STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255185	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indianola Rehabilitation and Healthcare Center	401 Highway 82 West Indianola, MS 38751

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to ensure that a resident's call light was within reach, which limited the ability to request assistance as needed for two (2) of three (3) survey days. Resident #14 Findings include: Review of the facility policy titled Answering the Call Light with a revision date of September 2022 revealed 5. Ensure that the call light is accessible to the residents . An observation and interview with Resident #14 on 4/22/25 at 11:00 AM, revealed the resident sitting on the side of her bed. Her call light cord was hanging from the wall by the foot of her bed and laying on the floor. The call light was not in reach. Resident #14 revealed, I can't reach it, they don't put it up here where I can. It's always hanging down there. An observation on 4/22/25 at 12:05 PM, and again at 3:09 PM, revealed the call light remains hanging from the wall, inaccessible to the resident An observation and interview on 4/23/25 at 8:25 AM, revealed the call light hanging from the wall, inaccessible to the resident. Resident #14 revealed the call light has been there all night, stating I guess they think I don't need my call button where I can reach it. During an interview and observation on 4/23/25 at 10:25 AM, Certified Nurse Aide (CNA) #2 confirmed Resident #14's call light was on the floor and inaccessible. She revealed the call light should have been placed on her bed where she could reach it. She stated, we are always supposed to make sure each resident's call light is where they can reach it. In an interview on 4/23/25 at 10:30 AM, the Assistant Director of Nurses (ADON) confirmed that staff are expected to ensure call lights are always within residents' reach so they can request assistance. This is important for residents' safety and care. During an interview on 4/24/25 at 8:40 AM, the Administrator confirmed that all residents are supposed to always have a call light accessible to them. A review of Resident #14's Admission Record revealed she was admitted to the facility on [DATE] with diagnoses that include Osteoarthritis, Anxiety Disorder, and Convulsions. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1-21-2025 revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident is cognitively intact.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 47874 Based on resident and staff interviews, record review, and facility policy review, the facility failed to promptly resolve resident grievances related to food quality and temperature for five (5) of nine (9) residents attending the Resident Council meeting. Residents #11, #14, #21, #25, and #46 Findings Include: Review of the facility policy titled Filing Grievances/Complaints, revised 6/2024 revealed under, Policy Statement: Our facility will assist residents, their representatives (sponsors), other interested family members, or advocates in filing grievances or complaints when such request are made . An interview with Resident #21 (Resident Council president) on 4/22/25 at 10:55 AM revealed they (the residents) have been discussing concerns with the food quality and temperature (cold food) in the previous monthly meetings. During a Resident Council meeting held on 4/22/25 at 2:45 PM, Resident #11, #14, #21, #25, and #46 all agreed the main concern from the previous council meetings was the food and continued to be an ongoing problem. The residents verbalized the food was not good, and Resident #14 stated, It's garbage. Resident #11 stated, We may have one good meal once or twice a week. She explained that the vegetables were always mushy and overcooked. All the residents said they had discussed the food concerns in the Resident Council and also in the monthly food committee meeting. They verbalized that nothing gets done about it. Resident #14 revealed the dietary manager asked her about the food, and she told her, It's terrible. Residents #11 and #25 revealed they would like more variety of foods and explained the facility serves the same thing over and over. Resident #11 explained that they get too many carbohydrates in a day and sometimes get mashed potatoes and french fries at the same meal. She revealed the french fries were always served cold. She stated, The cold foods are not cold, and the hot foods are not hot. Furthermore, she revealed they were served tea with no ice and stated, I just try to eat enough to live. The residents verbalized they would like more tacos and stated they had discussed this with dietary, but this had not been implemented. Resident #46 revealed he used to get a sandwich for supper, and he liked that, but the facility cut that out. Resident #21 (Resident Council president) stated, The Easter Sunday meal was good, but we only have one Easter a year. He explained that all the other meals were poured out of a can. He stated, These people can't cook. They all agreed they would like to have more fresh fruit and vegetables. Resident #21 revealed that he had suggested having a CNA (certified nurse aide) that floated on the hall to help deliver trays faster. He explained that he believed the food was getting cold because staff got delayed in the rooms. Record review of the Resident Council Minutes dated 1/07/25, 2/03/25, 3/03/25, and 4/07/25 revealed there was no documentation regarding resident food complaints. An interview with the Activities Director (AD) on 4/23/25 at 8:10 AM revealed the residents had told her in previous Resident Council meetings the food was not good, and they were not satisfied. She revealed that she went and got the dietary manager to come and talk to the residents. She explained that she did not write anything up on the food complaints and allowed the dietary manager to write up the residents' concerns in her notebook. The AD revealed she was not aware of what the dietary department had done about the complaints. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Food Committee Meeting Minutes dated 12/27/24 revealed under, How can we improve your dining experience? Change the menus to something interesting was indicated. Documentation lacked details identifying which residents made complaints or what actions were taken to address the concern. Record review of the Food Committee Meeting Minutes dated 2/28/25 revealed under, What would you like to see instead? Less mashed potatoes, more diced potatoes were indicated. Documentation lacked details identifying which residents made complaints or what actions were taken to address the concern. Record review of the Food Committee Meeting Minutes dated 3/28/25 revealed under, What would you like to see instead? Fresh fruits and vegetables were documented. Also revealed under, Are foods served at the proper temperature? No was indicated with additional comments, Resident asked could the facility purchase a heating cart. There was a lack of documentation to identify the residents that made complaints or what actions were taken to resolve the issues that were discussed. An interview with the Administrator (ADM) on 4/23/25 at 12:15 PM revealed she was aware of some food concerns. She explained the residents wanted more of a variety of potatoes, so the kitchen has been changing up and doing roasted potatoes, au gratin potatoes, and others. She revealed that at one time the residents were complaining about the vegetables being too soft. The ADM explained that she went to the kitchen and found that staff were cooking the vegetables around 9 to 10 in the morning and then placed them on the steam table until they were served. She revealed they had tried multiple things to fix Resident #21's food concerns and tried to focus on what he liked. The ADM stated, I understand they all like different things. She confirmed she was aware of the complaints regarding cold food from time to time. An interview with the Dietary Manager (DM) on 4/23/25 at 1:10 PM, revealed she goes to the monthly Resident Council meetings, and she has been writing down the resident food concerns. She explained that she documented the residents' concerns in a notebook and confirmed a grievance was not completed. She revealed they (the staff) did not have any documentation to prove the residents' food concerns were addressed or what action they took to correct and resolve their issues. An interview with the Regional Dietary Manager (RDM) on 4/23/25 at 2:30 PM revealed she knew the residents had complained about cold food in a previous Resident Council meeting. She revealed she was unsure why the food complaints were not written up as a grievance. She acknowledged they (staff) did not have a paper trail to track what was done to resolve the residents' complaints regarding food. An interview with the Administrator (ADM) on 4/24/25 at 8:44 AM confirmed that grievances should have been completed on the residents' food concerns so that all the staff were aware of the concerns and could work toward getting the concerns resolved. Record review of the Admission Record revealed the facility admitted Resident #11 on 10/03/24. Record review of the Brief Interview for Mental Status (BIMS) dated 4/17/25 revealed a summary score of 15, which indicated Resident #11 was cognitively intact. Record review of the Admission Record revealed the facility admitted Resident #14 on 7/03/20. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the BIMS dated 4/23/25 revealed a summary score of 15, which indicated Resident #14 was cognitively intact. Record review of the Admission Record revealed the facility admitted Resident #21 on 6/08/15. Record review of the BIMS dated 2/27/25 revealed a summary score of 15, which indicated Resident #21 was cognitively intact. Record review of the Admission Record revealed the facility admitted Resident #25 on 7/14/24. Record review of the BIMS dated 1/31/25 revealed a summary score of 15, which indicated Resident #25 was cognitively intact. Record review of the Admission Record revealed the facility admitted Resident #46 on 5/03/21. Record review of the BIMS dated 1/06/25 revealed a summary score of 15, which indicated Resident #46 was cognitively intact.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47158 Based on observation, staff interview, and facility policy review, the facility failed to provide a clean, home-like environment for one (1) of 68 resident rooms observed. Room A-21-W. Findings included: Record review of the facility policy, titled Cleaning and Disinfection of Resident-Care Items and Equipment reviewed 3/19/25 revealed Policy Statement, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Centers for Disease Control (CDC) recommendations . An observation on 4/22/25 at 10:50 AM, revealed that an oxygen concentrator was in use by the resident in room A-21-W. Three (3) dime-sized, light brown dried substances were visible on top of the concentrator, along with a two(2)-inch streak of a similar light brown substance down the front. During an interview with Housekeeper #1 on 4/22/25 at 1:01 PM, she stated that housekeepers do not clean any medical equipment currently in use by residents, as they are concerned about interfering with the device's settings. She further explained that the Nursing Department is responsible for cleaning the oxygen concentrator. In an observation of the oxygen concentrator in Room A-21-W and an interview with Registered Nurse (RN) #1 on 4/22/25 at 1:10 PM, she verified that the concentrator was soiled with formula from the resident's tube feeding. She stated that the concentrator should have been cleaned by nursing staff to prevent attracting pests, such as ants. In an interview with the Director of Nursing on 4/23/25 at 11:15 AM, she stated that it was her expectation that nursing staff would clean the oxygen concentrator if it became soiled.

