STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255207	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Community Living Center	4403 Hospital Road Pascagoula, MS 39581

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interviews, and facility policy review, the facility failed to ensure the residents' right to reside in a clean, comfortable, and homelike environment, as evidenced by dark-colored staining and residue on hallway vents and wall surfaces, damaged wall surfaces with paint scraped away exposing the underlying wall material, and recurring roof leaks for three (3) of six (6) halls. (Northeast, North Central, and South Central)Findings include:A review of the facility's policy, Resident Rights, dated 11/23/2016, revealed, .It is the policy of this facility to promote and protect the rights of the residents residing in this facility. Procedure. 3. The facility will make every effort to provide resident homelike environment.On 6/1/26 at 10:00 AM, during an observation of the facility, dark spot-like discoloration and residue were observed on vents and wall surfaces throughout the Northeast, North Central, and South Central hallways. Areas of wall damage were also observed with paint scraped away, exposing the underlying wall surface in Resident #31's room.On 6/1/26 at 11:10 AM, during an interview with Housekeeper #1 on the South Wing, she stated she had worked at the facility for three years and the roof had leaked intermittently during that time. She reported repairs were made to one area; however, water would subsequently leak from another location.On 6/1/26 at 11:20 AM, during an interview with Resident #70, the resident reported the ceiling leaked when it rained and staff placed barrels throughout the facility to collect water. The resident further reported water entered from the floor level causing portions of the flooring to buckle and expressed concern about falling due to the water intrusion.On 6/1/26 at 11:30 AM, during an interview with Resident #48, the resident reported observing roof leaks on multiple occasions near the north middle hall nurses' station and on the south middle hall. The resident reported observing dark-colored staining on ceiling and wall surfaces for several months and stated repairs were made to one area while leaks continued to occur in other locations. He stated he was concerned that that the discolored areas were mold caused by the leaking roof.On 6/1/26 at 1:00 PM, during an interview with Resident #93's family, he reported that the resident was no longer at the facility. He stated that during the latter part of April 2026, rain entered the facility through roof leaks. He reported staff placed barrels in the hallways to collect water and ceiling material was falling to the floor and being discarded by staff. On 6/2/26 at 9:00 AM, during an interview with the Activity Director, she reported the roof leaked intermittently and multiple repair attempts had been made; however, water continued to enter the building in different locations.On 6/2/26 at 10:30 AM, during an interview with Licensed Practical Nurse (LPN) 1, the nurse reported water leaked from the ceiling in the north hallways and staff routinely placed barrels in the hallways to collect water.On 6/2/26 at 1:00 PM, during an interview with the Maintenance Director, the director confirmed the roof had ongoing leaks. The director reported contractors had previously patched sections of the roof; however, water continued to leak from different locations. The director reported a licensed contractor had been contacted to provide an estimate for more extensive roof repairs, but work had been delayed due to weather conditions. The maintenance director also confirmed the paint was scrapped off the wall in Resident 31's room. The Director said he did not know the paint had been scraped off the wall. He had been really busy and had not had time to do environmental rounds.On 6/2/26 at 1:30 PM, during an interview with the Administrator, the (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator confirmed the roof had resumed leaking approximately two weeks earlier. The Administrator reported a licensed contractor had been hired and an invoice had been obtained for application of silicone coating to the roof in an effort to stop the leaks.On 6/2/26 at 3:00 PM, during an interview with the roofing contractor, the contractor confirmed he had previously performed patch repairs to the roof. The contractor reported patching was not effective in resolving the leaks and recommended application of a silicone roof coating. The contractor reported that the project was approved on 5/24/26 but had not yet been completed due to ongoing rain.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff interview, record review and facility policy review, the facility failed to provide written notification of a resident transfer to a resident or a resident's representative (RR) and failed to provide notification to the ombudsman for one (1) of three (3) closed records reviewed. Resident #93Findings include:A review of the facility's policy, Transfer or Discharge Notice, reviewed 04/10/2023, revealed, .Residents and/or representatives are notified in writing, and in a language and format they understand.Policy Interpretation and Implementation.4. