were behind locked doors, especially since they were not a licensed Alzheimer's unit. The Corporate Nurse confirmed that, without proper assessment, the residents were placed in an involuntary seclusion (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	area of the building. A record review of Resident #83's admission Record revealed the facility admitted the resident on 3/4/19 with diagnoses that included Type 2 Diabetes Mellitus, Schizoaffective Disorder and Peripheral Vascular Disease. A record review of Resident #83's MDS with an ARD of 12/5/25 revealed, under section C, a BIMS score of 14, which indicated the resident is cognitively intact.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure a resident's Minimum Data Set (MDS) was accurately coded for one (1) of twenty-seven (27) MDS assessments reviewed (Resident #105). Findings include:Review of a facility policy titled, Certifying Accuracy of the Resident Assessment, revealed, All personnel who complete any portion of the Resident Assessment must sign and certify the accuracy of the portion of the assessment .An observation on 1/05/26 at 11:30 AM revealed the resident's bilateral hands appeared contracted in appearance.Review of Section GG0115, Functional Limitation in Range of Motion (ROM), of the Quarterly MDS dated [DATE] revealed the resident was coded as having no impairment to the upper extremities.An interview with the Director of Nursing (DON) on 1/06/26 at 3:00 PM revealed she stated she had observed the resident's contracted hands and that the resident was supposed to have splints applied to his hands. She further stated that upon review of the resident's record, MDS Section GG had been coded incorrectly, as it was coded to reflect no impairment of the upper extremities despite the resident having bilateral hand contractures. She stated accurate MDS coding is required to provide an accurate depiction of the resident's functional status.Review of the admission Record revealed Resident #105 was admitted on [DATE] with diagnoses including type 2 diabetes and contracture of the right hand.Review of the Brief Interview for Mental Status (BIMS) for Resident #105 dated 11/20/25 revealed a score of nine (9), indicating the resident was moderately cognitively impaired.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to develop a communication care plan for (Resident #46), failed to implement a Behavioral care plan for (Resident #22), failed to implement an activities of daily living (ADL) care plan for (Resident #29, #64, and #105), and failed to implement a range of motion (ROM) care plan for (Resident # 105) for six (6) of 27 care plans reviewed.Findings include: Review of the facility policy titled, Care Plans, Comprehensive Person Centered, last revised March 2022, revealed the policy statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Resident #22 Review of the Behavior Management care plan, last revised 12/06/25, revealed the intervention: 1 on 1 (one-on-one) precautions. During an observation and interview with Resident #22 on 1/05/2026 at 11:40 AM, the resident stated he wanted to go back to where he came from, and this conversation with the resident continued for approximately five minutes. When asked if the gentleman asleep in a chair in his room was his family member, Resident #22 stated, No, he is supposed to be watching me but just look at him sleeping. The gentleman asleep in the chair did not awaken during the observation and interview. During the continued observation and interview on 1/05/26 at 11:48 AM, Certified Nurse Assistant (CNA) #3 stepped into the room and she identified the gentleman asleep in the chair as the Transporter assigned to sit with Resident #22 due to one-on-one supervision related to the resident's behaviors. The CNA loudly called the Transporter's name three times, and he did not awaken. An interview with the Minimum Data Set (MDS) nurse on 1/06/26 at 2:50 PM she stated that upon review of the resident's Behavior Management care plan, staff did not implement the one-on-one supervision when the assigned staff member was observed sleeping in the room and not observing the resident. She stated the purpose of the care plan is to direct the specific care each individual resident requires. Record review of the admission Record revealed Resident #22 was admitted on [DATE] with diagnoses including paranoid schizophrenia and bipolar disorder. Record review of the Brief Interview for Mental Status (BIMS) for Resident #22 dated 12/12/25 revealed a score of 15, indicating the resident was cognitively intact. Resident #29 Resident #29's Care plan revealed, I require assistance with my adls related to my history of cerebrovascular accident (cva) with left sided weakness/hemiplegia, right hand contracture, incontinent bowel/bladder, diagnosis of liver and colon cancer along with my history of Crohn's disease with small bowel obstruction. Under approaches: Shower every other day and PRN (as (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed). On 1/05/2026 at 11:30 AM, an observation and interview revealed that Resident #29 was lying in bed, with her hair disheveled, and was wearing a white gown with dried liquid in various circles, visible on her gown. The resident revealed that she is supposed