STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255229	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Springs Rehabilitation and Healthcare Center	1315 Highway 4 East Holly Springs, MS 38635

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review, staff interview, and facility policy review, the facility failed to have the required staff present and in attendance for each quarterly Quality Assurance and Performance Improvement (QAPI) meetings for four (4) of 4 quarterly meetings dated 09/30/25, 12/29/25, 03/31/26 and 05/01/26. Findings include:Review of facility document titled QAPI Program undated revealed, .Leadership of the QAPI committee will include the Medical Director and or Nurse Practitioner (NP), Administrator, and Director of Nurses.QAPI meetings will be held monthly. The following individuals serve on the committee: Administrator, or a designee who is in a leadership role; Director of Nursing services; Medical Director; Infection Preventionist; and Representatives of the following departments, as requested by the administrator: Pharmacy; Social Services; Activity Services; Environmental Services; Human Resources; and Medical Records.Review of facility documents titled Stand Up Sign-in Sheet/QA Meeting dated 9/30/2025, 12/29/2025, 3/31/2026, and 5/1/2026, failed to evidence participation of the facility Medical Director in the QAPI meetings reviewed. During an interview on 5/14/2026 at 9:30 AM, the Administrator stated the facility discussed concerns during QAPI meetings but was unable to provide evidence of additional ongoing performance improvement activities, sustained monitoring tools, or systemic corrective actions related to the identified recurring concerns. Additionally, the Administrator confirmed the Medical Director did not attend the QAPI meetings. He stated, I usually just call and fill her in about the meetings, and confirmed that the Medical Director was not in attendance at any of the QAPI meetings.

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 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. Based on resident and staff interviews, record review, and facility policy review, the facility failed to resolve resident grievances related to food service concerns identified during Resident Council meetings for five (5) of thirteen residents. (Resident #7, Resident #11, Resident #36, Resident #62, and Resident #74) Findings Include:Review of the facility policy titled Filing Grievances/Complaints with a revision date of 6/2024 revealed .3. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing (if requested), including a rationale for the response .A record review of the Resident Council Minutes dated 12/16/25, under New Business, revealed residents voiced concerns stating, The food is inedible and not worth eating, and The food is awful, it's the same every time and never a different variety. The minutes documented the Dietary Manager (DM) was present during the meeting.A record review of the Resident Council Minutes dated 1/20/26, under Old Business, revealed continued complaints that The food is awful and always the same.A record review of the Resident Council Minutes dated 2/17/26, under New Business, revealed residents voiced concerns including not receiving the foods listed on their meal tickets, tea glasses not being full or containing ice, repeated desserts such as fig newtons and graham crackers, green beans being served three days in a row, and food being served cold. The minutes documented the DM was present during the meeting.A record review of the Resident Council Minutes dated 3/16/26, under New Business, revealed residents complained of inadequate food portions, cold food, repetitive menu items such as rice and green beans being served multiple days in a row, lack of fresh fruit or sliced apples, receiving water instead of tea or lemonade, insufficient meat portions for sandwiches, not receiving the advertised meal of the month, and soup or oatmeal being served in dessert cups.A record review of the Resident Council Minutes dated 4/21/26, under New Business, revealed complaints that the food was too salty. Under Old Business, residents continued to voice concerns that the food was not hot, the food was awful, and fresh fruit was not being provided. The minutes documented the DM was present during the meeting.During an interview on 5/12/26 at 1:51 PM, the Activity Director (AD) confirmed that cold food and food issues had been an ongoing concern discussed during Resident Council meetings for a while. The AD stated the DM routinely attended the meetings and residents consistently voiced their concerns to him. The AD further stated she was unaware of any actions taken by the DM to resolve the issues. During the Resident Council meeting conducted on 5/12/26 at 2:00 PM, residents who were present continued to voice concerns regarding unresolved food service issues that had reportedly been discussed repeatedly during prior Resident Council meetings without a follow up or a resolution to their