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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HEIGHTS HEALTHCARE CENTER	402 ARNOLD AVENUE GREENVILLE, MS 38701

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M 000	Initial Comments The State Agency (SA) conducted an Annual Recertification Survey and a Complaint Investigation (CI MS #28032, 28486, 28842 and 29061)) at the facility from 6/3//25 through 6/5//25. During the survey, the SA determined the facility was not in compliance with the requirements of Minimum Standards for Institutions for the Aged or Infirm and cited deficiencies at M610, M640, M655, M1010 and M1570. The SA found the facility not to be in compliance with CI MS #28032 regarding sexual abuse and cited MS500. The SA found the facility to be in compliance regarding CI MS#28486, #29061 and #28842. The facility had a census of 57 at the time of survey and was licensed for 60 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		7/3/25

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M 500	Continued From page 1 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff	M 500		

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M 500	Continued From page 2 and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic	M 500		

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M 500	Continued From page 3 purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.	M 500		

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M 500	Continued From page 4 This Statute is not met as evidenced by: Level II Based on observation, staff interviews, record review,facility investigation review and facility policy review, the facility failed to: 1) honor a resident's and/or resident representative's right to be fully informed and participate in treatment decisions prior to the initiation of an antipsychotic medication (Resident #31); 2) protect the right to be free from sexual abuse (Resident #49); and 3) to be treated with dignity as evidenced by a failure to cover a urinary catheter drainage device (Resident #55) for four (4) of 40 sampled residents. Findings include: Review of the facility policy titled "Psychotropic Medication Use" with a revision date of 2/2025 revealed under, "Informed consent or refusal: 1. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: ... b. the indications and rationale for the recommendation; c. the potential risk and benefits (including possible side effects, adverse consequences, and the black box warning); and d. the resident's/representative's right to accept or decline the treatment." Record review of Resident #31's "Psych Progress Note" dated 11/8/24 revealed, "Facility request visit due to recent combative behavior. Staff report that a resident is displaying combative	M 500	1. On June 04, 2025 when discovered Resident #55 did not have a dignity bag, a dignity bag was immediately provided to Resident #55 by the Director of Nursing to cover his urinary bag and tubing. On June 05, 2025 Resident #31 was provided a consent form related to the use of psycho-trophic medication use risk and benefits. On February 20, 2025, Certified Nursing Assistant (CNA) witnessed Resident #52 with his hand underneath Resident #49 blouse rubbing her breasts in the facility's day room. Both residents were separated by the Certified Nursing Assistant staff (CNA). Resident #49 were assessed for injuries by the Charge Nurse on February 20, 2025 with no negative findings. Resident #52 was placed on 1:1 monitoring. On February 20, 2025 cognitive residents were interviewed by Social Services. Results from interviews revealed no negative findings. Resident #49 did not sustain an injury due to this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. On June 05, 2025 the Director of Nursing provided an in-service to all Certified Nursing Assistant (CNA) staff on the facility's "Dignity" policy to ensure resident's rights to dignity is being honored. A 100 percent audit on all residents with catheters was performed by the Director of Nursing on June 05,2025. One (1) of Three (3) residents was noted not having a genitourinary drainage bag.	

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M 500	Continued From page 5 behaviors ... Resident is often noted to be reaching for things or pulling at blankets and fidgety often. However, staff reported that the resident has now become combative with staff. Behaviors have been monitored for approximately 1 week and seem to be worsening." Additionally reveled under, "Recommendations: Initiate Rexulti 0.5 mg (milligram) q (every) pm (evening)" for a diagnosis of Alzheimer's disease. Record review of Resident #31's "Progress Notes" dated 11/08/24 revealed, "Psych (psychiatric) NP (nurse practitioner) gave recommendation for Rexulti. The proper name of RR (resident representative) called to make her aware of the new order. Explained med (medication) is for Alzheimer's and also treats agitation. The proper name of RR said she believed the agitation was related to her not being able to visit lately." There was no documentation that the representative was informed of the risk and benefits of the antipsychotic medication Rexulti, nor that alternative treatments were discussed or that informed consent was obtained. During an interview on 6/4/25 at 2:24 PM, the Director of Nursing (DON) confirmed that staff contacted the resident representative of Resident #31 to inform her of the new medication. However, the representative was not informed of alternative treatment options, potential risks and benefits, or provided the opportunity to consent or refuse treatment. The DON acknowledged the representative should have received this information to make an informed decision. Record review of the "Admission Record" revealed the facility admitted Resident #31 on 10/15/21 with diagnoses that included Dysphagia following Cerebral Infarction and Alzheimer's	M 500	The resident was provided a dignity bag on June 05, 2025. On June 05, 2025 an in-service was provided by the Corporate Nurse Educator to the Director of Nursing on the facility's "Pharmacy Overview" policy. On June 05, 2025 the Director of Nursing provided an in-service to all nursing staff on the facility's "Pharmacy Overview" policy. A 100% audit was performed by the Corporate Nurse Educator on all residents receiving anti-psychotic medication to ensure consent forms were provided. Findings were submitted to the Director of Nursing on June 05, 2025. The Director of Nursing in return provided the resident's Responsible Representative (RR) consent forms relating to the use of psycho-trophic medications use risks and benefits. On February 20, 2025 an in-service was initiated and completed by the Administrator on the facility's "Abuse and Neglect" policy. All staff in-serviced prior to working their shift. On June 05, the Director of Nursing conducted a 100% audit on the incident reports to monitor sexual inappropriate behavior between residents. No further allegations were found. 4. Beginning on June 05,2025, the Assistant Director of Nursing and/or the Lead Certified Nursing Assistant (CNA) will monitor all residents with catheters (three) 3 times a week for (twelve) 12 weeks to ensure residents requiring a catheter has a dignity bag is in place. Beginning on June 05, 2025 the Director of Nursing will make rounds three (3) times a week for (twelve) 12 results to	

