

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255166	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Arabella Health & Wellness of Meridian		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 28th Avenue Meridian, MS 39301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility policy review, the facility failed to ensure residents' rights to be free from abuse and neglect when the facility failed to protect Resident A from neglect by failing to initiate the admission process after the resident arrived at the facility following surgical repair of a left hip fracture, and failed to protect Resident #23 from verbal abuse by a Certified Nurse Aide (CNA), for two (2) of (19) sampled residents. The facility's failure to initiate the admission process for Resident A resulted in the resident remaining without a nursing assessment, implementation of physician orders, prescribed medications, pain management, assistance with toileting, and ongoing nursing care for approximately nine (9) hours after arriving at the facility following surgical repair of a left hip fracture, placing the resident at likelihood for serious injury, serious harm, impairment, or death. The situation was determined to be Immediate Jeopardy (IJ) and substandard Quality of Care (SQC) that began on 4/28/26 when Resident A arrived at the facility for admission. The facility's Administrator was notified of the IJ on 7/23/26 at 1:40 PM and was presented with the IJ template. The facility provided an acceptable Removal Plan on 7/23/26, in which they alleged all corrective actions to remove the IJ were completed on 7/23/26 and the IJ removed on 7/24/26. The State Agency (SA) validated the Removal Plan on 7/27/26 and determined that the IJ was removed on 7/24/26, prior to exit. Therefore, the scope and severity for 42 CFR S483.12 Freedom from Abuse, Neglect, and Exploitation (F600) was lowered from a J to a D while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: A review of the facility's Abuse, Neglect, and Exploitation with the reviewed date of 03/10/26, revealed .Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident . that prohibit and prevent abuse, neglect . Definitions: . Verbal Abuse means the use of oral communication that willfully includes disparaging or derogatory terms to residents. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Prevention of Abuse, Neglect, and Exploitation: . C. Assuring an assessment of the resources needed to provide care and services to all residents is included in the facility assessment . H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. Identification of Abuse, Neglect, and Exploitation: . B: . 8. Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning & positioning. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident A A record review of Resident A' s Medical Records including Discharge Summary Paperwork revealed . report called to (Proper Name) 04/28/2026 at 3:30 PM . Please include: . orders .D/C (discharge) summary . Discharge summary revealed admission date of 04/19/2026 and discharge date and time of 04/28/2026 at 12:49 PM. X-ray in ED (Emergency Department) showed left femoral neck fracture with procedure arthroplasty total hip (left). On 04/28/2026 accepted to facility, stable and ready for discharge. Upon discharge Apixaban (Anticoagulant (clot prevention-blood thinner) 2.5 mg (milligram) BID (twice a day) will be given until 05/20/2026 to finish her 30-day DVT (Deep Vein Thrombus (blood clot)) prophylaxis post hip surgery. Percocet q4 (every four hours) PRN (as needed) for pain. Hip precautions must be followed for at least 3 (three) months. Apixaban 2.5 mg last time was given 04/28/2026 at 8:12 AM and Zanaflex (muscle relaxer) 4 mg last time given was 04/28/2026 at 3:26 PM. Orders noted for Oxycodone-Acetaminophen 5-325 mg (Percocet (pain medication)) ordered 1 (one) tablet every 4 (four) hours as needed for pain. A record review of the Initial Authorization Insurance form for Resident A revealed the admission date of 04/28/2026 and length of stay approved to 05/04/2026. A record review of the Admission/Discharge To/From Report from 04/27/2026 through 05/01/2026 revealed Resident A was not listed. On 07/21/2026 at 10:10 AM, during an interview and record review, the Business Office Manager reported that the only information she could locate for Resident A was the initial hospital referral sent to the facility, which included an encounter date of 04/19/2026 but no discharge date . She provided the facility's admission/discharge log for the period of 04/27/2026 through 05/01/2026, which did not include Resident A. The Business Office Manager stated she remembered Resident A was expected to be admitted on [DATE] and that the planned admission was discussed during the facility's morning stand-up meeting with department heads and the Administrator. She also provided the admission approval documentation for Resident A, which showed an approved admission date of 04/28/2026 with authorization through 05/04/2026. On 07/21/2026 at 3:04 PM, during an interview, the