STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Choctaw Residential Center	135 Residential Center Rd Choctaw, MS 39350

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 47874 Based on resident and staff interviews, record review, and facility policy review, the facility failed to resolve a resident grievance in a timely manner related to missing clothing, activities, and noisy environment for four (4) of seven (7) residents that attended resident council. Residents #27, #76, #100, and #309 Findings Include: Review of the facility policy titled Grievance/Complaint Policy unrevised, revealed, It is a policy of this facility that a resident/responsible party/legal representative has the right to voice grievances as follows: . All grievances should be directed/reported to the departmental supervisor and departmental director. Review of the facility policy titled Resident Personal Belongings unrevised, revealed under, Policy: It is the policy of this facility to protect the resident's right to possess personal belongings, such as clothing and furnishings, for their use while in the facility. Also revealed under, Policy Explanation and Compliance Guideline: . 7. The facility will exercise reasonable care for the protection of the resident's property from loss or theft. Resident #27 On 3/03/25 at 12:13 PM, an interview with Resident #27 (Resident Council President) revealed he had 3 shirts, 2 pairs of pants, and 6 pairs of socks missing. He revealed he had reported the missing items to the staff on several occasions. On 3/05/25 at 9:20 AM, an interview with the Case Manager revealed the Ombudsman had come to her office and reported that Resident #27 had missing clothing. She revealed this happened a while back, but she could not recall the date. She revealed she got with the laundry person, and they were going to look for the items. The Case Manager explained that she did not know the status of the clothing, whether it was found or not. An interview with Laundry Staff #1 on 3/05/25 at 9:24 AM revealed she was made aware of Resident #27's missing clothing items about 2 weeks ago. She revealed she had been looking for them but, so far, had not found them. She explained that she would continue to look for the items for a couple more weeks and after that, if she had not located them, she would let the administrator know. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Long-Term Care Ombudsman on 3/05/25 at 10:10 AM revealed she visited the facility on 2/18/25. She confirmed she had notified the Case Manager that day Resident #27 was missing a black and a white pair of pants, a white shirt with a corvette design on it, a shirt with the saying, If I didn't remember it, it didn't happen, a white shirt with the tribal inauguration on it, 6 pairs of socks (2 white, 2 gray, and 2 black). She revealed the resident voiced to her that day the clothing had been missing for 3 weeks. Record review of the Grievance Forms revealed a grievance was not completed for Resident #27's missing clothing. An interview with Social Services (SS) on 3/05/25 at 1:45 PM revealed she was responsible for completing the grievances for the facility. She explained that when staff come to her with a complaint or concern, she completes the grievance form and then gives it to the necessary department to follow through. She revealed that she followed up to ensure the grievance was resolved later. SS confirmed a grievance was not completed related to Resident #27's missing clothing and revealed it probably should have been done. An interview with the Administrator (ADM) on 3/05/25 at 2:00 PM revealed she was not aware that Resident #27 had missing clothing and voiced that she was not made aware of it until this morning. She revealed the laundry department thinks the resident may have thrown away some of his socks because they were too tight. The ADM confirmed the clothing should have been written up as a grievance for tracking purposes so that staff knew and could quickly find a resolution. Record review of the Admission Record revealed the facility admitted Resident #27 on 10/11/24. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/25/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #27 was cognitively intact. Resident Council (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a Resident Council meeting held on 3/05/25 at 1:00 PM, the residents voiced they had discussed in the past meetings wanting more activities. Resident #76 explained there were not enough activities. He revealed they play Bingo on Tuesday, which he voiced that he would like to play more often (at least twice weekly). He revealed playing Bingo was the only thing the facility did that met his interest. Resident #100 revealed they (the residents) do not have activities on the weekends. She explained they sometimes have a church group that comes on Sunday. Resident #100 revealed during the week they do nails, arts and crafts, bingo, and stated, That's about all we do. She explained they may have some preacher or singing on the weekend and stated, We need activities on the weekends. Resident #76 expressed that not everybody likes arts and crafts, I don't. He explained that he told them (the staff) that there were not enough activities on the weekend, and they gave out coloring books. He stated, I'm not a child and I don't like to color. Resident # 309 revealed he was here for therapy. He revealed that during the