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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** 52240 Based on observation, staff interview, record review, and facility policy review, the facility failed to implement a person-centered care plan for providing personal hygiene for two (2) of 30 sampled residents care plans reviewed. Resident #23 and Resident #62. Findings Include: Review of the facility policy titled Care Plans, Comprehensive Person-Centered, with a review date January 2023, revealed: 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 #23 Record review of the Care Plan Report for Resident #23 revealed: I require staff assist with Activities of Daily Living (ADL) self-care performance deficit r/t (related/to) Dementia with confusion/impaired mobility and cognition, contractures to extremities, last revised 3/14/25. Interventions listed included: Personal Hygiene . Nail care as needed. An observation on 4/22/25 at 10:45 AM, revealed Resident #23's fingernails were long, approximately one-half (1/2) inch in length, with a brown substance under every nail bed. An interview with the Minimum Data Set (MDS) Nurse, on 4/23/25 at 10:45 AM, confirmed that Resident #23's ADL care plan had not been implemented in relation to personal hygiene. She stated the purpose of the comprehensive care plan is to direct staff on the resident-specific care needed. An interview with the Director of Nursing (DON) on 4/24/25 at 8:34 AM, confirmed that staff did not follow Resident #23's the ADL care plan. Record review of the Admission Record revealed the facility admitted Resident #23 on 2/09/22 with medical diagnoses that included Dementia and Contracture, unspecified joint. Record review of Resident #23's MDS with an Assessment Reference Date (ARD) of 3/06/25 revealed Section GG-Functional Abilities coded Dependent for Personal Hygiene. Record review of Task: GG - Personal Hygiene form for Resident #23 from 4/10/25 through 4/22/25 revealed no documentation of refusals. 46013 Resident #62 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #62's Care Plan Report revealed, I require staff assist with ADL self-care performance deficit related to right side hemiparesis, with contracture to right arm, impaired mobility. Goal: I will be neat, clean, and odor-free each shift. Under Interventions, Bathing/Showering: Bath daily. Total dependent x (times)1 staff with bathing. Personal Hygiene . Total dependent x 1-2 staff with hygiene/grooming. An observation on 4/22/25 at 11:04 AM, and again at 3:21 PM, revealed Resident #62 with unkempt, slick-appearing hair. Her fingernails were approximately one-half (1/2) inch long, jagged, and with a brown substance underneath them. An observation on 4/23/25 at 8:31 AM, revealed Resident #62 lying in bed, no change in her personal hygiene status. During an interview and observation on 4/23/25 at 10:30 AM, the Assistant Director of Nurses (ADON) revealed that the nurses are responsible for trimming the residents' fingernails. She stated, I would say they are done once a month and as needed, but nothing is set in stone as to when it is to be completed. The ADON confirmed Resident #62's fingernails were long, jagged, and had a brown substance underneath them, and needed to be cleaned and trimmed. She revealed that the resident's hair looked greasy and needed to be washed and revealed that we expect each resident to be kept clean and presentable. During an interview on 4/23/25 at 10:40 AM, the DON confirmed that while nurses are responsible for trimming fingernails, the Certified Nurse Aides (CNA's) are expected to clean under the fingernails and notify nursing staff when trimming is needed. She acknowledged that all aspects of personal hygiene for Resident #62 should have been done, and if it was not, then her care plan was not followed. During an interview on 4/23/25 at 2:30 PM, the MDS Coordinator revealed she is responsible for developing the care plans for the residents, and they are individualized to address each resident's needs. She revealed Resident #62's ADL care plan addressed personal hygiene, which staff know includes her nail care and hair washing. She confirmed that if the resident was found to not be properly groomed and cared for, then her ADL care plan was not being followed, and it should have been. A record review of Resident #62's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Cerebral Infarction, Hemiplegia, Hemiparesis, and Dementia.

