STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255250	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS Care Center of Morton	96 Old Highway 80 East Morton, MS 39117

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and facility policy review, the facility failed to honor a resident's right to refuse fingerstick blood glucose checks and use a Continuous Glucose Monitor (CGM) device for blood glucose monitoring for one (1) of (19) sampled residents (Resident #16).Findings include:A review of the facility's Resident Rights Policy, revised 9/2022, revealed, . Facility will ensure the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility will protect and promote the rights of each resident . The facility will provide equal access to quality care regardless of diagnosis, severity of condition, or payment source .A review of the facility's policy, Continuous Glucose Monitor (CGM) Use, undated, revealed, . 1. Purpose to ensure safe, accurate, and effective use of CGM systems for residents with diabetes, improving glucose control and reducing hypoglycemia events.A record review of the admission Record revealed the facility admitted Resident #16 on 1/12/26 with diagnoses including Type 2 Diabetes Mellitus.A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/19/26 revealed Resident #16 had a Brief Interview for Mental Status (MDS) score of 8, which indicated his cognition was moderately impaired.A record review of the Order Summary Report revealed Resident #16 had a Physician's order, dated 1/14/26 for sliding scale insulin two times daily and check blood glucose prior to lunch and supper. On 3/16/26 at 1:55 PM, during an observation and interview with Resident #16, the resident was observed sitting in a bedside chair with signage posted on the bulletin board that read, Nurses/CNA (Certified Nursing Assistant) Use freestyle Librera 3 (CGM) reading to check BS (blood sugar) Reader in the top drawer. When asked about the sign, the resident reported he was not aware of the sign but stated he does not like having his fingers poked.On 3/17/26 at 11:25 AM, during an observation, a CGM sensor reader was observed on the resident's overbed table.On 3/18/26 at 11:30 AM, during an interview and observation with Licensed Practical Nurse (LPN) #2, she confirmed the signage referenced use of a CGM device but reported she was not aware the resident had a CGM and had been checking blood glucose using the facility's glucometer. The resident's daughter was present and reported the sign had been placed because the resident did not like fingersticks and staff continued to perform them. The daughter showed the CGM device located on the resident's left upper arm and the reader on the overbed table. LPN #2 reported she had not previously observed the device. During the blood glucose check, the resident stated he did not like his fingers being poked and reported it hurt. LPN #2 continued to perform the fingerstick.On 3/18/26 at 12:00 PM, during an interview with LPN #1, she reported she was aware the resident had a CGM device and had used it after the daughter provided the equipment. She reported awareness of the signage placed in the room approximately three (3) weeks prior. She stated she was unsure if there was a physician's order for the device and believed staff were using the CGM. She confirmed the resident expressed discomfort with each fingerstick.On 3/18/26 at 4:30 PM, during a phone interview with the Resident Representative (RR), she reported she placed the sign in the room approximately (3) weeks prior because staff continued to perform fingersticks after she provided the CGM device and supplies. She reported the resident had the CGM prior to admission and she provided the necessary (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	equipment after admission. She stated she had communicated with multiple staff regarding use of the device.On 3/19/26 at 1:00 PM, during an interview with the Director of Nursing (DON), she reported she assisted with the resident's admission and discussed the CGM device with the resident's daughter. She confirmed the facility agreed to use the device if supplies were provided. She reported she was not aware of the signage in the room and had not followed up with staff or the daughter regarding use of the device. She confirmed there was no physician order for the CGM but stated staff had been trained on CGM use for another resident.On 3/19/26 at 4:46 PM, during an interview with the Director of Nursing (DON) and Administrator, they reported staff are expected to honor and respect resident rights and preferences.