former Director of Nursing (DON), who was serving as the DON at the time of the incident, stated she was aware of the incident involving Resident A, who arrived at the facility following surgical repair of a left hip fracture but was not admitted upon arrival or administered physician-ordered medications. The former DON reported that she, the nurse in charge, and the admission Coordinator had left for the day after instructing the 7:00 PM lead nurse, a Licensed Practical Nurse (LPN), to enter Resident A's information into the computer and complete the admission process. She confirmed Resident A was never admitted into the electronic medical record, no admission assessments were completed, and no admission paperwork was signed. The former DON described the incident as neglect by the facility and that she had reprimanded the staff the following day; however, she could not recall what corrective or disciplinary action was taken because the incident had occurred so long ago. On 07/21/2026 at 3:50 PM, during an interview, the Administrator reported he remembered the day Resident A was scheduled to be admitted after the charge nurse and Director of Nursing (DON) had (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	left for the day. He stated he remained at the facility until approximately 5:00 PM, saw Resident A arrive, and thought nothing further about the admission. He reported seeing Resident A's admission folder at the nurses' station but stated the folder was never located after that night. The Administrator reported the 7:00 PM Licensed Practical Nurse (LPN) was expected to complete the admission process. He stated he learned of the incident the following morning after the hospital called the facility to inquire about Resident A. The Administrator reported he spoke with the LPN responsible for entering Resident A into the electronic medical record about the incident. He stated he was not aware of any investigation or disciplinary action involving staff and did not report the incident as neglect because he believed the LPN's actions were the result of poor prioritization rather than intentional neglect. The Administrator reported the LPN believed passing medications was a higher priority than admitting Resident A. On 07/23/2026 at 9:10 AM, during a telephone interview, Resident A reported she sustained a hip fracture and underwent surgery on 04/19/2026. She stated she required rehabilitation services and her insurance approved placement at the facility. Resident A reported that the hospital informed her the facility had accepted her for admission and all admission paperwork had been faxed from the hospital to the facility at approximately 2:30 PM on 4/28/26. She stated physical therapy instructed her she only needed a rolling walker and could travel by private vehicle, so her brother transported her to the facility, arriving at approximately 4:30 PM on 4/28/26. Resident A reported a staff member brought a wheelchair to the vehicle and assisted her into the facility. As she was taken to her room, she attempted to give staff her admission paperwork but was told the person who completed admissions had already left for the day and she would have to wait until the following morning. She stated the bed was pushed against the wall and did not appear to be completely made, and no staff member assisted her with transferring into bed. Her brother assisted her into bed and left approximately 30 to 40 minutes later. Resident A reported she requested a walker but was told she could not receive one until she had been admitted. She stated she used the wheelchair to take herself to the bathroom because no staff assisted her. Resident A reported she experienced excruciating pain that caused nausea, observed other residents being served dinner, but did not receive a meal until approximately one and one-half hours later. She stated the meal was provided in a to-go container, appeared to have come from other residents' trays, and she was unable to eat it. Resident A reported she requested Tylenol for pain but was told she could not receive any medications. She stated she repeatedly attempted to contact her brother and sister-in-law to pick her up but was unsuccessful. She then posted about the situation on social media, and a neighbor contacted her after seeing the post. Resident A reported she informed staff her neighbor was coming to pick her up and requested the neighbor be allowed into the building. She stated a staff member told her they did not blame her for leaving. Resident A reported she left the facility with her neighbor at approximately 1:45 AM on 4/29/26. She stated the following morning the former Director of Nursing (DON) called, apologized, and asked her to return to the facility. Resident A reported she declined to return, after which the former DON ended the conversation. She also stated the Administrator called and apologized for the incident. On 07/23/2026 at 10:35 AM, during a telephone interview, the Medical Director reported he was not aware of the incident involving Resident A, who had