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge.d. An immediate transfer or discharge is required by the resident's urgent medical needs.5. The resident and representation are notified in writing of the following information: a. The specific reason for the transfer or discharge . A record review of admission Record revealed the facility admitted Resident #93 on 4/14/26 with diagnoses including Metabolic Encephalopathy.A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/05/2026 revealed Resident #93 had an unplanned discharged with return anticipated to a short-term general hospital.A record review of the Emergency Transfer Log for the Office of the State Long-Term Care Ombudsman for May 2026 revealed Resident #93 was not listed as having transferred during the month, despite being transferred on 5/5/26.A review of the medical record for Resident #93 revealed there was no written notification of transfer indicating the details of the transfer to the hospital on 5/5/26.On 06/04/2026 at 10:49 AM, during an interview with the Social Services Director (SSD) she revealed that residents are not provided with a written notification of transfer to the hospital which includes a reason for the hospitalization. The SSD noted that the RR usually knows the reason for the hospitalization because the facility staff will call them. The SSD stated she is responsible for sending a monthly report of all emergency hospital transfers to the local Ombudsman.06/04/2026 11:29 AM, during an interview with the Ombudsman he confirmed that he received the Emergency Transfer Log for the Office of the State Long-Term Care Ombudsman from the facility on 06/02/2026. The Ombudsman noted that Resident #93's name was not included on the list that he received.On 06/04/2026 at 2:30 PM, during an interview with the Business Office Manager (BOM), she revealed that she is responsible for sending out the bed hold and transfer notifications to the resident or the RR at the time the resident leaves the facility for the hospital. She confirmed that there was no transfer notification that included the details of the transfer to the resident or the RR when Resident #93 was transferred to the hospital on 5/5/26. The BOM reported that the reason for providing the RR information in writing regarding hospitalization is to keep the RR informed of the care their loved one is receiving. On 06/04/2026 at 2:41 PM, during an interview with the Administrator she revealed that she was made aware by staff that no written notification of transfer was being provided to the resident or the RR at the time of transfer. The Administrator further confirmed she was made aware that the Emergency Transfer Log for the Office of the State Long-Term Care Ombudsman form for May 2026 did not contain Resident #93's name. The Administrator stated that there should be a space on the hospital transfer form for the reason for hospitalization, but the facility was not using the form. The Administrator noted that the reason for providing information regarding the reason for hospitalization in writing is to maintain communication with the families regarding what's happening with the resident. The Administrator reported that the Business Office Manager is responsible for sending the bed hold and transfer notices. The Administrator stated that the SSD is responsible for submitting a monthly report to the Ombudsman of emergency hospitalizations. The Administrator affirmed that she expects all communication to be completed regarding resident transfers to the hospital.

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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. Based on record review, staff interview, and the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, the facility failed to ensure a Minimum Data Set (MDS) assessment accurately reflected services received by a resident by coding dialysis as not received when the resident received dialysis during the assessment reference period, affecting one (1) of eighteen (18) sampled residents for MDS accuracy. (Resident #2).Findings include:A review of CMS's RAI Version 3.0 Manual revealed, .1.3 Completion of the RAI.It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during the observation period) . A record review of the admission Record revealed Resident #2 was admitted by the facility on 7/5/21 with current diagnoses including Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, End Stage Renal Disease, and Dependence on Renal Dialysis.A record review of the Order Summary Report revealed Resident #2 had a Physician's Order, dated 2/25/26 for dialysis on Monday, Wednesday, and Friday.A record review of the Significant Change In Status Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/1/26 for Resident #2 revealed Section O0110, Special Treatments, Procedures, and Programs, Item J1 (Dialysis) was coded No, indicating the resident had not received dialysis during the look-back period. The MDS also revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment.A record review of the Dialysis Transfer Assessment forms revealed Resident #2 attended scheduled dialysis treatments on 4/22/26, 4/24/26, and 4/29/26, which were dates that fell within the MDS assessment reference period for the Significant Change In Status MDS with an ARD of 5/1/26.On 6/3/26 at 11:03 AM, during an interview with Certified Nursing Assistant (CNA) #1, she reported Resident #2 attended dialysis on Monday, Wednesday, and Friday.On 6/3/26 at 11:24 AM, during an interview with Licensed Practical Nurse (LPN) #2, she reported Resident #2 received dialysis on Monday, Wednesday, and Friday.On 6/4/26 at 12:05 PM, during an interview with Licensed Practical Nurse (LPN) #3, she stated it was her responsibility to complete MDS assessments. She reported medical records, including dialysis transfer forms, physician orders, progress notes, hospital records, and diagnoses, are reviewed to determine appropriate MDS coding. She confirmed Resident #2 received dialysis treatments on 4/22/26, 4/24/26, and 4/29/26 during the look-back period for the Significant Change In Status MDS with an ARD of 5/1/26. She further confirmed the MDS was coded No for dialysis and acknowledged the assessment should have been coded Yes because the resident received dialysis during the assessment period.On 6/4/26 at 12:20 PM, during an interview with the Director of Nursing (DON), she stated her expectation was that MDS assessments be completed accurately. She reported that the MDS nurse should review medical records, including dialysis transfer forms and dialysis pre- and post-treatment notes, when completing the assessment. The DON confirmed the Significant Change In Status MDS with an ARD of 5/1/26 was coded No for dialysis and acknowledged the assessment should have been coded Yes because the resident received dialysis.On 6/4/26 at 12:25 PM, during an interview with the Administrator, she stated it was the responsibility of the MDS nurse to complete MDS assessments accurately. The Administrator confirmed the MDS should have been coded Yes for dialysis because Resident #2 received dialysis during the assessment reference period.

