STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lamar Healthcare & Rehabilitation Center	6428 US Highway 11 Lumberton, MS 39455

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to conduct a thorough investigation related to a fracture of unknown origin for one (1) of four (4) residents reviewed for accidents. Resident #47.Findings include:A review of the facility's policy, Abuse Investigation and Reporting, revised July 2017, revealed, .All reports of resident abuse, neglect.injuries of unknown source.shall be.thoroughly investigated by facility management.Policy Interpretation and Implementation.Role of the Investigator: 1. The individual conducting the investigation will, as a minimum.j. Review all events leading up to the alleged incident.5. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator.On 4/2/26 at 9:00 AM, a record review of the facility's investigation revealed documentation identified Resident #47's diagnoses including Osteoporosis and Dementia and indicated the resident complained of right lower extremity pain on 10/20/25. The investigation documented the resident was sent to the hospital emergency room on [DATE] due to continued pain and returned on 10/21/25 with a diagnosis of Deep Vein Thrombosis (DVT). The investigation further documented the resident continued to complain of right leg and hip pain following return to the facility, and a mobile X-ray obtained on 10/21/25 revealed an acute nondisplaced subcapital femoral neck fracture of the right hip. The investigation indicated the physician and responsible party were notified and the resident was sent back to the hospital for evaluation. The investigation documentation did not include evidence of staff or resident interviews, witness statements, or a documented investigative summary identifying the possible cause of the injury.On 4/1/26 at 10:03 AM, during an observation and interview, Resident #47 was observed lying in bed and was unable to answer questions.On 4/1/26 at 3:10 PM, during an interview, the Social Worker (SW) explained incidents were discussed during daily clinical meetings and she conducted interviews with residents or staff when directed by the Director of Nursing (DON). She reported she was not directed to conduct interviews for the injury of unknown origin involving Resident #47 and was unable to explain why interviews were not completed.On 4/1/26 at 3:30 PM, during an interview, the DON stated the resident was interviewed at the time of the incident and reportedly indicated he fell but was unsure of details. The DON reported staff and other residents were interviewed but was unsure if documentation existed to support those interviews.On 4/2/26 at 10:28 AM, during an interview with Licensed Practical Nurse (LPN) #5, she confirmed she was working on 10/20/25 when Resident #47 complained of right leg pain. She explained she notified the physician and received an order for an X-ray. She reported the resident continued to complain of pain and was sent to the hospital where he was diagnosed with Deep Vein Thrombosis (DVT). She stated after the resident returned and continued to complain of pain, another X-ray was ordered, which revealed a fracture. She explained the facility was unable to determine how or when the fracture occurred and it could have occurred during transport or while at the hospital.On 4/2/26 at 11:19 AM, during a follow-up interview, the DON confirmed although staff and residents were reportedly interviewed, those interviews were not formally documented. After reviewing the facility policy, she acknowledged the facility did not follow their policy for investigating and documenting the injury.On (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/2/26 at 1:23 PM, during an interview, the Administrator reported she expected staff and resident interviews related to the injury of unknown origin for Resident #47 to be completed and documented and confirmed that documentation was not present.Record review of the admission Record revealed the facility admitted Resident #47 on 4/2/19 with diagnoses including Dementia.Record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident's cognition was severely impaired.