prior grievances.Resident #7 revealed he had repeatedly requested coffee prior to leaving for dialysis, but coffee service occurred after he had already left the facility. He further revealed the oatmeal was usually cold and it can't even melt butter. Resident #7 stated he had discussed the concerns with both the DM and the Administrator (ADM), but Nothing ever gets done.Resident #11 revealed The food is cold regardless of what you get, and stated, We discuss these food issues all the time, and it falls on deaf ears.Resident #36 revealed that The majority of our Resident Council meetings we are discussing cold food and how bad the food is. She stated the DM attends the meetings, listens to the concerns, but Nothing is ever done. Resident #36 further revealed residents discuss the Meal of the month during each meeting; however, they have never received those meals that they request.Resident #62 revealed, We talk about food issues in each meeting that we have. We just haven't seen any change.Resident #74 revealed, It doesn't matter if we mention how cold or bad the food is; nothing is ever done. He stated the DM attends the meetings and listens to the complaints, and that the Administrator and staff were aware of the residents' concerns.During an interview on 5/12/26 at 3:50 PM, the Administrator (ADM) confirmed awareness of ongoing food-related complaints voiced during Resident Council meetings. The ADM revealed the DM had attended several meetings and had been made aware of the concerns. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADM stated, I know there have been ongoing concerns about the food, and we are trying to change things up. The ADM confirmed there was no written follow-up documentation regarding the residents' grievances and acknowledged the facility had failed to ensure the residents' concerns were properly addressed and resolved.During an interview on 5/13/26 at 11:40 AM, the DM confirmed awareness of the concerns voiced during Resident Council meetings and stated he had discussed with residents that he was working to resolve the issues. The DM confirmed there was no documented follow-up and acknowledged the concerns had apparently not been resolved at that time.Record review of the admission Record revealed the facility admitted Resident #7 on 8/13/2025 with medical diagnoses that included Muscle weakness and Dependence on Renal Dialysis.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/9/2026 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #7 was cognitively intact.Record review of the admission Record revealed the facility admitted Resident #11 on 4/04/2025 with medical diagnoses that included Protein-Calorie Malnutrition and Anemia.Record review of the MDS with an ARD of 4/2/26 revealed under section C, a BIMS summary score of 15, indicating Resident #11 was cognitively intact.Record review of the admission Record revealed the facility admitted Resident #36 on 12/19/2025 with medical diagnoses that included Type 2 Diabetes Mellitus and Major Depressive Disorder.Record review of the MDS with an ARD of 3/26/26 revealed under section C, a BIMS summary score of 15, indicating Resident #36 was cognitively intact.Record review of the admission Record revealed the facility admitted Resident #62 on 8/01/2024 with medical diagnoses that included Schizophrenia and Anemia.Record review of the MDS with an ARD of 4/17/26 revealed under section C, a BIMS summary score of 14, indicating Resident #62 was cognitively intact.Record review of the admission Record revealed the facility admitted Resident #74 on 11/25/2021 with medical diagnoses that included Chronic Obstructive Pulmonary Disease and Anemia.Record review of the MDS with an ARD of 4/8/26 revealed under section C, a BIMS summary score of 14, indicating Resident #74 was cognitively intact.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and facility policy review, the facility failed to implement care plan interventions as written for three (3) of 19 sampled residents. (Resident #2, Resident #27, and Resident #39) The scope and severity for this deficiency were cited at an E due to previous citations of F656 on the last two annual recertification surveys completed on 1/4/24 and 6/19/25 representing a pattern of deficiency. Findings include: Review of the facility policy titled Care Plans, Comprehensive Person-Centered, reviewed 6/2/25, revealed, 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 #2 Review of Care Plan Report revealed under Focus: The resident has an ADL (activity of daily living) deficit r/t (related to CVA (cerebrovascular accident).Interventions .Staff to ask resident on shower days if they would like to be shaved and shave as needed (prn) resident or Responsible Party (RP) request. Observations on 5/11/2026 at 11:05 AM, and again on 5/12/2026 at 9:00 AM, of Resident #2 revealed his facial hair was approximately one (1) inch in length. On 5/12/2026 at 1:00 PM during an observation and interview Licensed Practical Nurse (LPN) #1 confirmed that