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M 500	Continued From page 6 Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/25 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score was not conducted because Resident #31 was rarely/never understood. Abuse Record review of the facility policy, titled "Abuse Prevention Program", revealed "Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion." Resident #49 Record review of the facility investigation titled "Report of Investigation" dated 2/24/25, regarding an allegation of sexual abuse involving Resident #52 and Resident #49 revealed that on 2/20/2025 at approximately 5:10 AM Certified Nurse Assistant (CNA) witnessed Resident #52 with his hand underneath Resident #49's blouse rubbing her breasts in the day room. The residents were separated, and Resident #52 was placed on one-on-one monitoring. Resident #49 was assessed and found to have no injuries. Record review of "Fact Finding Witness Interview-Confidential", dated 2/20/25 revealed that during interview with Social Services Resident #52 denied rubbing Resident #49's breasts, stating that she was trying to stand up and her breast fell out and he was trying to cover it.	M 500	ensure each resident has a dignity bag in place. Beginning on June 05, 2025 the Assistant Director of Nursing and/or Medical records will review medication orders daily to ensure residents with new orders that are anti-psychotic medications have consent forms explaining risks and benefits (three) 3 times a week for (twelve) 12 weeks. Any concerns will be immediately addressed by the Director of Nursing. Beginning on June 06, 2025, the Administrator and the Director of Nursing initiated facility rounds (three) 3 times a week for twelve (12) weeks to observe for any resident exhibiting inappropriate sexual behaviors. Any concerns will be corrected. Beginning on June 06, 2025, the Director of Nursing initiated monitoring weekly times (twelve) 12 weeks of the rounds audit. The Director of Nursing will observe the incident log weekly for (twelve)12 weeks to ensure incidents are reported timely and addressed. Result of findings will be reported to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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M 500	Continued From page 7 Record review of "Fact Finding Witness Interview-Confidential", dated 2/20/25 revealed that during interview with Social Services Resident #49 indicated that she was touched by Resident #52. In an attempted interview with Resident #49 on 6/3/25 at 8:18 AM she did not respond. In an attempted interview with Resident #52 on 6/3/25 at 8:21 AM, he stated "get the hell out". Interview with the DON on 6/3/25 at 11:00 AM, she confirmed that the facility investigation confirmed that Resident #52 was witnessed by a staff member rubbing Resident 49's breast and agreed that this action constituted abuse. Telephone interview with CNA #3 on 6/3/24 at 4:54 PM she stated on 2/20/25 around 5:10 AM she was making rounds and went to the day room area and saw Resident #52 with his right hand through the sleeve of Resident 49's shirt rubbing her breasts. She stated that she separated the residents and notified the nurse. She stated that Resident #52 has a history of inappropriately touching staff but has not touched a resident before. Record review of the "Admission Record" revealed the facility admitted Resident #49 on 12/26/23 with a diagnosis of Diffuse Traumatic Brain Injury and Cognitive Communication Deficit. Record review of the MDS with and ARD of 12/19/24 for Resident #49 revealed a BIMS score of 11, indicating the resident is moderately cognitively impaired. Record review of the "Admission Record"	M 500		

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revealed the facility admitted Resident #52 on 7/26/24 with diagnoses including Traumatic Hemorrhage of Cerebrum.

Record review of the MDS with an ARD of 1/23/25 for Resident #52 revealed a BIMS score of 11, indicating the resident is moderately cognitively impaired.

Urinary Catheter

A review of the facility policy, "Dignity" with a revision date of February 2021, revealed " ...12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: ... a. helping the resident to keep urinary catheter bags covered ..."

