STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255318	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J G Alexander Nursing Center	25112 Highway 15 Union, MS 39365

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 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. 43283 Based on observations, interviews, record reviews, and the facility policy review, the facility failed to honor residents' rights and dignity by not honoring requests for a second bed rail as an enabler and by posting signs at the head of the bed related to resident care for three (3) of 16 sampled residents: Resident #5, Resident #39, and Resident #54. Findings include: A review of the facility's Resident Rights Policy revised in 09/2022 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. Facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance and enhancement of their quality of life, recognizing each resident's individuality. The facility will protect and promote the rights of each resident . Resident #5 On 01/28/25 at 10:51 AM, Resident #5 requested to speak with the State Agency (SA). During the interview and observation, the resident explained that she had only one bed rail on the right side but had requested another on the left. She was told that the state removed bed rails. Resident #5 stated she needed both rails to assist with turning and to feel safer at night following an elective hip replacement. The SA observed one half-bed rail on the right side of the bed. The resident explained that she used a recliner on the left side to assist with turning, which was unsafe, and she feared rolling out of bed. On 01/28/25 at 01:25 PM, during an interview, Certified Nurse Aide (CNA) #2 stated that Resident #5 had repeatedly requested an additional bed rail, as had other residents. The management was notified, but residents and staff were informed that only one bed rail was allowed. CNA #2 confirmed that Resident #5 used the existing bed rail for turning and getting out of bed. After her hip surgery, Resident #5 required a stand-up lift and had difficulty moving in bed with only one bed rail. On 01/28/25 at 03:40 PM, Licensed Practical Nurse (LPN) #1 confirmed that Resident #5 had only one bed rail, similar to most residents. According to LPN #1, upper management instructed staff that no resident could have two bed rails due to SA regulations. Resident #5 struggled to get out of bed post-hip replacement and continued to request two bed rails but was denied. (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	On 01/29/25 at 04:10 PM, during an observation of Resident #5's transfer from a wheelchair to bed with the Therapy Director and CNA #3, staff used a stand-up lift. The resident demonstrated upper body strength while using the lift. Positioned on the left side of the bed, Resident #5 stated that an additional bed rail would assist with transfers. The Therapy Director confirmed that Resident #5 had requested another bed rail but was denied. A review of Resident #5's Admission Record indicated admission on 12/05/22 with diagnoses including Other Chronic Pain and Presence of Neurostimulator. A review of Resident #5's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/24 indicated a Brief Interview for Mental Status (BIMS) score of 12, signifying intact cognition. Section GG showed no upper extremity impairment, and the resident required supervision or touch assistance with transfers. A review of Resident #5's Bedrails Consent signed by her daughter on 08/01/24 did not specify the use of only one bedrail. The consent form had Yes checked under the question, Do you choose to use bedrails on your bed while in the facility? Resident #54 On 01/27/25 at 01:41 PM, during an observation and interview, the SA observed Resident #54 in bed with one bed rail up. The resident asked why he did not have four bed rails like he had in the hospital. On 01/28/25 at 02:50 PM, Registered Nurse (RN) #5 explained that the facility only allowed one bed rail unless deemed necessary. Resident #54 had only had one side rail since admission, and no residents were allowed four bed rails. On 01/28/25 at 03:00 PM, during an interview, Resident #54 stated he had been at the facility for nearly a year and had requested another bed rail to assist with turning. He was informed that only one was allowed. The resident denied upper arm weakness and continued to request a second bed rail for assistance. On 01/29/25 at 03:30 PM, during an interview, the Director of Nursing (DON) stated that the facility limited bed rails to one per resident for safety reasons but lacked documentation supporting this decision. She was unaware of requests from Resident #5 or Resident #54 and confirmed that alternative positioning aids had not been considered. A review of Resident #54's Admission Record indicated admission on 02/21/24 with diagnoses including Osteomyelitis of the Vertebra and Rheumatoid Arthritis. A review of Resident #54's Quarterly MDS with an ARD of 11/28/24 revealed a BIMS score of 14, indicating intact cognition. Section GG indicated no extremity impairments and the resident required supervision or touch assistance with transfers. A review of Resident #54's Bedrails Consent dated 02/21/24 did not specify the use of only