STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255328	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marion Health and Rehab, LLC	6434 A Dale Dr Marion, MS 39342

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, interviews, and facility policy review, the facility failed to apply a shoulder restraint during transportation in the facility van for one (1) of three (3) sampled residents (Resident #1).Findings include: A review of the facility's policy Procedure Accidents/Incident Reporting, undated, revealed, .Accident/Incident is defined as an unexpected happening, which may or may not have caused loss or injury to a visitor, resident and/or staff person. A review of the facility's policy Providing Resident Transport out of Facility, dated 7/2008, revealed, .It is the policy of this facility to arrange transportation for our residents to, out of the facility, consultation visits. A record review of the manufacture's guidelines Wheelchair Tie-Downs revealed, .Wheelchair restraints ensure the passenger remains in a safe, forward-facing position when the vehicle is in use.The wheelchair user should also use a shoulder and lap seat belt. A record review of the Resident Council Meeting Minutes dated 5/21/2026, revealed, Resident #1 was in attendance and discussed van safety with the Person Responsible listed as the Administrator.On 6/16/26 at 9:50 AM, an interview with the facility's State Ombudsman revealed that during the 5/21/26 Resident Council meeting, Resident #1 voiced a concern that during transportation to a physician appointment, the driver secured the wheelchair with the four-point securement system and lap belt but failed to apply the shoulder restraint. On 6/16/26 at 11:00 AM, during an interview, Resident #1 stated that when transported to a physician appointment, the transport team secured the resident's wheelchair using a four-point wheelchair securement system and applied a lap belt; however, a shoulder restraint was not applied. Resident #1 confirmed feeling unsafe during the transport and requested that the shoulder restraint be applied. Resident #1 revealed that despite the request, the transport driver did not apply the shoulder restraint. Resident #1 further revealed that the matter was later discussed with the Administrator, who informed the resident that the facility was not required to utilize both a lap belt and shoulder restraint during resident transportation.On 6/16/26 at 11:50 AM, during an interview, the Activities Director, who was responsible for transportation at the time of Resident #1's transport, revealed that during the Resident Council meeting held on 5/21/26, Resident #1 voiced concerns regarding transportation safety and reported that only a lap belt was applied during van transportation. Resident #1 expressed feeling unsafe being transported without a shoulder restraint. The Activities Director revealed that both the Ombudsman and Administrator were present during the meeting. According to the Activities Director, the Administrator explained that shoulder restraints were available and could be provided upon request; however, the facility believed it was operating in compliance with transportation requirements. The Activities Director confirmed being unaware of any other residents who had voiced concerns regarding transportation safety. The Activities Director further confirmed transporting Resident #1 to a physician appointment on 3/26/26 and securing the resident's wheelchair using the four-point securement system and lap belt; however, the shoulder restraint was not applied due to a lapse in judgment.On 6/16/26 at 1:15 PM, during an interview, the Administrator confirmed that Resident #1 was transported to a scheduled medical appointment on 3/26/2026. The Administrator revealed that the transportation driver secured the resident's wheelchair using the four-point floor securement system and applied the lap restraint; however, a shoulder restraint was not applied during (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the transport. The Administrator stated that transportation staff are expected to follow the manufacturer's safety guidelines when transporting residents and securing wheelchairs within the transport van. The Administrator further revealed that the manufacturer's guidelines require the use of both a lap restraint and shoulder restraint for wheelchair occupants during transport. The Administrator confirmed that transportation staff had received training on the proper use of the wheelchair securement system and occupant restraints. The Administrator acknowledged that the shoulder restraint should have been applied during Resident #1's transport and indicated that the failure to do so was an isolated occurrence and not consistent with the facility's usual transportation practices. The Administrator confirmed that he was not aware of the incident until the Resident Council meeting on 5/21/2026. A record review of the admission Record revealed Resident #1 was admitted by the facility on 9/22/2023 and had current diagnoses including Urinary Tract Infection and Anemia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/2/2026 revealed Resident#1 had a Brief Interview for Mental Status (BIMS) summary score of 14, which indicated Resident #1's cognition was intact.