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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** 52240 Based on observation, staff interview, record review, and facility policy review, the facility failed to provide personal hygiene for two (2) of 30 sampled residents. Resident #23 and Resident #62. Findings Include: Review of the facility policy titled Activities of Daily Living (ADL), Supporting with a revision date of March 2018, revealed: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good grooming and personal hygiene . Resident #23 An observation on 4/22/25 at 10:45 AM revealed Resident #23's fingernails were approximately one-half (1/2) inch in length past the fingertip and each nail had a brown substance underneath. An observation on 4/23/25 at 10:37 AM revealed no change in Resident #23's fingernails. Record review of the Minimum Data Set (MDS) for Resident #23, with an Assessment Reference Date (ARD) of March 6, 2025, revealed Section GG-Functional Abilities coded Dependent for Personal Hygiene. An interview with Licensed Practical Nurse (LPN) #1, on 4/23/25 at 10:38 AM, confirmed that Resident #23's fingernails were too long and nasty. She stated it appeared they had not been trimmed or cleaned in a while and confirmed they needed to be. She revealed that improper nail care could lead to a break in the skin that could increase the risk of infection. An interview with the MDS Nurse on 4/23/25 at 10:45 AM, revealed, after reviewing the last 30 days of the Progress Notes for Resident #23, no documentation was found regarding nail care or refusals. Record review of the Progress Notes for Resident #23 revealed no documentation of refusals for personal hygiene care or nail care from dates 3/22/25 through 4/22/25. An interview with Certified Nursing Assistant (CNA) #1 on 4/24/25 at 8:30 AM, regarding Resident #23's fingernail care, revealed: He does not refuse any type of ADL care. An interview with the Director of Nursing (DON) on 4/24/25 at 8:34 AM revealed that the facility's expectation is for nursing staff is to keep Resident #23's fingernails trimmed and cleaned. Record review of the Admission Record revealed the facility admitted Resident #23 on 2/09/22 with medical diagnoses that included Dementia and Contracture, unspecified joint. 46013 Resident #62 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 11:04 AM and again at 3:21 PM, observations revealed Resident #62 with unkempt hair that had a wet appearance. Her fingernails were long and jagged, reaching approximately one-half (1/2) inch past the fingertips with a brown substance underneath. An observation on 4/23/25 at 8:31 AM revealed Resident #62 lying in bed with no change in appearance. During an interview and observation on 4/23/25 at 10:15 AM, CNA #2 revealed that she was responsible for giving Resident #62 her bed bath, which was supposed to include washing her hair and cleaning underneath her fingernails. She stated, I took a towel and went over the resident's hair this morning, but I did not wash her hair, and I tried to clean underneath her fingernails. She confirmed the resident had a brown substance under her fingernails and revealed that her hair was dirty, and she should have washed it. During an interview and observation on 4/23/25 at 10:30 AM, the Assistant Director of Nurses (ADON) confirmed Resident #62's fingernails needed to be cleaned and trimmed and her hair looked greasy and needed washing. She stated that it was her expectation that each resident would be kept clean and presentable. During an interview on 4/23/25 at 10:40 AM, the DON confirmed that all aspects of personal hygiene for Resident #62 should have been done. She revealed it is both the nurses and the CNA's responsibility. A record review of Resident #62's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Cerebral Infarction, Hemiplegia, Hemiparesis, and Dementia. A record review of the MDS Section GG- Functional Abilities with an ARD of [DATE], revealed the resident is Dependent for Personal Hygiene.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 47874 Based on observation, staff interview, and facility policy review, the facility failed to ensure a medication cart was kept locked and attended for one (1) of three (3) survey days. Findings Include: Review of the facility policy titled Storage of Medications unrevised, revealed under, Policy Statement: The facility stores all drugs and biologics in a safe, secure, and orderly manner. Additionally revealed, 9. Unlocked medications carts are not left unattended. On 4/22/25 at 10:11 AM and again at 1:20 PM, an unlocked medication cart was observed parked in front of the A Hall nurses' station with no staff nearby or in sight. An interview with Registered Nurse (RN) #1 on 4/22/25 at 1:28 PM, confirmed she left the medication cart unlocked and unattended. She revealed the cart should never be left unlocked and explained that a resident could get medication out and overdose. She acknowledged the facility had one wanderer on the hall that could get into the cart and take something. An interview with the Administrator (ADM) on 4/22/25 at 2:38 PM confirmed the medications carts must be locked anytime a nurse stepped away. She acknowledged the risk and revealed that anybody that wanted to take something from the cart could and stated, There is a large potential there for an incident to occur.