one bedrail. The form had Yes checked under the question, Do you choose to use bedrails on your bed while in the facility? (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39 On 01/27/25 at 11:30 AM, the SA observed Resident #39 in bed with signage posted at the head of the bed, including: Enhanced barrier, Oral care, Turning schedule - keep heels floated, and Keep head of bed up at all times. A proper name was included on the signs. On 01/28/25 at 03:00 PM, CNA #5 confirmed that the signage had been in place for an extended period and contained resident care instructions. On 01/29/25 at 02:20 PM, the Administrator and DON confirmed that signage related to personal care should not be displayed on walls, as it violated Resident #39's dignity. The DON stated she was unaware of the postings and confirmed the signs would be removed. Both the Administrator and DON stated they expected all staff to honor residents' rights and avoid posting personal care instructions publicly. On 01/29/25 at 03:20 PM, RN #2 confirmed that one of the names on the signage belonged to a former staff member and acknowledged that resident care instructions should not be posted on the wall. She identified the postings as a dignity issue.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 50751 Based on observation, interview, and record review, the facility failed to notify the physician of a significant change in condition, as evidenced by the facility did not notify the physician of a resident's 33-pound weight loss of 17 percent (%) of total body weight, persistent drowsiness affecting oral intake, and the failure to implement dietary recommendations which delayed necessary medical interventions and contributed to continued weight loss for one (1) of sixteen (16) sampled residents (Resident #45) Cross Reference F692 and F758 Findings included: On 01/27/2025 at 1:01 PM, during an observation and interview with Resident #45's family member, the resident was in his room for lunch. He was drowsy and did not wake up for the Certified Nursing Assistant (CNA) who was attempting to feed him. He eventually woke up to eat two (2) small bites of food when encouraged by the family member. The family member expressed concern that the resident had lost approximately 20 pounds since being discharged from a behavioral health hospital in March 2024. During an observation an interview on 01/28/2025 at 12:10 PM, in the dining hall, Resident #45 was observed sleeping throughout the lunch period. CNA #1 attempted to wake him multiple times, but the resident did not respond and did not eat. CNA #1 stated that the resident frequently fell asleep during meals or slept entirely through mealtime. During an interview on 01/29/2025 at 12:01 PM, the Resident Representative (RR) expressed concern about Resident #45's recent psychiatric status, as he had been consistently sleeping through meals and was difficult to wake up. He reported requesting a psychiatric consultation on 01/24/2025. A record review of Resident #45's weight summary revealed that the resident weighed 191 pounds on 03/04/2024 and 158 pounds on 01/17/2025, reflecting a total weight loss of 33 pounds in ten (10) months. A record review of Resident #45's meal intake percentages from 01/01/2025 through 01/28/2025 revealed his documented meal intake was between 0-25 percent of meals on (13) of (28) days. A record review of the Progress Notes revealed Resident #45 had a Nutrition/Dietary Note, 9/11/2024, authored by the Registered Dietitian (RD), that indicated, .WT (Weight) Change: -3.7% x (times) 1 mo (month), -6.6% WL (Weight Loss) x 3 mo, -18.8% SWL (Significant Weight Loss) x 6 mo .Comments .Intake does not meet nutritional needs. Resident has experienced a continued WL with a SWL for 6 mo. Resident observed asleep in bed this morning. Resident has been receiving a SF (Sugar Free) house supplement TID (three times daily) but this was DC'd (Discontinued) on 9/10/25. Oral intake of meals has declined over the last month .Interventions: 1. House Supplement 8 oz (ounces) TID at medpass - document intake on eMAR (electronic Medication Administration Record) . (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	A record review of the Progress Notes revealed Resident #45 had a Nutrition/Dietary Note, 11/13/2024, authored by the Registered Dietitian (RD), that indicated, .Resident has experienced SWL x 6 mo. RD recommended a house supplement 8 oz BID at medpass at last visit in October. It does not appear the supplement was implemented .WT Change .