STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255139	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF BATESVILLE	154 WOODLAND ROAD BATESVILLE, MS 38606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 6/9/25 through 6/12/25. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F550, F600, F698, F761, F825, and F880. The census at the time of the survey was 116 and the facility is licensed for 130 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		7/4/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/30/2025

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to promote dignity for two (2) of 35 residents in the sample. (Resident's #44 and #106) Findings include: Review of the facility policy titled, "Resident Rights & Quality of Life," with an effective date of March 13, 2020, revealed, "Policy: It is the policy of "proper name" that all patients have the right to a dignified existence, self-determination, and communication with access to services inside and outside the facility. " ... Resident #44 An observation on 6/9/25 at 10:35 AM revealed Resident #44 was observed licking chocolate pudding from a small Styrofoam bowl. Chocolate pudding was observed on the resident's nose, around the mouth, and drops of pudding on his shirt, top sheet, and blanket. Resident #44 stated	F 550	1. Resident #44 was cleaned by team member and a spoon was provided on June 9, 2025. Resident #106 wound vacuum assisted closure canister device was removed immediately from the room and disposed accordingly on June 9, 2025. 2. Residents receiving snacks requiring assistive devices have the potential to be affected. Residents with wound vacuum assisted closure devices have the potential to be affected. An audit was completed on June 9, 2025 by Director of Nursing to ensure all residents that received a snack were provided an assistive device (spoon) had a spoon with snack if applicable. No other residents were identified. An audit was completed by Director of Nursing on June 9, 2025 for residents with wound vacuum assisted closure devices. No other resident was	

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F 550	Continued From page 2 he was trying to eat the pudding but was not given a spoon. No spoon was observed in the resident's room. An observation and interview with Certified Nurse Assistant (CNA) #5 on 6/9/25 at 10:38 AM confirmed that Resident #44 did not have a spoon to eat his pudding, and confirmed the resident had chocolate pudding on his face and bed linens from trying to eat the pudding with no utensils. CNA #5 revealed this is a dignity concern because the resident attempted to lick the pudding out of the bowl, resulting in him getting pudding on his face, clothing, and bed linens. An interview with the Infection Preventionist on 6/10/25 at 1:10 PM confirmed it would be a dignity concern and could be embarrassing to have pudding on his face and stated staff should have provided the resident with a spoon. An interview with the Director of Nursing (DON) on 6/10/25 at 1:45 PM confirmed it was a dignity concern for Resident #44 to have to lick pudding out of a cup, resulting in the resident getting pudding on his face and linens. Record review of the "Admission Record" revealed that Resident #44 was admitted to the facility on 9/1/22 with a diagnosis of nontraumatic intracranial hemorrhage. Record review of Resident #44's Section C of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/9/25 revealed a Brief Interview for Mental Status (BIMS) score of 8, indicating the resident was moderately cognitively impaired.	F 550	found to have need of removal of wound vacuum assisted closure devices. 3. Education by the Director of Clinical Education was initiated on June 9, 2025 to the nursing department on ensuring resident dignity with emphasis of providing needed equipment with snacks and removal or disposal of wound vacuum assisted closure devices from resident room once discontinued. 4. On June 9, 2025 the Administrator and Director of Nursing began an audit of three residents weekly for four weeks, then monthly for two months to ensure compliance of providing assistance devices with snacks and the removal of discontinued wound vacuum assisted closure devices. The results of the audits will be addressed in the Quality Assurance and Performance Improvement meeting on June 30, 2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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Resident #106
An observation of Resident #106's room on 6/9/25 at 10:10 AM revealed a Wound VAC (Vacuum-Assisted Closure) on the bedside nightstand next to the resident's bed, half full of dark, thick serous drainage, with a foul odor noted. The drainage container was visible from the doorway of the room and was not in use. Resident was observed sleeping.

During an observation and interview with Licensed Practical Nurse (LPN) #2 on 6/9/25 at 11:41 AM, she confirmed the wound VAC was sitting on Resident #106's nightstand and confirmed it was not in use. She confirmed the drainage container was half full of old, thick, drying, putrid serous drainage. She also confirmed this was a dignity concern to have the drainage visible for everyone to see.