Resident #2 has long facial hair. She stated his shower days are Monday, Wednesday, Friday, and that a Certified Nursing Assistant (CNA) comes on Wednesdays, Thursdays, and Fridays to shave residents. On 5/13/2026 at 9:40 AM, Minimum Data Set (MDS) Coordinator confirmed the care plan had been developed; however, facility staff failed to implement the interventions as written. She stated the purpose of the care plan was to guide staff in providing the care needed for Resident #2. Record review of the admission Record indicated Resident #2 was admitted to the facility on [DATE] with medical diagnoses that included Cerebral Infarction. Record review of the MDS, with an Assessment Reference Date (ARD) of 4/09/2026 revealed under Section C that a Brief Interview for Mental Status (BIMS) was 9, indicating moderate cognitive impairment. Resident #27 Record review of Resident #27's Self-Care Deficit Care Plan revealed, .CNA (Certified Nursing Assistant) to complete fingernail care for resident daily and PRN. CNA to trim/file fingernails PRN.Donn (apply) carrots to bilateral hands daily after lunch and doff (remove) at HS (bedtime) one time a day. Donn bilateral elbow rolls to resident daily after lunch and doff at HS one time a day. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/11/2026 at 11:05 AM, during an observation Resident #27's fingernails were observed to be approximately one (1) inch in length with jagged edges. The resident was also observed with contractures to bilateral hands without the ordered interventions in place. Observations of Resident #27 on 5/12/2026 at 9:54 AM and again at 12:44 PM, revealed no carrots, rolled cloths, or gauze in either hand for contracture prevention and the resident's fingernails were jagged and long. During an interview on 5/12/2026 at 2:57 PM, the Director of Nursing (DON) confirmed several of Resident #27's fingernails were very long. She stated long, jagged fingernails could cause injury to the resident and should be kept clean and trimmed. She further confirmed Resident #27 did not have ordered interventions in place for his hands or elbows to prevent contractures. On 5/13/2026 at 9:38 AM, Registered Nurse (RN) MDS Coordinator confirmed the care plan had been developed; however, facility staff failed to implement the interventions as written. She stated the purpose of the care plan was to guide staff in providing care for Resident #27. Record review of the admission Record indicated Resident #27 was admitted to the facility on [DATE] with medical diagnoses that included unspecified severe protein-calorie malnutrition and primary progressive multiple sclerosis. Record review of the MDS, with an ARD of 2/14/2026, revealed under Section C that a BIMS was not conducted because Resident #27 was rarely or never understood. Resident #39 Record review of Resident #39's Activities of Daily Living (ADL) self-care performance deficit care plan revealed, .Donn resting hand splint to left hand after breakfast daily and doff at dinner or as tolerated; check skin prior to donning left hand splint and after doffing left hand splint.oral hygiene: dependent.Personal hygiene: dependent. During an observation on 5/11/2026 at 10:32 AM, Resident #39's fingernails were observed to be approximately one (1) inch in length with jagged edges. Additionally, the resident's upper teeth appeared blackened and deteriorated with visible buildup along the gum line. Significant discoloration and poor oral hygiene were observed. Resident #39 was also observed without the ordered splint in place on his left hand. On 5/12/2026 at 9:51 AM and again at 2:16 PM, observations of Resident #39 revealed no brace or splint in place on the resident's left hand. During the 2:16 PM observation, when asked about the brace, the resident stated he did not know where it was but stated it helps to hold his hand open. On 5/12/2026 at 2:37 PM during an interview the Director of Nursing (DON) confirmed Resident #39 was in need of oral care and that his fingernails should be kept trimmed. She stated nail care and oral care should be provided daily and as needed. She further confirmed braces and splints should be applied as ordered to assist in preventing contractures and stated her expectation was for physician orders to be followed as written. During an interview on 5/13/2026 at 9:38 AM, the Minimum Data Set (MDS) Coordinator confirmed the care plan had been developed; however, facility staff failed to implement the interventions as written. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She stated the purpose of the care plan was to guide staff in providing care for Resident #39. Record review of the admission Record indicated Resident #39 was admitted to the facility on [DATE] with medical diagnoses that included post-traumatic seizures, hemiplegia affecting the left nondominant side, and metabolic encephalopathy. Record review of the MDS, with an ARD of 3/23/2026, revealed under Section C a BIMS summary score of 9, indicating Resident #39 was moderately cognitively impaired.