week, when the office staff were present, the facility had structure but, on the weekends, It's an entirely different atmosphere. He explained on the weekends it was a new group that came in and revealed it sounded like a cow bawling at times. Furthermore, he revealed that he had never heard such noise. He explained that his room was close to the nurse's station and the noise was so bad that he could not sleep. He revealed he would rather not move to another room because he liked his roommate. The residents agreed this was a big concern to them. Resident #309 revealed he had reported the noise to the staff and even to his aide. Resident #76 revealed he had complained several times about the noise on the weekends. He explained that the staff carry on loudly, play music, gather around the desk, and keep up too much noise. Resident #76 explained that he had been woken up many times at night due to the noise level. Record review of the Resident Council Meeting Minutes dated 12/2/24 revealed under, Material Discussed: Resident #76 stated weekends nights to loud and staff on the phone in hallway. An interview with the Administrator (ADM) on 3/05/25 at 2:00 PM revealed she was not aware that the residents had voiced complaints related to the noise level on the weekends. She revealed she did have staff that came in to check on things and revealed most of the staff that worked on the weekends were facility employees with a few agency staff. She acknowledged this concern should have been written up as a grievance. An interview with the Activity Director on 3/05/25 at 2:30 PM revealed they (the facility) did many activities during the week to meet the residents' interest. She revealed picking activities to meet all their preferences was getting harder and harder due to the age group that the facility was getting now. She explained that their youngest resident was in his 20's and revealed it was difficult to plan activities for all age groups. The Activity Director confirmed they had discussed in Resident Council doing more activities. She revealed she had explained to them, if they could come up with something they wanted to do, she was willing to try it. She confirmed they did not have an activity person for the weekend and revealed they sometimes have a church to come. The AD revealed if a concern was discussed during resident council, she would tell the Director of Nursing, or the Assistant Director of Nursing, and they would write up a grievance to investigate. She revealed she told the Assistant Director of Nursing about the Resident #76's complaint about the noisy weekend environment. An interview with the Assistant Director of Nursing (ADON) on 3/06/25 at 8:10 AM revealed he did not recall being made aware of Resident #76's complaint regarding the noise level on the weekends. Review of the Admission Record revealed the facility admitted Resident #76 on 7/30/21 with a medical diagnosis that included type 2 diabetes mellitus with unspecified complications. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/28/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #76 was cognitively intact. Review of the Admission Record revealed the facility admitted Resident #100 on 10/14/24 with a medical diagnosis that included chronic kidney disease, stage 3. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/31/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 13, which indicated Resident #100 was cognitively intact. Review of the Admission Record revealed the facility admitted Resident #309 on 2/18/25 with a medical diagnosis that included type 2 diabetes mellitus with foot ulcer. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/25/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident # 309 was cognitively intact.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41878 Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to provide a safe, clean homelike environment for Residents #6, #11, and #60. This was for one (1) of four (4) hallways. Findings include: A record review of facility policy titled Safe and Homelike Environment, dated 2024, revealed, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . A record review of the facility policy titled, Deep Cleaning Rooms undated revealed, (6) Check all room curtains if it needs taking to laundry for washing. Resident #6 During an observation and interview on 03/03/25 at 3:10 PM, Resident #6's room was noted to have a large section of the wall (approximately 3 feet by 3 feet) with scratches and paint missing. Behind the resident's headboard of her bed, a piece of plywood measuring approximately 4 feet by 3 feet was noted to be attached to wall. The plywood had large chunks of wood missing which left uneven and splintered edges on the broken part as well as on the edges of the plywood. Resident #6 stated she would like for it to be repaired. On 3/5/25 at 1:30 PM, during an observation and interview, the Administrator confirmed the paint on the wall was in disrepair and the broken and splintered plywood on the wall behind the resident's bed could cause an injury. She confirmed each resident should have a safe, clean, and homelike environment and the facility failed to provide this for Resident #6. Record review of Admission Record revealed the facility admitted Resident #6 on 12/16/2020. Diagnoses included Hemiplegia and Hemiparesis following Cerebral Infarction, Type 2 Diabetes Mellitus, and Dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/24 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Resident #60 During an observation on 03/03/25 at 1:06 PM, an overwhelmingly strong and foul-smelling urine odor was noted in the hallway near Resident #60's room with the smell covering approximately 15 - 20 feet of the hallway from the resident's doorway. Upon opening the door to the resident's room, the foul smell was overpowering. Neither of the residents living in that room were in the room at the time. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/25 at 12:20 PM, Certified Nursing Assistant (CNA) #1 revealed Resident #60 frequently urinated on the floor while he attempted to use the toilet. She stated they have tried to mop the floor every hour or two and replaced the flooring in his bathroom, but the smell is still overwhelming. An observation during the interview confirmed that the urine smell in the hallway of Resident #60's room was still foul and overpowering. An interview on 3/4/25 at 12:25 PM, with CNA #3 confirmed that Resident #60's room and hallway near the resident's room had a strong smell of urine present. She stated she felt that the resident attempted to urinate in the toilet but would frequently miss and urinate on the floor. Her interview revealed that housekeeping mopped the floor every hour or two, but there was still a strong and very unpleasant smell, and she had several residents complain about the bad smell. During an interview on 3/4/25 at 12:30 PM, Licensed Practical Nurse (LPN) #3 confirmed that the urine smell in and near Resident #60's room had been an ongoing problem. She acknowledged that the resident pees on the floor, and even though unintentional, it still smelled terrible and it is not fair to other residents. This is their home, and they should not have to live in a stinky home. She stated she did not know what else could be done to improve the situation, but they have had residents and family members complain about the awful smell. During an interview with the Director of Nursing (DON) on 3/5/25 at 10:30 AM, he revealed he and the staff had worked with Resident #60 to try to improve this concern. They had assisted him with voiding in the toilet and even tried to encourage him to sit down while toileting. The resident was unwilling to try that and was unwilling to be prompted by staff to toilet more often. The DON stated the resident would go into the bathroom but before he was positioned properly, he would urinate on the floor. The DON confirmed that he was aware of the terrible smell in the resident's room as well as in the hallway surrounding the resident's room and had tried multiple things to help improve the smell. The floor was replaced which helped for a while, but he confirmed there was a foul odor in that area of the facility which had not been successfully resolved. During an interview on 3/5/25 at 10:35 AM, the Administrator stated she was aware of the foul urine odor in and near Resident #60's room. She stated multiple options had been tried such as replacement of the floor and wall in bathroom, resealing the toilet, mopping frequently, education and encouragement of resident with different techniques of voiding, but none of these led to a permanent solution to the problem. She confirmed this concern had continued to occur and an acceptable and permanent solution had not been established. She also confirmed it was not fair for the other residents to have to accept this strong, foul urine smell in their home. She confirmed that each resident had the right to a clean, comfortable, homelike environment and the facility failed to provide this for the residents in that area. Record review of Resident #60's Admission Record revealed the facility admitted him on 3/25/2019. Diagnoses included Chronic Obstructive Pulmonary Disease and Borderline Intellectual Functioning. Record review of the MDS with an ARD of 1/10/25 revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated that Resident #60 had a moderate cognitive impairment. 46013 Resident #11 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 3/03/25 at 12:05 PM, revealed multiple large splotched discolored areas to the privacy curtain visible upon entering Resident #11's room. Resident #11 revealed that This curtain needs cleaning; they don't ever clean it. An observation on 3/04/25 at 10:10 AM and again on 3/5/25 at 8:20 AM revealed the privacy curtain remained dirty with multiple large, discolored splotches throughout the fabric on the curtain. During an observation and interview on 3/05/25 at 8:30 AM, LPN #2 confirmed the privacy curtain in Resident #11's room was dirty and stained and needed to be pulled down and cleaned. She revealed it is not a home-like environment and wasn't sure when it was last cleaned. During an observation and interview on 3/05/25 at 9:45 AM, the Administrator confirmed the privacy curtain in Resident #11's room was extremely dirty and stated, I was just in this room yesterday and didn't even notice it. Resident #11 revealed It's been dirty like this for a long time. A record review of Resident #11's Admission Record revealed the facility admitted the resident on 02/24/2012 with diagnoses that included Major Depressive Disorder, Unspecified Kidney Failure, and Anxiety Disorder. A record review of Resident #11's MDS Section C with an ARD of 1/23/2025 revealed a BIMS score of 15, indicating that the resident is cognitively intact.

