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	255268	A. BUILDING _____ B. WING _____	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ALBANY HEALTH & REHAB CENTER	118 SOUTH GLENFIELD ROAD NEW ALBANY, MS 38652

(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 recertification survey and a complaint investigation (CI) MS #29057 at the facility from 6/23/25 through 6/25/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F656, F677, F689, and F880. The SA investigated CI MS #29057 and no deficiencies were cited. The census at the time of the survey was 90 and the facility was licensed for 114 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		7/28/25

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

Electronically Signed | 07/02/2025

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rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff and resident interview, record review and facility policy review the facility failed to implement a comprehensive care plan for Activities of Daily Living (ADL) for two (2) of 18 sampled residents. Resident # 57, and #62

Findings Include:

Review of the facility's policy titled, "COMPREHENSIVE PLAN OF CARE" with a revision date of 2/17/2025, revealed under "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered

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care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality..."

Resident #57

Record review of Resident #57's "Care Plan Report" revealed that he had an ADL self-care performance deficit related to generalized muscle weakness and had interventions that included to assist with all ADL's as needed.

An observation on 06/23/25 at 11:15 AM revealed Resident #57 sitting up on the side of his bed with facial hair on his chin, above his upper lip and scattered facial hair was on his bilateral cheeks. Resident #57's hair was greasy and there was a mild body odor observed with facial hair that was approximately one-eighth to one-fourth inch long.

An observation and interview on 06/24/25 at 8:05 AM with Resident #57 revealed he had facial hair to his chin, above his top lip and scattered on his bilateral cheeks. His hair was greasy and there was a mild body odor. He revealed that his bath days were Tuesdays, Thursdays, and Saturdays and they forgot about him some days. Resident #57 revealed that he did not get a bath this past Saturday and that no one came in and offered to give him a bath. He revealed that he had not had a bath since Thursday, four days ago, and he felt dirty. Resident #57 revealed that getting a good bath always made him feel better and stated, "I don't feel clean when I miss my bath." He also revealed that he didn't like to have facial hair and

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wanted it shaved.

An observation and interview on 06/24/25 at 8:25 AM with Licensed Practical Nurse (LPN) #1, revealed that the hospice aid came in the facility on Tuesdays and Thursdays to give Resident #57 his bath. During this observation, Resident #57 told LPN #1 that he had not gotten his bath on Saturday. LPN #1 confirmed that Resident #57 had greasy hair, a mild body odor, and facial hair and revealed that this was a concern. She stated, "I definitely wouldn't want to go without a bath since Thursday" and revealed that she would make sure he got his bath today.

Record review of Resident #57's "Admission Record" revealed an admission date of 06/19/23 and that he had diagnoses that included Chronic Obstructive Pulmonary Disease, Unspecified Heart Failure, and Need for Assistance with Personal Care.

Record review of Resident #57's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/30/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated that he was cognitively intact.

Resident #62

An observation and interview with Resident #62, on 6/24/25 at 9:15 AM, revealed she had not received a bath this week and stated, "The aide on night shift told me that they no longer give baths on night shift." She then stated, "I always take my baths on Monday, Wednesday, and Friday nights."

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F 656	Continued From page 4 Record review of the Care Plan Report for Resident #62 revealed: "Requires assists with ADL'S due to diagnosis of severe protein calorie malnutrition, polyneuropathy, chronic pain, and depression. She has Limited Range of Motion (LROM) to upper and lower extremities and requires staff assists with ADL's." Interventions included, "Assist with ADL'S as needed..." During an interview on 6/24/25 at 2:07 PM with the Minimum Data Set (MDS) Coordinator, she confirmed that care plans were established to guide staff in providing necessary care. She stated, "The care plan is in place provide appropriate care for each resident." Record review of Resident #62 "Admission Record" revealed the resident was admitted 10/18/2022 with diagnosis of Polyneuropathy. Record review of the MDS, Section C, with an ARD of 6/15/25, revealed a BIMS score of 15, indicating Resident #62 is cognitively intact.	F 656		
F 677 SS=D	. ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		7/28/25

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Based on observation, staff and resident interviews, record review and facility policy review the facility failed to ensure resident's requiring assistance with Activities of Daily Living (ADL) were given care as they needed to maintain hygiene for two (2) of 18 sampled residents. Resident #57, and #62

Findings include

Review of the facility's policy titled, "Activities of Daily Living (ADL)" with a revision date of 9/15/2022, revealed under "Policy: Based on the resident's comprehensive assessment and consistent with the resident's needs and choices, the facility will ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care ...Policy Explanation and Compliance Guidelines ...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene ..."