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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. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident's right to a safe, clean, comfortable, and homelike environment for one (1) of (19) sampled residents (Resident #70) when the facility failed to repair a leaky faucet in the resident's room.Findings include:A review of the facility's policy, Maintenance Service (undated), revealed, .Maintenance service shall be provided to all areas of the building, grounds, and equipment.Policy Interpretation and Implementation.2. Functions of maintenance personnel include.d. Maintaining the.plumbing fixtures.in good working order.f. Establishing priorities in providing repair service.A review of the facility's policy, Resident Rights Policy (revised 9/2022), revealed, Policy Statement - It is the policy of this facility to provide services based on the following requirements.The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life.A record review of the admission Record revealed the facility admitted Resident #70 on 10/16/24 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD).A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/9/26 revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of (15), which indicated the resident was cognitively intact.On 3/17/26 at 9:28 AM, during an observation and interview with Resident #70, the sink in the resident's room was observed leaking water. The resident reported she had previously reported the issue, and it had not been repaired. The resident stated she had been told the sink would be fixed but could not recall when the request was made.On 3/19/26 at 11:02 AM, during an interview with the Maintenance Director, he explained he was aware of the issue and confirmed through the computerized reporting system that the work order was submitted on 1/26/26. He stated he spoke with a plumber the morning at that time and acknowledged the repair was overdue. He explained the repair required addressing the valves prior to replacing the faucet.On 3/19/26 at 12:44 PM, during a follow-up interview with Resident #70, she reported the leaky faucet interrupts her sleep due to the sound of water dripping into the sink. The resident stated the Administrator had previously attempted a temporary repair by adjusting a screw under the faucet knobs; however, the repair was not sustained and the faucet continued to leak. The resident reported no additional repairs had been completed. On 3/19/26 at 3:08 PM, during an interview with the Administrator, she acknowledged the repair request submitted on 1/26/26 had not been completed. She confirmed attempting a temporary repair in the past but could not recall the date. She explained her expectation is for maintenance to complete repairs in a timely manner.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure a resident was free from unnecessary chemical restraints related to psychotropic medications when the facility failed to attempt or document a Gradual Dose Reduction (GDR) for a resident receiving antipsychotic and antidepressant medications initiated on 5/20/25 for one (1) of five (5) residents reviewed for unnecessary medications. (Resident #79).Findings include:A review of the facility's policy, Tapering Medications and Gradual Drug Dose Reduction, revised April 2025, revealed, . Policy Statement . 2. Residents who use psychotropic medications receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these medications. Policy Interpretation and Implementation 1. Gradual Dose Reduction (GDR) refers to the stepwise tapering of a dose to determine if symptoms, conditions, or risk can be managed at a lower dose or if a medication can be discontinued. Psychotropic Medications 1. Within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. Documentation-Gradual Dose Reduction 1. Gradual dose reduction attempts are documented in the medical record. 2. Medical Provider documentation contains the rationale for why GDR attempts are clinically contraindicated for the resident.A record review of the admission Record revealed the facility admitted Resident #79 on 5/20/25 with diagnoses including Dementia.A record review of the Order Summary Report revealed Resident #79 had physician's orders for . Quetiapine Fumarate Tablet 25 milligrams (mg) give one (1) tablet by mouth at bedtime for hallucinations (dated 5/20/25) and Sertraline HCl Tablet 100 milligrams (mg) give two (2) tablets by mouth one time a day for depression (dated 5/20/25).A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/2/26 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of (12), which indicated the resident's cognition was moderately impaired. A review of Section N revealed the resident received antipsychotic and antidepressant medications, and documented, No Gradual Dose Reduction has been documented by a physician as clinically contraindicated.A record review of the Medication Administration Record for 3/1/26 through 3/31/26 revealed medications were administered as ordered for Quetiapine Fumarate and Sertraline HCl.A record review of the medical record revealed no documentation of a Gradual Dose Reduction (GDR).On 3/18/26 at 2:20 PM, during an interview with the Director of Nursing (DON), she reported there were no records of a GDR attempt since Resident #79 was admitted on [DATE]. She stated the