to get a shower each Tuesday, Thursday, and Saturday. She confirmed that she did not get a shower on Saturday and was not offered one. She revealed that the last time I had a shower was last Thursday, and that was the last time I had my clothes changed, so I have been wearing the same outfit for four (4) days. The resident revealed she had not had her hair combed since two days before Thanksgiving. In an interview and observation on 1/06/2026 at 11:05 AM, CNA #1 confirmed the resident's hair was disheveled and unkempt. On 1/06/2026 at 5:15 PM, during an interview and observation with the Director of Nurses (DON) present, Resident #29 reiterated her hair had not been combed since two days before Thanksgiving. The resident's hair remains disheveled and unkempt. The DON confirmed that the resident's hair needed attention and that she would ensure it was addressed. The DON revealed that each of our residents should always be adequately groomed and presentable, and with Resident #29 not adequately showered and her hair not attended to, then her plan of care was not being followed. An interview on 1/7/26 at 4:10 PM the MDS nurse revealed according to Resident #28's care plan she is supposed to receive a shower every other day and as needed. She revealed if her last shower was last Thursday then her plan of care was not being followed. She revealed hair care falls under the approach of having a shower. She revealed that the staff know that when a resident has a shower, they should also have their hair brushed. She confirmed that the resident's care plan was not implemented and revealed that we could do a better job by being more specific in developing each resident's individual plan of care. A record review of Resident #29's admission Record revealed the facility admitted the resident on 6/11/24 with diagnoses that included Crohn's Disease, Hemiplegia and Hemiparesis, and Malignant Neoplasm of Colon. A record review of Resident #29's MDS with an ARD of 11/14/26 revealed, under section C, a BIMS score of 15, which indicated the resident is cognitively intact. Resident #46 An observation and attempted interview with Resident #46 on 1/06/26 at 8:32 AM revealed he was lying in bed and unable to communicate. He shook his head back and forth as if he did not understand the questions. The resident's roommate verbalized that Resident #46 did not speak English. Record review of Resident #46's Care Plan Report revealed a care plan was not developed for his language/communication barrier. An interview with the MDS Nurse on 1/07/26 at 11:07 AM revealed the purpose of a care plan was for staff to know how to care for the residents. She stated Resident #46 used a phone as a translator to communicate with staff and confirmed a care plan was not developed because they were behind. Record review of the admission Record revealed the facility admitted Resident #46 on 12/11/25 with (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a diagnosis of Insomnia. Record review of the MDS with an ARD of 12/18/25 revealed under section A1110, What is your preferred language? Spanish was indicated. Section C revealed a BIMS summary score of 15, which indicated Resident #46 was cognitively intact. Resident #64 Record review of the resident's Care Plan identified that he required assistance with ADLs, with approaches including oral care daily and as needed (PRN). An observation and interview conducted on 01/05/2026 at 11:00 AM and 01/06/2026 at 4:35 PM revealed that Resident #64 was observed lying in bed receiving nutrition through a Percutaneous Endoscopic Gastrostomy (PEG) tube. The resident revealed he was unable to take anything by mouth due to difficulty swallowing. Upon observation, the resident's lower teeth exhibited a yellowish-tan substance along the gum line and between the teeth. Resident #64 revealed that staff did not brush his teeth. He stated he would feel cleaner if his teeth were brushed and stated that staff didn't have time, but they need to take time to do it. An observation and interview conducted on 01/06/2026 at 4:50 PM with the DON confirmed that Resident #64's teeth were visibly dirty and needed brushing. The DON stated that CNAs were responsible for providing oral care and that this intervention was included in the resident's care plan. The DON further stated that failure to provide appropriate oral hygiene could result in tooth decay, mouth sores, foul odors, and possible infection, and indicated that staff would address the issue immediately. She also confirmed that by not receiving the proper mouth care, his care plan was not followed. Record review of the admission Record indicated that Resident #64 was admitted on [DATE] with diagnoses including Dysphagia, Hemiplegia, and Hemiparesis. Record review of the MDS with an ARD of 12/23/2025 showed a BIMS score of 9, indicating moderate cognitive impairment. Under Section GG, the MDS documented that the resident was dependent on staff for oral hygiene. Resident #105 Review of a care plan for Resident #105 titled, Resident is at risk for ADLs related to decreased mobility, muscle weakness, and type two diabetes, revealed the following approaches: Nail care per nurse and ROM to upper and lower extremities with AM and PM care. During an observation on 1/05/26 at 11:30 AM revealed the resident's bilateral hands appeared contracted in appearance with no positioning devices in place, and the resident's fingernails were approximately one inch in length. During an observation of Resident #105's hands with CNA #2 on 1/06/26 at 2:18 PM, he confirmed the resident's bilateral hands were contracted and that the fingernails were very long and needed to be trimmed. He confirmed he did not perform any type of range of motion (ROM) to the resident's hands due to the severity of the contractures and stated the nurses were responsible for trimming the resident's fingernails. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the MDS nurse on 1/06/26 at 3:10 PM revealed she stated that if staff failed to trim the resident's fingernails or provide ROM services as outlined, staff failed to implement the resident's care plan as instructed. She stated the purpose of the care plan is to direct resident-specific care for each individual resident. Record review of the admission Record revealed Resident #105 was admitted on [DATE] with diagnoses including type two diabetes and contracture of the right hand. Record review of the BIMS for Resident #105 dated 11/20/25 revealed a score of 9, indicating the resident was moderately cognitively impaired.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interview, record review, and facility policy review, the facility failed to provide activities of daily living (ADL) care for three (3) of 113 residents residing in the facility. Resident # 29, #64, and # 105 Findings Include: Review of the facility policy titled, ADLs Supporting undated, revealed .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene . Review of the facility policy titled, Fingernail Care, Foot Care, and Podiatry Referral, effective date 4/18/2017, revealed the stated purpose was to provide guidelines for the delivery of safe, evidence-based nail and foot care which promote good personal hygiene, prevent hand, foot, and nail infections, soft tissue injury, and foot ulcers . Resident #29 An observation and interview on 1/05/2026 at 11:30 AM revealed that Resident #29 was lying in bed, with her hair disheveled, and was wearing a white gown with dried liquid in various circles, visible on her gown. The resident revealed that she is supposed to get a shower each Tuesday, Thursday, and Saturday. She confirmed that she did not get a shower on Saturday and was not offered one. She revealed that the last time I had a shower was last Thursday, and that was the last time I had my clothes changed, so I have been wearing the same outfit for four (4) days. The resident revealed she had not had her hair combed since two days before Thanksgiving. During an observation and interview on 1/06/2026 at 8:28 AM, Resident #29 was again observed lying in bed with disheveled hair and unchanged appearance from the previous day, wearing the same gown. The resident stated, Today is Tuesday, so I'm supposed to get my shower today. In an interview and observation on 1/06/2026 at 11:05 AM, with Certified Nursing Assistant (CNA) #1 confirmed that the resident gets her showers on Tuesday, Thursday and Saturday and stated, The resident does not refuse care. CNA #1 revealed I'm not sure what happened with her not getting a shower this past weekend, but she is supposed to get a shower today. She confirmed the resident's hair was disheveled and unkempt. Observation and interview on 1/06/2026 at 3:10 PM revealed Resident #29's clothing had changed; however, her hair remained disheveled and unkempt. Resident #29 revealed, I got my shower today, but the girl didn't comb my hair. She said she doesn't know how to braid my hair. During an interview and observation on 1/06/2026 at 5:15 PM, with the Director of Nurses (DON) present, Resident #29 reiterated her hair had not been combed since two days before Thanksgiving. The resident's hair remains disheveled and unkempt. The DON confirmed that the resident's hair required attention and that she would ensure it was taken care of. The DON revealed that each of our residents should always be adequately groomed and presentable. A record review of Resident #29's admission Record revealed the facility admitted the resident on 6/11/24 with diagnoses that included Crohn's Disease, Hemiplegia and Hemiparesis, and Malignant Neoplasm of Colon. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #29's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/25 revealed, under section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Resident #64 Review of the facility policy titled Mouth Care, revised February 2018, indicated that The purposes of this procedure are to keep the resident's lips and oral tissue moist, to cleanse and freshen the resident's mouth, and to prevent oral infection . Observations and interviews conducted on 01/05/2026 at 11:00 AM and on 01/06/2026 at 4:35 PM revealed Resident #64 lying in bed and receiving nutrition through his Percutaneous Endoscopic Gastrostomy (PEG) tube. The resident stated that he was unable to take anything by mouth due to difficulty swallowing. Observation revealed a yellowish-tan substance present along the lower gum line and between each tooth. Resident #64 stated that staff did not brush his teeth or keep his mouth clean