been accepted for admission, arrived at the facility, and did not have the admission process initiated or receive necessary care and services. He stated these actions were not acceptable resident care and that he could not believe the incident had (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	occurred. The Medical Director reported he expected all residents accepted for admission to have the admission process initiated and receive necessary care and services, including medications and assistance. On 07/23/2026 at 10:50 AM, during a telephone interview, Resident A's brother confirmed he transported Resident A from the hospital to the facility, arriving at approximately 4:30 PM. He reported a person leaving the building obtained a wheelchair for Resident A. He stated Resident A wheeled herself into the facility while he carried her belongings. Upon arriving at the nurses' station, Resident A attempted to give staff her admission paperwork but was told the person who completed admissions had already left for the day and she would have to wait until the following day. He reported the bed assigned to Resident A was against the wall in a semi-private room, had not been made, and staff had to locate a pillow before she could get into bed. He stated no staff assisted Resident A into bed. Resident A's brother reported he remained at the facility for approximately 30 to 40 minutes before leaving. At that time, staff were serving dinner and assisting other residents. He reported he missed several telephone calls from Resident A later that evening and felt terrible after learning what had occurred because he believed things would improve once staff had finished serving the evening meal. On 07/24/2026 at 10:20 AM, during an interview, the admission Coordinator reported her responsibilities included marketing for the facility and that she typically left before the end of the day. She reported Resident A arrived after business hours after she had already left the facility. The admission Coordinator explained that referrals are received electronically and are seldom faxed. Once a referral is received, she distributes the information to the clinical team, including the Director of Nursing (DON), Administrator, and Business Office Manager. She reported the Business Office obtains insurance authorization, and once approval is received, she notifies the referring facility that the resident has been accepted for admission. She explained admission paperwork is normally completed and signed on the day of admission. However, because she did not know what time Resident A would arrive, she planned to complete the admission paperwork the following day, but the admission was never completed. She stated completing the admission paperwork the day after arrival was not the usual practice but could occur occasionally. A record review of the facility's Punched In and Out time reports for 04/28/2026 revealed the Director of Nursing (DON) clocked out at 3:00 PM, prior to Resident A's arrival at approximately 4:30 PM. The staffing records also showed licensed nursing staff were on duty throughout Resident A's stay at the facility, including Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) during both the evening and overnight shifts. Despite the presence of licensed nursing staff, Resident A was not admitted into the facility, no admission assessments were completed, and no admission paperwork was initiated. Resident #23 On 7/23/26 at 9:25 AM, the Administrator called the hotline at the State Agency (SA) and reported an allegation of verbal abuse regarding Resident #23. The Administrator notified the survey team of the report to the SA. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/23/2026 at 11:27 AM, during an interview, Resident #23 revealed that at approximately 5:00 AM this morning (7/23/26), two (2) Certified Nursing Aides (CNAs) entered his room to help him get dressed. The resident stated that he tried to explain to the CNAs that he wanted his weak arm to go through the sleeve first, then his head and then his other arm. The resident reported that CNA #1 started cussing him and said, I'm not going to have this (expletive) out of you this morning and I have to go through this with you every morning. The resident stated he told CNA #1 that she doesn't have him every morning and reported that CNA #2 was standing and watching everything that occurred. The resident explained that he felt nervous and that he clinched his fist. The resident confirmed he waited until the Social Services Director (SSD) arrived to work and he went to her office to report the incident. On 07/23/2026 at 11:48 AM, during an interview with the Administrator he revealed the resident reported to him that two (2) CNAs came into his room to help him get dressed and he tried to tell them how he wanted his shirt put on. The Administrator noted that this is when CNA #1 started cussing him. The Administrator stated the resident told him the CNA #1 said, I don't have time for this (expletive). The Administrator stated that both CNAs have been