attending physician and nurse practitioner reviewed medications but did not document a GDR attempt or contraindication. She confirmed the pharmacist reviewed medications on admission but no additional GDR recommendations were documented.On 3/18/26 at 3:10 PM, during a phone interview with the Pharmacy Consultant, he reported he conducts monthly medication reviews and provides reports to the DON. He stated GDR recommendations are typically made every six (6) months for psychotropic medications. He reported he had not made a GDR recommendation for Resident #79 based on information that medications were reviewed and revised by the practitioner in October 2025 and January 2026.On 3/19/26 at 1:30 PM, during a phone interview with Nurse Practitioner #1, she reported she reviews medications at each visit and is aware of GDR requirements. She stated GDRs are typically initiated based on recommendations from the pharmacist or psychiatric services. She confirmed no GDR had been initiated for Resident #79.On 3/19/26 at 1:48 PM, during a phone interview with the attending physician, he reported he completes GDR documentation when recommendations are made by pharmacy or psychiatric services. He stated no GDR had been completed for Resident #79 and acknowledged the GDR was missed.On 3/19/26 at 4:46 PM, during an interview with the DON, she reported she expects GDRs to be completed per regulation and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged the GDR for Resident #79 was missed. She stated she assumed medication reviews without changes were considered a GDR.On 3/19/26 at 4:55 PM, during an interview with the Administrator, she reported she expects the pharmacy consultant and medical providers to ensure GDRs are completed in accordance with regulations.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review, interview, and facility policy review, the facility failed to ensure the comprehensive care plan was revised when residents experienced multiple falls and failed to ensure care plan interventions were dated to reflect new or revised individualized interventions for two (2) of (19) residents reviewed for care plans. (Resident #1 and Resident #3).Findings include:A review of the facility's policy Develop/Implement Comprehensive Care Plan, revised 9/2022, revealed the facility will develop and implement a comprehensive person-centered care plan for each resident.Resident #1A record review of the Care Plan Report revealed Resident #1 had a focus of SAFETY: I am a high risk for falls. which listed multiple fall dates from 1/17/25 through 1/21/26. A review of the interventions revealed multiple interventions were listed; however, the dates initiated did not align with the dates of the falls, and there was no evidence the care plan was revised following each fall to include new or individualized interventions to address the continued fall risk.A record review of the admission Record revealed the facility admitted Resident #1 on 1/29/25 with current diagnoses including Chronic Kidney Disease.A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/25 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of (11), which indicated the resident's cognition was moderately impaired.A record review of the facility's fall investigations revealed Resident #1 experienced falls on 12/5/25 at 11:00 PM, 12/7/25 at 4:55 PM, and 1/21/26 at 7:50 AM.Resident #3A record review of the Care Plan Report revealed Resident #3 had a focus of SAFETY: I am a high risk for falls. which listed multiple fall dates from 3/23/24 through 2/7/26. A review of the interventions revealed multiple interventions were listed; however, not all dates initiated aligned with the dates of the falls, and there was no evidence the care plan was revised following each fall to include new or individualized interventions to address continued fall risk.A record review of the admission Record revealed the facility initially admitted Resident #3 on 2/1/22 and readmitted the resident on 12/2/25 with current diagnoses including History of Falling.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/6/26 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated the resident was cognitively intact.A record review of the facility's fall investigations revealed Resident #3 experienced falls on 10/24/25 at 8:35 PM, 10/29/25 at 9:40 PM, 11/22/25 at 5:15 PM, 1/22/26 at 4:30 AM, and 2/7/26 at 3:20 PM.On 3/19/26 at 12:31 PM, during an interview with Registered Nurse (RN) #1, she explained care plans are developed based on resident-specific needs and are expected to be updated when there is a change in condition, including after a fall. She stated the interdisciplinary team should review fall events and determine whether additional or modified interventions are needed. She confirmed interventions added to the care plan should be documented with dates to reflect when they were initiated. After reviewing the care plans for Resident #1 and Resident #3, she confirmed the interventions did not reflect additional or revised measures following subsequent falls.On 3/19/26 at 12:50 PM, during a record review and interview with the Director of Nursing (DON), she explained the expectation is for care plans to reflect current resident needs and risk factors. She stated falls should trigger a review of contributing factors and prompt updates to the care plan. She confirmed staff should be able to identify current interventions through dated entries on the care plan. After reviewing the care plans for Resident #1 and Resident #3, she confirmed the care plans did not include updated or newly implemented interventions following repeated falls.