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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 interview and record review, the facility failed to revise a comprehensive care plan for one (1) of (19) resident care plans reviewed. Resident #47Findings include:A record review of the Care Plan Report revealed Resident #47 had an individual care plan with Focus of Impaired Skin Integrity.Stage III wound to sacrum-Healing Stage IV wound. The care plane included an intervention initiated on 1/28/26 to Remove old dressing, cleanse with wound cleanser, apply plurogel to wound to sacrum, use polymem AG (alginate) as the primary dressing, use allevyn border dressing as the secondary dressing, the order is to be carried out daily and PRN. This was inconsistent with the current physician order for wound treatment dated 2/19/26. A record review of the admission Record revealed the facility admitted Resident #47 on 10/31/25 with diagnoses including Pressure Ulcer of Sacral Region, Stage 4.A record review of the Order Summary Report with active orders as of 04/02/2026, revealed Resident #4 had a physician's order, dated 2/19/26, to Remove old dressing, cleanse with wound cleaner, apply Santyl to wound to sacrum as the primary dressing, apply Calcium Alginate, gauze and cover with Allevyn border dressing as the secondary dressing, the order is to be carried out daily and PRN (as needed). A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) Summary Score of 04, which indicated his cognition was severely impaired. A review of Section M revealed he had unhealed Pressure Ulcers/Injuries including one (1) Stage 3 Pressure Ulcer. On 04/02/2026 at 2:10 PM, during an interview, Registered Nurse (RN) #1 stated she updates care plans with each new order and believed she had done so for Resident #47's wound care order. RN #1 reviewed the physician orders and care plan for Resident #47 and confirmed the care plan had not been updated and reflected outdated wound care orders.On 04/02/2026 at 2:23 PM, during an interview with the Administrator, she reported that she expects resident care plan to be revised as needed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure weekly wound assessments that included wound dimensions and characteristics were completed and documented for one (1) of two (2) residents reviewed for pressure ulcers. Resident #47.Findings include:A review of the facility's policy, Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised April 2018 revealed, . Assessment and Recognition . 2.the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue .A record review of the Order Summary Report revealed a physician's order dated 2/19/26 to remove old dressing, cleanse with wound cleaner, apply Santyl to the sacral wound as the primary dressing, apply Calcium Alginate, gauze, and cover with Allevyn border dressing as the secondary dressing, to be completed daily and as needed.A record review of the Wound Care Visit, dated 3/10/26 revealed Resident #47 attended wound care at an outpatient provider. The visit documentation included assessment information that consisted of the wound dimensions, drainage, and wound characteristics and the Impression included that the wound had improved. A review of the next Wound Care Visit, dated 3/31/26 (three weeks later) revealed Resident #47 had another wound care visit at the outpatient provider. The documentation had wound information that included a complete assessment of the wound and documented the dimensions, drainage, and wound characteristics. The Impression included that the ulcer had improved.A record review of the medical record for Resident #47 revealed there was no wound assessment documented by the facility between the outpatient wound care visits on 3/10/26 and 3/31/26.On 3/30/26 at 11:24 AM, during an observation, Resident #47 was lying in bed on an air mattress with a positioning wedge in place between his knees.On 3/30/26 at 11:50 AM, during an observation and interview with Resident #47 and his Responsible Representative (RR), the RR expressed concerns regarding the resident's sacral pressure wound and reported she was unsure if the wound was being treated appropriately.On 3/31/26 at 11:55 AM, during an interview with Licensed Practical Nurse (LPN) #1, she reported Resident #47 had a longstanding sacral wound and stated the facility does not have a dedicated wound care nurse. She explained that medication cart nurses complete wound care and treatments daily for assigned residents. She confirmed Resident #47 attended outpatient wound care and reported the outpatient provider assessed the wound and provided treatment orders.On 3/31/26 at 3:43 PM, during an interview with the Director of Nursing (DON), she reported the facility did not have weekly wound reports that include measurements or assessments describing wound characteristics available. She confirmed there is no dedicated wound care nurse and that medication cart nurses completed treatments. She reported the facility relied on the outpatient wound care provider for wound assessments and monitoring. She acknowledged that pressure wounds should be assessed, measured, and documented weekly and explained that the facility did not have sufficient Registered Nurse (RN) staffing to complete weekly wound assessments.On 4/2/26 at 10:01 AM, during a phone interview with the Registered Dietician (RD), she reported she completed onsite visits to the facility twice monthly and reviewed residents with wounds. She explained that she often has to request information from the DON because there are no weekly wound reports available in the medical record.On 4/2/26 at 2:23 PM, during an interview with the Administrator, she reported she expected wound assessments to be completed as required.A record review of the admission Record revealed the facility admitted Resident #47 on 10/31/25 with diagnoses including Pressure Ulcer of Sacral Region, Stage 4.A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated his cognition was severely impaired. A review of Section M revealed he had unhealed pressure ulcers, including one (1) Stage 3 pressure ulcer.