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to provide facial hair grooming, fingernail care, and oral hygiene for three (3) of nineteen (19) samples residents reviewed for activities of daily living (ADL) care. Residents #2, Resident #27, and Resident #39. The scope and severity for this deficiency was cited at an E due to previous citations of F677 on the last two annual recertification surveys completed on 1/4/24 and 6/19/25 representing a pattern of deficiency. Findings include: Review of the facility policy titled Activities of Daily Living (ADL), with a revision date of March 2018, revealed, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living . Resident #2 On 5/11/2026 at 11:05 AM, and again on 5/12/2026 at 9:00 AM, observations of Resident #2 revealed facial hair that was approximately one (1) inch in length. During an observation and interview on 5/12/2026 at 1:00 PM, Licensed Practical Nurse (LPN) #1 confirmed that Resident #2 had long facial hair. She stated his shower days are on Mondays, Wednesdays, Fridays, and that a Certified Nursing Assistant (CNA) comes on Wednesdays, Thursdays, and Fridays to shave residents. During an interview on 5/14/2026 at 8:45 AM, the Administrator stated residents should be offered a shave on shower days. Record review of the admission Record indicated Resident #2 was admitted to the facility on [DATE] with medical diagnoses that included Cerebral Infarction. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/09/2026 revealed under Section C that a Brief Interview for Mental Status (BIMS) was 9, indicating moderate cognitive impairment. Resident #27 During an observation on 5/11/2026 at 11:05 AM, Resident #27's fingernails were observed to be approximately one (1) inch in length with jagged edges. During an interview on 5/12/2026 at 2:43 PM, CNA #2 confirmed several of Resident #27's fingernails were very long. She stated she was unsure whether she could trim the resident's fingernails because the resident might be diabetic and stated, I would have to ask the nurse. During an interview on 5/12/2026 at 2:57 PM, the Director of Nursing (DON) confirmed several of Resident #27's fingernails were very long. She stated long, jagged fingernails could cause injury to Resident #27 and should be kept clean and trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the admission Record indicated Resident #27 was admitted to the facility on [DATE] with medical diagnoses that included unspecified severe protein-calorie malnutrition and primary progressive multiple sclerosis. Record review of the MDS, with an ARD of 2/14/2026, revealed under Section C that a BIMS was not conducted because Resident #27 was rarely or never understood. Resident #39 During an observation on 5/11/2026 at 10:32 AM, Resident #39's fingernails were observed to be approximately one (1) inch in length with jagged edges. Additionally, the resident's upper teeth appeared blackened and deteriorated, with visible buildup along the gum line. Significant discoloration and poor oral hygiene were observed. During an interview on 5/12/2026 at 2:29 PM, the DON confirmed Resident #39 needed oral care and that his fingernails should be kept trimmed. She stated nail care and oral care should be provided daily and as needed. Record review of the admission Record indicated Resident #39 was admitted to the facility on [DATE] with medical diagnoses that included post-traumatic seizures, hemiplegia affecting the left nondominant side, and metabolic encephalopathy. Record review of the MDS, with an ARD of 3/23/2026, revealed under Section C a BIMS summary score of 9, indicating Resident #39 was moderately cognitively impaired.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, record review, and facility policy review, the facility failed to ensure a dignified existence by failing to apply a privacy bag to a urinary catheter drainage bag (Resident #82) and failing to provide dignified toileting assistance to a resident (Resident #22) for two (2) of 19 sampled residents. Residents #22 and Resident #82. Findings Include: Record review of facility policy titled Nursing Facility Resident Rights dated 3/6/26 revealed, .Facilities are required to protect and promote these rights for every resident. Dignity, Respect, and Freedom from Abuse: To be treated with dignity, courtesy, and respect .Quality of Care and Participation in Care: To receive care necessary to achieve the highest practicable physical, mental, and psychosocial well-being . Resident #22On 5/11/26 at 11:22 AM, observation and interview with Resident #22 revealed she was sitting in her wheelchair near the doorway of her room with frowning facial expressions and scrunched eyebrows. Resident #22 stated she needed to use the bathroom to have a bowel movement, but staff told her they could not put her on the toilet, and she would have to lie in bed, use the bathroom on herself, and then be changed. Resident #22 pointed toward her bed and stated she did not want to lie in bed and