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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. 47874 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for nail care, oral hygiene, and hand rolls for one (1) of 25 sampled residents. Resident #74 Findings Include: Review of the facility policy titled Comprehensive Care Plans unrevised, 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. Review of Resident #74's Care Plan Report revealed under, Focus: I require total assistance with my ADL's (activities of daily living) r/t (related to) CVA (cerebrovascular accident) with left hemiplegia and bilateral hand contractures. Also revealed under, Interventions: Caregiver to don (apply) bilateral hand rolls to bilateral hands to decrease risk of skin breakdown and decrease risk of further contracture formation with skin checks/cleanse at the end of each shift to ensure no adverse effects x(times) 7 days a week . Mouth care: Brush teeth twice daily in the morning and night. X (times) 1 staff to assist with oral care . Nail care: clean and file PRN (as needed), trim my nails weekly. On 3/03/25 at 12:00 PM, an observation of Resident #74, revealed he was lying in bed with long brown discolored nails on the left hand measuring approximately 1 inch (in.) in length. One of his nails was broken off and hanging inside his palm. The residents' upper and lower teeth and lower gum line were covered in a thick white substance. Contractures observed to both hands/fingers with no device in place for contracture management. An observation of Resident #74 on 3/04/25 at 10:15 AM revealed he was lying in bed without hand rolls in place. On 3/05/25 at 7:50 AM, an observation with interview revealed Resident #74 lying in bed with long brown, discolored nails on the left hand and a thick white substance on the upper and lower teeth and the lower gum line. He revealed he asked the staff to brush his teeth. Contractures observed to both hands/fingers with no device in place for contracture management. The resident voiced that sometimes the staff applied a hand towel inside his hands, and stated they were not in his hands now. On 3/05/25 at 8:00 AM an observation and interview with Registered Nurse (RN) #1 confirmed Resident #74 did not have his hand rolls in place, had long nails, and described the residents' teeth as, They need brushing. An interview with the Minimum Data Set (MDS) Nurse on 3/06/25 at 8:20 AM revealed staff should follow Resident #74's care plan. She revealed the purpose of having a care plan was to make staff aware of how to care for the resident. The MDS Nurse confirmed staff did not follow his care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Admission Record revealed the facility admitted Resident #74 on 2/02/22 with medical diagnoses that included Cerebral Infarction and Hemiplegia Unspecified Affecting the Left Nondominant Side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated the Resident #74 was cognitively intact.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure licensed nursing staff followed professional standards of practice for medication administration. This resulted in the administration of discontinued and incorrectly scheduled medications, and failure to administer prescribed medications. This deficient practice was identified for four (4) of 37 medication administration observation opportunities (Resident #39, Resident #90) CROSS REFERENCE F759 Findings include: A review of the policy titled Medication Administration revealed the following: Policy: Medications are administered by licensed nurses who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice.Policy Explanation and Compliance Guidelines: Section 10 states that staff must ensure the six rights of medication administration are followed: a. Right resident, b. Right drug, c. Right dosage, d. Right route, e. Right time, and f. Right documentation. Resident #39 On 3/05/25 at 8:15 AM, an observation of Licensed Practical Nurse (LPN) #1 administering medications revealed that LPN #1 administered Glipizide 10 mg (milligrams) one tablet orally and Albuterol Sulfate HFA Inhaler 108 (90 Base) (2 puffs) to Resident #39. LPN #1 was not observed verifying the six rights of medication administration by checking the medication label against the medication record. Record review of the Medication Administration Record for 3/05/25 for Resident #39 revealed Glipizide 10 mg (milligrams) was discontinued on 3/03/25.Albuterol Sulfate inhaler was scheduled every six hours at 6:00 AM, 1200 PM, 6:00 PM (1800), and 12:00 AM (0000). The medication was last signed off at 6:00 AM. Mometasone Furoate inhaler signed off as administered at 8:00 AM on 3/05/25. During an interview on 3/5/25 at 