An interview with Infection Preventionist on 6/10/25 at 12:57 PM confirmed that when Resident #106's wound VAC canister containing the old serous drainage was a dignity concern related to the drainage being visible to anyone entering the room.

An interview with the DON on 6/10/25 at 1:50 PM revealed she saw the serous drainage left in Resident #106's room in the wound VAC, stating, "It was awful." She stated the wound VAC was used a day and then changed because the resident kept taking it off. She stated that when the order was discontinued, the wound VAC should have been removed from the room and cleaned, and the vacutainer containing the serous drainage should have been disposed of in the biohazard room in a biohazard bag. She then revealed concerns about leaving the wound

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F 550	Continued From page 4 vacuum in the room for days after it was discontinued, as it is a dignity concern because the drainage was not covered. Record review of the "Admission Record" revealed that Resident #106 was admitted to the facility on 5/22/25 with diagnoses of end stage renal disease and an unspecified open wound to the lower leg. Record review of Resident #106's Section C of the MDS with an ARD of 5/29/25 revealed a BIMS score of 15, indicating the resident was cognitively intact.	F 550		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure a resident was free from neglect as evidenced by not ensuring	F 600	1. A skin assessment on Resident #96 was conducted with no negative findings by wound care nurse on 6/11/2025. Administrator requested new replacement	7/4/25

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F 600	Continued From page 5 the availability of a functioning total mechanical lift or alternative transfer method for one (1) of 36 residents that required the use of a total lift. (Resident #96) Findings Include: Review of the facility policy titled, "Abuse, Neglect, Misappropriation, Exploitation Policy," effective January 2019, revealed under "Purpose ...To prohibit and prevent abuse, neglect...Neglect: Failure of the center, its team members ...to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress ..." An interview on 06/09/25 at 1:19 PM with Resident #96 revealed that one night the previous week, she had to sit in her wheelchair from afternoon until approximately 3:00 AM because "all of the lifts were not charged." She stated that eventually, an ambulance service was called, and they lifted her manually and put her back to bed. The resident reported she had peed and pooped on herself and experienced pain requiring pain medication. She stated, "This is just ridiculous that all of their lifts were not working. I don't even like to get out of bed, much less stay up that long." Record review of Resident #96's lift/transfer assessment dated 5/21/25 documented that Resident #96 required a total mechanical lift for all transfers. Record review of Resident #96's Medication Administration Record (MAR) for the month of 6/2025 revealed the resident had one incident of	F 600	batteries on 05/30/2025. Replacement batteries were delivered on 06/06/2025. Maintenance Assistant replaced batteries. 2. All resident in the center using lifts are at risk for the deficient practice. 3. Education on Abuse and Neglect was initiated on 6/12/2025 by Administrator with facility team members. Facility Staff were in-service on 6/12/2025 by Administrator on reporting battery charging concerns timely to the administrator. 100% audit done on all lift batteries was completed on 06/05/2025 to assure functionality by the Administrator. Any requiring repair were immediately addressed by the Maintenance Assistant. The Administrator submitted an order for a manual lift on June 13, 2025. 4. Administrator, Director of Nursing, and/or Director of Clinical of Education will audit all batteries five times a week for four weeks to assure battery is charged, then two times a week for two weeks, and once monthly for three months. All variances will be immediately corrected and addressed in Quality Assurance and Performance Improvement. The deficient practice and the implemented plan correction was reviewed by the interdisciplinary team in Quality Assurance and performance improvement 06/30/2025 monthly times three months.	

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F 600	Continued From page 6	F 600		

reported pain on a 10/10 scale and received a PRN (as needed) pain medication and that was on 6/4/2025 at 7:38 PM.

An interview on 06/10/25 at 1:24 PM with CNA #2 confirmed the total lift batteries were not working on the night of the incident with Resident #96, which was 6/4/25. She stated that some batteries had been intermittently failing and that the Administrator had been informed prior to the incident.