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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. Based on observation, interviews, record review, and facility policy review, the facility failed to implement care plan interventions related to shaving for two (2) of 18 sampled residents. Residents #32 and #26. Findings include: A review of the facility's Care Plan Policy and Procedure, undated, revealed Purpose: To provide a comprehensive person-centered plan of care addressing resident's needs, strengths, goals and approaches. Policy: Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals and approaches. Resident #32 A record review of the admission Record revealed the facility admitted Resident #32 on 3/25/25 and she had current diagnoses including Cerebral Infarction due to Embolism of the Left Middle Cerebral Artery, Contracture of Muscle, Right Hand, and Need for Assistance with Personal Care. A record review of the Modified Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/3/26 for Resident #32 revealed Section GG0130I5, Personal Hygiene: The ability to maintain personal hygiene, including.shaving.) was coded as dependent. The MDS further revealed she had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. A record review of the Care Plan Report revealed Resident #32 had a Focus of I have an ADL (activities of daily living) self-care performance deficit r/t (related to) Stroke and Interventions/Tasks included Bathing.facial hair removed. A record review of the Task Record, Schedule for June 2026, for Resident #32 revealed documentation completed on 6/2/26 indicating bathing was provided and included the intervention to remove facial hair. During an observation on 6/1/26 at 11:09 AM, Resident #32 had facial hair measuring approximately one-fourth (1/4) inch in length on her chin. During an observation and interview on 6/2/26 at 10:23 AM, Resident #32 had facial hair on her chin. The resident stated that she did not want facial hair and that she wanted it to be shaved. During an observation on 6/3/26 at 8:35 AM and at 1:25 PM, facial hair remained present on Resident #32's chin, which was after her scheduled bath for 6/2/26. During an interview and observation on 6/3/26 at 8:35 AM, Registered Nurse (RN) #1 confirmed Resident #32 had facial hair and stated facial hair should be removed on shower days. During an interview on 6/3/26 at 10:40 AM, Certified Nursing Aide (CNA) #2 stated facial hair should be removed on shower days and confirmed Resident #32's shower day was on 6/2/26. CNA #2 acknowledged the resident's facial hair had not been removed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 6/3/26 at 2:34 PM, CNA #4 reported she provided Resident #32 with a bed bath and nail care on 6/2/26 but did not remove the resident's facial hair. Resident #26 A record review of the admission Record revealed Resident #26 was admitted by the facility on 6/10/25 and he had current diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/6/26 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A record review of the Care Plan Report revealed Resident #26 had a Focus of I have an ADL self-care performance deficit r/t Impaired balance, Pain Bilateral Lower extremities and Interventions/Tasks included .Self Care Personal hygiene: Requires (Substantial) to maintain personal hygiene, including.shaving. During an interview and observation on 6/1/26 at 11:18 AM, Resident #26 was dry shaving his face and head with a blue razor. There was no soap, shaving cream, or water present for the resident to use and no staff were in the room assisting the him. Resident #26 reported he shaved himself all the time because it was the only way he would get shaved and reported the Activity Director had given him the razor. During an interview and observation on 6/1/26 at 11:20 AM, Licensed Practical Nurse (LPN) #4 confirmed Resident #26 was using a razor to dry shaving his face and head. LPN #4 reported staff were expected to shave residents and residents were not permitted to shave themselves. During an interview on 6/4/26 at 2:19 PM, during an interview with Licensed Practical Nurse (LPN) #3, she stated she was responsible for the care plans and she expected the staff to implement care plan interventions. During an interview on 6/4/26 at 2:49 PM, the Director of Nursing (DON) reported that staff were expected to follow the resident care plan at all times.