-13% SWL x 6 mo .Comments .Intake does not meet nutritional needs .RD recommended a supplement at the last 2 visits. Recommendation was not implemented . Interventions: 1. House Supplement 8 oz BID at medpass - document intake on eMAR . A record review of the Order Summary Report with active orders as of 1/29/25 revealed Resident #45 had a physician's order dated 3/4/24 for a low concentrated sweets diet with regular texture related to Type 2 Diabetes Mellitus with Hyperglycemia, an order dated 4/2/24 for Trileptal 150 milligrams (mg) to be given twice daily for Dementia with Agitation and Depression and an order dated 4/2/24 for Rexulti 1 mg to be given daily for Dementia with Agitation. There were no current orders for the house supplement of MedPass as recommended by the RD. A record review of the eMAR for Resident #45 for October 2024, November 2024, December 2024, and January 2025 revealed there was no documentation that MedPass was administered as recommended by the RD. During an interview on 01/29/2025 at 3:00 PM, the Director of Nursing (DON) reviewed the RD's note dated 11/13/2024, which recommended starting house supplements based on prior dietary recommendations from 09/11/2024, which were never implemented. The DON stated that the recommendation was likely not received due to turnover among facility dietitians. She further explained that dietary recommendations were typically given to the physician via a communication folder, and the physician signed off for approval. She confirmed that the supplements were not started as they should have been, and stated she would initiate them immediately. During an interview on 01/30/2025 at 11:45 AM, the Medical Director stated he was unaware of the resident's weight loss and had not been notified by nursing staff. He stated that the resident was prescribed multiple psychotropic medications, including Rexulti, which could cause lethargy, and Trileptal, which could affect appetite. He explained that he should have been informed of the weight loss through dietitian reports in Quality Assurance meetings but had not been made aware. He acknowledged that the weight loss should have been addressed sooner. A record review of the Admission Record revealed the facility admitted Resident #45 on 03/04/2024 with diagnoses that included Alzheimer's Disease, onset date of 04/04/2024. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2024 revealed Resident #45 had lost five (5) % or more of his weight in the last month or 10 % in the last six months, and that he had current diagnoses of Alzheimer's Disease and Dementia. The MDS also revealed he had a Brief Interview for Mental Status (BIMS) score of (5), which indicated the resident's cognition was severely impaired.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 50751 Based on observation, interviews, and record review, the facility failed to ensure that a resident did not experience a significant weight loss of over 10% in six months, as evidenced by Resident #45 was observed to be lethargic and was unable to intake appropriate nutrition to sustain weight. Resident #45 did not have Registered Dietitian (RD) interventions implemented when ordered and did not have medications reviewed for one (1) of sixteen (16) sampled residents (Resident #45) Cross Reference F580 and F758 Findings included: During an observation and interview on 01/27/2025 at 1:01 PM, with Resident #45's family member, the resident was in his room for lunch. He was drowsy and did not wake up for the CNA who was attempting to feed him. He eventually woke up to eat two (2) small bites of food when encouraged by the family member. The family member expressed concern that the resident had lost approximately 20 pounds since being discharged from a behavioral health hospital in March 2024. During an observation on 01/28/2025 at 12:10 PM, Resident #45 was in the dining hall but remained asleep throughout the entire lunch period and did not wake up despite multiple attempts by CNA #1. During an interview on 01/29/2025 at 11:23 AM, Registered Nurse (RN)#2 stated that psychiatric services were being ordered for Resident #45 because his son requested a psychiatric consultation on 01/24/2025. RN #2 confirmed that the resident had not received a psychiatric follow-up since returning from the behavioral health hospital ten (10) months ago. During an observation on 01/29/2025 at 1:59 PM, Resident #45 was asleep in his wheelchair in the common area near the nurses' station. During an interview on 01/29/2025 at 3:12 PM, the Director of Nursing (DON) confirmed that a psychiatric consultation for medication management had not been in progress until the resident's son requested the consultation on 01/24/2025. The DON stated that it was standard practice for the facility's Medical Doctor of Behavioral Health (MDB) to follow up with residents discharged from behavioral health units but acknowledged that this did not occur in this case. During an observation on 01/30/2025 at 9:35 AM, Resident #45 was asleep in his wheelchair in his room. On 01/30/2025 at 11:45 AM, during an interview the Medical Director stated he was unaware of the resident's weight loss and had not been notified by nursing staff. He stated that the resident was prescribed multiple psychotropic medications, including Rexulti, which could cause lethargy, and Trileptal, which could affect appetite. He explained that he should have been informed of the weight loss through dietitian reports in Quality Assurance meetings but had not been made aware. He acknowledged that the weight loss should have been addressed sooner. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/30/2025 at 1:41 PM, RN #3 stated that Resident #45 had exhibited altered sleep patterns prior to his psychiatric hospitalization but that his drowsiness had worsened in the past few months, causing him to miss meals. A record review of the Progress Notes revealed Resident #45 had a Nutrition/Dietary Note, 9/11/2024, authored by the Registered Dietitian (RD), that indicated, .WT (Weight) Change: -3.7% x (times) 1 mo (month), -6.6% WL (Weight Loss) x 3 mo, -18.8% SWL (Significant Weight Loss) x 6 mo .Comments .Intake does not meet nutritional needs. Resident has experienced a continued WL with a SWL for 6 mo. Resident observed asleep in bed this morning. Resident has been receiving a SF (Sugar Free) house supplement TID (three times daily) but this was DC'd (Discontinued) on 9/10/25. Oral intake of meals has declined over the last month .Interventions: 1. House Supplement 8 oz (ounces) TID at medpass - document intake on eMAR (electronic Medication Administration Record) . A record review of the Progress Notes revealed Resident #45 had a Nutrition/Dietary Note, 11/13/2024, authored by the Registered Dietitian (RD), that indicated, .Resident has experienced SWL x 6 mo. RD recommended a house supplement 8 oz BID at medpass at last visit in October. It does not appear the supplement was implemented .WT Change .-13% SWL x 6 mo .Comments .Intake does not meet nutritional needs .RD recommended a supplement at the last 2 visits. Recommendation was not implemented . Interventions: 1. House Supplement 8 oz BID at medpass - document intake on eMAR . A record review of Resident #45's weight summary revealed that the resident weighed 191 pounds on 03/04/2024 and 158 pounds on 01/17/2025, reflecting a total weight loss of 33 pounds in ten (10) months. A record review of Resident #45's meal intake percentages from 01/01/2025 through 01/28/2025 revealed his documented meal intake was between 0-25 percent of meals on thirteen (13) of twenty-eight (28) days. A record review of the eMAR for Resident #45 for October 2024, November 2024, December 2024, and January 2025 revealed there was no documentation that MedPass was administered as recommended by the RD. A record review of Resident #45's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2024 revealed in Section N that the resident received antipsychotics on a routine basis. Section K revealed the resident had lost five (5) % percent or more of his weight in the last month or ten (10) % in the last six months. Section I indicated that the resident had current diagnoses of Alzheimer's Disease and Dementia. Section C revealed a Brief Interview for Mental Status (BIMS) score of (5), which indicated the resident's cognition was severely impaired. A record review of the Order Summary Report with active orders as of 1/29/25 revealed Resident #45 had a physician's order dated 3/4/24 for a Low concentrated sweets diet with regular texture related to Type 2 Diabetes Mellitus with hyperglycemia, an order dated 4/2/24 for Trileptal 150 milligrams (mg) to be given twice daily for Dementia with Agitation and Depression and an order dated 4/2/24 for Rexulti 1 mg to be given daily for Dementia with Agitation. There were no current orders for the House Supplement of MedPass as recommended by the RD. A record review of Resident #45's Admission Record revealed the facility admitted the resident on 03/04/2024 with a diagnosis of Alzheimer's Disease, with an onset date of 04/04/2024.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 43283 Based on observations, interviews, record review and facility policy review the facility failed to maintain a record log of bed rail maintenance for two (2) of 16 sampled residents (Resident #5 and Resident #54). Findings Include: A record review of the facility's policy, Side Rail Policy, dated 06/25/18, revealed, It is the policy of this facility to attempt to use appropriate alternatives prior to installing a side or bed rail. If a side or bed rail is used, the facility will ensure correct installation, use, and maintenance of bed rails . Follow the manufacturer's recommendations and specifications for installing and maintaining rails . A record review of the Zenith Series manual revealed . Recommended Maintenance . Regular maintenance of the Long Term Bed is necessary to ensure continuing proper and safe operations . Inspect all fasteners for wear or looseness every six (6) months . On 01/28/25 at 10:51 AM, during an interview and observation, Resident #5 requested to see the State Agency (SA). The resident explained she only had one bed rail on the right side but had asked for another on the left. She was told the state removed the bed rails. She stated she had at least six (6) falls from rolling out of bed and expressed a desire for another bed rail to assist with turning and to feel safer at night. She recently elected to undergo a hip replacement and stated she needed both rails to assist with turning in bed. The SA observed a half-bed rail on the right side of the bed. The resident explained that she had a recliner on the left side, which she used to assist with turning if she could reach it. However, she stated that this method was unsafe and that she was afraid of rolling out of bed. She also reported shaking the bed rail daily to ensure it was not too loose. The bed rail was observed to be loose but intact. On 01/28/25 at 3:00 PM, during an interview and observation, Resident #54 explained that he had been at the facility for almost a year. He stated that, while on therapy load, he asked why he could not have another bedrail on the left