use the bathroom on herself. An interview with Certified Nursing Assistant (CNA) #1 on 5/11/26 at 11:25 AM confirmed she told Resident #22 she would have to lie in bed to use the bathroom. During an interview on 5/12/26 at 5:22 PM, the Director of Nursing (DON) revealed Resident #22 required a total lift and the lift would not fit into the bathroom. The DON stated the facility did not have any bedside commodes available; however, the resident should have been offered a bedpan. The DON acknowledged being told to use the bathroom on herself was a dignity concern. Record review of the admission Record revealed the facility admitted Resident #22 on 4/13/26 with medical diagnoses that included Acute Kidney Failure, Chronic Kidney Disease, Anxiety Disorder, and Depression. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 11, indicating Resident #22 was moderately cognitively impaired. Resident #82 During an observation on 5/11/26 at 10:20 AM, Resident #82's catheter drainage bag was observed hanging on the lower bed frame, approximately one-third full of amber-colored urine, without a privacy cover in place. Record review of the Order Summary Report revealed an order dated 7/28/23 for Privacy bag or covering over urine collection bag for dignity. During an interview on 5/12/26 at 12:50 PM, Licensed Practical Nurse (LPN) #3 stated the urinary drainage bag should have a cover in place to provide privacy for the resident. Record review of the admission Record revealed the facility admitted Resident #82 on 7/25/23 with medical diagnoses that included Chronic Kidney Disease, Stage 3, Benign Prostatic Hyperplasia, and Personal History of Malignant Neoplasm of Prostate. Record review of the MDS with an ARD of 4/21/26 revealed under Section C, a BIMS summary score of 12, indicating Resident #82 was moderately cognitively impaired.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident/resident representative (RR) and staff interviews, record review and facility policy review the facility failed to honor a resident's Advance Directive for end-of life decisions for one (1) of 28 residents advance directives reviewed. Resident #25Findings Include:Review of the facility policy titled Advance Directives, with a revision date of [DATE], revealed, Advance directives will be respected in accordance with state law and facility policy.15. In accordance with current regulatory definitions and guidelines governing advance directives, our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to: f. Do Not Resuscitate- indicates that in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used .Record review of the Advance Health Care Directive for Resident #25, revealed under End -of-life decisions.Choice Not to Prolong Life signed by the resident and notarized with a date of [DATE].Record review of the Order Summary Report revealed an order for CPR with a date of [DATE].During an interview on [DATE] at 8:27 AM, Licensed Practical Nurse (LPN) #3 confirmed Resident #25's physician order reflected full code status.During a phone interview on [DATE] at 9:13 AM, Resident #25's Resident Representative (RR) stated, My sister has always said she did not want to be resuscitated. The RR stated the facility contacted him some time ago, but I truly didn't understand what they were asking me. He stated, A girl asked if they should do anything for her if she quits breathing, and I responded, 'Well, I guess you should. The RR revealed he was unaware this would change his sister's previously established end-of-life wishes, which were documented when she was in a better mindset, and they should keep them as she wanted.In an interview on [DATE] at 9:22 AM, Resident #25 confirmed her end-of-life wishes were that she had no resuscitation if anything happened to her. She stated, I have always said that because I have heart disease and a pacemaker, and further confirmed that she had completed paperwork documenting those wishes. In an interview on [DATE] at 9:48 AM, the Director of Nurses (DON) confirmed Resident #25 had an Advance Health Care Directive signed on [DATE], indicating under End-of-Life Decisions a Choice Not to Prolong Life. The DON confirmed the residents' previously documented end-of-life decisions should have remained consistent with the advance directive despite the change in the RR.During an interview on [DATE] at 11:11 AM, the Director of Business Development revealed that she is responsible for discussing end-of-life decisions with residents and/or the RRs. She revealed she contacted Resident #25's RR the previous year after he assumed responsibility as the resident's RR because the facility needed to update paperwork, including the code status.Record review of the admission Record revealed Resident #25 was initially admitted to the facility on [DATE] with diagnoses that include Unspecified Dementia, Chronic Kidney Disease, and Presence of Cardiac Pacemaker. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 07, which indicated Resident #25 has severe cognitive impairment.