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, record review, and facility policy review, the facility failed to ensure services were provided in accordance with professional standards of practice when the facility failed to obtain a physician order for the use of a Continuous Glucose Monitor (CGM), failed to ensure a consistent and clinically directed method was used to obtain blood glucose readings, and failed to ensure accurate and complete documentation of blood glucose results for one (1) of (19) sampled residents. (Resident #16)Findings include:A review of the facility's policy Administering Medications with revised date of April 2019 revealed . Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . 2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. 4. Medications are administered in accordance with prescriber orders, including any required time frame . 6. Medications errors are documented, reported, and reviewed by the QAPI (Quality Assessment and Performance Improvement) committee to inform process changes and or the need for additional staff training . 10. The individual administering the medication checks to verify the right resident, right medication, right dosage, right time, and right method (route) of administering before giving the medication. 18. The individual administering the medication initials the resident's MAR (Medication Administration Record) on the appropriate line after giving each medication and before administering the next ones. 19. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered. b. the dosage c. the route of administration d. the injection site (if applicable) e. any complaints or symptoms for which the drug was administered.A review of the facility's policy Continuous Glucose Monitor (CGM) Use (undated) revealed . 1. Purpose to ensure safe, accurate, and effective use of CGM systems for residents with diabetes, improving glucose control and reducing hypoglycemia events. 5. Physician orders required. Type of CGM device . 6. Staff responsibilities . Document readings and interventions . 13. Resident's rights and Education. Respect refusal .A record review of the admission Record revealed the facility admitted Resident #16 on 1/12/26 with diagnoses including Type 2 Diabetes Mellitus.A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/19/26 revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident's cognition was moderately impaired. A review of Section N revealed the resident received insulin injections.A record review of the Order Summary Report revealed Resident #16 had a physician's order, dated 1/14/26, for NovoLog (Insulin Aspart) 100 units per milliliter (mL) to inject an alternating dose subcutaneously two (2) times daily for hyperglycemia, with instructions to check blood glucose prior to lunch and supper at 11:00 AM and 4:00 PM, and administer five (5) units if blood glucose was greater than 200, ten (10) units if greater than 300, and hold if less than 200. There was no physician order identified for the use of a Continuous Glucose Monitor (CGM).A record review of the Medication Administration Records (MARs) for January, February, and March 2026 for Resident #16 revealed the following: MAR for 01/01/26-01/31/26 at 11:00 AM revealed on 01/24/26 no blood glucose (BG) reading was documented and a code of nine (9) was entered indicating other/see progress note with no corresponding note. On 01/25/26 a BG reading of 145 was documented with five (5) units of insulin administered; however, a code of nine (9) was also entered and a progress note indicating no insulin was given. On 01/30/26 a BG reading of 162 was documented with five (5) units administered, with no corresponding progress note documented. MAR for 01/01/26-01/31/26 at 4:00 PM revealed on 01/20/26 no BG reading was documented with a code of five (5) entered indicating hold/see progress note, however there was no corresponding progress note. On 1/30/26 no BG reading was documented with a code of four (4) entered indicating Vitals outside of Parameters for Administration. MAR for 02/01/26-02/28/26 at 11:00 AM revealed on 02/12/26, 02/13/26, and 02/18/26, no BG readings were documented with a code of nine (9) entered indicating other/see progress note, with no progress (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notes recorded. On 2/26/26 and 2/27/26, no BG reading and Code 13 was entered indicating No Insulin Required. On 02/24/26 a BG reading of 144 was documented with five (5) units administered, with no corresponding progress note documented. MAR for 02/01/26-02/28/26 at 4:00 PM revealed on 02/05/26 no BG reading was documented with a code of four (4) entered indicating vitals outside of parameters for administration. On 02/11/26, 02/14/26, 02/23/26, 02/26/26 and 02/27/26 no BG readings were documented with a code of thirteen (13) entered indicating no insulin required. On 02/12/26, 02/13/26, and 02/18/26 no BG readings were documented with a code of nine (9) entered indicating other/see progress note with no corresponding progress note. MAR for 3/1/26-3/31/26 at 11:00 AM revealed on 3/1/26, 3/4/26, 3/7/26, 3/9/26, and 3/13/26 no BG reading was documented with a code of 13 recorded. 