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure a resident received necessary nutritional and hydration care and services to maintain nutritional status, including failing to offer alternative food items when meals were refused, failing to consistently document meal intake and weights, and failing to monitor, evaluate, and implement timely interventions, which contributed to a delay in identifying and addressing significant weight loss for one (1) of two (2) residents reviewed for nutrition. Resident #47Findings include:A record review of the admission Record revealed the facility admitted Resident #47 on 10/31/25 with diagnoses including Pressure Ulcer of Sacral Region, Stage 4.A record review of the Order Summary Report with active orders as of 4/2/26, revealed Resident #47 had a physician's order, dated 3/9/26, for double portions of ordered diet for lunch and supper tray. Mighty shakes or equivalent supplement to be added to each tray and as a bedtime snack. Add a magic cup to lunch and supper tray. There were physician's orders, dated 3/2/26 to document the percentage of meal intake at each meal and document total fluid intake at end of each shift. There was a physician's order, dated 3/12/26 to check the resident's weight each Thursday while RP (Responsible Party) in the room. A record review of the Weights and Vitals Summary revealed Resident #47's weight decreased from 128.0 pounds on 9/10/25 to 123 pounds on 1/22/26. It further decreased to 112.8 pounds on 2/26/26, and then to 94.4 pounds on 3/4/26 (six days later), representing a weight loss of 26.25% over six (6) months (9/10/25 to 3/4/26) and 16.46% within a 30-day period (2/26/26 to 3/4/26).A record review of the Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident's cognition was severely impaired. A review of Section K revealed his weight was recorded as 123 pounds and did not indicate a significant weight loss.A record review of the Documentation Survey Report recorded by the Certified Nurse Aides (CNAs) for Resident #47 for February 2026 revealed documentation representing the amount eaten at each meal was not recorded for all meals on 2/2, 2/3, 2/6, 2/7, 2/8, 2/11, 2/14, 2/16, 2/17, 2/20, 2/21, 2/22, 2/25, 2/26, and 2/27 and for the supper meal on 2/12. This was a total of 46 times the resident's meal intake was not recorded for the month of February.A record review of the Medication Administration Record (MAR) for March 2026, revealed there was no documentation recording the percentage of meal intake for Resident #47 for 15 meals recorded by the nurses on 3/2 (lunch and dinner), 3/6 (breakfast, lunch and dinner), 3/11 (dinner), 3/13 (dinner), 3/16 (dinner), 3/17 (breakfast, lunch and dinner), 3/21 (dinner), 3/22 (lunch and dinner), and 3/29 (dinner). A record review of Progress Notes for Resident #47 revealed a Registered Dietician (RD) Assessment Summary, dated 02/28/2026 at 2:07 PM for . wt.: (weight) 123-January; February weight is pending . There was also an RD Assessment Summary, dated 03/05/2026 at 7:25 AM, for .wt.: 94 lb. weight is down -16.8% x 30 days, 23.6% x 90 days, and 26.6% x180 days .A record review of Resident #47's Progress notes revealed a nurses note dated 03/04/2026 at 4:02 PM, revealed, . dietician contacted to look at resident's weight decline and make any suggestions that may benefit resident . On 3/30/26 at 11:21 AM, during an observation, Resident #47 was observed lying in bed with a thin appearance and visible bony prominences.On 3/30/26 at 11:50 AM, during an observation and interview with Resident #47 and the resident's Responsible Representative (RR), the RR expressed concerns regarding Resident #47's weight loss and reported she had been visiting daily to assist with meals due to concerns that Resident #47 was not eating. She also expressed concerns that his weight was not being consistently monitored.On 3/30/26 at 12:01 PM, during an observation, CNA #4 was assisting Resident #47 with feeding. Resident #47 attempted to push staff away, refused food, and told staff to eat the food.On 3/30/26 at 2:00 PM, during an interview with CNA #4, she reported Resident #47 continued to refuse meals and demonstrated variable intake, sometimes eating and other times refusing. She reported Resident #47 could become combative during care and would push staff away during feeding attempts. CNA #4 reported that when Resident #47 refused meals, staff (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	would encourage him to eat; however, she did not indicate that alternative food items were routinely offered following refusals.On 3/31/26 at 11:25 AM, during a follow up interview with CNA #4, she reported Resident #47 again refused lunch despite encouragement from staff and nursing. She reported Resident #47 was not offered an alternative meal or substitute food items after refusing the meal.On 3/31/26 at 11:55 AM, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed Resident #47 had experienced ongoing weight loss and frequently refused meals. She reported the facility had attempted interventions including supplements, appetite stimulants, and double portions. She confirmed weights were obtained by CNAs but were not obtained on consistent days, and she reported that all staff were able to the document meal intake of residents.On 4/1/26 at 3:30 PM, during an interview with the Dietary Manager, she reported Resident #47 had periods of refusing meals and had been provided supplements, including Ensure Plus. She reported the RD monitors residents with weight loss and wounds.On 4/1/26 at 4:30 PM, during an interview with the Director of Nursing (DON), she reported there was no staff