1:10 PM, LPN #1 confirmed that she administered Glipizide 10 mg, which had been discontinued on 3/3/25. She also confirmed that she administered Albuterol Sulfate HFA inhaler at an incorrect time, as it had already been given at 6:00 AM. LPN #1 lastly confirmed that she documented administration of Mometasone Furoate inhaler at 8:00 AM, despite not administering it. She acknowledged that failure to verify the six rights of medication administration could lead to adverse resident outcomes. Record revew of the Admission Record of Resident #39 revealed was admitted on [DATE], with diagnoses including Type 2 Diabetes Mellitus and Chronic Systolic Congestive Heart Failure. Resident #90 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/05/25 at 8:46 AM, an observation of LPN #4 administering medications revealed that LPN #4 administered Aspirin Enteric Coated (EC) 81 mg to Resident #90. LPN #4 did not verify the six rights of medication administration by checking the medication label against the medication record. Record review of the Medication Administration Record for 3/05/25 for Resident #90 revealed Aspirin 81 mg chewable tablet signed off as administered. During an interview on 3/5/25 at 1:20 PM, LPN #4 confirmed that she administered Aspirin EC 81 mg, but later realized it was not the correct medication. She confirmed after reviewing the medication record that she gave the incorrect form of aspirin. She also confirmed she did not thoroughly check the six rights of medication administration and stated that if she had done so, she likely would not have made the error. Record review of the Admission Record revealed Resident #90 was admitted on [DATE], with a diagnosis of End-Stage Renal Disease.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47874 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure a resident dependent on staff for Activities of Daily Living (ADLs) received oral care and nail care for one (1) of 25 sampled residents. Resident #74 Findings Include: Review of the facility policy titled Activities of Daily Living Policy with a revision date of 7/2014, revealed under, Policy Statement: Based on previous evaluations and current date, the nursing staff, in conjunction with Attending Physician, Consultant Pharmacist, therapy staff, and others, will seek to identify the level of care a resident requires for ADLs. An observation of Resident #74, on 3/03/25 at 12:00 PM, revealed he was lying in bed with fingernails that were approximately 1 inch (in.) in length on the left hand with a brown substance on each nail and one nail that was broken off and hanging inside his palm. The residents' upper and lower teeth and lower gum line were covered in a thick white substance. An observation with interview on 3/05/25 at 7:50 AM with Resident #74 revealed no change in the resident's appearance and he stated that he had asked the staff in the past to brush his teeth. An observation and interview with Registered Nurse (RN) #1 on 3/05/25 at 8:00 AM confirmed Resident #74 had long nails on the left fingers that could cause skin breakdown due to his contracted fingers, which were turned inward toward the palm. She revealed the nurses, or the aides, could trim his nails. RN #1 described the residents' teeth as, They need brushing. She confirmed that staff failing to do this could cause gingivitis and tooth decay. She revealed the aides were responsible for brushing his teeth daily. An interview with the Administrator (ADM) on 3/05/25 at 2:00 PM revealed her expectations were for staff to perform the care tasks listed and document accordingly. Record review of the March 2025 Documentation Survey Report for Resident #74 revealed the resident requires total dependence for personal hygiene with the assist of 1- two (2) staff. Record review of the Admission Record revealed the facility admitted Resident #74 on 2/02/22 with medical diagnoses that included Cerebral Infarction and Hemiplegia Unspecified Affecting the Left Nondominant Side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated that Resident #74 was cognitively intact.