3/12/26 and 3/13/26 no BG recorded and code of 9 recorded. 3/14 26 BG of 186 recorded with 5 units of insulin administered and on 3/15/26, BG recorded as 161 with 5 units of insulin administered. MAR for 03/01/26-03/31/26 at 4:00 PM revealed on 3/3/26, 3/4/26, 3/7/26, 3/8/26, 3/12/26, and 3/13/26 no BG reading was recorded, and Code 13 was entered. On 3/9/26, 3/13/26, and 3/16/26 no BG reading was recorded, and Code 9 was entered. On 3/1/26, BG recorded as 247 and 10 units of insulin administered.On 3/16/26 at 1:55 PM, during an observation and interview with Resident #16, the resident was observed sitting in a bedside chair. A sign was observed posted on the bulletin board stating, Nurses/CNA Use freestyle Librera 3 reading to check BS (blood sugar) reader in the top drawer. The resident reported he did not like to have his fingers stuck.On 3/17/26 at 11:25 AM, during an observation and interview with Resident #16, the resident remained in his bedside chair. A blood glucose sensor was observed on the overbed table.On 3/18/26 at 11:30 AM, during an observation and interview with Licensed Practical Nurse (LPN) #2, she confirmed signage was posted on Resident #16's bulletin board instructing staff to use the CGM device when checking blood sugars and reported she was not aware the resident had a CGM device. She stated she had always obtained blood glucose readings using the facility's glucometer. The CGM device was identified on Resident #16's left upper arm and the reader was observed on the overbed table. LPN #2 reported she had not previously observed the device on the resident. She performed an Accu-Chek using the facility's glucometer and stated she attempts to document blood glucose readings at the time obtained and writes a progress note if needed. She said she had not paid attention to the Xs documented on Resident #16's MAR or the absence of blood glucose results and reported the codes used on the MAR are explained on the last page of the MAR.On 3/18/26 at 12:00 PM, during an interview with Licensed Practical Nurse (LPN) #1, she reported she was aware the resident had a CGM device and had used the device since it was brought to the facility. She stated she was not aware whether there was a physician order for the device and believed staff were using the CGM rather than the facility glucometer.On 3/18/26 at 4:30 PM, during a phone interview with the Resident Representative (RR), she reported she provided the CGM device and supplies after admission and placed the sign in the room due to staff continuing to obtain fingerstick blood glucose readings. She reported she had spoken with multiple staff but was unsure if leadership had been notified.On 3/19/26 at 1:00 PM, during an interview with the Director of Nursing (DON), she reported she was not aware of missing blood glucose documentation or concerns related to blood glucose monitoring for Resident #16 and had not been informed of any irregularities. The DON confirmed that, to her knowledge, no irregularities had been identified or reported. She stated nursing staff had been trained on the use of CGM devices for other residents and reported staff were expected to document blood glucose readings on the MAR.On 3/19/26 at 1:15 PM, during an interview with the Administrator, she reported she was not aware the resident had a CGM device.On 3/20/26 at 12:00 PM, during a post-exit telephone interview with the Nurse Practitioner, she reported she expects staff to follow physician orders and notify her of any concerns or discrepancies related to resident care. She confirmed she had not been notified of any concerns related to blood glucose monitoring or documentation for Resident #16. She explained she relies on accurate and complete documentation to make clinical decisions.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview, record review, and facility policy review, the facility's consultant pharmacist failed to ensure monthly medication regimen reviews (MMRs) identified and reported medication-related irregularities regarding insulin administration and documentation (Resident #16), failed to identify and report the absence of a Gradual Dose Reduction (GDR) for a resident receiving psychotropic medications (Resident #79), and failed to provide resident-specific documentation of MMRs to demonstrate which residents were reviewed for two (2) of (19) sampled residents.Findings include:A review of the facility's policy Pharmacy Services-Role of the Consultant Pharmacist, revised April 2019 revealed . The facility shall have the services of a consultant pharmacist. Policy Interpretation and Implementation . 3. The consultant pharmacist shall provide consultation on all aspects of pharmacy services in the facility, and collaborate with the facility and medical director to: . e. Strive to assure that medications are requested, received, and administered in a timely manner as ordered by the authorized prescriber; . 