suspended pending investigation. On 07/23/2026 at 12:26 PM, during an interview with CNA#1 she revealed that Resident #23 would get aggressive with her every morning. CNA #1 recalled that she and CNA #2 entered the resident's room at approximately 6:00 AM to put on the resident's clothes. CNA #1 noted that she put the resident's arm in the sleeve and he swung at her and he said she was putting his shirt on wrong. CNA #1 attested that she told the resident she was just there to help him and the resident started cussing her and stated, Y'all (expletives), I can do what I want to do. CNA #1 confirmed that she asked the resident why he tried to hit her because she was trying to help him and that nothing was good enough for him. CNA #1 reported that as she finished, CNA #2 left the room, and the Human Resources Director (HRD) was outside the resident's room door. The HRD asked why she was cussing the resident, and CNA #1 replied that she was not cussing him, but that he was cussing her. CNA #1 stated her shift ended; she left the facility and received a voicemail from the HR Director that she would be suspended until further notice. CNA #1 revealed that the resident has a history of talking badly to the staff. On 07/23/2026 at 12:40 PM, during an interview, CNA #2 revealed at around 6:00 AM or 7:00 AM she went into Resident #23's room with CNA #1 because she asked for help due to the residents' aggression with staff. CNA #2 noted that she stood at the door to observe as CNA #1 helped the resident get dressed. CNA #2 reported that when CNA #1 put the resident's shirt on, he pulled away and told her that she put the clothes on rough. CNA #2 stated the resident told CNA #1, You aint got to do (expletive) for me. I can do it on my own. Ya'll don't do nothing right. CNA #2 stated she left the room first and saw the HRD standing outside the door. CNA #2 revealed the HRD asked her if there is any reason she and CNA #1 were cussing. CNA #2 noted that she left the facility at the end of her shift and received a call from the HRD stating that she was suspended pending an investigation. CNA #2 stated that Resident #23 was repeatedly inappropriate with staff. On 07/23/2026 at 12:50 PM, during an interview, the HRD revealed that approximately 6:15-6:30 AM she was on the floor helping a resident when she was flagged down by a housekeeper to come to the resident's room. The HRD reported that the housekeeper told her that a CNA was cussing in the room. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the LPN Medical Records Nurse verified all Medications were available and administered as ordered. On 7/23/26 at 4:00 PM, The RN Unit Manger verified pain assessments were completed. 3. On 7/23/26 at 5:00 PM, the Facility Administrator implemented an admission Nurse Assignment. Every admission is assigned by the Director of Nursing Services to a specific licensed nurse before the resident arrives. The Licensed Nurse is responsible for the initial assessment, medication reconciliation, physician order implementation, pain assessment, admission documentation, physician communication, and shift handoff. 4. On 7/23/26 at 5:00 PM, the Facility Administrator implemented an admission checklist, which includes admission assessment, skin assessment, pain assessment, medication reconciliation, pharmacy notification, physician orders, medication administration, vital signs, fall precautions, toileting needs, and family notification. The checklist will be reviewed by the Director of Nursing Services, the RN Unit Manager, the Facility Administrator, and the RN Minimum Data Set (MDS) Coordinator before the admission process is considered complete. 5. On 7/23/26 at 5:00 PM, the facility Administrator implemented an admission Acceptance Process. Before accepting any admission, regardless of the time of day, the facility verifies that physician orders have been received and reviewed, a specific licensed nurse has been assigned responsibility for the admission, prescribed medications are available or can be obtained and administered without unnecessary delay. If these requirements cannot be met, the facility will not accept responsibility for the residents until the resources necessary to provide safe care are available. 6. On 7/23/26 at 5:30 PM, education was conducted by the RN Unit Manager. 8 Licensed Practical Nurses, the Admissions Coordinator, the LPN Medical Records Nurse, and the Wound Care LPN received education regarding admission responsibilities, physician order implementation, medication administration, pain management, documentation requirements, and the escalation process for barriers to care. No employee will work until he or she has attended this education and/or in-service. In addition, an Abuse/Neglect in-service was conducted by the Facility Administrator on 7/23/26 at 6:00 PM, totaling 32 staff members received education. No employee will work who hasn't attended the Abuse/Neglect in-service. 