An observation on 06/03/25 at 7:49 AM, and again at 9:08 AM, revealed Resident #55 lying in his bed in his room. A urinary catheter bag containing 200 milliliters of yellow urine was hanging on his bed and visible from the hall, with no privacy bag in place.

During an interview on 6/04/25 at 10:05 AM with Certified Nurse Aide (CNA) #4 and CNA #6, CNA #4 revealed that all urinary catheters are supposed to be kept inside a privacy bag, so the resident's urine is not visible to anyone else; it's a dignity issue. CNA #6 (lead CNA) revealed that the catheter is always supposed to be kept inside the privacy bag and confirmed that the urinary catheter bag was uncovered the previous morning, stating, "We are doing much better today, looking at that."

In an interview on 6/4/2025 at 2:42 PM, the Director of Nurses (DON) revealed that it is our

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M 500	Continued From page 9 expectation that if a resident has a urinary catheter, it should be placed inside a privacy bag so that the urinary contents are not visible to anyone else. She revealed that if it were not inside a privacy bag, then it would be a dignity issue. Record review of Resident #55's "Admission Record" revealed the facility admitted the resident on 4/15/2025 with medical diagnoses that included Multiple Sclerosis, and Neuromuscular dysfunction of the Bladder. Record review of Resident #55's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/21/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated that the resident had moderate cognitive impairment.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II	M 610	1. Resident #1 received oral care on June 04, 2025 by the Certified Nursing Assistant (CNA) staff. Resident #1 care plan was	7/3/25

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M 610	Continued From page 10 Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care to maintain personal hygiene (Resident #1 and #17) and failure to provide timely assistance with meals (Resident #49) for three (3) of 57 residents in the facility. Findings include: Review of facility policy titled, "Activities of Daily Living (ADL) Supporting" with revision date March 2018, revealed, " ...Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene ..." Resident #1 During observations and interviews on 6/3/25 at 8:22 AM and again at 1:54 PM, Resident #1 had a buildup of a thick brown/yellow substance on his teeth. This buildup was observed on both the upper and lower teeth. The resident stated he would like to have his teeth cleaned and it had been a while since anyone had offered. He verified he would not decline if they offered. During an observation and interview on 6/4/25 at 12:20 PM with Certified Nursing Assistant (CNA) #2, she confirmed the resident's teeth had buildup and should have been brushed. She revealed that not receiving daily oral care could lead to gum disease and/or cavities. During an observation and interview with the Director of Nursing (DON) on 6/4/25 at 12:26 PM, she confirmed that Resident #1 was in need of oral care and that the CNAs were responsible for providing that daily. She further revealed that	M 610	updated by the Care Plan Nurse on June 04, 2025 to reflect oral care. On June 04, 2025 Resident #17 was provided finger nail care, oral care, and a shave by the Certified Nursing Assistant (CNA) staff. On June 04, 2025 Resident #17 care plan was updated by the Care Plan Nurse to reflect finger nail care, oral, and a shave. On June 04, 2025 Resident #49 breakfast tray was left on the bedside table by Certified Nursing Assistant (CNA) staff. On June 04, 2025 Certified Nursing Assistant staff received corrective counseling. 2. All residents have the potential to be affected. 3. On June 04, 2025 an in-service was initiated and completed by the Director of Nursing to all nursing staff on the facility's "Care Plan" policy and following the care guide to ensure resident's plan of care are followed at all times. A 100% care plan audit was initiated on June 04, 2025 and completed on June 09, 2025 by the Care Plan Nurse to ensure updated care plans reflect oral care, finger nail care, shave, and assistance with feeding. Two (2) of Fifty-nine (59) residents care plan was updated regarding oral care by the Care Plan Nurse on June 04, 2025. Two (2) of Fifty-nine residents care plan was updated regarding toenail and fingernail care by the Care Plan Nurse on June 04, 2025. One (1) of 59 resident care plan was updated regarding shaving by the Care Plan Nurse on June 04, 2025. One (1) of 59 resident care plan was updated regarding feeding with assistance.	