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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. Based on observation, interview, record review, and policy review the facility failed to provide necessary assistance with activities of daily living (ADLs) to maintain personal hygiene and grooming in accordance with a resident's needs and preferences by failing to remove facial hair for two (2) of eighteen (18) sampled residents. (Resident #32 and #26). Findings include: A review of the facility's ADL Care of a Resident Policy and Procedure, undated, revealed, .Resident ADL care will be provided to the resident according to the individualized resident needs. Resident #32 A record review of the admission Record revealed the facility admitted Resident #32 on 3/25/25 and she had current diagnoses including Cerebral Infarction due to Embolism of the Left Middle Cerebral Artery, Contracture of Muscle, Right Hand, and Need for Assistance with Personal Care. A record review of the Modified Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/3/26 for Resident #32 revealed Section GG0130I5, Personal Hygiene: The ability to maintain personal hygiene, including.shaving.) was coded as dependent. The MDS further revealed she had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. A record review of the Task Record, Schedule for June 2026, for Resident #32 revealed documentation completed on 6/2/26 indicating bathing was provided and included the intervention to remove facial hair. On 6/1/26 at 11:09 AM, during observation of Resident #32, she had facial hair measuring approximately one-fourth (1/4) inch in length on her chin. On 6/2/26 at 10:23 AM, during an observation and interview with Resident #32, facial hair was observed on her chin. The resident stated that she did not want facial hair and that she wanted it to be shaved. On 6/3/26 at 8:35 AM and at 1:25 PM, facial hair remained present on Resident #32's chin. On 6/3/26 at 8:35 AM, during an interview and observation with Registered Nurse (RN) #1, she confirmed Resident #32 had facial hair and stated facial hair should be removed on shower days. On 6/3/26 at 10:40 AM, during an interview with Certified Nursing Assistant (CNA) #2, she stated facial hair should be removed on shower days and confirmed Resident #32's shower day was 6/2/26. CNA #2 acknowledged the resident's facial hair had not been removed. On 6/3/26 at 10:55 AM, during an interview with CNA #1, she reported Resident #32 required assistance with ADLs, including shaving. She stated the resident's shower schedule was Tuesday, Thursday, and Saturday and that the hospice aide provided a bed bath on Tuesday and Thursday. She confirmed Resident #32 had facial hair present. On 6/3/26 at 1:45 PM, during an interview with the Director of Nursing (DON), she stated she had (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	spoken with hospice staff on 6/2/26 and no refusals of care had been reported. The DON stated refusals would be communicated to nursing staff and documented in the medical record. On 6/3/26 at 2:34 PM, during a phone interview, CNA #4 reported she provided Resident #32 with a bed bath and nail care on 6/2/26 but did not remove the resident's facial hair. She stated she did not report to facility staff that the facial hair had not been removed. On 6/3/26 at 3:18 PM, during an interview with Registered Nurse #2, she confirmed Resident #32 had facial hair on her chin and stated the resident did not usually refuse care. On 6/3/26 at 3:25 PM, during an interview with CNA #3, she stated she provided a bed bath to Resident #32 on 6/2/26 but did not provide facial hair removal. She stated the resident had not refused care and hospice staff had not reported any refusals to her. On 6/3/26 at 3:38 PM, during a phone interview with Resident #32's Resident Representative (RR), she stated her mother did not want facial hair and that facility staff should be removing it. She further stated she had removed the resident's facial hair herself on occasion. On 6/4/26 at 12:35 PM, during an interview with the Administrator, she stated she expected staff to provide residents with ADL care necessary to meet their needs, including grooming and removal of facial hair when needed. Resident #26 A record review of the admission Record revealed Resident #26 was admitted by the facility on 6/10/25 and he had current diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/6/26 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. On 6/1/26 at 11:18 AM, during an interview and observation, Resident #26 was dry shaving his face and head with a blue razor. There was no soap, shaving cream, or water present for the resident to use and no staff were in the room assisting the resident. Resident #26 reported he shaved himself all the time because it was the only way he would get shaved and reported the Activity Director had given him the razor. On 6/1/26 at 11:20 AM, during an interview and observation with Licensed Practical Nurse (LPN) #4, she confirmed Resident #26 was using a razor to dry shave his face and head. LPN #4 reported staff were expected to shave residents and residents were not permitted to shave themselves On 6/2/26 at 11:22 AM, during an interview, Certified Nursing Assistant (CNA) #5 reported she did not know how the resident obtained the razor and reported residents were not permitted to shave themselves and shaving should be completed by staff. On 6/2/26 at 1:09 PM, during an interview with the Assistant Director of Nursing (ADON), she reported she was unaware how Resident #26 obtained the razor and reported residents were not permitted to use razors without staff assistance because they could cut themselves. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/26 at 2:04 PM, during an interview, the Director of Nursing (DON) reported that the facility policy required staff to assist residents with shaving. On 6/3/26 at 4:13 PM, during an interview, the Administrator reported staff were expected to follow facility policy regarding shaving and residents should be assisted by staff when shaving.

