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

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M 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 Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M225, M500, M655, M685, and M1570. The census at the time of the survey was 116 and the facility is licensed for 130 beds.	M 000		
M 225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility. c. Facilities of one-hundred eighty (180) beds or	M 225		7/4/25

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M 225	Continued From page 1 more shall have an assistant director of nursing services, who shall be a registered nurse. d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This Statute is not met as evidenced by: Level II Based on staff interviews, record review, and facility policy review, the facility failed to maintain the required minimum staffing of 2.80 hours per resident day (HPRD) on two (2) weekend days during the second quarter of Fiscal Year 2025 (January 1, 2025 - March 31, 2025).	M 225	1. On June 12, 2025, the Director of Nursing Services ensured that all residents were assessed. There were no concerns identified due to staffing practices. 2. All residents are at risk for the deficient practice.	

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M 225	Continued From page 2 Findings include: Review of the facility policy titled "Staffing", with no revision date, revealed the facility's practice is, "to assure that adequate staffing is maintained to provide the necessary care and services for each resident. Expectations of staffing are based on resident acuity and assessed needs ..." Review of the PBJ (Payroll-Based Journal) Staffing Data Report for Quarter 2 (January 1, 2025 - March 31, 2025) revealed the facility triggered for low weekend staffing. Further review of the facility's daily staffing grid revealed the HPRD fell below the required 2.80 minimum on the following two (2) dates: 2/23/25, with a Census of 115 and 2.78 HPRD and on 3/14/25, with a Census of 118 and 2.77 HPRD. During an interview on 6/13/25 at 8:50 AM with Licensed Practical Nurse (LPN) #2, who is also a Workforce Manager, confirmed that on 2/23/25 and 3/14/25, the direct care hours submitted fell below the required 2.80 HPRD. She stated, "I put in the direct hours for the staffing grid," and acknowledged she had communicated the direct hours to the Administrator.	M 225	3. The Director of Clinal Operations provided education to the Administrator and Director of Nursing regarding staffing requirements in accordance of the Mississippi Regulations for Minimum Standards. Going forward the center will ensure the requirements is provided to meet resident's needs in a manner that promotes each resident's needs in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being. Beginning June 12, 2025 and ongoing, the center administrative staff will conduct a workforce manager's meeting Monday through Friday to review schedule, projected coverage and call ins. Any need for additional staffing will be addressed at that time. 4. To monitor the performance of our corrective action and to ensure sustainability, the administrator will indefinitely audit the predicted staffing versus the actual staffing daily starting 06/12/2025 to ensure staffing is in accordance with or above the minimum requirement. Any negative finding will be brought to the Quality Assurance Performance Improvement meeting monthly for minimum of three months beginning June 30, 2025 by the administrator for review and revision as necessary. Quality Assurance team will review the findings and determine if a need to alter our corrective action.	
M 500	45.17.2 Residents' Rights	M 500		7/4/25

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M 500	Continued From page 3 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; 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;	M 500		

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M 500	Continued From page 4 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 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	M 500		

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M 500	Continued From page 5 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 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	M 500		

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M 500	Continued From page 6 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. This Statute is not met as evidenced by: Level III Based on resident and staff interviews, record review, and facility policy review, the facility failed to: 1) promote residents rights related to dignity for (Resident s #44 and #106) and, 2) failed to ensure a resident was free from neglect as evidenced by not ensuring 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). This affected three (3) of 35 residents in the sample. Findings include:	M 500	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	

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M 500	Continued From page 7 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 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	M 500	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 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. 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 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.	

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M 500	Continued From page 8 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. 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.	M 500	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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M 500	Continued From page 9 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 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. Resident #96 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 ..."	M 500		

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M 500	Continued From page 10 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 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	M 500		

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M 500	Continued From page 11 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 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	M 500		

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M 500	Continued From page 12 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 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	M 500		

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M 500	Continued From page 13 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 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.	M 500		
M 655	45.21.11 Special needs	M 655		7/4/25

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M 655	Continued From page 14 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 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 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	M 655	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 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	

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M 655	Continued From page 15 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 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	M 655	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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M 685	Continued From page 16	M 685		
M 685	45.23 REHABILITATIVE SERVICES REHABILITATIVE SERVICES This Statute is not met as evidenced by: Level II Based on staff interview, record review and facility policy review, the facility failed to ensure a 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	M 685	1. Physical Therapy and Occupational Therapy evaluations were scheduled and completed on June 11, 2025 for Resident #25. 2. All residents have the potential 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	7/4/25

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M 685	Continued From page 17 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 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.	M 685	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 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.	
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. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education,	M1570		7/4/25

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M1570	Continued From page 18 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 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.	M1570	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	

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M1570	Continued From page 19 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 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	M1570	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 and then monthly for three consecutive months to assure continued compliance. Any variance will be addressed immediately.	

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M1570	Continued From page 20 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. 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.	M1570		