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M 610	Continued From page 11 lack of oral care could lead to dental caries. Record review of the "Admission Record" revealed that Resident #1 was admitted to the facility on 8/30/24, with medical diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other lack of coordination, need for assistance with personal care, contracture of muscle right hand, contracture of muscle left hand, and muscle weakness (generalized). Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/29/25 revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 11, indicating that the resident had moderate cognitive impairment. Resident #17 An observation on 6/3/25 at 7:37 AM revealed Resident #17's fingernails on both hands had a brown substance under each nail bed, was jagged and long extending approximately three-fourths (3/4") of an inch long past the tips of fingers; facial hair was visible on the resident's cheeks, chin and upper lip that was approximately one-half (1/2") inch long. During an observation and interview on 6/4/25 at 12:14 PM with CNA #2, she confirmed Resident #17 had 1/2" facial hair to his face and upper lip and that his fingernails were very long and dirty as well. She verbalized that he should be clean shaven, and his fingernails should also be trimmed. She confirmed that having long fingernails and long facial hair could be a source for bacteria to grow. Additionally, he could cause a skin tear with his long nails.	M 610	4. Beginning on June 05,2025, the Lead Certified Nursing Assistant and/or the Care Plan Nurse will make observation rounds (three) 3 times per week for twelve (12) weeks to ensure care plan implementations are followed for residents. Beginning June 05, 2025, results of the observation rounds will be submitted to the Director of Nursing to monitor for accuracy and completeness. The Administrator will be forwarded to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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M 610	Continued From page 12 During an observation and interview on 6/4/25 at 12:20 PM with Licensed Practical Nurse (LPN) #2, she confirmed that Resident #17, "scratches and digs," with his fingernails, however they should be kept trimmed and clean. She also confirmed that his facial hair was several days old and should have been shaved off. She verbalized that he could scratch himself with his long nails and cause infection. During an interview with the DON on 6/4/25 at 12:26 PM, she confirmed that fingernails should be trimmed and cleaned as needed and that Resident #17 should have already been shaved. She confirmed he could cause a skin tear and/or infection with long, jagged nails. Record review of the "Admission Record" revealed Resident #17 was admitted to the facility on 1/24/24, with medical diagnoses that included Epilepsy and Vascular Dementia. Record review of the quarterly MDS with an ARD of 4/18/25 indicated, under Section C, a BIMS score of 7, which indicated the resident had moderate cognitive impairment. Section GG revealed Resident #17 was dependent on staff for personal hygiene. Resident #49 An observation on 6/3/25 at 7:30 AM revealed Resident #49's breakfast tray sitting on her bedside table, not opened or set up. The resident was in bed with her head covered with a blanket. Continued observation revealed that staff finally came in to assist the resident with breakfast at 8:00 AM. An interview with CNA #1 on 6/3/25 at 8:00 AM	M 610		

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M 610	Continued From page 13 verified that Resident #49 has to be assisted with meals. She revealed that staff know they are not supposed to leave trays in the rooms of residents that need assistance, if they cannot feed them at that time. She stated that if a resident needs to be fed you are supposed to sit down and feed the resident when you bring the tray into the room. She stated that the tray should have been left on the cart until she was available to assist the resident. She verified that the food could get cold and that residents may not want to eat it. An interview with CNA #2 on 6/3/25 at 8:03 AM confirmed that when a meal tray is placed in the room you are to assist the resident at that time and not leave the tray sitting in the room. An interview with LPN #1 on 6/3/25 at 8:05 AM confirmed that if a resident requires assistance with meals they are to be assisted when the tray is taken into the room and Resident #49 should have been assisted with breakfast when the tray was delivered. An interview with the Administrator on 6/4/25 at 11:00 AM stated that she expected the staff to assist residents with their meals when they bring their tray to their rooms. Record review of the "Admission Record" revealed the facility admitted Resident #49 on 12/26/23 with a diagnoses including DiffuseTraumatic Brain Injury. Record review of the MDS with an ARD of 12/19/24 for Resident #49 revealed a BIMS score of 11, indicating the resident is moderately cognitively impaired.	M 610		

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M 640	Continued From page 14	M 640		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observations, staff interviews, record review, and facility policy review, the facility failed to provides an environment that is free from accident hazards as evidenced by failure to implement interventions to reduce fall hazards for one (1) of 40 residents sampled, Resident #15. Findings include: Review of the facility policy titled, "Safety and Supervision of Residents" with a revision date of July 2017 revealed under, "Policy Statement...Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities...Resident Risk and Environment Hazards...c. Falls". During observations on 6/03/25 at 10:18 AM and again at 2:00 PM, revealed Resident #15 lying in bed with a fall mat folded up and leaning against the wall and without a wedge placed between his thighs. During an observation and interview on 6/4/25 at 11:03 AM, with Certified Nursing Assistant (CNA) #1, she confirmed that the fall mat was folded up	M 640	1. On June 06, 2025 Resident #15 was assessed by the Director of Nursing for any ill effects noted related to staff not following the care guide while making room rounds ensuring fall mat was placed at bedside and a wedge was placed between his thighs. Resident #15 had no noted effects noted. Resident #15 physician order to implement wedge was discontinued on June 10, 2025. 2. All residents have the potential to be affected by this deficient practice. 3. On June 05, 2025 an in-service was completed and completed by the Director of Nursing to all nursing staff on the facility's "Accident/Incident" policy to ensure accidents are prevented. A 100% care plan audit was initiated on June 04, 2025 and completed on June 09, 2025 by the Care Plan Nurse to ensure updated care plans reflect accident prevention. One (1) of 59 resident care plan was updated by the Care Plan Nurse on June 04, 2025 regarding accident prevention. A 100% care guide audit was completed by the Assistant Director of Nursing to ensure care guide implementation of assistant	7/3/25