and reported that he would feel better and cleaner if his teeth were brushed. He further stated that staff didn't have time, but they needed to take time to provide this care. During an observation and interview on 01/06/2026 at 4:40 PM, Licensed Practical Nurse (LPN) #4 confirmed the presence of a yellowish-tan substance along Resident #64's lower gum line and between his teeth. LPN #4 stated that mouth care was to be completed every shift and that failure to provide oral care could result in tooth decay, pain, gingivitis, and possible infection. An observation and interview on 01/06/2026 at 4:50 PM with the DON confirmed that Resident #64's teeth were visibly soiled and required brushing. DON stated that CNAs were responsible for providing mouth care every shift. DON further stated that failure to provide appropriate mouth care could result in tooth decay, mouth sores, foul odors, and possible infection and stated that staff would address the issue. An interview conducted on 01/07/2026 at 10:37 AM with CNA #5 revealed that she had provided care for Resident #64 the previous day. CNA #5 stated that mouth care was expected to be completed every shift but confirmed that she did not brush the resident's teeth. She stated that providing mouth care was difficult due to the resident's PEG tube feeding and the need for the resident to remain upright during that time. CNA #5 further stated that she would want her own teeth brushed daily and agreed that Resident #64 should have his teeth cleaned as well. Record review of the admission Record indicated that Resident #64 was admitted on [DATE] with diagnoses including dysphagia, hemiplegia, and hemiparesis. Record review of the MDS with an ARD of 12/23/2025 revealed a BIMS score of 9, indicating moderate cognitive impairment. Section GG indicated that Resident #64 was dependent on staff for oral hygiene. Resident #105 An observation on 1/05/26 at 11:30 AM revealed Resident #105's bilateral hands appeared contracted in appearance, and his fingernails were approximately one inch in length. An observation on 1/05/26 at 3:00 PM revealed Resident #105's fingernails remained approximately (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one inch in length. An observation of Resident #105's hands with CNA #2 on 1/06/26 at 2:18 PM revealed he confirmed the resident's fingernails were very long and needed to be trimmed. He stated the nurses are responsible for trimming residents' nails. Upon continued observation of the resident's right hand, it was observed that the first and second fingernails were digging into the resident's palm. CNA #2 stated that untrimmed fingernails could lead to skin breakdown. An observation of Resident #105's fingernails with LPN #1 on 1/06/26 at 2:35 PM revealed he confirmed the resident's fingernails were long, bent inward toward the palm of the hand, and needed to be trimmed. He stated the nurses are responsible for trimming the resident's fingernails due to the resident being diabetic. An interview with the DON on 1/06/26 at 3:00 PM revealed she had observed the resident's contracted hands and that the fingernails on the right hand were digging into the palm and required trimming. She stated failure to provide nail care services could result in worsening skin breakdown and accidents. Record review of the admission Record revealed Resident #105 was admitted on [DATE] with diagnoses including type 2 diabetes and contracture of the right hand. Record review of the BIMS for Resident #105 dated 11/20/25 revealed a score of 9, indicating the resident was moderately cognitively impaired.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide Range of Motion (ROM) services for (2) two of 60 residents who have limited ROM. (Resident #24 and #105) Findings include: Review of the facility policy titled, Resident Mobility and Range of Motion, with no revision date, revealed the policy statement: Residents with limited range of motion will receive treatment and services to increase and/or prevent further decrease in range of motion . Resident #24 An observation and interview on 01/05/2026 at 11:17 AM with Resident #24, revealed him sitting up in his wheelchair in his room. He had contractures to the second, third, fourth, and fifth digits on his left hand. His fingers were stiff and bent inward, and his fingernails were touching the palm of his hand. Resident #24 stated he had a brace that he wore sometimes, and it was located in the top drawer of his dresser. Resident #24 revealed that the last time he had therapy, the Certified Occupational Therapy Assistant (COTA) told him to let the nurses or aides help him put the brace on. He also revealed that sometimes he had a hard time applying the brace because part of it would fold up and due to his limited use of his hand, he had problems with it. Resident #24 revealed that not everyone knew how to put the brace on and sometimes he didn't get to wear it. He also confirmed that the nurses nor aides offered to put his hand splint on, and he had to go to them and ask for them to put it on him. He confirmed that now since his fingers are touching his palm of his hand that it is harder to get the splint on by himself and he needs help. An interview on 01/06/26 at 3:41 PM with Registered Nurse (RN) #1, revealed