STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A178	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jasper County NH	15 A South Sixth Street Bay Springs, MS 39422

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 0605 Level of Harm - Actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident was free from unnecessary medications when the resident received an antipsychotic medication without an appropriate diagnosis and without informed consent, which resulted in lethargy, weight loss, and poor meal intake for one (1) of five (5) residents reviewed for unnecessary medications. Resident #79.Findings include:A review of the facility's policy titled .Use of Psychotropic Medication(s), dated 9/17/25, revealed, .It is the intent of this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated.During an observation on 10/6/25 at 12:15 PM, Resident #79 was observed asleep in her wheelchair in the common area.On 10/8/25 at 1:05 PM, Resident #70 was observed asleep in her wheelchair and remained asleep until 5:15 PM.On 10/8/25 at 4:17 PM, during an interview with Certified Nurse Aide (CNA) #1, she explained that Resident #79 had good days and bad days, often refusing to eat on her bad days. She stated the resident had been refusing meals that day and was uncooperative, often falling asleep during mealtime. She stated that CNAs typically set up the meal tray and later return to check on the resident.On 10/8/25 at 3:00 PM, during an interview with the Nurse Practitioner (NP), she explained that Resident #79 had lost over fifty (50) pounds in the past year. She stated Resident #79 often refused meals and care. She stated the resident was prescribed Geodon for psychosis related to combative behaviors but acknowledged that the resident did not have a diagnosis of bipolar disorder or Schizophrenia. She added that she had intended for the medication to be prescribed as needed (PRN) rather than scheduled daily. She stated that weight loss and lethargy could be side effects of the medication.A record review of the Behavior Monitoring and Interventions Report Log from 9/8/25 through 10/8/25 revealed there were no documented behaviors for Resident #79.On 10/8/25 at 3:30 PM, during an interview with the Director of Nursing (DON), she stated that psychosis was listed in the resident's medical history but acknowledged that it was not an approved indication for Geodon use. She confirmed that while the resident had a history of behaviors, the behavior documentation for the past month did not reflect any recorded behaviors.On 10/8/25 at 5:10 PM, during an interview with Licensed Practical Nurse (LPN) #3, she stated that Resident #79 often slept through meals and that it was difficult to get her to eat due to combativeness. She stated that CNAs had reported the resident's sleepiness and that she had reported these observations to her supervisor. She added that Resident #79 sometimes refused medications or slept through medication passes.On 10/9/25 at 10:00 AM, during an interview with Registered Nurse (RN) #2, Medical Records Nurse, she explained that the facility was unable to provide a signed consent for antipsychotic medication for Resident #79. She stated that Geodon was started in June 2024, prior to the facility's implementation of the consent process for antipsychotic use. She further explained that the medication was prescribed for psychosis, which was not an approved indication for use. She confirmed that the facility did not retroactively seek consent from the resident's representative or family after the regulation regarding consents for psychotropic medications went into effect.On 10/9/25 at 10:30 AM, during an interview with the Administrator and the DON, they stated it was their expectation that residents would be free from unnecessary (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 0605 Level of Harm - Actual harm Residents Affected - Few	medications and that medications would be administered only for appropriate diagnoses.On 10/9/25 at 11:04 AM, Resident #79 was observed asleep in her wheelchair in the dining area.A record review of Resident #79's admission Record revealed the facility admitted the resident on 10/17/23 with current diagnoses including Dementia.A record review of the Order Summary Report revealed Resident #79 had a physician's order, dated 1/8/25 for Ziprasidone (Geodon) HCL Cap (Capsule) 20 MG (Milligrams) Give 1 capsule by mouth at bedtime related to Unsp (Unspecified) psychosis not due to a substance or known physiological cond (condition).A record review of Quarterly Minimum Data Set (MDS) with an Annual Assessment Reference Date (ARD) of 8/19/25 revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated her cognition was moderately impaired.A record review of the Amount Eaten from 9/11/25 through 10/8/25 revealed the staff documented that Resident #79 refused her meal 38 times during the month.A record review of the Vital: Weight log for Resident #79 revealed that she weighed 214.2 pounds on 10/1/24 and 159.2 pounds on 10/1/25, which was a total of 55 pounds and 25.7 percent total weight loss in twelve (12) months.A record review of the RD (Registered Dietician) Assessment Summary, dated 10/7/25 revealed Resident #79 the Reason for Assessment was SWLX30/90/180 (Significant Weight Loss times 30/90/180 days) and included Observations/statements from chart/staff/resident. Assessment due to weight loss.Needs cueing r/t (related to) falling asleep while eating.A record review of the Psych (Psychiatric) Progress Note dated 9/25/25 revealed Resident #79's medication included Geodon 20 mg and the Case Conceptualization revealed, Chart indicates poor appetite and ongoing wt (weight) loss.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, staff interview, record review, and facility policy review, the facility failed to follow infection prevention and control practices, as evidenced by failure to wear gloves during the administration of eye drops and by placing medication containers on contaminated surfaces without cleaning or using a barrier for two (2) of three (3) residents observed for medication administration (Residents #14 and #96). Findings include:A review of the facility's .Medication Administration Policy, dated 7/30/25, revealed, . Medications are administered by licensed nurses.as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .Resident #14A record review of the admission Record revealed the facility admitted Resident #14 on 11/14/22 with current diagnoses including Unspecified Glaucoma.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/28/25 revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact.A record review of the Order Summary Report revealed Resident #14 had a Physician's Order for Combigan Opthalmic Solution 0.2-0.5%, dated 11/14/2022.On 10/7/25 at 8:18 AM, during an observation, Licensed Practical Nurse (LPN) #2 was observed administering medications to Resident #14 during the morning medication pass. LPN #2 administered one (1) drop of eye drops to each of the resident's eyes without wearing gloves. She then placed the plastic medication bag on the resident's bed, retrieved it, and returned it to the medication cart without sanitizing the container.On 10/7/25 at 8:21 AM, during an interview, LPN #2 stated that gloves should have been worn during eye drop administration to prevent the spread of infection through bodily fluids or potential eye infections such as conjunctivitis (pink eye). She further stated medication containers should not be placed on the resident's bed or returned to the cart without sanitizing. She stated that a barrier, such as a paper towel, should be used between items and contaminated surfaces to prevent infection transmission.Resident #96A record review of the admission Record revealed the facility admitted Resident #96 on 3/11/24 with current diagnoses including Pulmonary Fibrosis.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/26/25 revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident's cognition was moderately impaired.A record review of the Order Summary Report revealed Resident #96 had a physician's order, dated 8/27/24, for Artificial Tears eye drops. On 10/7/25 at 8:37 AM, during an observation, LPN #1 administered eye drops to Resident #96 without wearing gloves.On 10/7/25 at 8:45 AM, during an interview, LPN #1 stated she should have worn gloves while administering eye dops to Resident #96.On 10/7/25 at 10:15 AM, during an interview with the Director of Nursing (DON), she stated that any items placed on a resident's bed or bedside table must have a clean barrier and should be sanitized before being returned to the medication cart. She further stated that gloves should always be worn for procedures involving the eyes to prevent the spread of infection.