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M 640	Continued From page 15 and propped against the wall. She revealed that the fall mat was supposed to be laid out on the floor in case he fell. She further confirmed that should he fall out of bed without the fall mat in place, he could potentially break a bone or get seriously hurt. She confirmed he did not have a wedge between his thighs, nor did he even have a wedge in his room. During an observation and interview on 6/4/25 at 11:06 AM, with Licensed Practical Nurse (LPN) #1, she confirmed the fall mat was propped against the wall but should be on the floor beside his bed. She verbalized that the mat was there to help prevent injury should the resident fall out of bed. Additionally, she stated that he could break a bone if he fell out of bed without the mat in place. She confirmed that Resident #15 did not have a wedge between his thighs. She also could not find one in his room as well. During an interview on 6/4/25 at 11:10 AM, with the Director of Nursing (DON), she confirmed the fall mat should have been in place on the floor beside his bed and he should have the wedge cushion in place. She confirmed that the mat was put in place to help prevent a serious injury should he fall out of bed. Record review of the "Admission Record" that Resident #15 was admitted to the facility on 7/10/18 with medical diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and unspecified convulsions. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/17/25, under Section C for Resident #15, revealed, " ...resident is rarely/never	M 640	devices are noted to prevent accidents. On June 09, 2025 the Director of Rehabilitation initiated and completed a 100% audit on residents receiving therapy to ensure residents have appropriate relieving devices documented. Results revealed (two) 2 of (ten) residents receiving therapy wedge order was discontinued on June 10, 2025. 4. Beginning on June 05, 2025, the Assistant Director of Nursing will make observation audit rounds (three) 3 times a week for eight (8) weeks to ensure care guide implementation for residents and ensure resident environment remains free of accident hazards. Beginning June 05, 2025 the Director of Rehabilitation will monitor residents receiving therapy services (three) 3 times a week for (eight) 8 weeks to ensure appropriate relieving devices are documented. Results of audits will be submitted to the Administrator weekly times (eight) 8 weeks for accuracy and completeness. The Administrator will forward results to the Quality Assurance Committee meeting held on June 20, 2025,then monthly times (three) 3 months for review and further recommendations.	

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M 640	Continued From page 16 understood ..."	M 640		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide the necessary foot care to maintain skin integrity and prevent complications for one (1) of three (3) residents reviewed that needed assistance with foot care. Resident #7 Findings Include: Review of the facility policy titled "Foot Care" with a revision date of 10/2022 revealed under, "Policy Statement: Resident receive appropriate care and treatment in order to maintain mobility and foot health." Also revealed under, "Policy Interpretation and Implementation: 1. Residents are provided with foot care and treatment in accordance with professional standards of practice. 2. Overall foot care includes the care and treatment of medical conditions to prevent foot complications from these conditions."	M 655	1. Resident #7 received fingernail and toenail care by the Certified Nursing Assistant (CNA) staff on June 04, 2025. On June 04, 2025 Resident #7 care plan was updated by the Care Plan Nurse to reflect fingernail and toenail care. On June 11, 2025 Resident #7 received foot care by the Podiatrist. Resident #7 is scheduled for another visit by the Podiatrist on August 13, 2025. 2. All residents have the potential to be affected by this deficient practice. 3. On June 04, 2025 an in-service was initiated and completed by the Director of Nursing to all nursing staff on the facility's "Care Plan" policy and following the care guide to ensure resident's plan of care are followed at all times. A 100% care plan audit was initiated on June 04, 2025 and completed on June 09, 2025 by the Care Plan Nurse to ensure updated care plans reflect nail care. One (1) of 59 residents reflected nail care. A 100% Head to Toe	7/3/25