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41878 Based on resident and staff interviews, record review, and facility policy review, the facility failed to provide activities that met the interest of the residents for three (3) of 25 sampled residents. Resident #6, #9, and #41 Findings Include: Review of the facility policy titled Activities revealed under, Policy: It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interest of each resident, as well as support their physical, mental, and psychosocial well-being. Resident #6 During an interview on 3/4/25 at 9:00 AM, Resident #6 stated the facility does not offer activities on the weekends and she would like to have activities on these days as well as during the week. She revealed she had been sick and had preferred to do activities in her room, but lately she felt better and wanted to participate in group activities. An interview with the Activity Director (AD) on 3/5/25 at 8:00 AM, revealed she worked Monday through Friday and on the weekends the charge nurse would assist the residents with independent activities. She stated she left puzzles and coloring sheets for the residents that wanted to do those activities. She stated that church groups would occasionally have services in the facility on the weekend, but otherwise, she confirmed there were no organized group activities planned for the residents on the weekend. An interview with the Administrator (ADM) on 3/6/25 at 8:45 AM, revealed the facility did not have a weekend activity staff member, but she was attempting to hire one. She stated the Activity Director would leave puzzles and coloring sheets for the residents. She confirmed the facility failed to provide structured and scheduled activities on the weekends for the residents that preferred to participate on those days. Review of the February and March 2025 activity schedules confirmed on Saturdays and Sundays Independent activities of choice was listed. Record review of the February 2025 Activity Attendance Record for Resident #6 revealed there was no activity documentation for the weekend days. Record review of Resident #6's Admission Record revealed the facility admitted her on 12/16/2020. Her diagnoses included Hemiplegia and Hemiparesis following Cerebral Infarction, Type 2 Diabetes Mellitus, and Dementia. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/19/24 Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated this resident was cognitively intact. Review of section F revealed for the question how important is it to you to do your favorite activities and the resident's response was very important. Resident #9 During an interview on 3/04/25 at 8:46 AM, Resident #9 stated she participated in the bingo and singing activities during the week, but there were not any activities on the weekends. She stated she would like for the facility to offer activities on the weekend for her and other residents to participate in. Record review of the February 2025 Activity Attendance Record for Resident #9 revealed there was no activity documentation for the weekend days of the month. Record review of Resident #9's Admission Record revealed the facility admitted the resident on 7/6/2018 originally with the most recent admitted [DATE]. Diagnoses included Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, and Hemiplegia and Hemiparesis following Cerebral Infarction. Record review of Resident #9's MDS with an ARD of 10/24/24 Section C revealed a BIMS score of 15 which indicated the resident was cognitively intact. Review of Section F revealed for the question how important is it to you to do your favorite activities and the resident's response was very important. For the question how important is it to you to do things with groups of people the resident's response was very important. 47874 Resident #41 An interview with Resident #41 on 3/05/25 at 8:10 AM revealed she liked to play cards such as Spades and Monopoly. She revealed there were no activities on the weekends and all they did was sit around. The resident explained that during the weekend they (the facility) sometimes had church singing, but she did not like music. She revealed she would like more things to do that she liked. She voiced they (the residents) do have puzzles that were always available, but she was tired of that. Record review of Resident #41's February 2025 Activity Attendance Record revealed there was no activity participation for the weekend days of the month. Also revealed the resident was marked as participating in outside time (smoking), hall social, watching TV, and being up in her wheelchair. An interview with Certified Nurse Aide (CNA) #1 on 3/05/25 at 7:55 AM revealed she worked some weekends. She confirmed the facility did not have weekend activities and stated, We sometimes have church members that come sing, but it's not often. She revealed there were no other activities conducted on the weekends. An interview with Housekeeping #1 on 3/05/25 at 9:18 AM revealed she worked four (4) days on and two (2) days off, which included her working some weekends. She confirmed the facility had no weekend activities and stated, No, they don't do anything. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the January, February 2025 activity calendars revealed on the weekends, Independent activities of choice were listed. An interview with the AD on 3/05/25 at 2:30 PM revealed she had been in the activity position for about five (5) years and acknowledged the residents should have activities, including the weekends, which included their likes. The AD revealed Resident #41 liked to play Bingo. She revealed that she included smoking as part of the resident's activity record and hall social, which included social conversation while she was waiting in the hall to go smoke. She revealed, in her opinion, she had done all she could do to meet the interest of Resident #41. Record review revealed the Activity Director completed the 40 Hour Basic Activity Director Course dated 11/8/21. Record review of the Admission Record revealed the facility admitted Resident #41 on 9/6/24 with a medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Right Dominant Side. Record review of the MDS with an ARD of 9/16/24 revealed under, Section C, a BIMS summary score of 13, which indicated Resident #41 was cognitively intact. Also revealed, under section F0500 . F. How important is it to you to do your favorite activities? Very important was marked.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47874 Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure hand rolls were applied for a resident with finger contractures for one (1) of 25 sampled residents. Resident #74 Findings Include: Review of the facility policy titled Prevention of Decline in Range of Motion unrevised, revealed under, Policy: Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable. Record review of the Treatment Administration Record (TAR) revealed an order dated 7/08/24, Caregiver to don (put on) B (bilateral) hand rolls to B (bilateral) hands to decrease risk of skin breakdown and decrease risk of further contracture formation with skin checks/cleanse at the end of each shift to ensure no adverse effects x (times) 7 days a week every shift. The hand rolls were signed as applied/administered on each shift (day, evening, and night) for the dates of 3/3/25 and 3/4/25. An observation on 3/03/25 at 12:00 PM revealed Resident #74 lying in bed. Contractures observed to both hands/fingers with no device in place for contracture management. An observation of Resident #74 on 3/04/25 at 10:15 AM revealed he was lying in bed without hand rolls in place. An observation and interview on 3/05/25 at 7:50 AM with Resident #74 revealed the resident was lying in bed with no hand rolls in place. The resident voiced that sometimes the staff applied a hand towel inside his hands but confirmed that he did not have any now. An observation and interview with Registered Nurse (RN) #1 on 3/05/25 at 8:00 AM confirmed Resident #74 were supposed to have hand rolls that the nurses applied, but did not have the hand rolls in place. She revealed the resident could develop worsening contractures and skin breakdown by not wearing them as ordered. Record review of the Therapist Progress & (and) Discharge Summary dated 1/04/24 revealed under, Discharge Plans & (and) Instructions: Patient discharged to nursing care for placement of B (bilateral) hands rolls to decrease risk of skin breakdown as well as decreased risk of further contracture formation. An interview with the Occupational Therapist (OT) on 3/05/25 at 8:34 AM revealed she recommended Resident #74 to wear hand rolls due to his severe hand/finger contractures. She revealed the purpose of him wearing them was to prevent skin breakdown and further worsening of his contractures, and confirmed without staff applying them, his contractures could become worse. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator (ADM) on 3/5/25 at 2:00 PM confirmed that the staff should be applying Resident #74's hand rolls or have documentation to reflect why it was not. Record review of the Admission Record revealed the facility admitted Resident #74 on 2/02/22 with medical diagnoses that included Cerebral Infarction and Hemiplegia Unspecified Affecting the Left Nondominant Side. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated that Resident #74 was cognitively intact. Also revealed under section GG, functional limitation in range of motion (shoulder, elbow, wrist, hand), impairment on both sides was marked.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47157

Based on observations, resident and staff interviews, record review and facility policy review, the facility failed to maintain a medication error rate less than 5% as evidence by the administration of discontinued and incorrectly scheduled medications and failure to administer prescribed medications. This deficient practice was identified in four (4) of 37 medication administration observation opportunities. The medication error rate was 10.81%. This affected Resident #39 and Resident #90.