7. An emergency Quality Assurance and Performance Improvement (QAPI) Meeting was held on 7/23/26 at 6:00 PM, to review policies on admissions, resident care, and medication administration. No changes were made to the policies. In attendance was the Facility Administrator, RN Unit Manager, LPN Medical Records Nurse, and the Medical Director by telephone. The Facility alleges all actions were completed to remove the immediacy on 7/23/26 and the Immediate Jeopardy was removed on 7/24/26. Validation: The SA validated the removal plan through observations, interviews, and record reviews on 07/27/2026 and the immediacy was removed on 07/24/2026 prior to exit.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to provide sufficient nursing staff with the appropriate competencies and skill sets to meet residents' assessed needs, resulting in delays in providing incontinent care for two (2) of (18) residents reviewed for Activities of Daily Living (ADLs). Residents #10 and #34. This deficient practice had the potential to affect all residents residing in the facility who depended on staff for nursing care and assistance with activities of daily living. Findings Include: A review of the facility's policy, Nursing Services and Sufficient Staff, revised 2/19/26, revealed, .Policy: it is the policy of the facility to provide sufficient nursing staff with appropriate competencies and skill sets to assure resident safety and attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individualized plans of care. A review of the facility's Facility Assessment, dated 6/25/26, revealed the facility identified staffing needs based on resident census, acuity, admissions, discharges, infection prevention needs, and resident outcomes. The assessment documented an average daily census of 72 residents with staffing resources consisting of two (2) Registered Nurses (RN), five (5) Licensed Practical Nurses (LPN), and thirteen (13) Certified Nursing Assistants (CNA). Cross Reference: F727 The facility failed to ensure the services of a Registered Nurse (RN) were provided for at least eight (8) consecutive hours a day, seven (7) days a week, and failed to employ a full-time Director of Nursing (DON) to supervise the nursing services of the facility for three (3) of (3) months reviewed for staffing (May through July 2026), reducing nursing supervision, clinical oversight, and continuity of nursing care. Resident #34A record review of Resident #34's admission Record revealed the resident admitted to the facility on [DATE] with diagnoses including Morbid Obesity, Urgency of Urination, Generalized Muscle Weakness, and Need for Assistance with Personal Care. A record review of Resident #34's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 7/7/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. A review of Section H revealed the resident was always incontinent of bowel and bladder. A record review of the Care Plan Report revealed a focus for bowel and bladder incontinence related to overactive bladder with interventions including, clean peri-area with each incontinent episode. An additional focus for ADL self-care performance deficit related to morbid obesity and limited mobility with interventions including required assistance of two (2) staff for toileting and toileting hygiene. On 7/20/26 at 10:00 AM, Resident #34 was observed lying in bed in a visibly saturated incontinent brief with a strong urine odor. The resident stated staff had not responded to the requests for assistance. The resident's family member reported the resident had been wet since approximately 8:00 AM. Resident #34 stated there was no Certified Nursing Assistant (CNA) assigned to the hall. On 7/20/26 at 11:00 AM, Resident #34 remained in the same saturated brief. No staff had provided incontinent care. On 7/20/26 at 11:56 AM, CNA #5 acknowledged the resident required changing but reported staff had been busy providing morning care and she had just been called in to work. On 7/20/26 at 12:15 PM, RN #5 confirmed there had been no CNA assigned to that hall until approximately 11:56 AM and stated residents requiring incontinent care should receive assistance promptly. Resident #10A record review of Resident #10's admission Record revealed the resident admitted to the facility on [DATE] with diagnoses including acquired absence of the left leg below the knee and end-stage renal disease. A record review of Resident #10's Quarterly MDS with ARD 7/2/26 revealed a BIMS score of 15, indicating intact (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Arabella Health & Wellness of Meridian		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 28th Avenue Meridian, MS 39301	
