

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2026
NAME OF PROVIDER OR SUPPLIER New Albany Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 118 South Glenfield Road New Albany, MS 38652	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview, and facility policy review, the facility failed to label and store food properly for one (1) of three (3) kitchen tours. Findings Include: Review of facility policy titled Food Storage with a revision date of 11/28/2017 revealed, Ready-to-eat foods shall be marked with a discard date at the time of opening or preparation. During the initial tour of the kitchen with the District Dietary Manager (DM) on 6/8/2026 at 10:10 AM, the walk-in freezer was observed to have open boxes of corn dogs, chicken patties, and mixed vegetables exposed to the air. In the walk-in refrigerator, a gallon milk jug that was about one-fourth (1/4) full had no date indicating when it was opened. In the dry storage room, one-third (1/3) of a bag of spaghetti noodles and one-half (1/2) of a five-pound bag of egg noodles were open and exposed to the air. A bottle of soy sauce that contained less than one-fourth (1/4) of its contents had no date indicating when it was opened. During an interview with the District Dietary Manager (DM) on 6/8/2026 at 10:30 AM, she confirmed that all opened food items should be labeled with the date they were opened and acknowledged that failure to do so could increase the risk of foodborne illness. She also confirmed that food stored in the freezer and dry storage areas should be kept sealed.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 255268	If continuation sheet Page 1 of 9

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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 observation, resident and staff interview, record review, and facility policy review, the facility failed to follow the resident's comprehensive care plan for grooming preferences for two (2) of (21) care plans reviewed. Resident #11 and Resident #65. Findings include: Record review of the facility policy titled Comprehensive Plan of Care, revised 2/17/25, revealed under, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Resident #11 Record review of Care Plan Report revealed Shave as indicated/requested. During an observation on 6/8/2026 at 11:04 AM and again on 6/9/2026 at 2:50 PM, Resident #11 was observed lying in bed. Several hairs, approximately one-fourth (1/4) inch in length, were observed on her chin. She stated she does not like hair on her chin, and she sometimes must shave it herself. She stated she had just received her shower. During an interview on 6/9/2026 at 3:02 PM, Certified Nursing Assistant (CNA) #1 revealed Resident #11 is scheduled for a bath on Monday, Wednesday, and Friday. She stated the shower aide should have shaved the resident's chin during her shower. She stated that shaving is an important part of grooming and personal care for residents. During an interview on 6/9/2026 at 3:13 PM, Licensed Practical Nurse (LPN) #1 revealed that the CNAs are responsible for shaving residents during their showers. She stated that making sure residents are shaved helps them feel better about themselves and makes them look clean and neat. She revealed that Resident #11 likes to apply full makeup and have her eyebrows waxed and acknowledged that appearance is important to Resident #11. During an interview on 6/9/2026 at 3:26 PM, the Director of Nursing (DON) confirmed the resident should have been shaved during her bath. An interview with the Minimum Data Set (MDS) Nurse on 6/10/26 at 3:35 PM, revealed the purpose of the resident's care plan was to let staff know the care the resident needed or desired. She acknowledged Resident #11 had a care plan for shaving and the care plan was not followed according to her preferences. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission Record indicated Resident #11 was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease (COPD). Review of the MDS, with an Assessment Reference Date (ARD) of 3/19/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #11 was cognitively intact. Resident #65 Record review of Resident #65's Care Plan Report revealed under, Focus: ADLs (activities of daily living): Resident requires assist with ADLs. The care plan further revealed under, Interventions: Shave as indicated/requested. During an observation and interview with Resident #65 on 6/8/26 at 11:09 AM, and again on 6/9/26 at 11:02 AM, Resident #65 was lying in bed with long gray facial hair measuring approximately one-half (1/2) inch in length. Resident #65 stated he preferred to be clean shaven and stated he would feel better if he were shaved. He explained he was no longer able to go to the shower room due to his health decline, but he received bed baths and was not always shaved on those days. Resident #65 stated it was important to him to be well groomed. During an observation and interview on 6/9/26 at 11:08 AM, CNA #2 confirmed Resident #65 had long, unshaven facial hair, which was inconsistent with his preference to be clean shaven. An interview with the MDS Nurse on 6/10/26 at 3:30 PM revealed the purpose of the resident's care plan was to let staff know the care the resident needed or desired. She acknowledged Resident #65 had a care plan for shaving and the care plan was not followed according to his preferences. Record review of the admission Record revealed the facility admitted Resident #65 on 2/17/26 with medical diagnoses that included Chronic Obstructive Pulmonary Disease. Record review of the Progress Notes, dated 5/20/26, revealed a BIMS summary score of 10, indicating Resident #65 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 observation, resident and staff interview, record review, and facility policy review, the facility failed to provide grooming assistance related to shaving unwanted facial hair for two (2) of (103) residents reviewed for activities of daily living (ADLS) during the initial tour. Residents #11 and #65 Findings Include: Review of the facility policy titled Activities of Daily Living revised 9/15/22 revealed under, Policy: . Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care; Additionally revealed under, Policy Explanation and Compliance Guidelines: . 3. Residents who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #11 During an observation on 6/8/2026 at 11:04 AM and again on 6/9/2026 at 2:50 PM, Resident #11 was observed lying in bed with several hairs, approximately one-fourth (1/4) inch in length, were observed on her chin. She stated she does not like hair on her chin, and she sometimes must shave it herself. She stated she had just received her shower and the staff failed to shave her chin hairs. During an interview on 6/9/2026 at 3:02 PM, Certified Nursing Assistant (CNA) #1 revealed Resident #11 is scheduled for a bath on Monday, Wednesday, and Friday. She stated the shower aide should have shaved the resident's chin during her shower. She stated that shaving is an important part of grooming and personal care for residents. During an interview on 6/9/2026 at 3:13 PM, Licensed Practical Nurse (LPN) #1 revealed that the CNAs are responsible for shaving residents during their showers. She stated that making sure residents are shaved helps them feel better about themselves and makes them look clean and neat. She revealed that Resident #11 likes to apply full makeup and have her eyebrows waxed and confirmed that appearance is very important to Resident #11. During an interview on 6/9/2026 at 3:26 PM, the Director of Nursing (DON) confirmed the resident should have been shaved during her bath. Review of the admission Record indicated Resident #11 was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/19/2026, revealed under Section C a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #11 was cognitively intact. Resident #65 (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 6/8/26 at 11:09 AM, and again on 6/9/26 at 11:02 AM, revealed Resident #65 lying in bed with long gray facial hair measuring approximately one-half (1/2) inch in length. The resident stated he preferred to be clean shaven and stated he would feel better if he were shaved. He explained he was no longer able to go to the shower room due to his health decline but received bed baths and was not always shaved on those days. The resident stated it was important to him to be well groomed. An observation and interview with CNA #2 on 6/9/26 at 11:08 AM revealed she was assigned to Resident #65. She stated that when the resident received a bed bath, he was shaved by the aide providing care on Tuesday, Thursday, and Saturday. She stated the resident should have been shaved on Saturday and confirmed the length of his facial hair did not appear consistent with having been shaved on that date. An interview with the DON on 6/9/26 at 11:20 AM revealed her expectation was that residents who preferred to be shaved would receive shaving care on their scheduled bath day. She stated the aides were responsible for providing the care and Resident #65 should be shaved according to his preference. Record review of the admission Record revealed the facility admitted Resident #65 on 2/17/26 with a medical diagnosis that included Chronic Obstructive Pulmonary Disease. Record review of the Progress Notes dated 5/20/26 revealed a BIMS summary score of 10, indicating Resident #65 was moderately cognitively impaired.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on record review, facility policy review, staff interviews, and resident representative interviews, the facility failed to ensure binding arbitration agreements were presented and explained in a form and manner understood by resident representatives and failed to ensure resident representatives (RR) were informed that signing the arbitration agreement was voluntary and not a condition of admission for two (2) of three (3) residents reviewed for arbitration agreements. Residents #27 and #92 Findings Include: Review of the facility policy titled Binding Arbitration Agreement revealed under, Policy: This facility asks all residents to enter an agreement for binding arbitration. Additionally revealed under, Policy Explanation and Compliance Guidelines: 1. When the arbitration agreement is presented: a. The resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, this facility. b. The agreement must be presented to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. Review of the admission Packet revealed the Arbitration Agreement was incorporated into the electronic admission packet and presented with other admission documents. Resident #27A telephone interview on 6/10/26 at 2:41 PM, with Resident #27's RR revealed she signed paperwork for the resident's admission to the facility; however, nothing related to the arbitration agreement was explained to her. She stated, No I don't recall anyone explaining anything about resolving disputes. She revealed she was never told the agreement was voluntary and that she did not have to sign it as a condition of admission. The RR stated that if she signed the agreement, she did not recall doing so. Record review of the admission Record revealed the facility admitted Resident #27 on 5/29/26 with medical diagnoses that included Disorder of Thyroid and Manic Episode. Record review of Resident #27's Arbitration Agreement