An interview on 06/10/25 at 1:27 PM with the Administrator and Director of Nursing (DON) confirmed that no charged total lift batteries were available during parts of the 3 PM-11 PM and 11 PM-7 AM shift on Wednesday 6/4/25. The Administrator stated she had been informed on Monday 6/2/25 about battery charging issues and ordered replacements, which did not arrive until Friday. She acknowledged being notified around 8 PM on 6/4/25 that the lifts were nonfunctional, but they continued to try and get them to charge. She admitted that she eventually instructed staff to call the ambulance service and was notified that the resident was returned to bed at approximately 11:51 PM. Both the Administrator and DON agreed the resident should not have had to sit up that long in her wheelchair.

A phone interview on 06/10/25 at 1:38 PM with Licensed Practical Nurse (LPN) #1 confirmed she worked the 7 PM-7 AM shift on C Hall 6/4/25 and that none of the batteries were charged at the start of her shift. She stated only one battery eventually charged and was used to put one resident back to bed, but it was depleted by the time A Hall needed it. She confirmed that EMS was called and arrived around 11 PM to assist

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F 600	Continued From page 7	F 600		

with returning Resident #96 to bed. She acknowledged no manual backup lift was available and that being without a total lift for so long bothered her.

An interview on 06/10/25 at 2:00 PM with the DON confirmed Resident #96 was totally incontinent and left in her wheelchair from approximately 2 PM until around 11 PM on 6/4/25. She stated no skin or body assessment was completed after the resident was returned to bed but acknowledged that one should have been done. She confirmed the facility did not have an alternative back up lift to replace the non-functioning battery-operated lifts.

An interview on 06/10/25 at 2:30 PM with the Wound Nurse confirmed she had not been made aware of the incident and agreed a post-incident assessment should have occurred.

A phone interview on 6/11/25 at 10:38 AM with CNA #3, who worked 10:30 PM-6:30 AM on 6/4/25, revealed that Resident #96 was returned to bed around 11 PM. She reported the resident was saturated with urine and had a bowel movement extending from her back to her perineal area. She stated no nurse assessed the resident's skin and expressed frustration about the lack of working equipment.

An interview on 6/11/25 at 10:45 AM with the DON confirmed that Resident #96 had no documentation of incontinent care for the time she was in the wheelchair on 6/4/25, which was approximately 2 PM-11 PM. She was not aware of the resident's state of incontinence when she was finally transferred back to bed at approximately 11 PM, reported a pain score of

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10/10 or the PRN pain medication given that evening and stated, "That's terrible."

An interview on 6/11/25 at 11:20 AM with the Registered Nurse (RN)/Lift Champion revealed she had been notified on 5/30/25 about the charging issues with the total lift batteries and had reported the issue to the Administrator, who then ordered new batteries. She confirmed that none of the lifts were functional on the night of 6/4/25 and stated, "It's terrible that the resident was left that long." She stated that her job as the lift champion was to make sure the slings were not broken and admitted that she made random rounds to check the lift batteries and there were no issues on the day of 6/4/25 that she was aware of.

A phone interview on 6/11/25 at 11:34 AM with CNA #4 confirmed that Resident #96 had been gotten up by therapy around 2 PM after receiving a bed bath earlier in the day. She admitted the resident was not toileted or put back to bed before the end of her shift at 3 PM.

An interview on 6/11/25 at 11:40 AM with the Certified Occupational Therapy Assistant (COTA) confirmed therapy got Resident #96 up around 1-1:30 PM on 6/4/25. She was not soiled at the time, and therapy concluded around 2:30 PM.

An interview on 6/11/25 at 12:45 PM with the Administrator confirmed she was unaware the resident experienced a pain score of 10/10 or that she was saturated with urine and feces on the night of 6/4/25.