that Resident #24 was somewhat independent and liked to do what he could for himself. She revealed that he had a hand splint and the therapy department trained them on how to apply it when he was discharged from therapy. RN #1 revealed that Resident #24 knew he was supposed to ask for help getting it on, sometimes he did, and sometimes he didn't and stated, It was nothing he had to wear every day. RN #1 confirmed that the nurses did not make sure Resident #24 applied the brace as recommended, but they helped him if he asked. An interview on 01/07/26 at 12:03 PM with Director of Nursing (DON), confirmed that there was no order for the use of a hand splint for Resident #24. She agreed that a nurse should have been monitoring, assisting the resident with the splint and ensuring the brace was applied as recommended to prevent worsening of the contracture. She revealed that she did not know how this got missed. An interview on 01/07/26 at 2:41 PM with the COTA, revealed that Resident #24 had therapy for his left-hand contracture about a year ago. She revealed that he had a resting hand splint that the staff were trained on how to apply when Resident #24 was discharged . She revealed that he could apply the hand splint sometimes himself. She revealed that when they discharged him from therapy, they educated the nursing staff and CNAs (Certified Nursing Assistants) on how to apply the resting hand splint, and they took it over. She revealed that the purpose of wearing the hand splint was to prevent the fingers from tightening back up causing worsening contractures and confirmed that if the resident (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	has not worn the splint consistently then the contracture would worsen. An interview on 01/07/26 at 3:03 PM with Assistant Director of Nursing (ADON), revealed that Resident #24 had a splint in his room and they were trained on how to apply and take off. She revealed that Resident #24 applied his own brace sometimes and sometimes he didn't. She revealed that when Resident #24 was discharged from therapy, COTA came down to them and trained the Certified Nursing Assistants (CNA)s and trained the nurses on how to apply correctly. She revealed that it was the CNAs responsibility to apply and ensure that the splint stays on for the appropriate time and to report to the nurse if there were any problems. The ADON revealed that she knew there was no order for the hand splint to be applied and stated, This is a learning experience, and we as a whole dropped the ball and will have to fix it. The ADON revealed that they had new staff in and out and she would have COTA to train all staff again on the floor now so that the splint was applied properly. She also confirmed that the nurses were supposed to oversee the CNAs and ensure the splint was applied according to therapy recommendations. Record review of Resident #24's OT (Occupational Therapy) Discharge summary dated [DATE] revealed under Discharge Recommendations that he had a left resting hand splint. Therapist has trained staff on self-range of motion exercises using Right upper extremity to perform Left Upper Extremity Passive Range of Motion exercises and on splint wear to apply three times a week for two to four hours to maintain good Range of Motion and decrease further risk for contracture. Dates of service 12/05/24-01/24/25; Prognosis to maintain Current Level of Functioning (CLOF)= Good with consistent staff follow through Record review of Resident #24's Order Summary Report and his Visual/Bedside Kardex Report documented no orders to apply his hand splint. Record review of Resident #24's admission Record revealed an admission date of 02/21/24 and that he had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side and Unspecified Pain. Record review of Resident #24's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/03/25 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 15 which indicated that he had no cognitive deficits. Record review of Resident #24's MDS with ARD of 10/03/25 under Section GG revealed under Functional Limitation in Range of Motion that he had upper extremity impairment on one side. Resident #105 An observation on 1/05/26 at 11:30 AM revealed the resident's bilateral hands appeared contracted in appearance, with no positioning devices in place. An observation on 1/05/26 at 3:00 PM revealed the resident's hands remained in a contracted position. An observation of Resident #105's hands with CNA #2 on 1/06/26 at 2:18 PM revealed he confirmed the resident's bilateral hands were contracted, with the right hand more severely affected. Upon continued observation of the right hand, it was observed that the first and second fingernails were digging into the resident's palm. CNA #2 stated he frequently provided care to the resident and (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed he did not perform range of motion exercises to the resident's hands due to the severity of the contractures. He further revealed splinting devices were present in the resident's dresser drawer and stated restorative services were responsible for applying the splints; however, the splints had not been applied for approximately two days. He stated failure to provide range of motion and apply