revealed an electronically signed RR signature dated 5/29/26 accepting the arbitration agreement. Resident #92A telephone interview with Resident #92's RR on 6/10/26 at 2:56 PM, revealed he signed the admission paperwork electronically after it was emailed to him. He stated nobody contacted him to determine whether he understood the documents. He stated nobody explained to him that he was signing an arbitration agreement and he asked, What exactly is it? He revealed he was not told anything about arbitration and was not informed the agreement was voluntary. He stated, No, I do not remember signing it. Record review of the admission Record revealed the facility admitted Resident #92 on 4/20/26 with a medical diagnoses that included Traumatic Subdural Hemorrhage. Record review of Resident #92's Arbitration Agreement revealed an electronically signed RR signature dated 4/17/26 accepting the arbitration agreement. An interview with the Director of Care Transition on 6/10/26 at 3:16 PM revealed she was responsible for the arbitration agreement as part of the admission process. She stated approximately 90% of admission packet paperwork was completed electronically through email and that they did not sit down with the majority of RRs and go over the Arbitration Agreement paperwork. She stated she did not contact families before or after sending the paperwork to explain arbitration and simply just informed families that If they have any questions they can reach out to me. She stated families were expected to read the document and contact her if they had questions. She stated she had not had any families refuse to sign the arbitration agreement, stating, They always sign it. An interview with the Corporate Nursing Consultant on 6/10/26 at 3:26 PM, revealed the facility's arbitration agreement was straight forward, and families were expected to read it because the agreement read that it was not required to be signed. After surveyor inquiry regarding the lengthy (continued on next page)		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission paperwork requiring signatures and whether some individuals may not read every document word for word, she stated, I would never sign anything that I did not read. She stated families had the ability to accept or decline the agreement, which indicated the agreement was voluntary. An interview with the Administrator on 6/10/26 at 3:35 PM, revealed the families were offered the option to complete the paperwork electronically or come to the facility to complete it in person. She stated families were expected to read the document and, if they did not want to sign it, they were not required to do so. She acknowledged the arbitration agreement was not presented separately from the admission paperwork and acknowledged this could be misconstrued by some families as a required admission document if not read fully. She confirmed no one contacted RRs to ensure they had read and understood the agreement, that it was voluntary, or that signing the agreement involved waiving the right to pursue future litigation.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, record review, and facility policy review, the facility failed to ensure reasonable accommodation of resident needs by maintaining access to the call system for one (1) of (21) residents reviewed. Resident #62. Findings include: Review of facility policy titled Call Lights: Accessibility and Timely Response revealed The purpose of this policy is to ensure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. 5. Staff will ensure the call light is within reach of the resident and secured, as needed. During observations on 6/8/2026 at 11:28 AM and again at 2:05 PM, Resident #62 was observed lying in bed with the call light on the floor next to the wall at the head of the bed and out of the resident's reach. During an interview on 6/9/2026 at 3:36 PM, the Director of Nursing (DON) confirmed Resident #62 would not have been able to reach the call light to request assistance while it was lying on the floor. Review of the admission Record indicated Resident #62 was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease (COPD). Review of the Progress Notes *NEW*, with an effective date of 2/24/2026, revealed a Brief Interview for Mental Status (BIMS) summary score of 13, indicating Resident #62 was cognitively intact.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and facility policy review, the facility failed to obtain a physician-ordered laboratory test for one (1) of five (5) residents reviewed for medication management and laboratory services. Resident #63. Findings Include: Review of the facility policy titled Diagnostic Services: Lab Tests and X-Ray with a revision date of 11/28/2017, revealed, It is the policy of this facility to provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Review of Resident #63's Order Details with a Physician's order date of 12/24/2025, revealed under Description: A1C every 3 months (Dec Mar June Sept.) During an interview on 6/10/2026 at 10:00 AM, the Director of Nursing (DON) confirmed Resident #63 had physician orders for a Hemoglobin A1C to be obtained quarterly in December, March, June, and September. The DON acknowledged that the facility had failed to obtain the ordered laboratory test for March. The DON revealed that monitoring the resident's Hemoglobin A1C is important for assessing blood glucose control and ensuring appropriate diabetes management. Record review of the admission Record revealed Resident #63 was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/28/26 revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated Resident #63 was severely cognitively impaired.		