side of his bed to assist with turning and repositioning. The resident denied any upper arm weakness and stated he had asked staff for another bed rail but was told he could only have one. He clarified that he did not want or need four (4) bed rails but would like a second to assist with turning. On 01/29/25 at 2:20 PM, during an interview, Maintenance #1 explained that upon admission, if a resident needed a bed rail, the therapy director or nursing department notified him to install one. He stated that this was usually done upon admission and that he did not perform any maintenance on the bed rail or bed afterward unless staff submitted a complaint in the maintenance logbook at the nurse's station. He stated he had never checked bed rails for security or looseness unless staff reported an issue and submitted a maintenance request work order. He further stated that he did not maintain a log for bed rail maintenance. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/27/25 at 1:41 PM, during an observation, Resident #54 was observed upright in bed with one (1) bed rail up. The resident questioned why he did not have all four (4) rails up as he did in the hospital. He stated that he had requested another bed rail to help with positioning but was told he could only have one. On 01/29/25 at 2:45 PM, during an interview, the Administrator stated that he was not aware of any log for bed or bed rail maintenance. He confirmed that the facility had a maintenance book at the nurse's station and that staff were expected to document maintenance needs in the book. On 01/30/25 at 11:00 AM, during an interview, the Maintenance Director stated that he could not find any maintenance guidelines related to bed rails. He explained that he installed the bed rails by sliding the pins into the slots and did not check them again unless a maintenance request was submitted. On 01/30/25 at 2:30 PM, during an interview, the Administrator reported that he was not aware that maintaining a log of bed rail maintenance was a requirement but stated that the facility would make changes to comply with regulations. A record review of Resident #5's Admission Record revealed the facility admitted her initially on 12/05/22 with diagnoses of Other Chronic Pain and Presence of Neurostimulator. A record review of Resident #5's Bedrails Consent revealed that her daughter signed the consent on 08/01/24. The consent did not specify the use of only one bed rail. The question Do you choose to use bedrails on your bed while in the facility? was checked Yes. A record review of Resident #54's Admission Record revealed the facility admitted him on 02/21/24 with diagnoses of Osteomyelitis of the Vertebra, Sacral, and Sacrococcygeal Region and Rheumatoid Arthritis, Unspecified. A record review of Resident #54's Bedrails Consent dated 02/21/24 revealed an X in place of a signature. The consent did not specify the use of only one bed rail. The question Do you choose to use bedrails on your bed while in the facility? was checked Yes.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 43283 Based on observations, interviews, and facility policy review the facility failed to post daily nursing staffing information in a clean and readable format in a prominent place readily accessible to residents and visitors. The postings also failed to include the facility name, date, census, and the total number and actual hours worked per shift for two (2) of four (4) survey days. Findings include: A record review of the facility's policy, Posted Nurse Staffing Information, revised in September 2022, revealed: . The facility posts the following information on a daily basis: 1. Facility Name 2. Current date 3. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: . 4. Resident census. The facility must post the nurse staffing data mentioned above on a daily basis at the beginning of each shift. The data must be posted in a clear and readable format and in a prominent place readily accessible to residents and visitors . On 01/27/25 at 3:00 PM, during a walk-through of the facility, the State Agency (SA) observed no staffing posting. On 01/28/25 at 9:25 AM, during a walk-through of the facility, no staffing posting was observed. On 01/28/25 at 10:25 AM, during an interview, the Director of Nursing (DON) explained that staffing is usually posted around the nurse's station and that there is also a binder containing staffing information. On 01/28/25 at 3:25 PM, during a walk-through of the facility, no staffing posting was noted. On 01/29/25 at 1:50 PM, during an interview, Registered Nurse (RN) #1 stated that staffing had never been posted since she had been at the facility. She explained that she fills out the staffing information daily and that it is kept in a binder. She also reported that she completed the total number of hours most days at the end of her shift. On 01/29/25 at 2:00 PM, during an interview, the DON and Administrator both stated that they were not aware staffing had to be visibly posted daily. They understood that staffing information had to be available for access if someone requested to view it, but not that it needed to be visibly displayed. They stated that this issue would be addressed, and that staffing would be posted daily.