CROSS REFERENCE F658

Findings include:

A review of the policy titled Medication Administration revealed the following, Policy: Medications are administered by licensed nurses who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice .Policy Explanation and Compliance Guidelines: Section 10 states that staff must ensure the six rights of medication administration are followed: a. Right resident, b. Right drug, c. Right dosage, d. Right route, e. Right time, and f. Right documentation .

Resident #39

An observation of Licensed Practical Nurse (LPN) #1 on 3/05/25 at 8:15 AM, administering medications revealed that LPN #1 administered Glipizide 10 mg (milligrams) (one tablet orally) and Albuterol Sulfate HFA Inhaler 108 (90 Base) (2 puffs) to Resident #39. LPN #1 did not verify the six rights of medication administration by comparing the medication label with the electronic/paper medication administration record before administration.

Record review of the Medication Administration Record for 3/05/25 for Resident #39 revealed Glipizide 10 mg was discontinued on 3/03/25. Albuterol Sulfate inhaler was scheduled every six hours at 6:00 AM, 1200 PM, 6:00 PM (1800), and 12:00 AM (0000). The medication was last signed off at 6:00 AM. Mometasone Furoate inhaler signed off as administered at 8:00 AM on 3/05/25.

On 3/5/25 at 1:10 PM, during an interview LPN #1 confirmed that she made medication errors when administering Resident #39's medications. She admitted that she administered Glipizide 10 mg, which had been discontinued on 3/3/25 and also Albuterol Sulfate HFA inhaler at an incorrect time, as it had already been given at 6:00 AM. She then confirmed that she also documented administration of Mometasone Furoate inhaler at 8:00 AM, despite not administering it. She acknowledged that failure to verify the six rights of medication administration could lead to adverse resident outcomes.

Resident Admission Record: Resident #39 was admitted on [DATE], with diagnoses including Type 2 Diabetes Mellitus and Chronic Systolic Congestive Heart Failure.

Resident #90

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of LPN #4 administering medications on 3/05/25 at 8:46 AM, revealed that LPN #4 administered Aspirin Enteric Coated (EC) 81 mg to Resident #90. LPN #4 did not verify the six rights of medication administration by checking the medication label against the medication record. Record review of the Medication Administration Record for 3/05/25 for Resident #90 revealed Aspirin 81 mg chewable tablet signed off as administered. On 3/5/25 at 1:20 PM, during an interview LPN #4 confirmed after reviewing the medication record that she gave the incorrect form of aspirin when she administered Aspirin EC 81 mg, but later realized it was not the correct medication. She also confirmed she did not thoroughly check the six rights of medication administration and stated that if she had done so, she likely would not have made the error. Record review of Resident #90's Admission Record revealed the facility admitted the resident on 1/04/25, with diagnoses that included End-Stage Renal Disease.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47874 Based on observation, staff interview, and facility policy review, the facility failed to ensure a medication cart was locked and secured for one (1) of four (4) survey days. Findings Include: Review of the facility policy titled Medication Storage unrevised, revealed, Policy Explanation and Compliance Guidelines . c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. An observation on 3/03/25 at 12:45 PM revealed the medication cart located on C hall was unlocked and unattended without a nurse in view. An observation and interview with Licensed Practical Nurse (LPN) #1 on 3/03/25 at 12:49 PM confirmed she walked away from the medication cart and left it unlocked. She explained that she got called away and forgot to lock it. LPN #1 revealed leaving the medication cart unlocked gave the residents access to the cart and stated, Any of the residents can get in it and take something. An interview with the Administrator (ADM) on 3/04/25 at 10:11 AM confirmed the nurses should never leave the medication cart unlocked when out of view. She revealed that any resident could walk by and take some medication and have an allergic reaction.