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognition. Review of Section H revealed the resident was always incontinent of bowel. A record review of Resident #10's Care Plan Report revealed a focus for ADL self-care performance deficit related to amputation left BKA (below the knee amputation) with interventions including the resident requires assistance of one (1) staff for toileting and hygiene needs. On 7/20/26 at 10:35 AM, Resident #10 activated the call light requesting assistance with incontinent care. On 7/20/26 at 11:45 AM, the call light remained on. Resident #10 reported remaining in a bowel movement-soiled incontinent brief for over one hour, causing discomfort. On 7/20/26 at 12:30 PM, CNA #1 acknowledged the resident had been waiting for assistance and reported staffing shortages delayed incontinent care because she had just been called in to assist on the hall. On 7/20/26 at 12:15 PM, Registered Nurse (RN) #5 reported four (4) CNAs called in that morning. She reassigned two restorative CNAs, the transportation aide, and called in one additional CNA; however, one hall remained without CNA coverage until additional staff arrived. Registered Nurse (RN) #5 stated she frequently had difficulty obtaining staff, often worked double shifts, and staffing shortages occurred regularly. On 7/21/26 at 9:30 AM, the Local Ombudsman reported receiving complaints from facility staff regarding mandatory double shifts because relief staff were unavailable. The Ombudsman stated she discussed staffing concerns with the Administrator and Director of Nursing and informed them she would report the staffing shortages to the State Agency. On 7/21/26 at 10:00 AM, the Scheduler confirmed the facility frequently experienced staffing shortages, numerous employee call-offs, and several days without RN coverage. The Scheduler reported she had no additional staff available to call in and that the facility did not utilize agency staff. On 7/22/26 at 3:04 PM, the former Director of Nursing (DON) stated she resigned on 5/19/26 because the facility did not have sufficient staff to meet resident needs. She reported frequently working as floor staff, including weekends, and stated the company would not allow the use of agency nursing personnel despite staffing shortages. On 7/24/26 at 12:37 PM, Licensed Practical Nurse (LPN) #1 confirmed the facility experienced ongoing staffing shortages and stated it was difficult to provide resident care when sufficient staff were unavailable. The nurse stated staff do the best they can. On 7/24/26 at 12:45 PM, the DON acknowledged she worked 32 hours per week. The DON acknowledged the facility continued to experience staffing shortages, and stated efforts were underway to recruit additional nursing staff. On 7/24/26 at 12:53 PM, the Administrator confirmed the facility had multiple staffing shortages, difficulty recruiting and retaining staff, frequent weekend call-offs, significant CNA turnover, and resident acuity that exceeded available staffing resources. The Administrator acknowledged the facility did not have sufficient nursing staff to consistently meet resident needs.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the medication error rate was five (5) percent (%) or less for three (3) of (35) medication opportunities. Medication error rate of 8.57% Findings Include: A review of facility policy titled, Medication Administration revised on 2/19/26, revealed, Policy: Medications are administered by licensed nurses.as ordered by the physician and in accordance with professional standards of practice .Policy Explanation and Compliance Guidelines.24. Correct any discrepancies and report to nurse manager.Resident #15On 07/22/26 at 9:31 AM, during a medication pass observation, Licensed Practical Nurse (LPN) #4 prepared medications for Resident #15. During medication preparation, the State Agency (SA) and LPN #4 identified that Linzess, Sulfasalazine, and Folic Acid were unavailable for administration. LPN #4 stated she would contact the pharmacy to determine the status of the medications. LPN #4 administered the remaining scheduled medications but did not administer Linzess, Sulfasalazine, or Folic Acid as ordered because the medications were unavailable.A record review of Resident #15's Medication Administration Record (MAR) dated 07/22/26 revealed code 11 was documented for Linzess, Sulfasalazine, and Folic Acid. The MAR legend identified code 11 as Held due to ordered parameters.A record review of Resident #15's Progress Notes dated 07/22/26 at 11:40 AM revealed the three medications remained pending from the pharmacy.A record review of Resident #15's Order Listing Report failed to identify physician orders or parameters for Linzess, Sulfasalazine, or Folic Acid to be held on 07/22/26. Review of the medical record revealed the medications were unavailable because they had not been supplied by the pharmacy and not because physician-ordered parameters existed to withhold administration.A record review of Resident #15's Order Summary Report revealed active physician orders for . folic acid tab 1 mg (milligram) give 1 tablet orally one time a day related to iron deficiency anemia, order date 3/23/26, Linzess Oral Capsule 72 mcg (microgram) give 1 capsule by mouth one time a day every other day related to Mixed Irritable Bowel Syndrome, order date 5/5/26, and Sulfasalazine tab 500 mg give 1 tablet orally two times a day related to Rheumatoid arthritis, order date 3/23/26 .On 07/23/26 at 10:05 AM, during an interview, LPN #4 stated she did not obtain a physician's order regarding the unavailable