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	255318	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J G Alexander Nursing Center	25112 Highway 15 Union, MS 39365

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 50751 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident received received necessary behavioral health services to address psychiatric needs and psychotropic medication management. Specifically, the resident was prescribed Rexulti and Trileptal for behavioral health needs in April 2024 but had not been reassessed by a psychiatric provider for ten (10) months which resulted in Resident #45 exhibiting excessive drowsiness, missing multiple meals, and experiencing a significant weight loss of over (10) percent (%) in six months for one (1) of (16) sampled residents. (Resident #45) Findings included: During an observation and interview on 01/27/2025 at 1:01 PM, Resident #45 was in the dining room being assisted by Certified Nursing Assistant (CNA) #1 with eating. The resident's family member was also present. The resident mostly slept throughout the meal, awakening briefly when the family member prompted him to eat. The family member stated that she was concerned because the resident had lost approximately 20 pounds since being discharged from a behavioral health hospital in March 2024. She explained the resident had been increasingly drowsy and sleeping throughout the day. During an observation on 01/28/2025 at 12:10 PM, Resident #45 was in the dining hall but remained asleep throughout the entire lunch period and did not wake up despite multiple attempts by CNA #1. During an interview on 01/29/2025 at 11:23 AM, Registered Nurse (RN) #2 stated that psychiatric services were being ordered for Resident #45 because his son requested a psychiatric consultation on 01/24/2025. RN #2 confirmed that the resident had not received a psychiatric follow-up since returning from the behavioral health hospital ten (10) months ago. During an observation on 01/29/2025 at 1:59 PM, Resident #45 was asleep in his wheelchair in the common area near the nurses' station. During an interview on 01/29/2025 at 3:12 PM, the Director of Nursing (DON) confirmed that a psychiatric consultation for medication management had not been in progress until the resident's son requested the consultation on 01/24/2025. The DON stated that it was standard practice for the facility's Medical Doctor of Behavioral Health to follow up with residents discharged from behavioral health units but acknowledged that this did not occur in this case. During an observation on 01/30/2025 at 9:35 AM, Resident #45 was asleep in his wheelchair in his room. On 01/30/2025 at 11:45 AM, during an interview, the Medical Director stated that typically, the facility's psychiatric Nurse Practitioner evaluates residents returning from psychiatric hospitalization s. He confirmed that Resident #45 should not have gone (10) months without a psychiatric follow-up and stated that a psychiatric consultation should have been completed within 90 days of admission to a behavioral health unit. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/30/2025 at 1:41 PM, during an interview, RN #3 stated that Resident #45 had exhibited altered sleep patterns prior to his psychiatric hospitalization but that his drowsiness had worsened in the past few months, causing him to miss meals. A record review of Resident #45's Admission Record revealed the facility admitted the resident on 03/04/2024 with a diagnosis of Alzheimer's Disease, with an onset date of 04/04/2024. A record review of Resident #45's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2024 revealed that the resident was currently prescribed an antipsychotic medication. The MDS also revealed the resident had lost five (5) percent or more of his weight in the last month or ten (10) % in the last six months. Section I indicated the resident had current diagnoses of Alzheimer's Disease and Dementia. Section C revealed a Brief Interview for Mental Status (BIMS) score of (5), which indicated the resident's cognition was severely impaired. A record review of the Order Summary Report with active orders as of 1/29/25 revealed Resident #45 had a physician's order dated 3/4/24 for a Low concentrated sweets diet with regular texture related to Type 2 Diabetes Mellitus with hyperglycemia, an order dated 4/2/24 for Trileptal 150 milligrams (mg) to be given twice daily for Dementia with Agitation and Depression and an order dated 4/2/24 for Rexulti 1 mg to be given daily for Dementia with Agitation. A record review of the facility's psychiatric consultation/referral criteria revealed that symptoms warranting a psychiatric consultation/referral included being prescribed an antipsychotic medication and experiencing changes in mood, withdrawing,or apathy (marked indifference to environment).