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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. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure a resident's right to privacy and dignity during medication administration when licensed nursing staff administered prescribed eye drops to a resident in the dining room while other residents were present, for one (1) of three (3) residents reviewed for medication administration, Resident #96.Findings include:A review of the facility's .Medication Administration Policy, dated 7/30/25, revealed, .Policy Explanation and Compliance Guidelines.7. Provide privacy.On 10/7/25 at 8:37 AM, during an observation, LPN #1 administered medications to Resident #96 while the resident was in the dining room. At the time of the observation, nine (9) other residents were also present in the dining room.On 10/7/25 at 8:45 AM, during an interview, LPN #1 stated she normally administered medications in the dining room for residents who were present there during the morning medication pass. She reported that Resident #96 had not expressed a problem with receiving medications in the dining room but acknowledged that privacy could be an issue when medications were given in the presence of other residents.On 10/7/25 at 10:15 AM, during an interview, the Director of Nursing (DON) stated medications should not be administered in the dining room in front of other residents. She stated her expectation was that all medications be administered in a private setting to ensure resident dignity and privacy.A record review of the admission Record revealed the facility admitted Resident #96 on 3/11/24 with current diagnoses including Pulmonary Fibrosis.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/26/25 revealed Resident #96 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident's cognition was moderately impaired.A record review of the Order Summary Report revealed Resident #96 had a physician's order, dated 8/27/24, for Artificial Tears eye drops.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on staff interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) related to an insulin medication for Resident #2 and an anticoagulant medication for Resident #14 for two (2) of (21) sampled residents.Findings include: A review of the facility's policy, Assessment Frequency/Timeliness dated 10/1/23, revealed, The purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI (Resident Assessment Instrument) Manual . Resident #2A record review of Drugs.com website revealed the drug classification for Trulicity is GLP-1 receptor agonists.A review of the admission Record revealed the facility admitted Resident #2 on 6/19/24 with current diagnoses including Type 2 Diabetes Mellitus with Diabetic Neuropathy. A record review of the Quarterly MDS with an ARD of 8/04/2025 revealed Section N, N0300. Insulin was marked as Resident #2 had received two (2) insulin injections in the seven (7) day look-back period.A record review of the Order Summary Report with Active Orders As Of 7/01/2025 revealed Resident #2 had a Physician's Order, dated 9/18/24, for Trulicity Subcutaneous Solution Pen-Injector 3mg(milli-gram)/0.5 ml (milli-liters) (Dulaglutide) Inject 3 mg subcutaneously one time a day every Wednesday related to Type 2 Diabetes Mellitus Without Complications. Further review revealed there were no Physician's Order for an insulin medication. A record review of Resident #2's MAR for July and August 2025, revealed Trulicity was documented as administered. There was no documentation indicating that insulin was administered.Resident #14A record of the admission Record revealed Resident #14 was admitted by the facility on 11/14/2022 with diagnoses including Hypertensive Heart Disease with heart failure. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/28/25 for Resident #14 revealed Section N, N0415. High-Risk Drug Classes: Use and Indication was marked as Yes, indicating Resident #14 had taken an anticoagulant medication during the seven (7) day look-back period. A record review of the Order Summary Report with Active Orders as of 7/28/2025 revealed there were no Physician's Orders for an anticoagulant medication.A record review of the Medication Administration Record (MAR) for the month of July 2025 revealed there were no anticoagulant medications administered to Resident #14.On 10/7/25 at 12:41 PM, during an interview with the Registered Nurse/Minimum Data Set (RN/MDS) Coordinator, she confirmed that Resident #14 did not have a Physician's order for an anti-coagulant medication and was not administered an anticoagulant during the look-back period, although the MDS reflected anticoagulant use. The RN/MDS further confirmed Resident #2 was prescribed an insulin medication but was on Trulicity injections. She reported that the MDS was coded incorrectly for both residents.On 10/7/25 at 4:30 PM, during an interview with Director of Nurses (DON), she stated that MDS assessments must be completed accurately and acknowledged the errors for Resident #2 and Resident #14.