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M 655	Continued From page 17 On 6/03/25 at 10:28 AM, during an observation and interview with Resident #7 she stated, "Are you here to trim my toenails?" She revealed her toenails needed cutting and the podiatrist was here weeks ago, but she was told she was not on the list to be seen. The resident reported she was having left heel pain and explained she had told the nurse. An observation of the left heel revealed a circular area with excessively thick dry and peeling skin, with dark redness surrounding the area. There was a small open area inside the patch of dryness that measured approximately 0.8 centimeters (cm) x 0.5 centimeters (cm) and was V-shaped in appearance with no intact skin and dark purple outer edges. The resident stated she had been applying lotion to it every day, but the staff were not doing a treatment. She stated the area was painful to touch. Several calluses were observed on both feet and her toenails on both feet were excessively thick and long extending approximately eight (8) millimeters (mm) past the tips of the toes. Record review of Resident #7's "Progress Notes" revealed there was no documentation regarding a skin concern. Record review of Resident #7's June 2025 "Treatment Administration Record (TAR)" there were no orders to provide care to the left heel. Record review of Resident #7's "Skin Check" dated 6/03/25, 5/27/25, 5/20/25, and 5/13/25 revealed "No skin issues" was documented. An interview with the Wound Care Nurse on 6/04/25 at 10:21 AM revealed she worked weekends and helped some during the week with wound care. She explained Resident #7 did not have skin concerns other than some dry skin at	M 655	skin assessment audit was performed by the Registered Nurse on June 05, 2025. The results of the audit revealed no negative findings. 4. Beginning on June 05,2025, the Lead Certified Nursing Assistant and/or the Care Plan Nurse will make observation rounds (three) 3 times per week for twelve (12) weeks to ensure care plan implementations are followed for residents. Beginning June 05, 2025, results of the observation rounds will be submitted to the Director of Nursing to monitor for accuracy and completeness. The Administrator will be forwarded to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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M 655	Continued From page 18	M 655		

times. The Wound Nurse stated," She's complaining all the time that her feet felt like they were bursting." Following an observation of Resident #7's left heel with the Wound Nurse, she stated she was unaware of the wound. She described the area as dry, thick cracking skin with redness around the edges. The resident confirmed the area was tender to touch. The Wound Nurse provided measurements of the entire circumference of the wound that measured 9.5 centimeters (cm) x 3.5 centimeters (cm). She confirmed the resident had excessively long thick toenails that needed to be cut. She revealed this could cause skin concerns or injury to the resident. The Wound Nurse acknowledged the residents' foot concerns should have been discovered during routine weekly skin checks and stated early identification could prevent foot complications.

An observation and interview with the Assistant Director of Nursing (ADON) on 6/04/25 at 10:46 AM revealed the medication nurses were responsible for doing the weekly body audits. She revealed she was not aware of any skin concerns the resident had. After assessing Resident 7's left heel, she confirmed this should have been detected during the body audit done yesterday and a treatment initiated.

An interview with Licensed Practical Nurse (LPN) #2 on 6/04/25 at 2:10 PM revealed she conducted the skin audit on Resident #7 yesterday. She confirmed she did not document accurately to reflect the resident skin condition. LPN #2 stated she had been applying lotion to the area, but she did not have any documentation to prove she had been doing it. She explained the podiatrist was here last month and she thought he saw her and stated, "Maybe he didn't

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M 655	Continued From page 19 document it." Record review of Resident #7's "Foot Care Progress Note" dated 2/24/25 revealed the resident was seen for toenail care with recommendations of "Daily moisturizer twice daily and 60 day follow up" for corns and callus. An interview with the Director of Nursing (DON) on 6/05/25 at 8:15 AM confirmed Resident #7 had excessively long thick toenails. She revealed the resident was at risk for infection and ingrown toenails or injury. She confirmed the resident was last seen by the podiatrist in February 2025. Record review of "Admission Record" revealed the facility admitted Resident #7 on 5/08/20 with medical diagnoses that included Cornes and Callosities, Unspecified Intellectual Disabilities and Paranoid Schizophrenia. 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 Resident #7 was cognitively intact.	M 655		
M1010	45.35.1 Housekeeping Facilities and Services Housekeeping Facilities and Services. 1. The physical plant shall be kept in good repair, neat, and attractive. The safety and comfort of the resident shall be the first consideration. 2. Janitor closets shall be provided with a mop-cleaning sink and be large enough in area to store house cleaning supplies and equipment. A	M1010		7/3/25

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M1010	Continued From page 20 separate janitor closet area and equipment should be provided for the food service area. This Statute is not met as evidenced by: Level II Based on observation, staff interviews, record review, and facility policy review, the facility failed to provide a safe, homelike environment as evidenced by an unsanitary bathroom for one (1) of the thirty resident shared bathrooms observed. Room #133, and Room #135 Findings include: Review of the facility policy titled "Safe environment", undated, revealed, "The facility must provide- (1) A safe, clean, comfortable, and homelike environment ....(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior ... " Review of the facility policy titled "Bathrooms," undated, revealed that "Bathrooms shall be maintained in a clean and sanitary manner and shall be cleaned on a daily basis." Record review of "Grand Rounds" for room #135 dated 5/27/25, 5/28/25, 5/29/25, 6/2/25, and 6/3/25 revealed that, under "Free from urine odors, and bathroom cleaned" it was documented No (N). An observation on 6/3/25 at 2:40 PM revealed a strong urine odor in the shared bathroom of Rooms #133 and #135. A thick black substance was around the base of the toilet. An observation on 6/4/25 at 8:55 AM, and again at 1:25 PM, revealed a strong urine odor in the	M1010	1. On June 04, 2025 resident bathroom #133 and #135 revealed a urine odor. On June 5, 2025 resident bathroom #133 and #135 received a complete room cleaning by the Housekeeping Supervisor. On June 06, 2025 the Maintenance Director replaced the tile in resident bathroom #133 and #135. On June 09, 2025 resident bathroom #133 and #135 received another complete room cleaning by the Housekeeping Supervisor. Residents noted in bathroom #133 and #135 revealed no ill effects from staff failure to maintain a safe, clean, comfortable, and homelike environment. 2. All residents have the potential to be affected by this deficient practice. 3. On June 04, 2025 an in-service was provided by the Administrator to the Environmental staff on the long-term care regulation "Resident's Rights" policy ensuring a safe, clean, comfortable, and homelike environment. On June 05, 2025, the Administrator provided an in-service to the Housekeeping Supervisor and the Maintenance Director on ensuring complete room cleanings are documented and environmental issues are documented in the maintenance log. 4. Beginning on June 06, 2025, the Housekeeping Supervisor and/or the Lead Certified Nursing Assistant will conduct	