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F 0758 Level of Harm - Actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 50751 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure that a resident received a Gradual Dose Reduction (GDR) as required for psychotropic medications. Specifically, the resident was prescribed Rexulti and Trileptal for behavioral health needs in April 2024 but had not undergone a GDR for over ten (10) months. Resident #45 exhibited excessive drowsiness, missing multiple meals, and significant weight loss exceeding 10 percent (%) over six (6) months for one (1) of sixteen (16) sampled residents (Resident #45) Cross Reference F580 and F692 Findings included: A review of the facility's policy titled Free From Unnecessary Psychotropic Concerns, revised September 2022, revealed, The facility will ensure based on the comprehensive assessment of the resident that .b. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs .i. Dose reductions will occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor symptom recurrence. Compliance with the requirement to perform a GDR may be met, for example, within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, a facility attempts a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated . At 1:01 PM on 01/27/2025, during an observation and interview with Resident #45's family member, the resident was in his room for lunch. He was drowsy and did not wake up for the CNA who was attempting to feed him. He eventually woke up to eat two (2) small bites of food when encouraged by the family member. The family member expressed concern that the resident had lost approximately 20 pounds since being discharged from a behavioral health hospital in March 2024. On 01/28/2025 at 12:10 PM, during an observation, Resident #45 was in the dining room, but slept throughout the entire lunch period and did not wake up despite multiple attempts by Certified Nursing Assistant (CNA) #1. On 01/29/2025 at 1:59 PM, during an observation, Resident #45 was asleep in his wheelchair in the common area near the nurses' station. On 01/30/2025 at 9:35 AM, during an observation, Resident #45 was asleep in his wheelchair in his room. A record review of Resident #45's Admission Record revealed the facility admitted the resident on 03/04/2024 with a diagnosis of Alzheimer's Disease, with an onset date of 04/04/2024. (continued on next page)

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F 0758 Level of Harm - Actual harm Residents Affected - Few	A record review of Resident #45's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2024 revealed in Section N that the resident received antipsychotics on a routine basis. Section K revealed the resident had lost five (5) % or more of his weight in the last month or ten (10) % in the last six months. Section I indicated that the resident had current diagnoses of Alzheimer's Disease and Dementia. Section C revealed a Brief Interview for Mental Status (BIMS) score of (5), which indicated the resident's cognition was severely impaired. A record review of the Order Summary Report with active orders as of 1/29/25 revealed Resident #45 had a physician's order dated 4/2/24 for Trileptal 150 milligrams (mg) to be given twice daily for Dementia with Agitation and Depression and an order dated 4/2/24 for Rexulti 1 mg to be given daily for Dementia with Agitation. A record review of Resident #45's Weight Summary revealed the resident weighed 191 pounds on 03/04/2024 and 158 pounds on 01/17/2025, reflecting a total weight loss of 33 pounds in (10) months. A record review of Resident #45's meal intake percentages from 01/01/2025 through 01/28/2025 revealed his documented meal intake was between 0-25 percent of meals on (13) of (28) days. A record review of the medical record for Resident #45 revealed there was no documentation that a GDR had been attempted for Trileptal or Rexulti. On 01/29/2025 at 11:23 AM, during an interview, Registered Nurse (RN) #2 confirmed that Resident #45 had not received a GDR for psychotropic medications since returning from the behavioral health hospital (10) months ago. On 01/29/2025 at 3:12 PM, an interview with the Director of Nursing (DON) confirmed that a GDR had not been completed and should have been attempted within six (6) months of the resident being placed on psychotropic medications, including Trileptal and Rexulti. On 01/30/2025 at 11:45 AM, during an interview, the Medical Director stated that typically, the facility's psychiatric Nurse Practitioner (NP) evaluates residents returning from psychiatric hospitalization s. He agreed that a GDR should have been attempted and noted that a GDR for Rexulti was initiated on 01/29/2025. On 01/30/2025 at 1:41 PM, during an interview, RN #3 stated that Resident #45 had exhibited altered sleep patterns prior to his psychiatric hospitalization but that his drowsiness had worsened in the past few months, causing him to miss meals.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50921 Based on observations, interviews, and facility policy review, the facility failed to label and date food stored in the refrigerator and freezer and failed to dispose of expired food for one (1) of four (4) days of kitchen observations. Findings include: A review of the facility ' s Food Storage Labeling policy, revised on ,d+[DATE], revealed: .8.a.i. Identify the food item's use-by date or expiration date . iv. Food in storage units will be surveyed routinely to identify and discard foods that have passed their manufacturer use-by or expiration date . 