member designated to consistently obtain weights and confirmed weights were not consistently obtained or entered into the medical record in a timely manner. She confirmed delays in documenting weights resulted in delayed identification of weight loss and delayed implementation of interventions. She reported interventions were initiated for Resident #47 after family concerns were raised. She confirmed Resident #47 had significant weight loss and acknowledged the lack of consistent monitoring contributed to delayed intervention.On 4/2/26 at 10:01 AM, during a phone interview with the facility's RD, she reported she had been coming to the facility for years and visits twice a month to review residents, including those with significant weight loss. She reported she accesses weights through the computer during her visits and explained that when she documents weights as pending, it indicates no weight has been entered into the record. She reported that weights have been hit and miss at the facility for several months. She explained the DON contacted her on 3/5/26 regarding Resident #47's weight loss, and after reviewing the medical record, she identified inconsistencies with both weights and meal intake documentation. She reported she reviewed Resident #47's weights and stated the amount of weight loss, including approximately 18 pounds in six (6) days, was not normal and would not be expected from refusal of some meals alone. She reported she communicated with the facility, including the DON and Dietary Manager, and recommended providing Ensure Plus to increase protein intake and to continue offering Magic Cup supplements for Resident #47.On 4/2/26 at 2:23 PM, during an interview with the Administrator, she reported she expects staff to obtain and document weights consistently and to notify the physician and RD of any significant weight loss in a timely manner.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and facility policy review, the facility failed to ensure appropriate pain management when nursing staff failed to assess and manage pain prior to and during wound care for Resident #4 which resulted in the resident experiencing avoidable pain during wound care and failed to administer ordered pain medication for Resident #47 for two (2) of three (3) residents reviewed for pain management.Findings include: A review of the facility's policy, Pain – Clinical Protocol, undated, revealed, Assessment and Recognition.2. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever this is a significant change in condition, and when there is onset of new pain or worsening of existing pain.4. The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated; for example, wound care.Monitoring.2. The staff will evaluate and report the resident/patient's use of standing and PRN (as needed) analgesics. A. Depending on the characteristics of pain, the physician may start with PRN doses or supplement standing doses with PRN doses for breakthrough pain. Resident #4 A record review of the Order Summary Report revealed Resident #4 had a physician's order dated 12/9/25 for wound care to the left heel two times daily and an additional order dated 2/27/26 for wound care to the left heel two times daily. The record review further revealed an order dated 2/18/26 for Acetaminophen (Tylenol) 500 milligrams (mg) three times daily for pain. A record review of the electronic Medication Administration Record (eMAR) for March 2026 revealed Resident #4 was scheduled to receive Acetaminophen at 1:00 PM on 3/31/26, however, the eMAR was reviewed prior to observing wound care and Resident 4's Acetaminophen was not documented as administered at that time. On 3/31/26 at 1:45 PM, during an observation, Licensed Practical Nurse (LPN) #1 performed wound care to Resident #4's left heel. During the procedure, the resident vocalized that he was in pain, stated the treatment hurt, and began crying. The nurse continued the wound care procedure without stopping to assess pain or provide pain medication. On 3/31/26 at 2:00 PM, during an interview, LPN #1 reviewed the physician's orders and initially indicated the resident did not have pain medication ordered. Upon further review, she confirmed Resident #4 had a scheduled order for Acetaminophen at 1:00 PM and acknowledged the medication had not been administered prior to performing wound care. On 3/31/26 at 2:20 PM, during an interview, the Director of Nursing (DON) stated the expectation was for nursing staff to assess pain prior to wound care and administer pain medication before initiating treatment when pain was anticipated. On 4/1/26 at 4:30 PM, during an interview, the Administrator stated the expectation was for staff to follow the facility's pain management policy and ensure residents received appropriate pain control during treatments such as wound care. A record review of the admission Record revealed the facility admitted Resident #4 on 10/10/25 with (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	diagnoses including Acute Kidney Failure. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/7/26 revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident's cognition was severely impaired. Resident #47 A record review of the facility's investigation revealed Resident #47 complained of right lower extremity pain on 10/20/25 and was sent to the hospital on [DATE] and returned on 10/21/25 with a diagnosis of Deep Vein Thrombosis (DVT). The record review revealed the resident continued to complain of right leg and hip pain and a mobile X-ray obtained on 10/21/25 revealed an acute nondisplaced subcapital femoral neck fracture. A record review of the Progress Notes revealed on 10/20/25 at 4:37 PM, a Certified Nurse Aide (CNA) reported Resident #47 was experiencing pain throughout the shift when being changed. The nurse documented the resident yelled out and would not move his leg and the physician was notified and an X-ray was ordered. The progress note did not address how the resident's pain was managed. A progress note dated 10/20/25 at 8:15 PM revealed the resident continued to complain of pain with movement of the right leg and was sent to the emergency department. There was no documentation pain medication was administered. A progress note dated 10/21/25 at 11:48 PM revealed the resident continued to complain of pain to the right leg and hip and did not address how his pain was managed. A record review of the Order Summary Report revealed Resident #47 had a physician's order with a start date of 10/3/24 for Acetaminophen (Tylenol) 325 milligrams (mg) to be given every eight (8) hours as needed for pain. A record review of the Medication Administration Record (MAR) for October 2025 revealed Resident #47 was assessed for pain each shift and was documented as having a pain level of 0 on 10/20/25 and did not receive any documented pain medication, including Acetaminophen, during the month. On 4/1/26 at 10:03 AM, during an observation and interview, Resident #47 was observed lying in bed and was unable to answer questions. On 4/2/26 at 10:28 AM, during an interview, Licensed Practical Nurse (LPN) #5 confirmed she worked on 10/20/25 when Resident #47 complained of right leg pain. She stated she notified the physician and received an order for an X-ray. She reported she thought she had administered Tylenol but was unable to recall and confirmed there was no documentation to support that pain medication was administered. On 4/2/26 at 11:19 AM, during an interview, the Director of Nursing (DON) confirmed the resident complained of pain and there was no documentation that pain medication was administered despite an order being in place. She stated she expected nursing staff to provide pain relief when residents complained of pain. On 4/2/26 at 1:23 PM, during an interview, the Administrator stated it was the expectation that nursing staff provide pain relief to residents when they complained of pain. A record review of the admission Record revealed the facility admitted Resident #47 on 4/2/19 with (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	diagnoses including Dementia. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident's cognition was severely impaired.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, and facility policy review, the facility failed to ensure Registered Nurse (RN) staffing was adequate to meet the needs of residents and failed to designate a licensed nurse to serve as the designated charge nurse for each tour of duty for one (1) of four (4) days of survey. Findings include:A review of the facility's policy, Staffing, Sufficient and Competent Nursing, revised August 2022 revealed, .Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.Policy Interpretation and Implementation Sufficient Staff.2. A licensed nurse is designated as a charge nurse on each shift.b. A charge nurse is a licensed nurse with designated responsibilities that may include staff supervision, emergency coordination, provider or physician support and direct resident care.A record review of the Facility Assessment revealed, Staffing Hours per Resident Day data for October 1 through December 31, 2025, revealed Registered Nurse (RN) hours were reported as 0.173 hours per resident per day, which equals ten (10) minutes of RN time per resident per day. The report documented an average resident census of 88.6 residents, which equals 15.3 RN hours per day based on the facility's reported staffing levels.A record review of the facility's daily assignments revealed that on 3/30/26, there was no designated Charge Nurse or RN Supervisor for the 6PM or 6AM shift.On 3/31/26 at 3:43 PM, during an interview with the Director of Nursing (DON), she reported the facility did not have sufficient RN staffing to complete weekly wound assessments for residents with pressure ulcers. The facility relies on the outpatient wound clinic to complete these assessments. She explained there was no weekly wound documentation that include measurements or assessments describing wound characteristics available for residents with wounds. On 4/1/26 at 2:35 PM, during an interview, the DON explained she also served in the capacity of the Infection Preventionist and was responsible for staffing, scheduling, and daily facility operations. She reported she had not had time to complete infection surveillance, track infections, or conduct infection control rounds for several months because she was working the medication cart or functioning as the nursing supervisor.On 4/1/26 at 3:00 PM, during an interview, the Administrator stated that the DON had sufficient time to complete infection prevention duties in addition to her other responsibilities.On 04/02/2026 at 7:45 AM, during an interview with the DON, she confirmed there was no designated charge nurse indicated on the daily assignment sheets because it was known by the staff that the Licensed Practical Nurse (LPN) or cart nurse for the hall was in charge. The DON confirmed there was no charge nurse with specific duties including staff supervision, emergency coordinator, physician liaison and direct resident care. The DON said she was unaware she was unable to function in the role of Nursing Supervisor due to the facility's census. The DON stated that the facility has posted job openings and has tried to hire RNs. On 04/02/2026 at 1:17 PM, during an interview with the Administrator, she stated that the benefit to having a licensed nurse designated as the charge nurse is to cut down on confusion and to allow the staff to know who is in charge. She stated she did not know that due to the facility census being over 60 residents, that the DON could not function in the capacity of the charge nurse or RN Supervisor. The Administrator reported that the facility has placed job listings to recruit RNs.