5. The Consultant Pharmacist will provide specific activities related to medication regimen review including: a. A documented review of the medication regimen of each resident at least monthly, or more frequently under certain conditions, based on applicable federal and state guidelines; b. Appropriate communication of information to prescribers and facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record as indicated; c. Providing the facility with written or electronic reports and recommendations related to all aspects of medication and pharmaceutical services review.Resident #16A record review of the admission Record revealed the facility admitted Resident #16 on 1/12/26 with diagnoses including Type 2 Diabetes Mellitus.A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/19/26 revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident's cognition was moderately impaired. A review of Section N revealed he received insulin injections.A record review of the Order Summary Report revealed Resident #16 had a Physician's Order, dated 1/14/26, for NovoLog (Insulin Aspart) 100 units per milliliter (mL) to inject an alternating dose subcutaneously two (2) times daily for hyperglycemia, with instructions to check blood glucose prior to lunch and supper at 11:00 AM and 4:00 PM, and administer five (5) units if blood glucose was greater than 200, ten (10) units if greater than 300, and hold if less than 200.A record review of the Medication Administration Records (MARs) for January, February, and March 2026 for Resident #16 revealed the following: MAR for 01/01/26-01/31/26 at 11:00 AM revealed on 01/24/26 no blood glucose (BG) reading was documented and a code of nine (9) was entered indicating other/see progress note with no corresponding note. On 01/25/26 a BG reading of 145 was documented with five (5) units of insulin administered; however, a code of nine (9) was also entered and a progress note indicating no insulin was given. On 01/30/26 a BG reading of 162 was documented with five (5) units administered, with no corresponding progress note documented. MAR for 01/01/26-01/31/26 at 4:00 PM revealed on 01/20/26 no BG reading was documented with a code of five (5) entered indicating hold/see progress note, however there was no corresponding progress note. On 1/30/26 no BG reading was documented with a code of four (4) entered indicating Vitals outside of Parameters for Administration. MAR for 02/01/26-02/28/26 at 11:00 AM revealed on 02/12/26, 02/13/26, and 02/18/26, no BG readings were documented with a code of nine (9) entered indicating other/see progress note, with no progress notes recorded. On 2/26/26 and 2/27/26, no BG reading and Code 13 was entered indicating No Insulin Required. On 02/24/26 a BG reading of 144 was documented with five (5) units administered, with no corresponding progress note documented. MAR for 02/01/26-02/28/26 at 4:00 PM revealed on 02/05/26 no BG reading was documented with a code of four (4) entered indicating vitals outside of parameters for administration. On 02/11/26, 02/14/26, 02/23/26, 02/26/26 and 02/27/26 no BG (continued on next page)

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	255250	A. Building B. Wing	03/19/2026

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	readings were documented with a code of thirteen (13) entered indicating no insulin required. On 02/12/26, 02/13/26, and 02/18/26 no BG readings were documented with a code of nine (9) entered indicating other/see progress note with no corresponding progress note. These irregularities were not identified or reported in the consultant pharmacist's monthly medication regimen reviews conducted in January or February 2026.Resident #79A record review of the admission Record revealed the facility admitted Resident #79 on 5/20/25 with diagnoses including Dementia.A record review of the Order Summary Report revealed Resident #79 received psychotropic medications including Quetiapine and Sertraline initiated on 5/20/25.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/2/26 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident's cognition was moderately impaired. Section N documented the resident received antipsychotic and antidepressant medications and indicated no Gradual Dose Reduction (GDR) had been documented as clinically contraindicated.A record review of the medical record revealed no documentation of a Gradual Dose Reduction (GDR).A record review of the facility's report Psychopharmacological Medications & Antipsychotics Drug Utilizations report for January and February 2026 revealed Resident #79 was listed as being prescribed Quetiapine Fumar with an Order Date of 2/12/2026 and next evaluation listed as 8/30/26 and Sertraline with an Order Date of 1/29/26 and next evaluation listed as 7/28/26. These order dates were inconsistent with the order dates reflected in the Physician's Orders and MARs.A record review of the facility's Psychoactive and Sedative/Hypnotic Utilizations, dated January 2026, and signed by the pharmacist consultant revealed . The pharmacist reviewed the use of all psychoactive drugs in the facility . The facility continues to monitor use of antipsychotics and document proper diagnosis of these medications. The pharmacist will continue to monitor the use of psychoactive medications and recommend any changes deemed necessary . There were no details indicating which individual residents were reviewed or if Resident #79 was reviewed.A record review of the facility's Monthly Pharmacy Report for January 2026 revealed . The Consultant pharmacist reviewed 97 charts over 3 days. 1. The Nurse Practitioner reviewed all dose reductions prior to time for review. The consultant had many discussions