splints could result in worsening of the resident's contractures. An observation of Resident #105's hands with Licensed Practical Nurse (LPN) #1 on 1/06/26 at 2:35 PM revealed he confirmed the resident's bilateral hands were contracted and his fingernails were long and bent inward toward the palms of the hands and the resident did not have a splint on his hands. An interview with the DON on 1/06/26 at 3:00 PM revealed she stated she had observed the resident's contracted hands and that the fingernails on the right hand were digging into the palm. She stated the resident was supposed to have splints applied to his hands. She further stated failure to provide range of motion services and apply splints could result in worsening contractures. The DON confirmed the facility did not have restorative services at that time and stated she was unable to locate documentation in the resident's record related to range of motion services or application of splints. Record review of an Occupational Therapy Discharge Summary for Resident #105 dated 3/05/25 revealed the resident had a right wrist-hand-finger orthosis (WHFO) to promote wrist extension, digit extension, and thumb abduction to prevent further risk for joint contracture. The summary further revealed therapy staff had trained facility staff on the resident's restorative program, including splint wear, hand hygiene, and passive range of motion. An interview with the COTA on 1/07/26 at 11:00 AM revealed she stated the resident should wear hand positioning devices daily and receive passive range of motion. She stated she was unaware of when or why the facility stopped applying the devices but confirmed the resident required them to aid in prevention of worsening contractures. Record review of the admission Record revealed Resident #105 was admitted on [DATE] with diagnoses including type two diabetes and contracture of the right hand. Record review of the BIMS for Resident #105 dated 11/20/25 revealed a score of 9, indicating the resident was moderately cognitively impaired.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and record review, the facility failed to provide adequate supervision to prevent accidents for one (1) of twenty-seven (27) residents on the sample (Resident #22). Findings include:Review of a facility policy titled, Safety and Supervision of Residents, with no revision date, revealed the policy statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .An observation and interview with Resident #22 on 1/05/2026 at 11:40 AM revealed the resident stated he wanted to go back to where he came from, and the conversation with the resident continued for approximately five minutes. When asked if the gentleman asleep in a chair in the room was his family member, Resident #22 stated, No, he is supposed to be watching me but just look at him sleeping. The gentleman asleep in the chair did not awaken during the observation and interview.During a continued observation and interview on 1/05/26 at 11:48 AM Certified Nurse Assistant (CNA) #3 entered the room and revealed that the gentleman asleep in Resident #22's room was the Transporter assigned to sit with the resident due to one-on-one supervision related to behaviors. The CNA loudly called the Transporter's name three times, and he did not awaken. CNA #3 then went and got the nurse and the State Agency continued to stay in the room.An observation from the doorway of Resident #22's room on 1/05/26 at 11:50 AM revealed the Transporter remained asleep in the chair.An observation on 1/05/26 at 11:52 AM revealed the Transporter was awakened by another staff member who entered Resident #22's room.An interview with the Transporter on 1/05/26 at 11:54 AM revealed he stated he was sitting with the resident and guessed he had dozed off. He stated he knew he was not supposed to sleep while on duty.An interview with Licensed Practical Nurse (LPN) #2 on 1/05/26 at 11:58 AM revealed Resident #22 had been on one-on-one supervision since the end of December due to behaviors, including threats to kill staff and other residents. She stated that while staff were asleep, the resident was not being supervised and could have acted on his threats or experienced worsening behaviors.Record review of the Order Recap Report for Resident #22 revealed an order dated 12/31/25 for one-on-one precautions related to aggressive behaviors for seven days.An interview with the Director of Nursing on 1/07/26 at 9:34 AM revealed she confirmed Resident #22 was on one-on-one supervision related to behaviors. She stated that if staff were asleep and not monitoring the resident as directed, it could have led to increased behaviors.An interview with Social Services Staff #2 on 1/07/26 at 11:00 AM revealed he confirmed Resident #22 was to remain on one-on-one supervision due to behaviors and aggression. He stated the resident would continue on one-on-one supervision until appropriate placement was determined through the court system.Record review of the admission Record revealed Resident #22 was admitted on [DATE] with diagnoses including paranoid schizophrenia and bipolar disorder.Record review of the Brief Interview for Mental Status (BIMS) for Resident #22 dated 12/12/25 revealed a score of 15, indicating the resident was cognitively intact.