medications because she had been instructed to contact the pharmacy to verify when the medications would be available. LPN #4 acknowledged documenting code 11 on the MAR, indicating the medications were held due to ordered parameters. LPN #4 confirmed there were no physician orders or parameters for the medications to be held. LPN #4 further confirmed she did not notify the physician or Resident #15 that the medications were unavailable.On 07/23/26 at 10:20 AM, during an interview, Resident #15 stated she received all of her medications that morning. She further stated she had not been informed the previous day that three of her prescribed medications were unavailable and had not been administered.A record review of Resident #15's admission Record revealed the facility admitted the resident on 06/15/2025 with diagnoses including Other Rheumatoid Arthritis with Rheumatoid Factor of Unspecified Site, Mixed Irritable Bowel Syndrome, and Iron Deficiency Anemia, Unspecified. A record review of Resident #15's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/06/2026 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating cognition intact. On 07/23/26 at 4:00 PM, during an interview, the Administrator stated all physician orders are entered electronically, and the facility does not maintain paper physician orders. The Administrator stated he expected medications to be administered as ordered and staff to follow facility policy when medications were unavailable, including obtaining physician direction when medications could not be administered.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure controlled substances were securely stored and accessible only to authorized personnel for one (1) of (4) medication storage areas reviewed (Director of Nursing's office). Narcotic medications were left unsecured in the Director of Nursing's office, allowing an unauthorized maintenance employee to access, remove, and destroy controlled substances. Findings include: A review of the facility's policy, Medication Storage, revised [DATE], revealed, .Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biological will be stored in locked compartments. b. Only authorized personnel will have access to the keys to locked compartments. 2. Narcotics and Controlled Substances: a. Schedule II drugs and back-up stock of Schedule III, IV and V medications are stored under double-lock and key. A record review of the facility's Reportable Incident Form reported by the facility to the State Agency included a Brief description of what happened as On [DATE], 2 members of Nursing Services entered into the Director of Nursing Services (DON) Office to recover some narcotics that were held in a sealed drawer. The 2 Nurses stated they were informed by the former DON of the location of the narcotics. The 2 Nurses stated that when they walked into the office, they found the drawer containing the narcotics, but the seals were broken that had been placed over the drawer. According to the nurses, they immediately called the former DON to verify what the contents of the drawer should be. The former DON informed the nurses there were several bubble packs of narcotics along with 1 bottle of morphine, 2 boxes of fentanyl patches and 20 narcotic administration sheets. According to the 2 nurses, the bubble packs were not in the drawer nor were the bubbles packs accounted for. According to the 2 nurses, after their conversation with the former DON, they went to the Human Resources Manager to initiate an investigation into this matter. The 2 nurses then stated it was discovered that (Proper Name), Maintenance Tech, had been cleaning out the office during the day. Under suspicion (Proper Name) was called into the HR Office to discuss if he had any information concerning the seals being broken on the drawer and possibly having knowledge of the missing bubble packs of narcotics. (Proper Name) stated that he took the drugs out of the sealed drawer across the street to the adjoining office building and destroyed the narcotics and placed them into the garbage dumpster. When asked if he knew that he was not to touch medications of any type, especially narcotics, (Proper Name) said I did not know that wasn't supposed to do that. I was only doing what I was told to do by the former DON. the HR Manager walked over to the dumpster to visually see or physically find any medications that might be in the dumpster. The HR Manager did find medications in the dumpster and retrieved what she could. Some of the medications appeared to have the liquid used to destroy narcotics on them. The number of narcotics that had been thrown into the dumpster is unknown because there is no accounting for them or inventory for them. A record review of a signed statement by Licensed Practical Nurse (LPN) #1, dated [DATE], revealed, At approximately 1330 (1:30 PM) on Wednesday, [DATE], entered the office of former DON. to recover some narcotics that were placed in a secured, sealed drawer in the office per former DON instruction; the medication had either expired, order