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and facility policy review, the facility failed to implement resident-specific care plan interventions when staff did not provide personal hygiene (shaving) as identified in the care plans (Residents #6 and #11), and failed to develop a care plan addressing triggers and interventions for a resident with Post-Traumatic Stress Disorder (PTSD) (Resident #2) for three (3) of (21) sampled residents.Findings include:A review of the facility's Care Plan Assessment (CAA) Care Planning Policy (undated), revealed, It is the policy of this facility that the CAA/Care Planning Process will be done as follows: Includes.Each triggered CAA will be assessed to facilitate a plan of care based on problems identified through the assessment process.Resident #2On [DATE] at 11:55 AM, during an interview with Resident#2 she confirmed she had the diagnosis of PTSD and reported it is related to her husband died due to a stab wound to his leg. He bled out and said he waited to tell her that he loved her, and he died. She no longer likes knives and does not watch knife shows. She thinks staff are aware of the PTSD. A record review of the admission Record revealed the facility admitted Resident #2 on [DATE] with current diagnoses including Post-Traumatic Stress Disorder, Unspecified.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Section I indicated she had an active diagnosis of Post-Traumatic Stress Disorder.A record review of the Psych Eval, dated [DATE], revealed Past Medical History Active Medical Problems included Post-Traumatic Stress Disorder. The Case Conceptualization section indicated, . demonstrates how she wrapped her arms around her younger siblings to protect them from hearing her abusive father's [NAME] . Hesitates and almost tears up before expounding upon these scenarios saying she doesn't want to be sent to a psychiatric hospital, then exhibits the same display of hesitation near tearfulness when she talks . My husband passed away, and I found him by myself, and they said it was PTSD .A record review of Resident#2's clinical record revealed there was no care plan developed with interventions that included trauma or triggers. Resident #6A record review of the Care Plan Report revealed Resident #6 had a Focus of Resident requires total ADL assistance . with Interventions/Tasks including Assist as needed with ADL'S . A record review of the admission Record revealed the facility admitted Resident #6 on [DATE] with diagnoses including Alzheimer's Disease.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident's cognition was moderately impaired. Section GG revealed Resident #6 had limitations in range of motion in both lower extremities and was dependent on staff for bathing and personal hygiene.During an observation and interview on [DATE] at 10:44 AM, Resident #6 was noted to have long facial hair. He explained the staff were supposed to shave him, but he had not been shaved in a long time. He expressed that he wished to be shaved. During an observation on [DATE] at 12:32 PM, Resident #6 continued to have long facial hair. During an interview on [DATE] at 3:00 PM, Certified Nurse Aide (CNA) #2, confirmed Resident #6 had long facial hair that appeared not to have been shaved in several days, possibly a week. She reported that Resident #6 preferred to be clean-shaven and that she had last shaved him approximately two (2) weeks ago when his facial hair was also long.Resident #11A record review of the Care Plan Report revealed Resident #11 had a Focus of Resident requires ADL assistance with Interventions/Tasks of Assist As Needed With ADL'S .A record review of the admission Record revealed the facility admitted Resident #11 on [DATE] with diagnoses including Alzheimer's Disease.A record review of the Quarterly MDS with an ARD of [DATE] revealed a BIMS score of 3, which indicated the resident's cognition was severely impaired. Section GG revealed Resident #11 had limitations in range of motion in both lower (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extremities and was dependent on staff for bathing and personal hygiene.During an observation on [DATE] at 12:11 PM, Resident #11 had numerous long stray hairs that were several inches long on her chin. During an interview and observation on [DATE] at 12:15 PM, CNA #3 confirmed Resident #11 had long chin hair and that shaving should be completed during showers. During an observation on [DATE] at 12:31 PM, Resident #11 had long chin hair visible.During an observation on [DATE] at 8:35 AM, Resident #11 was lying in bed and continued to have long chin hair.During an interview on [DATE] at 12:00 PM, Registered Nurse (RN)#1 explained that the purpose of the care plan was to guide staff in providing individualized care for each resident. She stated that she expected all staff to follow the care plans as written to ensure residents received the highest quality of care. She reviewed Resident #2's care plan and confirmed that no care plan had been developed for Post-Traumatic Stress Disorder (PTSD) and that no triggers were identified for prevention of recurrence. She stated that since the diagnosis was present on admission, a care plan might have been in the medical record but confirmed that if it was not included in the comprehensive care plan, staff would not be aware of the triggers or how to prevent recurrence.During an interview on [DATE] at 1:01 PM, the Administrator and the Director of Nursing (DON) stated that they expected staff to follow each resident's care plan and provide quality care to support residents in achieving their highest practicable level of well-being. They stated that care plans should be developed based on each resident's comprehensive assessment and confirmed that Resident #2 should have had a care plan addressing Post-Traumatic Stress Disorder (PTSD), and that Residents #6 and #11 should have been shaved in accordance with their care plans for activities of daily living (ADL) care.