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	255229	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Springs Rehabilitation and Healthcare Center	1315 Highway 4 East Holly Springs, MS 38635

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility policy review, the facility failed to maintain a clean and sanitary environment by allowing a resident bathroom toilet to remain soiled for one (1) of 32 rooms on the 200 hall. room [ROOM NUMBER]Findings Include:Review of the facility policy titled 7-Step Daily Washroom Cleaning revealed under, Purpose: To teach Environmental Services employees the proper method to sanitize a washroom or bathroom . Additionally, the policy revealed under, 7-Step Daily Washroom Cleaning Procedure:. 5. Clean and Sanitize Commode - .Use [NAME] mop or toilet brush to disinfect the inside of the bowl .An observation of room [ROOM NUMBER]'s bathroom toilet on 5/11/26 at 2:15 PM revealed dark yellow stagnant urine present inside the toilet bowl and black discoloration adhered along the inner rim/water line of the toilet. The black substance appeared as multiple small circular black spots with a mold-like appearance.An observation and interview on 5/11/26 at 2:21 PM with Licensed Practical Nurse (LPN) #4 confirmed there was stagnant urine in the toilet bowl and a black substance along the water line. She stated, It looks like mold. She confirmed the bathroom environment was unclean and unsanitary.An observation and interview with the Training Center Accounts Manager (TCAM) on 5/11/26 at 2:26 PM confirmed the toilet was unclean and that the inside of the toilet looks to have mold. He revealed housekeeping staff were responsible for cleaning the residents' bathrooms, including the toilets, every day, confirming the toilet had not been properly cleaned.

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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 ensure the resident and/or resident representative were provided with written notification of transfer to the hospital for two (2) of 2 residents reviewed for hospitalization. Resident #3 and Resident #95Findings Include:Review of the facility policy titled, Transfer or Discharge Notice with a revised date of 3/3/2026 revealed, .5. The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which is resident is being transferred or discharged . Record review of Resident #3's Progress Note dated 5/8/26 revealed the Resident was transported to Proper Name of Hospital for tube/drain replacement. Record review of Resident #95's Progress Note dated 3/27/26 revealed Nurse Practitioner (NP) recommended sending to emergency room (ER) for evaluation due to hitting head. Emergency Medical Transport (EMT) transported resident to Proper Name of Hospital. During an interview on 5/13/2026 at 11:26 AM, the Business Office Manager (BOM) revealed when a resident is transferred to the hospital, the facility only sends the bed-hold notice and notifies the ombudsman. She further revealed the facility was unaware that a written notification explaining the reason, date of transfer, and location of transfer was required to be provided to the resident and/or resident representative. Record review of the admission Record revealed the facility admitted Resident #3 on 4/18/25 with a medical diagnosis that included Disease of Biliary Tract. Record review of the admission Record revealed the facility admitted Resident #95 on 3/12/26 with a medical diagnosis that included Malignant Neoplasm of unspecified part of unspecified Bronchus.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and facility policy review, the facility failed to provide necessary care and services to prevent worsening contractures and maintain range of motion (ROM) for two (2) of four (4) residents reviewed. (Residents #27 and Resident #39)Findings include:Review of facility policy titled Contracture Management Program revised 3/4/2026, revealed, Intent: To have a program within the facility geared towards the prevention of new contractures and maintenance or improvement of Range of Motion.Nursing Responsibilities:.When the resident is discharged from therapy and a Restorative Nursing Program (RNP) has been written, the Director of Nursing (DON) or designee is to ensure the RNP is written correctly and then implemented timely.Resident #27 Review of Resident #27's Order Summary Report, revealed physician orders to Donn (apply) bilateral elbow rolls to patient daily after lunch and doff (remove) at HS (bedtime) and Donn carrots to bilateral hands daily after lunch and doff at HS, both with a start date of 2/21/2024.During an observation on 5/11/2026 at 2:05 