with nursing staff about medications and doses . Having an in-house Nurse Practitioner has helped with gradual dose reduction and reducing the number of patients on antipsychotics . There were no details indicating which individual residents were reviewed for the MMR, including Residents #16 and 79.A record review of the facility's Monthly Pharmacy Report for February 2026 revealed . The Consultant pharmacist reviewed 98 charts over 3 days. 1. The Nurse Practitioner reviewed all dose reductions prior to time for review. The consultant had many discussions with nursing staff about medications and doses . Having an in-house Nurse Practitioner has helped with gradual dose reduction and reducing the number of patients on antipsychotics . There were no details indicating which individual residents were reviewed for the MMR, including Residents #16 and 79.On 3/18/26 at 2:20 PM, during an interview with the Director of Nursing (DON), she confirmed there was no documentation of a GDR for Resident #79 and reported she had not received any recommendation from the consultant pharmacist regarding a GDR.On 3/18/26 at 3:10 PM, during a phone interview with the consultant pharmacist, he reported he conducts monthly reviews and provides reports of findings and concerns but stated he does not always review residents' MARs and was not aware of any medication errors or irregularities for Resident #16. He also reported he relies on information from nursing staff and providers regarding medication changes and had not made a GDR recommendation for Resident #79.On 3/19/26 at 1:00 PM, during an interview and record review with the DON, she confirmed the MARs for Resident #16 contained missing blood glucose readings, inconsistent documentation, and insulin dosages that did not align with physician orders. She reported she had not been notified of these irregularities and expected the consultant pharmacist to identify and report medication-related concerns during monthly reviews.On 3/19/26 at 3:30 PM, during an interview with the DON, she confirmed the pharmacy reports provided were the only documentation available and did not include resident-specific findings or recommendations. She stated she expects (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the consultant pharmacist to identify and report medication irregularities and provide recommendations, including GDRs when indicated.On 3/19/26 at 4:55 PM, during an interview with the Administrator, she reported she expects the consultant pharmacist to fulfill all responsibilities related to medication regimen reviews and to communicate any identified concerns or recommendations.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, record review, and facility policy review, the facility failed to prevent significant medication errors when nursing staff administered insulin outside of physician-ordered parameters for one (1) of (19) sampled residents (Resident #16).Findings include:A review of the facility's policy Administering Medications, revised April 2019 revealed . Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . 2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. 4. Medications are administered in accordance with prescriber orders, including any required time frame . 6. Medications errors are documented, reported, and reviewed by the QAPI (Quality Assessment and Performance Improvement) committee to inform process changes and or the need for additional staff training . 10. The individual administering the medication checks to verify the right resident, right medication, right dosage, right time, and right method (route) of administering before giving the medication.A review of the facility's policy Medication Errors (undated) revealed . Medication error is defined as administration of medication other than as ordered by the physician, i.e., omission of medication, incorrect medication, incorrect dosage . Note: a significant medication error is one that cause resident discomfort and/or jeopardizes his/her health and/or safety, and one that requires the immediate notification of the physician and the Director of Nursing (DON) . Medication errors shall be reported immediately to the Head Nurse and the attending physician, who will determine and write order for the necessary follow-up treatment.A record review of the admission Record revealed the facility admitted Resident #16 on 1/12/26 with diagnoses including Type 2 Diabetes Mellitus.A record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/19/26 revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated his cognition was moderately impaired. A review of Section N revealed he received insulin injections.A record review of the Order Summary Report revealed Resident #16 had a Physician's Order, dated 1/14/26, for NovoLog (Insulin Aspart) 100 units per milliliter (mL) to inject an alternating dose subcutaneously two (2) times daily for hyperglycemia, with instructions to check blood glucose prior to lunch and supper at 11:00 AM and 4:00 PM, and administer five (5) units if blood glucose was greater than 200, ten (10) units if greater than 300, and hold if less than 200.A record review of the Medication Administration Records (MARs) for Resident #16 for January, February, and March 2026 revealed insulin was administered outside of ordered parameters. On 1/25/26 at 11:00 AM, a blood glucose reading