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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. Based on observation, interviews, record review, and facility policy review, the facility failed to provide shaving for residents who were dependent on staff for Activities of Daily Living (ADLs) for two (2) of (21) sampled residents, Residents #6 and #11.Findings include:A review of the facility's Shaving Policy, (undated) revealed, It is the policy of this facility that male residents will be shaved as follows: - Encouraged to be shaved daily and as needed .Resident #6A record review of the admission Record revealed the facility admitted Resident #6 on 2/13/23 with diagnoses including Alzheimer's Disease.A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/9/25 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident's cognition was moderately impaired. Section GG revealed Resident #6 had limitations in range of motion in both lower extremities and was dependent on staff for bathing and personal hygiene.A record review of the facility's Bath Schedule - Group C revealed Resident #6 received a pan bath daily on the night shift.On 10/6/25 at 10:44 AM, during an observation and interview, Resident #6 was lying in bed with long facial hair. He stated that staff were responsible for shaving him, but he had not been shaved in a long time and wished to be shaved.On 10/7/25 at 12:32 PM, during an observation, Resident #6 was observed sitting in his wheelchair with long facial hair.On 10/7/25 at 3:00 PM, during an interview with Certified Nurse Aide (CNA) #2, she stated that Resident #6 received a bed bath daily on the evening shift (7:00 PM-7:00 AM) and required total assistance for all ADLs except feeding. She stated the resident was cooperative and never refused care, including baths. CNA #2 stated that shaving was part of the bath or shower routine and should occur daily or at least every other day. She confirmed Resident #6 had long facial hair that appeared not to have been shaved in several days, possibly a week. She reported that Resident #6 preferred to be clean-shaven and that she had last shaved him approximately two (2) weeks ago when his facial hair was also long.On 10/7/25 at 3:30 PM, during an interview with Licensed Practical Nurse (LPN) #4, she stated that Resident #6 was cooperative and dependent on staff for all ADLs except feeding. She confirmed the resident received a bed bath nightly, which included shaving. She stated the resident had long facial hair and that she had not been informed of any refusals. Resident #11A record review of the admission Record revealed the facility admitted Resident #11 on 12/13/18 with diagnoses including Alzheimer's Disease.A record review of the Quarterly MDS with an ARD of 8/13/25 revealed a BIMS score of 3, which indicated the resident's cognition was severely impaired. Section GG revealed Resident #11 had limitations in range of motion in both lower extremities and was dependent on staff for bathing and personal hygiene.A record review of the facility's Bath Schedule - Group A revealed Resident #11 received a pan bath daily on the day shift.On 10/6/25 at 12:11 PM, during an observation, Resident #11 was sitting in her wheelchair with multiple long hairs several inches in length noted on her chin.On 10/6/25 at 12:15 PM, during an interview and observation with CNA #3, she confirmed Resident #11 had long chin hair and that shaving should be completed during showers. She stated the resident received her showers on the evening shift.On 10/7/25 at 12:31 PM, during an observation, Resident #11 was sitting in the dining room with long chin hair visible.On 10/7/25 at 12:35 PM, during an interview and observation with CNA #4, she stated that she worked restorative care and also assisted on the floor as needed. She confirmed that ADL care included bathing, brushing teeth, dressing, and shaving as needed on shower days. She stated Resident #11 had long chin hair that appeared to have been there for some time.On 10/7/25 at 2:20 PM, during an interview and observation with CNA #5, she stated that Resident #11 was totally dependent for all ADLs and was scheduled for showers on the evening shift, which included shaving. She stated the resident was usually cooperative with care, though occasionally confused. She confirmed the resident had long chin hairs that appeared to have not been recently shaved.On 10/7/25 at 3:25 PM, during an interview with LPN #4, she stated that Resident #11 received showers on the evening shift and that she had not been informed of any refusals of care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated the resident was confused but easily redirected and cooperative.On 10/8/25 at 8:35 AM, during an observation, Resident #11 was lying in bed and continued to have long chin hair.On 10/8/25 at 9:00 AM, during an observation and interview with the Director of Nursing (DON), Resident #6 was sitting in the dining room eating breakfast. The DON stated that both men and women were expected to be shaved as part of bathing or shower care. She stated that, as a woman, she would not want to have long chin hair and expected staff to shave or pluck such hairs as needed. She confirmed that Resident #6 had long facial hair and stated she would follow up on Resident #11.On 10/9/25 at 1:01 PM, during a follow-up interview with the DON, she confirmed Resident #11 had numerous chin hair and stated she expected staff to provide shaving for all residents as needed to meet each resident's individual needs and ensure quality care.