PM, Resident #27 was observed with contractures to bilateral hands and elbows without ordered interventions in place.During an observation on 5/12/2026 at 2:44 PM, Resident #27 did not have carrots, rolled cloths, or gauze in either hand for contracture prevention and did not have bilateral elbow rolls or splints in place.During an observation and interview on 5/12/2026 at 2:57 PM, Licensed Practical Nurse (LPN) #2 confirmed Resident #27 did not have carrots, towels, or gauze in either hand or did not have bilateral elbow rolls in place as ordered. LPN #2 searched the resident's room and found two elbow rolls in the chest of drawers and two carrots in the bedside table drawer.During an interview on 5/12/2026 at 3:04 PM, the Director of Nursing (DON) confirmed Resident #27 did not have the ordered interventions in place for his hands or elbows to assist in preventing worsening contractures.Record review of the admission Record indicated Resident #27 was readmitted to the facility on [DATE] with medical diagnoses that included unspecified severe protein-calorie malnutrition and primary progressive multiple sclerosis.Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/14/2026, revealed under Section C that a Brief Interview for Mental Status (BIMS) was not conducted because Resident #27 was rarely or never understood.Resident #39Review of Resident #39's Order Summary Report, revealed physician orders dated 01/14/26 to Check skin prior to donning left hand splint and after doffing left hand splint two times a day and to Donn resting hand splint to left hand after breakfast daily and doff at dinner or as tolerated; may remove prior to dinner if not tolerated .During observations on 5/11/2026 at 10:32 AM and again on 5/12/2026 at 9:51 AM, Resident #39 was observed without the ordered splint in place on his left hand.During an additional observation and interview on 5/12/2026 at 2:16 PM, Resident #39 was again observed without a splint or brace on his left hand. When asked about the brace, the resident stated he did not know where it was but stated it helps to hold his hand open.During an interview and record review on 5/12/2026 at 2:18 PM, Licensed Practical Nurse (LPN) #5 stated, I really don't know about any brace, I don't usually work this hall. Review of the Medication Administration Record (MAR) revealed the splint order was listed on the MAR. LPN #5 further stated the brace was used to help prevent contractures and confirmed that they have not been on the resident.During an interview on 5/12/2026 at 2:37 PM, the Director of Nursing (DON) confirmed braces and splints should be applied as ordered to assist in preventing contractures. She stated her expectation was for physician orders to be followed as written.Record review of the admission Record indicated Resident #39 was admitted to the facility on [DATE] with medical diagnoses that included post-traumatic seizures, hemiplegia affecting the left nondominant side, and metabolic encephalopathy.Record review of the MDS, with an ARD of 3/23/2026, revealed under Section C a BIMS summary score of 9, indicating Resident #39 was moderately cognitively impaired.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to clarify a clinically questionable dialysis fluid restriction order, failed to accurately transcribe and implement the physician order, and failed to monitor fluid intake for one (1) of five (5) residents reviewed for dialysis services. Resident #22 Findings Include:Review of the facility policy titled Dialysis Management Policy revised 3/12/26 revealed under, Policy: The facility will ensure that residents requiring dialysis receive appropriate clinical oversight, coordination with dialysis providers, and monitoring to maintain health and safety. The facility will coordinate care with the dialysis center and physician to ensure appropriate monitoring of the resident's clinical status, dialysis access, laboratory values, dietary needs, and complications related to dialysis therapy .Record review of Resident #22's Medication Administration Record (MAR) revealed an order dated 4/13/26, Resident to receive dialysis 3 (three) days a week on Tues (Tuesday), Thurs (Thursday), Sat (Saturday) at ?Proper name of dialysis center'.Record review of the Proper name of dialysis center Physician Order Sheet for Resident #22 revealed an order dated 4/14/26 for 3200 fluid ounces daily fluid restriction, which reflected a clinically questionable fluid restriction amount for a resident receiving dialysis.Record review of Resident #22's MAR revealed the facility transcribed and implemented the order dated 4/14/26 as, Fluid Restriction: Resident to have 3200 