An observation and interview on 6/11/25 at 2:09 PM with Resident #96 and the Wound Care

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F 600	Continued From page 9 Nurse revealed no skin breakdown or complaints during a sacral/perineal skin assessment. Record review of Resident #96's "Admission Record" revealed the facility admitted the resident on 9/12/24 with diagnoses including Malignant Neoplasm of the Center Portion of the Left Breast, Joint Stiffness and Pain. Record review of Resident #96's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/21/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14 indicating the resident was cognitively intact and in Section GG that the resident was dependent for transfers with 2-person assistance and toileting.	F 600		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and review of the facility's dialysis contract, the facility failed to assess and document the presence of a bruit and thrill at the dialysis access site as part of routine monitoring as ordered for one (1) of four (4) dialysis residents reviewed: Resident #86 Findings include: Review of the typed statement on facility	F 698	1. Dialysis access site for Resident #86 was assessed by Unit Manager on June 10, 2025, with no negative findings. Corrections were immediately implemented to record the daily assessment of the residents dialysis shunt in the medical record. 2. Residents with dialysis access sites have the potential to be affected. An audit	7/4/25

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F 698	Continued From page 10 letterhead dated 6/12/25 revealed that "it is the practice of (the facility) to follow contracts with their partnered Dialysis center and provide care in accordance with CMS guidance. Review of the facility's contract "Long Term Care Facility Outpatient Dialysis Services Coordination Agreement" with the off-site dialysis provider (effective 1/18/17) revealed, " ...Long Term Care Facility participates as a residential and health care provider of services ...and promotes its End-Stage Renal Disease (ESRD) Resident's rights to obtain ...benefits and services appropriate to their needs ..." Record review of "Order Summary Report" for active orders as of 6/1/25, revealed, "...Hemo-Dialysis: Auscultation/Palpitation of shunt site for Bruit and Thrill every (Q) shift" with order date 11/14/2024. Review of Dialysis Communication Records for June revealed assessment of site for bruit/thrill on 6/3/25, 6/5/25. 6/7/25, and 6/10/25. Record review of the "Medication Administration Record (MAR)" for 6/1/25 - 6/10/25 revealed the order for assessment of shunt site for bruit and/or thrill of Resident #86's shunt in his left arm was not on the MAR. During an interview on 6/10/25 at 2:35 PM with the Director of Nursing (DON) regarding Resident #86, it was confirmed the order was not listed on the MAR/TAR (Treatment Administration Record) and the only documentation for auscultation/palpitation of the shunt site for bruit and thrill was on the dialysis communication forms. She stated that the purpose of checking	F 698	of residents receiving dialysis services was completed on June 10, 2025 by Director of Nursing to ensure daily documentation of dialysis shunts/sites. There were no other residents affected. 3.Education was provided to licensed nurses by the Director of Clinical Education on June 10, 2025 ensuring daily documentation of residents with dialysis access sites is present in the medical record. 4.To monitor the performance to assure sustainability, the Director of Nursing Services or team member will conduct an audit once weekly for four weeks beginning on June 10, 2025, then monthly for two months to ensure daily documentation for monitoring dialysis access sites is present in the medical record. The results of the audits will be addressed in the Quality Assurance and Performance Improvement meeting on June 30, 2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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F 698	Continued From page 11 the shunt site is to ensure that the shunt is functioning properly and has not malfunctioned. She further verbalized that should the shunt stop working, the resident would not be able to receive dialysis and would possibly have to have his shunt replaced. Record review of the "Admission Record" revealed that Resident #86 was admitted to the facility on 2/29/24 with a diagnoses End-stage Renal Disease (ESRD). Record review of Resident #86's Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/8/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderate cognitive impairment	F 698		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		7/4/25

