STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255125	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE , JACKSON, Mississippi, 39204

(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted a Complaint Investigation (CI) MS #2561750, Ci MS #2600576, and CI MS #2568526 on 9/15/25 through 9/17/25. CI MS #2568526 was investigated related to discharge; CI MS #2561750 was investigated related to abuse and peri care. CI MS #2600576 was investigated related to neglect. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F628 related to CI MS#2568526. F656, F690 and F880 was cited related to CI MS CI #2600576. There were no citations related to CI MS # 2561750. The facility held a license for 102 beds, with a census of 93.	F0000		
F0628 SS = E	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate.	F0628		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0628 SS = E	Continued from page 1 (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by	F0628		

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F0628 SS = E	Continued from page 2 the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes	F0628		

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F0628 SS = E	Continued from page 3 available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:	F0628		

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F0628 SS = E	Continued from page 4 (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility statement review the facility failed to issue a bed-hold notice when a resident went out on therapeutic leave for one (1) of two (2) residents reviewed for discharge. (Resident #1). Findings Include: Record review of a typed statement on facility letterhead and signed by the Executive Director (ED) revealed, "The facility does not have a policy for Bed Hold." On 09/15/25 at 4:42 PM, in an interview the ED stated Resident #1 was discharged due to escalating behavior. She would pull her dress while walking down the hall and go into male residents' rooms. She stated Resident #1 was discharged for her safety and welfare. She stated the facility could not meet her needs. She stated Resident #1's family declined the 30-day notice. Resident#1 left on 5/30/25 and family decided to take resident home. Resident was discharged on 5/30/25 due to the family decision. On 09/16/25 at 10:58 AM, a phone interview with Resident #1's Resident Representative (RR) stated that Resident #1 is with her sister at this time. The RR stated he received only one letter from the facility, and it was certified. He stated it took him a while to get the letter because he works nights and by the time he woke up post office was closed. He stated he was given a second discharge letter when he came to pick up personal belongings and medication on 6/2/25. He stated he was not aware and did not understand the appeal process. He stated he contacted the Ombudsman and was told there was nothing he could do about it. The RR stated when her sister picked up Resident #1 on 5/30/25	F0628		

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F0628 SS = E	Continued from page 5 they did not inform her that Resident #1 was being discharged. The RR stated her sister tried to bring her back Sunday and was told resident was discharged on Friday. He stated Resident #1 did not have enough medications for all those days. He stated when Resident #1 left Friday they did not remove the wander guard, and it is still attached to her leg now. He stated if she was discharged on 5/30/25 they should have removed the wander guard at that time. He stated they only gave her enough medicine for the three (3) days she was on leave with her sister. He stated when her sister tried to return her Sunday, they met them at the door and told them she couldn't bring her back. He stated she requires help with activity of daily living (ADL) care, and they did not provide home health. The RR stated the facility contacted him to come get her personal belongings and medication. On 09/16/25 at 12:09 PM, in an interview the Social Worker (SW) stated that Resident #1 was not eligible for home health, and she has Medicaid. She stated home health requires Medicare. She stated she could not set it up because the resident did not have a payor source. She stated Resident#1 went on an outing on 5/30/25 with family and did not return and she was discharged when she did not return to the facility. On 09/16/25 at 1:07 PM, during an interview, the Director of Nursing (DON) started Resident #1 left on 5/30/25 and the facility knew she was not coming back. She stated the resident was discharged on 5/30/25 and family was aware. She stated a nurse phoned her and told her resident was leaving and she informed nurse to give the resident her medication. She stated she told nurse that she would contact the RR about picking up personal belongings and medication. She stated the RR came back Monday to pick up medications and instructions on how to give medication. She stated the residents have supportive families and would go on leave often with family. The DON stated the RR would have to come back Monday to get all medications and personal items. They only give personal items to the RR. On 09/16/25 at 1:45 PM, an interview with Business Office Manager (BOM) stated there are two types of bed hold. There is a 15-day bed hold when a resident goes out on therapeutic leave. She stated when a resident goes on therapeutic leave, they do not notify the family about bed hold. On 09/16/25 at 3:18 PM, in an interview with the ED, she stated therapeutic leave is when a resident leaves the facility with family. The family lets the facility	F0628		