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure triggers and resident specific interventions were identified and initiated for a resident with Post Traumatic Stress Disorder (PTSD) for one (1) of (21) sampled residents. Resident #2.Findings include:A review of a written statement provided and signed by the Administrator revealed, (Proper Name) Nursing Home does not have a policy on Post-Traumatic Stress Disorder.A record review of the admission Record revealed the facility admitted Resident #2 on [DATE] with current diagnoses including Post-Traumatic Stress Disorder, Unspecified.A record review of the Order Summary Report revealed orders for .May consult (Proper Name) Health Services for Psych (Psychiatric).as needed, dated [DATE], and May have Psych consult as needed, dated [DATE].A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Section I indicated she had an active diagnosis of Post-Traumatic Stress Disorder.A record review of the Certified Nurse Aide (CNA) Kardex for the Behavior Monitoring and Interventions Report for [DATE] revealed staff were to indicate behaviors observed, interventions attempted, and outcomes. There were no resident-specific triggers identified in the document related to PTSD.A record review of the Psych Eval, dated [DATE], revealed Past Medical History Active Medical Problems included Post-Traumatic Stress Disorder. The Case Conceptualization section indicated, . demonstrates how she wrapped her arms around her younger siblings to protect them from hearing her abusive father's [NAME] . Hesitates and almost tears up before expounding upon these scenarios saying she doesn't want to be sent to a psychiatric hospital, then exhibits the same display of hesitation near tearfulness when she talks . My husband passed away, and I found him by myself, and they said it was PTSD .A record review of Resident #2's medical record revealed there was no documentation indicating that the resident had been evaluated to identify PTSD triggers or that any resident-specific interventions had been developed or implemented.On [DATE] at 11:55 AM, during an interview, Resident #2 confirmed she had been diagnosed with PTSD and stated it was related to the death of her husband, who had died from a stab wound to his leg. She explained she no longer likes knives and does not watch television shows involving knives. She stated she believed the staff were aware of her PTSD diagnosis. On [DATE] at 2:20 PM, during an interview with Certified Nurse Aide (CNA) #6, she stated that Resident #2 had never mentioned PTSD or exhibited complaints about triggers. She reported the resident occasionally became anxious and complained about various issues. She reviewed the Kardex and stated that the resident was monitored every shift for behaviors, but neither the resident nor staff had ever identified PTSD-related triggers.On [DATE] at 3:10 PM, during an interview with Licensed Practical Nurse (LPN) #4, she stated she was not aware of Resident #2 having PTSD, and the resident had never discussed it or any triggers. She confirmed that Resident #2 spoke frequently about anxiety and had medications for anxiety management. After reviewing the resident's admitting diagnoses, LPN #4 confirmed that PTSD was listed among them.On [DATE] at 11:01 AM, during an interview with the Director of Nursing (DON), she stated she was not aware of any trauma-informed or PTSD-specific assessments being completed for residents. She explained she had been employed at the facility since August and was not aware of any existing assessments. The DON stated she would verify whether Resident #2 had received a psychiatric evaluation addressing PTSD. She reported she had consulted with the Assistant Director of Nursing (ADON), who informed her that Resident #2 was admitted with the PTSD diagnosis but that neither she nor the ADON knew the associated triggers. The DON confirmed that there was no documentation identifying PTSD-related triggers and acknowledged that without such information, staff would be unable to recognize or avoid potential triggers. The DON provided a copy of Resident #2's initial Psych Eval Note, dated [DATE]-four (4) months after admission-which listed PTSD under past medical history and included trauma-related (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A178	A. Building B. Wing	10/09/2025