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M1010	Continued From page 21 shared bathroom of Rooms #133 and #135. The thick black substance remained around the base of the toilet. During an observation and interview on 6/04/25 at 3:55 PM, Registered Nurse (RN) #1 revealed that the bathroom shared by Room #133 and Room #135 has been a work in progress for quite some time. He revealed that four men share that bathroom, and maintenance has changed out the toilet several times. He confirmed the room had a strong urine smell, and there was a black substance around the base. An observation and interview on 6/04/25 at 4:17 PM with the Maintenance Assistant revealed that he wasn't aware of the significant amount of black corrosion around the base of the toilet and stated, "That's on us. I'll let my maintenance director know." He confirmed the bathroom had a strong urine smell. During an interview on 6/04/25 at 4:30 PM, the Housekeeping Director revealed he was aware of the strong urine smell in the resident's bathroom. He revealed that four males share it, and we are cleaning that room more frequently because the men are missing the toilet; it is just a constant battle. During an interview on 06/04/25 at 4:52 PM, the Maintenance Director revealed the department heads make rounds to each resident's rooms and bathrooms each morning and report anything that may be in disrepair or need cleaning during the stand-up meeting. He revealed that he was not aware of the black corrosion around the base of the toilet until his Maintenance Assistant took him into the bathroom a few minutes ago to show him. He confirmed that the toilet had black	M1010	room rounds checking bathrooms for urine odors and tile replacement or commode replacement on (five) 5 residents (three) 3 times a week for twelve (12) weeks to ensure a safe and homelike environment for residents. Beginning on June 06, 2025 the results of the room rounds will be submitted to the Administrator weekly times (twelve) 12 weeks for accuracy and completeness and maintained in the Administrator's office. The Administrator will present results to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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M1010	Continued From page 22 corrosion around its base, and the strong urine smell was because the tile needed to be replaced. During an interview and observation on 6/04/25 at 5:06 PM, the Administrator revealed that department heads conduct "Grand Rounds" each morning in each resident room, which includes their bathroom, and discuss any issues found during the stand-up meeting. She confirmed that there was a strong urine odor in the bathroom that rooms #133 and #135 shared. She acknowledged there was a black corrosion around the base of the toilet and stated, "We will replace the tile, but until then, a little bleach and Pine-Sol would do a lot of good." During an interview on 6/04/25 at 5:13 PM, Medical Records revealed she is responsible for the morning Grand Round for the shared bathroom of rooms #133 and #135. She revealed that "Every day, I go in there. Honestly, it has a strong odor of urine, and the bathroom is dirty. I always put it down on the sheet and notify housekeeping in the hallway, and I also address it during our morning stand-up meeting." She revealed this has been a constant issue.	M1010		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases.	M1570		7/3/25

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	76AA	A. BUILDING: _____ B. WING _____	06/05/2025

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M1570	Continued From page 23 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observations, staff interviews, record reviews, and facility policy review, the facility failed to help prevent the possible transmission of infections when staff failed during medication administration to ensure a multi-use glucometer was properly cleaned and disinfected and failed to use Enhanced Barrier Precautions (EBP) during catheter care (Resident #55) for two (2) of three (3) infection control practices observed. Findings include: Review of the policy titled, "Enhanced Barrier Precautions Checklist" with no revision date revealed "Staff shall apply Enhanced Barrier Precautions to the care of all residents in high contact care activities ...5. Barriers include gloves, gowns ...	M1570	1. On June 04, 2025 the glucometer was cleaned per manufacture instructions for (two) 2 minutes then sit to dry for an additional (two) 2 minutes by the Licensed Practical Nurse (LPN) staff. The Director of Nursing educated all nursing staff on instructions of cleaning glucometers on June 04, 2025. On June 04, 2025 all Certified Nursing Assistant (CNA) staff was provided education on the facility's "Enhanced Barrier Precautions" policy to ensure staff wear personal protective equipment while providing care to resident with noted catheters. 2. All residents have the potential to be affected by this deficient practice. 3. The Director of Nursing educated all nursing staff on instructions of cleaning glucometers on June 04, 2025. On June	