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F0628 SS = E	Continued from page 6 know and the nurse documents in the chart, give medication to the family for the days out. She stated she calls therapeutic leave out on pass. She stated Resident #1 was out on a pass on 5/30/25 with family. She stated she found out Monday that Resident #1 did not return. She stated the resident returns on Sunday or Monday. She stated she was informed on Monday that the RR came to pick up personal items and all medications. She stated they do not give bed hold letters to family or residents when they go on therapeutic leave. She stated they only give them when resident goes to hospital and is admitted for 24 hours or more. She stated the facility has never given out bed hold letters for therapeutic leave. She stated she has been the ED at the facility for one year and 7 months. On 09/16/25 at 8:31 PM, in a phone interview with Resident #1's sister she stated she picked up Resident #1 on 5/30/25. She stated that her and the other sister take turns picking her up on the weekends. They each do two weeks out of the month. She stated when she picked up the resident nobody informed her of a discharge. She stated a nurse asked when the resident was coming back and she told them Sunday at 2:00 PM. She started to return around 2:00 PM and rang the doorbell, it took them a while before someone finally came to the door. She stated there were other people waiting to get into the facility. She stated a nurse came to the door and let the other people in the building and told her to stay right there. She stated finally a nurse came to the door and told her when you picked up Resident #1 on 5/30/25 she was discharged. They told her the RR was sent a letter. They would not let her in the building. She stated when she picked up Resident #1 she was never told about bed hold. On 09/17/25 at 10:00 AM, in an interview with the ED she stated she had done her homework on therapeutic leave and now realized they should have done bed hold on therapeutic leave. On 09/17/25 at 11:23 AM, in an interview the SW stated she was not aware that Medicaid would pay for a limited number of home health visits. She stated after Resident#1 was discharged she did not follow up with family. She stated she did not reach out to the RR. She stated she did not follow up with Resident #1 care at all. On 09/17/25 at 11:52 AM, during an interview the DON stated they remove wander guards when a resident is discharged home. She stated she was not aware that the wander guard was not removed prior to the resident	F0628		

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F0628 SS = E	Continued from page 7 being discharged on 5/30/25. She stated, “The nurse should have removed it.” A record review of Resident #1 “Progress Notes” revealed on 1/31/25, 2/7/25, -2/9/25, 2/11/25-2/13/25,2/28/25-3/2/25, 3/7/25-3/8/25, 4/4/25-4/5/25, 4/11/25-4/12/25, 4/25/25-4/26/25, 5/3/25-5/4/25, 5/23/25-5/25/25 and 5/30/25 revealed resident was out on therapeutic leave with family. A record review of Resident #1 “Discharge Summary Instructions” dated 6/2/25 revealed resident did not return to the facility after Therapeutic leave on 5/30/25. A record review of Resident #1 timeline provided by facility revealed that the resident was out on therapeutic leave on 1/31/25, 2/7/25 -2/9/25, 2/11/25-2/13/25, 2/28/25-3/2/25, 3/7/25-3/9/25, 4/4/25-4/6/25, 4/11/25-4/12/25, 4/25/25-4/27/25, 5/2/25-5/4/25, 5/23/25-5/25/25 and 5/30/25 revealed resident was out on therapeutic leave with family. A record review of Resident #1 “Admission Record” revealed an admission date of 9/22/24 with diagnoses that included Schizophrenia and Wandering in Diseases Classified elsewhere. A record review of Resident #1 Minimum Data Set (MDS) with Assessment Reference Date (ARD) 6/2/25 revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicates severely cognitively impaired. Section A is coded for discharge not anticipated returning. A record review of a typed statement on facility letterhead, undated and signed by the ED revealed “Facility Acquired Discharges 2025” revealed Resident #1’s (proper name) was the only name listed on this form.	F0628		
F0656 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	F0656		

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F0656 SS = D	Continued from page 8 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 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, interview, record review, and facility policy review, the facility failed to implement the comprehensive care plan while providing perineal care for one (1) of two (2) residents observed for activities of daily living (ADL) care (Resident #4). Findings Include:	F0656		