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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 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. Based on observation, staff interview, and facility policy review, the facility failed to ensure Schedule II controlled substances were maintained in permanently affixed compartments when two (2) of four (4) medication carts contained removable narcotic storage boxes.Findings include:A review of the facility's Medications Storage Policy and Procedure, undated, revealed, Purpose: To properly secure medications and biologicals according to CMS (Centers for Medicare and Medicaid Services) guidelines.Policy.3. Schedule II controlled medications will be maintained within a.permanently affixed compartment .On 06/03/2026 at 11:26 AM, during an interview and observation of the south wing medication carts, there were one (1) of two (2) medication carts that contained a narcotic storage box that was not permanently affixed within the medication cart drawer and could be removed from the cart. Licensed Practical Nurse (LPN) #2 confirmed the narcotic storage box was not affixed within the medication cart and could be removed.On 06/03/2026 at 11:37 AM, during an interview and observation of the north wing medication carts, there were one (1) of two (2) medication carts that also contained a narcotic storage box that was not permanently affixed within the medication cart drawer and could be removed from the cart. LPN #1 also confirmed the narcotic storage box was not affixed within the medication cart and the entire compartment could be removed.On 06/03/2026 at 2:23 PM, during a phone interview with the facility's Pharmacist, he stated he completes monthly pharmacy visits, provides recommendations, and performs random controlled substance reconciliations. He reported he had reviewed medication cart narcotic storage during his last visit but was unaware the narcotic storage boxes were not permanently affixed within the medication carts. On 06/03/2026 at 2:42 PM, during an interview and observation with the Director of Nursing (DON), two (2) of the four (4) medication carts were observed to contain narcotic storage boxes that were not permanently affixed within the medication cart drawers. The narcotic storage boxes were capable of being removed from the medication carts. The DON confirmed the narcotic storage boxes were not permanently affixed.On 06/03/2026 at 2:49 PM, during an interview with the Administrator and Registered Nurse (RN) #2, both stated they were unaware the narcotic storage boxes were not permanently affixed within the medication carts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255207	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Community Living Center	4403 Hospital Road Pascagoula, MS 39581

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to provide the residents with a homelike environment during an annual recertification survey on 01/09/2025 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of seven (7) deficiencies cited. F584.Findings Include:Review of the facility's policy, QAPI Plan, revealed, Purpose: The purpose of QAPI.is to take a proactive approach to continually improve the way we care for.our residents.Scope.The QAPI committee analyses performance to identify and follow-up on areas of opportunity. The facility will utilize the best available evidence.to define and measure goals. The facility continually identifies opportunities for improvement and reviews the following areas to prioritize opportunities. 1. Regulatory Requirements.A record review of the Provider History Report revealed the facility received a citation for F584 - Safe/Clean/Comfortable/Homelike Environment during the previous recertification on 01/09/2025. A record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 01/09/2025, revealed the facility received a citation for F584, .Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure residents' rights to a clean , sanitary, and home-like environment as evidenced by resident rooms with holes in the walls and leaks in the ceilings in the dining room and hallways for one (1) of four (4) days of survey .During the current recertification survey, the facility failed to ensure the residents' right to reside in a clean, comfortable, and homelike environment, as evidenced by dark-colored staining and residue on hallway vents and wall surfaces, damaged wall surfaces with paint scraped away exposing the underlying wall material, and recurring roof leaks for three (3) of six (6) halls. (Northeast, North Central, and South Central).On 06/04/2026 at 2:09 PM, during an interview, the Administrator stated that in response to the previous recertification survey and citation for F584 in 2025, the QAPI Committee developed a plan of correction that included discussion of residents' rights to a homelike environment, roof repairs, and ongoing monitoring of the facility's physical environment. The Administrator reported the facility repaired one section of the roof and initially did not identify additional leaks. She stated that in April 2026, roof leaks were identified again. The Administrator reported the plan of correction also included routine monitoring of the facility to identify areas in need of repair or replacement. She stated maintenance and administrative staff conducted weekly rounds of resident rooms and common areas to identify concerns such as roof damage, chipped paint, and other structural issues. The Administrator reported each department was responsible for identifying and reporting environmental concerns and that findings were discussed during QAPI meetings. The Administrator stated the monitoring period was conducted from 10/13/2025 through 04/30/2026 and was reimplemented every six months. The Administrator reported no complaints regarding roof leaks or other structural concerns had been reported to staff. The Administrator further stated she had been in communication with the corporate office and a decision had been made to replace the entire roof.