changed, and or the patient had transitioned. A record review of a handwritten statement from the Maintenance Tech, unsigned and undated, revealed, I. was told to destroy any all (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medicine that was not any good or that was expired up in the DON office. (Proper name of former DON) was who told me to get rid of it. Not known that a nurse or pharmacy has to be there to look or make sure that it was done. I was told to do it and that was what I did. When I saw the drawer no tape was on it. On [DATE] at 1:14 PM, during an interview the Administrator confirmed narcotic medications were expected to remain secure and accessible only to authorized personnel. The Administrator acknowledged an unauthorized employee gained access to the medications because they were being stored in the DON's office in her desk drawer. He confirmed the facility could not verify that all medications removed from the office had been recovered. On [DATE] at 2:00 PM, during an interview the Human Resources (HR) Director, reported Licensed Practical Nurse (LPN) #1 and LPN #6 notified her that the Director of Nursing (DON) instructed them by text message to retrieve narcotics stored in the bottom drawer of the DON's office and place the medications back to the medication carts. The HR Director reported the nurses discovered the tape seal securing the drawer had been broken and the drawer was unlocked. The HR Director stated the Maintenance Assistant had been cleaning DON's office earlier that day. When questioned, the Maintenance Assistant admitted removing the medications from the drawer and stated the DON instructed him to empty the office and destroy the medications. The HR Director reported the Maintenance Assistant was immediately suspended pending investigation. The HR Director further reported the DON sent a text message to the administrative staff at approximately 6:15 PM on [DATE] notifying them that she had resigned effective immediately. On [DATE] at 2:15 PM, during an interview with LPN #1, the nurse reported she received a text message from the DON instructing her and LPN #6 to retrieve narcotics from the bottom drawer of the DON's office and reconcile the medications to the medication carts. LPN #1 reported upon entering the office they observed the tape seal had been broken and the drawer was unlocked. LPN #1 reported the drawer contained two boxes of fentanyl patches, one bottle of morphine, and approximately (20) narcotic accountability records. LPN #1 stated there were no bubble-packed controlled medications in the drawer. The nurse reported she contacted the DON, who stated there should have been (14) bubble-packed medications stored in the drawer. On [DATE] at 2:30 PM, during an interview with the Business Office Manager (BOM), the BOM reported she and the HR Director searched for the discarded medications. The BOM reported recovering routine medications, narcotic medications, inhalers, vials, liquid medications, and damaged bubble-pack medications that had been saturated with an unidentified cleaning solution. The BOM stated several medication packages were no longer legible and confirmed the facility was unable to determine whether all medications had been recovered. On [DATE] at 2:46 PM, during an interview with LPN #6, the nurse confirmed the DON instructed LPN #1 by text message to retrieve the narcotics from the office and place them to the medication carts. LPN #6 reported when they entered the office, the tape seal on the drawer had been broken and the drawer was unlocked. LPN #6 confirmed the drawer contained only two boxes of fentanyl patches, one bottle of morphine, and approximately (20) narcotic accountability records. The nurse confirmed the bubble-packed medications were missing and reported notifying the HR Director and Administrator immediately. LPN #6 further reported observing the Maintenance Assistant cleaning the DON's office earlier that day. On [DATE] at 3:04 PM, during an interview with the former DON acknowledged controlled substances had been stored in her office and confirmed the Maintenance Assistant was not authorized to access, handle, transport, or destroy narcotic medications. She denied that she had asked him to destroy the medications. On [DATE] at 3:15 PM, during an interview with the Maintenance Tech, he acknowledged removing medications from the DON's office, pouring cleaning solution over the medications, and discarding the medications into the facility dumpster. He stated the DON had asked him to destroy the medications. On [DATE] at (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:45 PM, during an interview with the Consultant Pharmacist, the pharmacist reported controlled substances must remain secured in locked medication storage areas and accessible only to authorized personnel. The pharmacist reported that unauthorized access or destruction of controlled substances placed residents at risk for medication diversion, medication loss, interruption of prescribed therapy, and inability to account for controlled substances.		