Resident #57

On 06/23/25 at 11:15 AM an observation of Resident #57 revealed facial hair on his chin, above his upper lip and on his bilateral cheeks. Resident #57's hair was greasy and there was a mild body odor. His facial hair was approximately one-eighth to one-fourth inch long.

On 06/24/25 at 8:05 AM an observation and interview with Resident #57 revealed he had facial hair to his chin, above his top lip and scattered on his bilateral cheeks. His hair was

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greasy and there was a mild body odor. He stated that his bath days were Tuesdays, Thursdays, and Saturdays and they forgot about him some days. Resident #57 revealed that he did not get a bath this past Saturday and that no one came in and offered him a bath. He revealed that he had not had a bath since Thursday, four days ago, and he felt dirty. Resident #57 revealed that getting a good bath always made him feel better and stated, "I don't feel clean when I miss my bath." He also revealed that he didn't like to have facial hair and wanted it shaved.

On 06/24/25 at 8:25 AM an observation and interview with Licensed Practical Nurse (LPN) #1, revealed that the hospice aid came in on Tuesdays and Thursdays to give him his baths. During this observation, Resident #57 told LPN #1 that he had not gotten his bath on Saturday. LPN #1 confirmed the facial hair, mild body odor and stated that this was a concern. She stated, "I definitely wouldn't want to go without a bath since Thursday" and revealed that she would make sure he got his bath today.

On 06/24/25 at 10:40 AM an observation and interview with Certified Nursing Assistant (CNA) Supervisor, revealed that Resident #57's scheduled bath days were Tuesdays, Thursdays and Saturdays. She revealed that he was on hospice and that their CNAs came in on Tuesdays and Thursdays and that the facility CNAs were responsible for his baths on all other days. During this observation, Resident #57 told CNA Supervisor that he did not get his bath on Saturday and that no one had offered him a bath or shower. He also told the CNA Supervisor that he used to get his baths on Tuesdays, Thursdays, and Saturdays but he hadn't been getting them

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on Saturdays lately. CNA Supervisor revealed that Resident #57 was cognitively intact and if he said he hadn't been getting his showers on Saturdays lately, he hadn't.

Record review of Resident #57's "Admission Record" revealed an admission date of 06/19/23 and that he had diagnoses that included Chronic Obstructive Pulmonary Disease, Unspecified Heart Failure, and Need for Assistance with Personal Care.

Record review of Resident #57's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/30/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated that he was cognitively intact.

Resident #62

On 6/24/25 at 9:15 AM, an observation and interview with Resident #62, revealed Resident #62 had not received a bath this week. She stated, "The aide on night shift told me that they no longer give baths on night shift. I always take my baths on Monday, Wednesday, and Friday nights."

During an interview with CNA #2 on 6/24/25 at 9:17 AM, she stated Resident #62 did not have a bath on night shift, and she usually gets her baths on Monday, Wednesday, and Fridays nights, and has for as long as she can remember.

Record review of the chart did not reveal any notes or documentation of Resident #62 refusing a bath.

During an interview on 6/24/25 at 11:15 AM, with

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F 677	Continued From page 8 the Infection Preventionist, she stated, "Resident #62 gets her baths at nights because she is private and doesn't want to get her bath during the day. She has been getting her baths at night for a long time." During an interview with on 6/24/25 at 2:00 PM with the Director of Nursing, she confirmed Resident #62 did not have a bath on Monday night. She stated, "(Proper Name of Resident #62) gets a bath at night on Mondays, Wednesdays, and Fridays. I do not know of any reason why she has not received a bath if she wanted one." Record review of Resident #62 "Admission Record" revealed the resident was admitted 10/18/2022 with diagnosis of Polyneuropathy. Record review of Resident #62's MDS, Section C, with an ARD of 6/15/25, revealed a BIMS score of 15, indicating Resident #62 is cognitively intact.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review the facility failed to ensure an environment that is	F 689		7/28/25

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free from accident hazards and the safety of a resident during care for one (1) of 18 sampled residents. Resident #31

Findings Include:

Review of the facility policy titled, "INCIDENT AND ACCIDENT REPORTING", with a revised date of 9/05/2023, states "It is the policy of this facility that everything possible should be done to avoid accidents or incidents involving patients ...Proper reporting helps correct the current incident and prevent future incidents like it ..."

An observation and interview on 06/23/25 at 10:30 AM with Resident #31, revealed a bandage on her right arm. Resident #31 stated, "The aide scratched me with her nails when she was giving me care."

During an interview with Resident #31's daughter on 6/23/25 at 10:35 AM at the facility, her daughter stated that she noticed the bandage on her arm last week and stated her mother told her someone scratched her, and she saw the bandage on her right arm.