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F0656 SS = D	Continued from page 9 A record review of the facility's "Comprehensive Person-Centered Care Plans "dated 1/25 revealed, "Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences and goals that will identify how the interdisciplinary team will provide care..." A record review of Resident #4's "Care Plan Report" revealed a care plan with an initiation date of 10/2/24, "Focus: (Proper name of Resident #4) is incontinent of bladder and bowel…Interventions… Incontinent checks/care every two (2) hours and as needed (PRN) x (times) 2-person assistance for total dependence..." On 9/16/25 at 4:03 PM, during an observation of perineal care revealed CNA #1 provided perineal care without 2-person assistance as indicated on the care plan. On 09/16/25 at 4:16 PM, during an interview CNA #1 confirmed that he did not follow the care plan by using 2 persons for assistance with perineal care. On 09/16/25 at 5:08 PM, in an interview with Executive Director (ED) she stated, All CNAs should be able to provide care correctly." On 09/17/25 at 11:35 AM, during an interview the Director of Nursing (DON) stated CNA#1 did not follow the care plan. She stated her expectation is for CNA's is to give good quality care and follow proper procedure for giving care. On 09/17/25 at 12:55 PM, during an interview Registered Nurse (RN) #2/Minimum Data Set (MDS) nurse stated she could not comment on what CNA #1 did or did not do, she was not there when he provided the care. She stated "I can only say what the care plan says. The care plan states (2) people assistance with peri care." She stated the purpose of the care plan is to inform the CNAs of the care that is to be provided. She stated the interventions indicate what the facility is doing for the residents. A record review of Resident #4's "Admission Record" revealed the facility admitted the resident on9/27/18 with diagnoses including Hemiplegia and Hemiparesis following unspecified cerebrovascular disease affecting the right side, Dysphasia following unspecified cerebrovascular disease, Aphasia following unspecified cerebrovascular disease, and Gastroesophageal Reflux Disease without esophagitis.	F0656		

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F0656 SS = D	Continued from page 10 A record review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident was unable to complete the interview.	F0656		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record reviews and facility policy review the facility failed to provide perineal (peri-care) according to acceptable standards for one (1) of two (2) observations. Resident #4. Findings Include:	F0690		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHADWICK NURSING AND REHABILITATION CENTER LLC	1900 CHADWICK DRIVE , JACKSON, Mississippi, 39204

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F0690 SS = D	Continued from page 11 A record review of the facility's "Incontinent Care" dated 07/12 revealed "…10. Wash the resident's entire perineal area, and all areas affected by incontinence with a washcloth, soap, warm water, peri-wash or wipes. 11. When washing perineal area, wash the entire perineal, wash the entire area…" On 09/16/25 at 4:03 PM, in an observation, Certified Nursing Assistant #1 (CNA) provided perineal care for Resident #4. CNA #1 placed the feeding pump on hold. He used three wipes and wiped front to back in the groin area on the right side. He then folded the wipe and wiped the same area again. He retrieved three (3) more wipes and wiped the left side front to back. He picked up the remaining wipes and wiped down the center of the vagina front to back one time. He turned resident on her left side to remove soiled brief. He placed soiled brief on the bed and placed a clean brief on the resident. CNA#1 did not separate the labia and wipe down each side and the center. He did not clean the rectal area. On 9/16/25 at 4:16 PM, during an interview CNA #1 stated he had been trained to place the feeding pump on hold during care. He confirmed that he did not perform perineal care correctly. He stated he was nervous and forgot to follow proper procedure. CNA #1 acknowledged that his actions could cause Resident #4 to develop an infection. On 9/16/25 at 4:21 PM, during an interview Registered Nurse (RN) #2/ Unit Manager for the B Unit confirmed that CNA #1 did not provide care properly. She stated CNAs are not permitted to operate feeding pumps and that only nurses are authorized to do so On 9/16/25 at 5:08 PM, during an interview the Executive Director (ED) stated that the State Agency (SA) "should have picked anyone other than him to do peri care." She further stated all CNAs should be able to perform care correctly. On 9/17/25 at 11:35 AM, during an interview the Director of Nursing (DON) stated CNA #1 should have informed the nurse so she could place the feeding pump on hold, as CNAs are not permitted to operate feeding pumps. The DON stated the pump could malfunction and cause harm to the resident if not handled properly. The DON further stated CNA #1 should have performed perineal care correctly, including applying clean gloves before providing care to the buttocks and skin folds. She stated CNA #1 did not provide care correctly. The DON stated her expectation is for CNAs	F0690		

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F0690 SS = D	Continued from page 12 to provide quality care and to follow proper procedures when giving care. A record review of Resident #4's "Admission Record" revealed the facility admitted the resident on9/27/18 with diagnoses including Hemiplegia and Hemiparesis following unspecified cerebrovascular disease affecting the right side, Dysphasia following unspecified cerebrovascular disease, Aphasia following unspecified cerebrovascular disease, and Gastroesophageal Reflux Disease without esophagitis. A record review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident was unable to complete the interview.	F0690		
F0880 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 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	F0880		

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F0880 SS = D	Continued from page 13 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 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, interview, record review, and facility policy review, the facility failed to provide perineal care in a manner that would prevent the possible spread of infection for one (1) of two (2) residents observed for perineal care. (Resident #4). Finding include:	F0880		