cc/ml (cubic centimeters/milliliters) fluid per 24 hours. Dietary to give 1600 cc/ml per shift. Nursing to give 1600 cc/ml per shift, without obtaining clarification from the dialysis center or physician regarding the questionable order.Further review of the MAR revealed no documented monitoring or tracking of fluid intake since the resident admitted to the facility on [DATE].On 5/12/26 at 4:26 PM, during a telephone interview with the Registered Nurse (RN) at Proper name of dialysis center, she revealed 3200 fluid ounces was not an accurate fluid restriction order and stated dialysis residents were typically instructed to follow approximately a 32-ounce (946 milliliters) daily fluid restriction. The RN confirmed the order should have been clarified by the facility prior to implementation.During an interview with the Director of Nursing (DON) on 5/13/26 at 10:08 AM, she confirmed the fluid restriction order received from the dialysis center was not realistic and they should have communicated with the dialysis center and clarified the order. The DON stated the nurse who received the order then converted the order from ounces to milliliters without obtaining physician or dialysis center clarification. The DON further confirmed the facility monitored dialysis residents' fluid intake through MAR documentation; however, Resident #22's fluid intake had not been monitored or documented since admission, which could result in excess fluid accumulation.Record review of the admission Record revealed the facility admitted Resident #22 on 4/13/26 with diagnoses including Acute Kidney Failure, Chronic Kidney Disease, and Dependence on Renal Dialysis.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 11, which indicated Resident #22 was moderately cognitively impaired. Further review revealed under Section O, dialysis was indicated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and facility policy review, the facility failed to implement infection prevention and control practices for one (1) of two (2) sampled residents reviewed for transmission-based precautions (TBP). The facility failed to ensure proper infection control measures related to disposable meal tray use and cleaning/disinfection of a shared shower room following use by a resident on transmission-based precautions. Resident #8 Findings Include:Review of the facility policy titled, Infection Prevention and Control Program, with a review date of 3/03/2026 revealed, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmissions of communicable diseases and infections .Record review of physician orders revealed Resident #8 had an order dated 04/24/2026 for contact isolation precautions related to ESBL (Extended-Spectrum Beta-Lactamase) in wound every shift until 06/06/2026. On 5/12/2026 at 9:21 AM, observation revealed Resident #8, who was on transmission-based precautions, was served breakfast on a regular reusable tray rather than a disposable tray, the tray was picked up by an unidentified staff member and carried out with other trays.During an interview on 5/12/2026 at 3:50 PM, the Infection Preventionist (IP) stated she sent a message to dietary staff at approximately 8:00 AM regarding disposable trays for residents in isolation. She also confirmed food trays for residents on transmission-based precautions should be disposable.During an interview on 5/12/2026 at 9:30 AM with Housekeeper #1, she stated the shower room Resident #8 uses, she routinely cleans it at 6:00 AM, and again at approximately 2:00 PM daily.During an interview on 5/12/2026 at 9:42 AM, Infection Preventionist stated residents on transmission-based precautions should be showered last and the shower room should be cleaned after use. She confirmed allowing another resident to use the shower room prior to cleaning was not proper infection control practice.An observation on 5/12/2026 at 10:00 AM revealed Resident #8, who was on transmission-based precautions, was transported to the shower room and showered in the common shower area prior to other residents completing their showers for the day. Observation revealed that the shower room was not disinfected after use.An interview with the Director of Nursing at 10:45 AM on 5/12/2026 confirmed infection control practices should be used to prevent the spread of infection.Record review of the admission Record indicated Resident #8 was admitted to the facility on [DATE] with medical diagnoses that included Atherosclerotic Heart Disease.Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/10/2026 revealed under Section C that a Brief Interview for Mental Status (BIMS) score was 9, indicating moderate cognitive impairment.