2. Refrigerator storage weekly On [DATE] at 11:14 AM, during an initial tour with the Dietary Manager (DM), the following observations were made: In Refrigerator #1, one (1) package of sliced ham was opened and unlabeled, and a spill of orange juice was observed on the bottom of the refrigerator. In Refrigerator #3, one (1) bag of bacon bits was opened and unlabeled, and (1) package of sliced roast beef with a use-by date of [DATE], received on [DATE], was opened. Additionally, three (3) unopened packs of sliced roast beef had a use-by or freeze-by date of [DATE]. A five (5)-lb bag of shredded cheddar cheese was opened and unlabeled. Also, a thawed, unopened fire-braised pork loin with a use-by or freeze-by date of [DATE], received on [DATE], was observed. The DM confirmed these items were expired and collected them for disposal. In Freezer #1, one (1) bag of frozen biscuits was open and unlabeled. In Freezer #2, one (1) bag of frozen chicken patties and (1) package of hamburger patties was open and unlabeled. A 10-inch pecan pie with an expiration date of [DATE] was also observed. In the dry storage room, (1) 48-oz container of Real Lemon Juice was observed opened on [DATE] but not stored in the refrigerator, despite manufacturer instructions to refrigerate after opening. On [DATE] at 11:20 AM, the DM confirmed the presence of expired and improperly stored food items and collected them for disposal. On [DATE] at 11:10 AM, during an interview, the Certified Dietary Manager (CDM) and Registered Dietitian (RD) stated that their expectations for kitchen staff include completing education and training for their positions, following federal guidelines, and adhering to food labeling and handling policies to prevent foodborne illness among residents. On [DATE] at 02:00 PM, during an interview, the Administrator revealed that he was aware that some items had been out of date but had since been discarded. He explained that the facility added a kitchen in [DATE] because the previous contract with the local hospital's kitchen to service residents ended in [DATE]. The Administrator stated there is now a completely different kitchen staff and that he believes the staff is competent. He also noted that the facility changed food providers in [DATE], which may have contributed to expired foods being delivered to the facility.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43283 Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to sustain corrective actions to prevent recurrence of a previously cited deficiency. Specifically, the facility was cited for failing to label and date food stored in the refrigerator and freezer during an annual recertification survey on [DATE] and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of nine (9) deficiencies cited. F812 Findings Include: Record Review of the facility's policy Quality Assessment and Performance Improvement (QAPI) Program revised [DATE], revealed, .The facility will .5. To establish that the facility's Quality Assurance and Assessment (QAA) committee has made a good faith attempt to correct an identified quality deficiency, a facility will do more than just subjectively assert it has made a good faith attempt; rather, the facility's actions, taken as a whole, will evidence a good faith attempt to identify and correct quality deficiencies . The Governing Body and/or executive leadership (or organized group of an individual who assumes full legal authority and responsibility for operation of the facility), must ensure the QAPI Program: is defined, implemented, and ongoing; . is sustained through transitions in leadership and staffing . Record review of the Provider History Profile on the Certification and Survey Provider Enhanced Reporting (CASPER) report revealed the facility received a citation for F812 - Food Procurement, Store/Prepare/Serve Sanitary on the previous annual survey conducted [DATE]. Record review of the Centers for Medicare and Medicaid Services (CMS-2567) (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of [DATE], revealed the facility received a citation for F812, .Based on observation, staff interviews, and facility policy review, the facility failed to ensure items in the kitchen refrigerator/freezer were dated and labeled and food items were discarded by the expiration date . During the current annual recertification survey, the facility failed to label and date food stored and dispose of expired foods in the refrigerator and freezer in one (1) of four (4) days in kitchen observations. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:20 PM, during an interview, Registered Nurse (RN) # 3 who was previously responsible for QAPI stated that she was still overseeing QAPI despite the facility hiring someone else for the role. She explained that the new hire had not yet taken over the responsibilities, and the facility had scheduled a meeting to address the transition. RN #3 stated she was unaware that food storage issues were still occurring in the kitchen. She explained that at the time of the last survey, the facility's kitchen was associated with the hospital, but since [DATE], the facility had transitioned to its own independent kitchen. Since that transition, the kitchen staff has undergone several turnovers, and the facility was now on its third kitchen director. RN #3 reported that after the last survey on [DATE], concerns related to food storage were discussed in QAPI meetings every month for the first four (4) months. She stated that audits were completed and submitted to the Director of Nursing (DON) until [DATE]. However, she acknowledged that no further kitchen audits had been conducted since then, nor had kitchen issues been discussed, as the facility believed the concerns had been addressed with the new kitchen. She confirmed that although the facility had implemented the initial plan of correction, it failed to sustain those corrective actions following kitchen staff turnover and operational changes. RN #3 stated she would present these concerns to the QAPI committee again to develop new action plans and resume audits of the kitchen. On [DATE] at 2:30 PM, during an interview, the Administrator and the DON confirmed that the facility had completed the plan of correction for the previous kitchen-related deficiency from [DATE]. The Administrator stated that the kitchen had been in operation since [DATE] and had undergone multiple staff turnovers. He further stated that he had spoken with the new kitchen manager, who was currently in training, and that they planned to continue addressing the kitchen-related concerns.