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F0880 SS = D	Continued from page 14 A record review of the facility's "Hand Washing" policy, with a history of 9/19 revealed "POLICY: Staff will use proper handwashing technique to prevent the spread of infection…" A record review of the facility's Enhanced Barrier Precautions (EBP) policy, with a history of 4/24 revealed "… 2. Enhanced Barrier Precautions only require use of gown/gloves when performing high contact resident…f. Changing briefs or assisting with toileting..." A record review of the Enhanced Barrier Precautions (EBP) signage revealed that everyone must clean their hands, including before entering and when leaving the room. The signage further revealed that providers and staff must wear gloves and gowns for high-contact resident care activities, including changing briefs, assisting with toileting..." On 9/16/25 at 4:03 PM, observed signage on Resident #4's door that revealed that Resident #4 was on Enhanced Barrier Precautions (EBP). Personal protective equipment (PPE) was observed outside of the resident's room. CNA #1 gathered supplies consisting of a brief, perineal wipes, and gloves. He entered the room with the supplies in hand and explained the care procedure to Resident #4. CNA #1 placed the brief and wipes directly on the table without a barrier in place. He applied gloves, placed the enteral feeding pump on hold, and used the bed control to adjust the bed in preparation for care. CNA #1 removed 10 perineal wipes from the pack and placed them on top of the pack on the table. He used three wipes to clean the right groin area front to back, folded the wipe, and wiped the same area again. He retrieved three additional wipes and cleaned the left groin area front to back. He then used the remaining wipes to clean the center of the vaginal area front to back one time and placed the soiled wipes on the bed. CNA #1 turned Resident #4 onto her left side to remove the soiled brief, placed the soiled brief on the bed, and applied a clean brief. CNA #1 did not wash his hands before, during, or after providing care. He did not wear a gown or change gloves during care. CNA #1 did not separate the labia to clean each side and the center individually and did not clean the rectal area. After completing care, CNA #1 removed one glove and adjusted the bed, picked up the soiled brief and gloves, disposed of them in the garbage can, removed his final glove, and exited the room without washing or sanitizing his hands. On 9/16/25 at 4:16 PM, an interview was conducted with	F0880		

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F0880 SS = D	Continued from page 15 CNA #1. CNA #1 stated he had been trained to place the feeding pump on hold during care. He confirmed that he did not wear a gown and did not wash his hands at any point during care. He confirmed that he did not perform perineal care correctly. CNA #1 stated he was nervous and forgot to follow procedure. He stated he should have had a bag for the soiled brief and acknowledged that his actions could cause Resident #4 to develop an infection. On 9/16/25 at 4:21 PM, an interview was conducted with Registered Nurse (RN) #2, Unit Manager for the B Unit. RN #2 confirmed that CNA #1 did not provide care properly and did not wear a gown before providing care. She stated CNA #1's actions constituted cross-contamination and exposed the resident to pathogens. On 9/16/25 at 5:08 PM, during an interview, the Executive Director (ED) stated she had heard about the perineal care provided by CNA #1. She stated the State Agency (SA) "should have picked anyone other than him to do care." The NHA further stated all CNAs should be able to perform care correctly. On 9/17/25 at 11:35 AM, during an interview the Director of Nursing (DON) stated CNA #1 should have followed EBP guidelines by wearing a gown. She stated CNA #1 should have used a barrier for supplies and performed hand hygiene before, during, and after care. The DON stated CNA #1 should not have touched the bed controls while wearing contaminated gloves. She further stated CNA #1 should have placed the soiled brief and wipes into a clear bag instead of on the bed, changed gloves, performed hand hygiene, and applied clean gloves before performing perineal care on the buttocks area and skin folds. The DON stated EBP is implemented to protect residents and staff from infection, and CNA #1's actions placed the resident at risk for numerous infections, including urinary tract infection. She stated her expectation is that all CNAs provide quality care and follow proper procedures when providing resident care. On 9/18/25 at 8:12 AM, during a post-survey telephone interview, Registered Nurse (RN) #3, Infection Preventionist (IP), stated CNA #1 should have washed his hands before, during, and after providing care. She stated staff are trained in EBP and should wear gowns when providing care to high-risk residents. She stated CNA #1 should have followed infection control training. RN #3 stated she has conducted several in-service trainings on infection control and EBP, and that these trainings are conducted to prevent the spread of	F0880		

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F0880 SS = D	Continued from page 16 infection and are expected to be followed. A record review of Resident #4's "Admission Record" revealed the facility admitted the resident on9/27/18 with diagnoses including Hemiplegia and Hemiparesis following unspecified cerebrovascular disease affecting the right side, Dysphasia following unspecified cerebrovascular disease, Aphasia following unspecified cerebrovascular disease, and Gastroesophageal Reflux Disease without esophagitis. A record review of Resident #4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident was unable to complete the interview.	F0880		