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F 761	Continued From page 12 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure medications on the treatment cart were locked and secured for one (1) of five (5) medication /treatment carts observed. Findings include: Review of the facility's policy titled, "(Proper Name) Medication Storage", revised 4/23, states, "...it is the responsibility of the facility to keep the medication cart locked and secure at all times when not in use ..." During an observation on 6/9/25 at 11:29 AM, of the treatment cart on Hall A, revealed it was unlocked and unattended, with keys placed on top of the cart. Wound Nurse exited a resident's room, and the room door had been closed. During an interview with the Wound Nurse she stated, "A resident could have walked by, opened up the cart, and ingested something they should not have" and confirmed, "I should not have left it open, and I should not have left my keys on my cart." An interview was conducted on 6/9/25 at 2:31 PM with the Director of Nursing (DON), who confirmed that the nurse should never leave the	F 761	1. Treatment cart was immediately locked and education was provided by the Director of Nursing on June 9, 2025 to wound care Nurse to assure understanding of storage of drugs and biologicals and ensuring possession of medication cart keys at all times. There were no individual residents affected with this deficiency. All cart items were accounted for. 2. All residents of the facility have the potential to be affected by the practice. 3.100% Audit was completed by the Director of Nursing on all Medical/treatment carts to ensure all carts were locked according to policy of storage of drugs and biologicals on 06/09/2025. Education by Director of Clinical Education was started on June 9, 2025 with nursing staff to address proper storage of drugs and Biologicals. 4. To monitor the performance to assure sustainability, the Director of Nursing Services or pharmacy representative or team member will conduct observations three times a week for four weeks	

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F 761	Continued From page 13 cart unlocked and should not have left her keys on top of the cart.	F 761	beginning June 9, 2025, then monthly for three months to ensure the drugs and biologicals are properly stored in the locked medication cart. The results of the audits will be addressed in the Quality Assurance and Performance Improvement meeting on June 30, 2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to ensure a	F 825	1. Physical Therapy and Occupational Therapy evaluations were scheduled and	7/4/25

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F 825	Continued From page 14 timely evaluation by therapy services after a referral was made for one (1) of 35 sampled residents. Resident #22. Findings include: Record review of facility policy titled, "Resident Screening Guidelines" updated 3/14/18 revealed, "screenings be completed by (Formal Name) employees ... upon referral by the medical and/or nursing department of a facility ..." Record review of Interdisciplinary Rehabilitation Screening Form with effective date 5/23/2025, revealed, "Nursing referral due to onset of decreased strength, decreased endurance, and functional decline. Occupational Therapy (OT) evaluation indicated." An interview on 6/11/25 at 1:45 PM with the Director of Nursing (DON) confirmed, nursing did make a referral on 5/23/25 for an OT evaluation, however there was no documentation of an evaluation by OT. She stated, "you will have to check with therapy about that." An interview on 6/11/25 at 3:11 PM with the Director of Therapy confirmed the nursing referral date 5/23/25 was not processed timely. She stated, "I'm not sure how we missed that one." She further verbalized that the person that performed their OT evaluations was out on medical leave, however they did have someone available via telehealth for evaluations and that she was evaluating Resident # 22 right now (today). When asked could this evaluation been performed via telehealth when nursing made the referral on 5/23/25, she confirmed, "yes." She revealed referrals for evaluations are expected to	F 825	completed on June 11, 2025 for Resident #25. 2. All residents have the potential to be to be affected. Screens were reviewed initiated on 06/11/2025 to audit for any positive screens that have not had the recommended therapy to have an evaluation completed by the director of Rehab Services. Evaluations were scheduled to be completed. Education on June 11, 2025 was provided by the Regional Director of Operations to Director of Rehab on urgency of soliciting evaluators through to assure all recommended evaluations for all patients are completed timely. Evaluators were identified to travel to complete therapy evaluations that exceeded the onsite staff capacity. 3. Beginning on June 27, 2025, the Director of Rehab will begin reporting five times a week to Regional Director and Interdisciplinary discipline team results of all screen completed the day prior. In-service initiated on June 27, 2025, by Regional Director of Operations to the Director of Rehab to assure timely evaluations are completed in accordance of policies and regulations. 4. Systemic changes going forward to assure compliance, the Director of Rehab will review five times a week beginning June 27, 2025 with the administrator all completed therapy screening findings to indicate scheduled evaluations and ensure a completion date. The results of	