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	content, but no identified triggers or interventions. The DON confirmed that while the resident was seen by a Mental Health Nurse Practitioner quarterly and a psychotherapist weekly, the facility had not conducted an assessment to identify triggers or develop corresponding interventions. She stated the facility did not have a PTSD policy.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, record review and facility policy review, the facility failed to maintain an accurate resident clinical record related to a physician's order for a resident hospital transfer for one (1) of (21) sampled residents. Resident #7Findings include: A review of the facility's Physician's Orders Policy, revised 8/29/17 revealed .Reminders.The nurse noting the order is responsible for.Transcribing the orders to the appropriate place. A record review of the facility's admission Record revealed the facility admitted Resident #7 on 4/23/2019 with current diagnoses including Type 2 Diabetes Mellitus A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/25/25 revealed Resident #7 was transferred from the facility due to a unplanned discharge to a Short-Term General hospital on 7/25/2025. A record review of Progress Notes revealed Resident #7 had a Transfer to Hospital Summary note, dated 7/25/2025, which indicated she had been sent to an acute hospital for further evaluation. A review of the clinical record for Resident #7 revealed there was no physician order documented related to the 7/25/25 transfer to the hospital. On 10/08/2025 at 11:56 AM, during an interview with the Assistant Director of Nursing (ADON), she acknowledged there was no Physician's order in the medical record related to Resident #7's transfer to an acute hospital on 7/25/25. She stated it was the responsibility of the nurse that receives the order to transcribe it and follow it through. On 10/08/2025 at 1:21 PM, during an interview with the Director of Nursing (DON), she confirmed there was no physician's order in the clinical record for Resident #7 when she was transferred to the hospital on 7/25/25. The DON stated that when a verbal order is received from the physician the nurse must put that information in the computer immediately or as quickly as possible.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, staff interview, and facility policy review, the facility failed to ensure nurse staffing information was posted in a location daily that was visible to residents and the public for two (2) of four (4) survey days.Findings include:A review of the facility's Posting Daily Staffing Information Policy (undated) revealed, It is the policy of this facility that Nurse Staffing information will be posted as follows.The information will be posted daily.This form will be posted in the foyer of the building.On 10/6/25 at 11:05 AM, during an observation of the common areas, including the facility's foyer, and surrounding the nursing stations on Unit 200, Unit 300, and Unit 400, there was no posted nurse staffing information visible.On 10/7/25 at 2:09 PM, during an observation of the common areas, including the facility's foyer, and surrounding the nursing stations on Unit 200, Unit 300, and Unit 400, there was no posted nurse staffing information visible.On 10/7/25 at 3:25 PM, during an interview with the Assistant Director of Nursing (ADON), she explained that the daily nurse staffing information was completed daily but was posted inside a locked room near the time clock with a sign on the door that read Staff Only. She further stated that the staffing information was also kept in a binder behind the nursing station counter. The ADON confirmed that no staffing information was posted in the common areas surrounding any of the three nursing stations.On 10/7/25 at 3:40 PM, during an interview with the Director of Nursing (DON), she confirmed that there was no nurse staffing information posted in the common areas near Units 200, 300, or 400. She explained that while the nurse staffing information was completed, it was kept in binders behind the nursing station counter. The DON stated that posting nurse staffing information is important to demonstrate that the facility has adequate staff to meet residents' needs and provide appropriate care.