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M1570	Continued From page 24 An observation of catheter care for Resident #55 on 6/4/25 at 10:05 AM revealed Enhanced Barrier Precautions (EBP) signage on the outside of the room door. Certified Nurse Aide (CNA) #4 entered the room, performed hand hygiene, applied clean gloves, and did not apply a gown for enhanced barrier precautions. The Lead CNA assisted CNA #4 with catheter care and washed her hands, applying gloves, but did not put on a gown. The Lead CNA was observed leaning into the residents' bed with her clothes touching the bed. During an interview on 6/4/2025, at 10:20 AM, CNA #4 confirmed that she failed to wear a gown while providing catheter care for Resident #55. The Lead CNA revealed the resident is on EBP because he has a urinary catheter, and we should have both worn a gown to protect ourselves and also the resident from any possible spread of infection. An interview on 6/04/25 at 1:20 PM, the Infection Preventionist confirmed that enhanced barrier precautions are supposed to be used when providing catheter care. She revealed that the staff is to wear their gowns and gloves to protect themselves and the residents from any possible transmission of infection. An interview on 6/04/25 at 2:49 PM, the Director of Nurses (DON) confirmed that Resident #55 was under enhanced barrier precautions due to having a urinary catheter. She revealed it is our expectation that the staff members providing catheter care should always wear a gown and gloves to help prevent the spread of infections. Record review of Resident #55's "Admission Record" revealed the facility admitted the resident	M1570	04, 2025 all Certified Nursing Assistant (CNA) staff was provided education on the facility's "Enhanced Barrier Precautions" policy to ensure staff wear personal protective equipment while providing care to resident with noted catheters. On June 05, 2025 the Administrator and the Director of Nursing completed a 100% walk through, observing staff to see if there are any staff that are not in compliance with the policies and procedures on Infection Control Standards. 4. Beginning on June 05, 2025, the Charge Nurse(s)/and or Lead Certified Nurse Assistant will monitor Certified Nursing Assistant (CNA) staff wearing proper protective equipment while performing care on residents with Enhanced Barrier Precautions signage (two) 2 times a week for (twelve) 12 weeks to ensure staff are in compliance into Infection Control standards. The Charge Nurse(s)/and or Lead Certified Nursing Assistant will report results to the Assistant Director of Nursing beginning on June 05, 2025. The Director of Nursing and the Administrator will monitor Certified Nursing Assistant (CNA) staff daily during facility rounds beginning on June 05, 2025 (one) 1 time a week for (twelve) 12 weeks to ensure ongoing compliance. Results will be submitted to the Quality Assurance Committee meeting held on July 01, 2025, then monthly times (three) 3 months for review and further recommendations.	

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M1570	Continued From page 25 on 4/15/2025 with medical diagnoses that included Multiple Sclerosis, and Neuromuscular dysfunction of the bladder. Record review of Resident #55's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/21/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated that the resident had moderate cognitive impairment. Multi-Use Glucometer Review of facility policy titled, "Obtaining a Fingerstick Glucose Level" with no date, revealed, " ...clean and disinfect reusable equipment between uses according to the manufacturer's instructions ..." Review of manufacturer's "User Instruction Manual" with no date, revealed, "...PDI Super Sani-Cloth Germicidal Disposable Wipe...Contact time: two (2) minutes..." During an observation and interview in between glucose checks on 6/4/25 at 11:17 AM with Licensed Practical Nurse (LPN) #1 revealed she cleaned the glucometer with a Sani-wipe by wiping down the meter with the wipe for a few seconds, then proceeded to set her clock for two (2) minutes. She placed the glucometer on a clean surface and allowed it to dry for two (2) minutes before use. She verbalized they were taught to wipe it down and let it sit and dry for 2 minutes. She further stated, "We used to do it that way (have contact with the germicidal wipe for two (2) minutes), but then they said we were doing it wrong." She confirmed that not following the manufacturer's guidelines could result in the	M1570		

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M1570	Continued From page 26 spread of infection. During an interview on 6/4/25 at 11:28 AM, with the Director of Nursing (DON), she confirmed they (nursing staff) were taught to wipe the glucometer and then let it dry for two (2) minutes. She stated, "We misunderstood the directions." Additionally, she verbalized that reusable equipment should be cleaned according to manufacturer's guidelines to prevent the spread of infection.	M1570		