of 145 was documented with five (5) units administered. On 1/30/26 at 11:00 AM, a blood glucose reading of 162 was documented with five (5) units administered. On 2/24/26 at 11:00 AM, a blood glucose reading of 144 was documented with five (5) units administered. On 3/14/26 at 11:00 AM, a blood glucose reading of 186 was documented with five (5) units administered. On 3/15/26 at 11:00 AM, a blood glucose reading of 161 was documented with five (5) units administered. On 3/1/26 at 4:00 PM, a blood glucose reading of 247 was documented with ten (10) units administered. On 3/14/26 at 4:00 PM, a blood glucose reading of 180 was documented with five (5) units administered. There was no corresponding documentation or clarification identified in the medical record regarding administering insulin outside of the parameters on these dates.On 03/18/2026 at 11:30 AM, during an observation and interview with Licensed Practical Nurse (LPN) #2, she performed an Accu-Chek on Resident #16 using the facility's glucometer and stated that she tries to record the blood glucose results right away. She said that she will write a progress note if one is needed. She reported that she has not paid attention to the Xs recorded Resident #16's MAR or that there was no BG results recorded. She said that the Codes used are explained on the last page of the MAR. On 3/19/26 at 1:00 PM, during an interview and record review with the Director of Nursing (DON), she confirmed the blood glucose readings and insulin dosages documented on the MAR did not align with physician orders and would be considered medication errors. She reported she had not been notified of these medication (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	errors. She stated the facility has a Quality Assurance Nurse responsible for monitoring medication practices, and nursing staff are trained and checked off on medication administration and documentation.On 3/19/26 at 4:46 PM, during an interview with the DON, she stated she expects to be notified immediately of any medication errors or irregularities.During a post exit phone interview on 3/20/26 at 12:00 PM, with Nurse Practitioner #2, she stated she expects staff to follow medication orders as prescribed and to notify her of any concerns or discrepancies. She confirmed she had not been notified of any medication errors related to Resident #16's insulin administration and explained incorrect insulin dosing could result in low blood glucose levels and associated adverse symptoms.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, record review, and facility policy review, the facility failed to store, prepare, and serve food in accordance with professional standards for food safety, when the facility failed to repackage, label, and date opened food items, failed to discard expired and deteriorated food items, and failed to store food according to manufacturer's instructions for one (1) of two (2) kitchen observationsFindings include:A review of the facility's policy, Food Procurement, Store/Prepare/Serve - Sanitary (revised 9/2022), revealed, .The facility will.d. Store, prepare, distribute and serve food in accordance with professional standards for food service safety.A record review of the facility's Inservice Report, dated 8/5/25, revealed dietary staff received training regarding food preparation practices for food safety.On 3/16/26 at 11:17 AM, during an observation and interview with the Dietary Manager (Dietary Department #1) and Group Consultant (Dietary Department #3), in the freezer there were frozen sliced pizza that was not repackaged, labeled, or dated. There were (2) opened bags of Mexican beef taco meat that were opened, used, and resealed with rubber bands without labeling or dating. During the refrigerator inspection, a bag of shredded lettuce labeled Best if Used by March 2, 2026 was observed opened and dated March 16, 2026. The Dietary Manager stated the lettuce had been received approximately two weeks prior. (1) bag of celery was observed deteriorated and breaking down inside the packaging. Four (4) half gallons of buttermilk with expiration dates of March 4 and March 12 were also observed. (2) partially used bags of chopped boiled eggs were resealed with rubber bands. DD #1 confirmed eggs are not shipped in that manner and acknowledged improper storage. There was (1) open container of imitation bacon bits stored in the refrigerator without labeling or dating. There was (1) bottle of Kikkoman Reduced Sodium Soy Sauce that was opened, used, and stored on a shelf in the dry goods room despite manufacturer instructions requiring refrigeration after opening. DD #3 acknowledged the product was not stored according to manufacturer's instructions. DD #1 explained that all staff that are putting away deliveries are responsible for checking expiration dates.On 3/19/26 at 10:52 AM, during an interview with DD #2, she explained the plan to address the identified concerns included re-educating staff through in-service training on proper storage and labeling procedures and increasing monitoring of staff compliance.On 3/19/26 at 3:08 PM, during an interview with the Administrator, she stated she was aware of the issues identified in the dietary department and stated her expectation is for dietary staff to properly package, store, and date all food items in accordance with facility policy.