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F 825	Continued From page 15 be evaluated between 24-48 hours after they are received. She further stated that Resident # 22 was at increased risk for further decline and even increased risk for hospitalization due to the delay in the evaluation. Record review of the "Admission Record" revealed Resident #22 was admitted on 4/11/19 with diagnoses including Alzheimer's Disease. Record review of Resident #22's Section C of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/22/25 revealed a Brief Interview for Mental Status (BIMS) score of 9, indicating the resident had moderate cognitive impairment.	F 825	the audits will be addressed in the Quality Assurance and Performance Improvement meeting on June 30, 2025 and then monthly for a minimum of three consecutive months to assure continued compliance. Any variance will be addressed immediately.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		7/4/25

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F 880	Continued From page 16	F 880		

arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 17 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to maintain proper infection control practices for one (1) of 35 sampled residents. (Resident #106) Findings Include Review of the facility policy titled, "Policies and Practices-Infection Control," effective date November 1, 2017, revealed: "Policy Statement: This center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help manage the transmission of diseases..." On 6/9/25 at 10:10 AM an observation of Resident #106's room revealed a Wound VAC (Vacuum-Assisted Closure) on the bedside nightstand next to the resident's bed, half full of dark, thick serous drainage, with a foul odor noted. The drainage container was visible from the doorway of the room and was not in use. On 6/9/25 at 11:41 AM during an observation and interview with Licensed Practical Nurse (LPN) #2 , she confirmed the wound VAC was sitting on Resident #106's nightstand and that it was not in use. She also confirmed the drainage container was half full of old, thick, drying "putrid" serous drainage and stated this was an infection control concern due to the resident being medically	F 880	1. Resident #106 wound vacuum assisted closure canister was removed immediately from the room disposed accordingly on 06/9/2025. 2. Residents with wound vacuum assisted closure devices has the potential to be affected. An audit was completed by Director of Nursing on June 9,2025, for residents with wound vacuum assisted closure devices. No other resident was found to have need of removal of wound vacuum assisted closure devices. 3. Education by the Director of Clinical Education on June 9, 2025 to the nursing department on ensuring proper infection control protocol with emphasis of removal/disposal of wound vacuum assisted closure devices. 4. On June 9, 2025, the Director of Nursing or team member began an audit on three residents weekly for four weeks then monthly for two months to ensure compliance of infection control protocol for the removal of discontinued wound vacuum assisted closure devices. The results of the audits will be addressed in the Quality Assurance and Performance Improvement meeting on June 30, 2025	

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F 880	Continued From page 18 compromised and at increased risk of infection. Review of the May 2025 "Treatment Record" for Resident #106 revealed, "wound care to right lower extremity to be done every three days as needed for soilage and dislodgement. Cleanse area with wound cleanser, pat dry, protect peri wound by applying no sting barrier films. Picture frame wound with transparent film dressing. Apply black foam to wound bed only, cover with transparent dressing. Cut quarter size hole in dressing, connect to port. Set at 125 mmHg (millimeters of mercury) one time a day every Wednesday and Friday related to open wound with an order date of 5/28/25 and a discontinue date of 5/30/25." On 6/10/25 at 12:57 PM an interview with the Infection Preventionist confirmed that the wound VAC device and the canister containing the biohazard waste should have been immediately removed from the room and the waste properly disposed of in the biohazard room. The Infection Preventionist expressed concerns about leaving the wound vacutainer with old serous drainage in it, as it poses an increased risk of spreading infection. On 6/10/25 at 1:50 PM an interview with the Director of Nursing (DON) confirmed she saw the serous drainage left in Resident #106's room in the wound VAC, stating, "It was awful." She stated that it was only used one day and should have been removed when it was discontinued. She further revealed concerns that leaving the wound VAC in the room for days after it was discontinued could increase the risk of spreading infection.	F 880	and then monthly for three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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F 880	Continued From page 19 Review of the "Admission Record" revealed that Resident #106 was admitted to the facility on 5/22/25 with diagnoses of End Stage Renal Disease and an unspecified open wound to the lower leg. Record review of Resident #106's Section C of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.	F 880		