Record review 6/23/25 3:21 PM, revealed no order or note regarding skin tear to right arm.

Record review of the facility skin assessment dated 06/24/25 revealed, "Right antecubital; Right forearm; Skin tear identified. New orders noted. Resident noted with skin tear to right forearm. Resident states, An aid was turning me and her nails scratched me. Treated with Xeroform gauze daily and as needed (PRN). Oriented to place. Oriented to time."

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F 689	Continued From page 10 During an interview on 6/24/25 at 11:38 AM, with the Wound Care Nurse, she confirmed that she was unaware of the skin tear on Resident #31's right arm until this morning, but that she had assessed the area, and new orders were given for care of the area. During an interview on 6/24/25 at 3:08 PM, with the Director of Nursing, she confirmed that the incident was not reported to her but that she had spoken with the wound nurse and that new orders were given for care of the skin tear/scratch area to the resident's forearm. She stated, "We are investigating this, I am not aware of how this incident occurred and who placed a bandage on her right arm," but confirmed that there was an injury to the resident's forearm. Record review of Resident #31's "Admission Record" revealed the resident was admitted 12/10/2024 with diagnoses that included Parkinson's Disease. Record review of Resident #31's Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of 4/24/2025, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident is cognitively intact.	F 689		
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.	F 880		7/28/25

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F 880	Continued From page 11 §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 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	F 880		

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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 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 observation, staff and resident interview, record review and facility policy review the facility failed to utilize Personal Protective Equipment (PPE) for a resident (Resident #188) who was under contact isolation on one (1) of three (3) survey days.

Findings Include:

Review of the facility policy "Infection Prevention and Control" with revision date of 02/17/25 revealed, "This facility has established and maintains 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 as per accepted national standards and guidelines..."

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(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 880	Continued From page 13	F 880		

An observation on 06/23/25 at 9:36 AM, revealed Certified Nursing Assistant (CNA) #1 enter Resident #188's room to answer her call light without utilizing Personal Protective Equipment (PPE). There was "Contact Precaution" signage on her door and a three-drawer cart outside of her room in the hall with gowns, gloves, masks and shoe covers inside.

An interview on 06/23/25 at 9:40 AM with CNA #1, revealed that she went into Resident #188's room to answer her call light and did not provide care. She revealed that they did not have to wear gowns and gloves if they did not provide care. CNA #1 confirmed that Resident #188 was on contact precautions for Clostridium Difficile (C-Diff) and confirmed the contact precautions signage on the door. She revealed that the purpose of wearing gowns and gloves with a resident on contact precautions was to prevent the spread of infection and agreed that she should have worn gloves and a gown prior to entering her room. CNA #1 confirmed that she confused Enhanced Barrier Precautions (EBP) with Contact Precautions and stated, "It's a little different when they are on contact precautions." She revealed that when a resident was on EBP, they could answer the call lights without having to dress out in PPE but with contact precautions, they were supposed to dress in appropriate PPE before entering the room.

An interview on 06/23/25 at 9:45 AM with Registered Nurse (RN) #1, revealed that Resident #188 was on contact precautions for C-Diff. She revealed that she came from the hospital with this and had been in isolation since admission. She revealed that there was a small cart outside of her door and staff were supposed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255268	A. BUILDING _____ B. WING _____	06/25/2025

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to apply gloves and gowns before entering her room to prevent the spread of infection. RN #1 revealed that the resident had completed her antibiotics and was supposed to be out of isolation, but they extended it due to her continued diarrhea.

An interview on 06/23/25 at 2:05 PM with Resident #188 revealed that she spent nine days in the hospital with C-Diff prior to coming to the facility. She revealed that she still had diarrhea, but it had slowed down. Resident #188 revealed that most staff members wore gowns and gloves when they came into her room but some of them did not.

An interview on 06/24/25 at 1:35 PM with Infection Preventionist (IP), revealed that Resident #188 had C-Diff and was on contact precautions. She revealed that there was a small cart placed outside of her room and staff were supposed to apply gowns and gloves before entering the room. She revealed that C-DIFF was contagious and by not wearing the proper PPE, the staff could cause the spread of infection.

Record review of Resident #188's "Admission Record" revealed an admission date of 06/10/25 and that she had diagnoses that included Enterocolitis due to Clostridium Difficile, Retention of Urine, and Unsteadiness on Feet.

Record review of Resident #188's Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/17/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that she was cognitively intact.

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F 880	Continued From page 15 Record review of Resident #188's "Order Summary Report" revealed orders for Contact Precautions related to Enterocolitis Due To Clostridium Difficile. Record review of Resident #188's "Care Plan Report" initiated on 06/11/25 revealed that she had C. Difficile with interventions that included "Contact Precautions."	F 880		